CMS Restraint and Seclusion (COPS) 2013
August 6, 2013  10-11:30 am EDT

Speaker

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Headlines You Don’t Want to See

Girl, 16, dies during restraint at an already-troubled hospital

BY BLYTHE BERNHARD * bbernhard@post-dispatch.com > 314-340-8129 AND JEREMY KOLLER * jkoller@post-dispatch.com > 314-340-8337 ©2010, St. Louis Post-Dispatch | Posted: Sunday, August 1, 2010 10:00 am | (135) Comments

The charge nurse found Alesis Evette Richie alone in a small room at SSM DePaul Health Center, motionless and sprawled facedown on a bean bag chair.

Minutes earlier, the 16-year-old foster child had tried to hit, scratch and bite staff members in the adolescent psychiatric ward. Two aides grabbed her.

Hospital Fined $71,000 For Man’s Restraint Death

By Dave Reynolds, Inclusion Daily Express

LEHIGHTOWN, PA—On October 4, 2004, Benjamin Wolfe died after being restrained facedown by several employees at Gnaden Huetten Memorial Hospital.

According to the Allentown (PA) Morning Call, the county coroner listed Wolfe’s cause of death as “excited delirium aggravated by a physical struggle”. The death certificate does not list a manner of death because state police are still investigating.

The state Department of Health has fined the hospital $71,000 after issuing a 38-page report saying it violated state law in Wolfe’s treatment.

The report showed that Wolfe, 29, who had bipolar disorder and asthma, was involuntarily committed to the hospital the day before his death because of outbursts he made toward a family member after he stopped taking his psychiatric medication.

The day he died, Wolfe was ‘hugging a peer and dancing around the nurses station’, refusing to leave the area, when a security guard was called in. Wolfe reportedly lunged at a nurse but was taken to the ground and held down by at least five employees — one of which worked for the housekeeping department and had no training in restraint techniques.

Wolfe was restrained for 17 minutes – even after one of the workers told the others to release him and after he had been injected with two different medications.

The report noted that the form of prone restraint was not approved, and that staff failed to try non-physical means to calm Wolfe.
DENVER -- Four patients at state facilities have died as a result of a controversial prone restraint technique, including one who died after the technique was banned in other state-regulated facilities, a CALL7 investigation found.

CALL7 Investigators have also learned that Pueblo grand jury is investigating recent deaths at the Colorado Mental Health Institute at Pueblo -- deaths first brought to light by 7News.

In the most recent death in August, Troy Geske, 41, was restrained face down with his arms at his side in the forensic unit of the CMHIIIP, records show. He was being treated for schizoaffective disorder and depression, and he also had burglary and sex abuse charges.
The Conditions of Participation CoP

- Regulations first published in 1986 with the current version published December 22, 2011
  - Many changes since then such as Anesthesia, Rehab and Respiratory Orders, IV Medications, Blood, Pharmacy, Visitation, timing of medications, privacy, standing orders, insulin pens, safe injection practices, and Telemedicine

- First published in the Federal Register and then CMS published Interpretive Guidelines and some of the standards have a survey procedure which is direction to the surveyors

1. Good way to keep up is sign up for the Federal Register
2. Hospitals should check the survey and certification website once a month for changes
3. Another good place to check monthly is the transmittal website
4. Have one person assigned to check these once a month

1. www.gpoaccess.gov/fr/index.html
3. www.cms.gov/Transmittals/01_overview.asp
CMS Survey and Certification Website

Policy & Memos to States and Regions

www.cms.gov/SurveyCertificationGenInfo/PMSR/list.asp#TopOfPage

CMS Transmittals

Overview

Program transmittals are used to communicate new or changed policies, and/or procedures that are being incorporated into a specific Centers for Medicare & Medicaid Services (CMS) program manual. The cover page (or transmittal page) summarizes the new changed material, specifying what is changed.

Downloads

There are no Downloads

Related Links Inside CMS

Internet-Only Manuals Table of Contents

Related Links Outside CMS
Location of CMS Hospital CoP Manual

Medicare State Operations Manual
Appendix

- Each Appendix is a separate file that can be accessed directly from the SOM Appendices Table of Contents, as applicable.
- The appendices are in PDF format, which is the format generally used in the IOM to display files. Click on the red button in the ‘Download’ column to see any available file in PDF.
- To return to this page after opening a PDF file on your desktop, use the browser “back” button. This is because closing the file usually will also close most browsers.


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Hospital CoP Manual Dec 22, 2011

State Operations Manual
Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals

Table of Contents

(Rev. 74, 12-02-11)
(Rev. 75, 12-02-11)
(Rev. 77, 12-22-11)
(Rev. 78, 12-22-11)

Transmittals for Appendix A

Survey Protocol

Introduction
- Task 1 - Off-Site Survey Preparation
- Task 2 - Entrance Activities
- Task 3 - Information Gathering/Investigation
- Task 4 - Preliminary Decision Making and Analysis of Findings
- Task 5 - Exit Conference
- Task 6 - Post-Survey Activities

New
Access to Hospital Complaint Data

- CMS issued Survey and Certification memo on March 22, 2013 regarding access to hospital complaint data
- Includes acute care and CAH hospitals
  - Does not include the plan of correction but can request
  - Questions to bettercare@cms.hhs.com
- This is the CMS 2567 deficiency data and lists the tag numbers
- Will update quarterly
  - Available under downloads on the hospital website at www.cms.gov
Access to Hospital Complaint Data

- There is a list that includes the hospital’s name and the different tag numbers that were found to be out of compliance
  - Highest number was on R&S with 362 hospitals cited for being out of compliance
- Two websites by private entities also publish the CMS nursing home survey data
  - The ProPublica website for LTC
  - The Association for Health Care Journalist (AHCJ) websites for hospitals
### Number of Patient Rights Violations

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<td>Care in a safe setting</td>
<td>Tag 133</td>
<td>309</td>
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<td>Patient Rights</td>
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<td>135</td>
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<td>Personal privacy</td>
<td>Tag 143</td>
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<td>Tag 119 and 120</td>
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<td>Tag 144)</td>
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<td>Tag 146</td>
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<td>Tag 133</td>
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<td>Tag 215-217</td>
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<td>Access to Medical Records</td>
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<td><strong>Total patient rights violations</strong></td>
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<td><strong>950</strong></td>
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### TJC Revised Requirements

- TJC hospital manual has many changes
- Brought their standards into closer compliance with the CMS CoP and many R&S changes
- Different standards for those who use TJC for deemed status and those who do not
  - Example: VA Hospitals do not use TJC for deemed status since they do not apply for Medicaid or Medicare
TJC Requirements

- Hospitals that use the Joint Commission (TJC) to get deemed status so they can get paid for Medicare and Medicaid patients
- Deleted PC.03.02.01 to 03.03.31 and added ten restraint standards which are based on CMS R&S standards
- Kept two remaining standards
- Same in manual along with standards in HR, PC, and RC chapters

TJC Restraint Standards

- HR.01.04.01 Hospital orients external law enforcement and security on difference between administrative and clinical seclusion and restraint
- PC.01.01.01 Hospital accepts patients if can take forensic patients (and handcuff and shackles are not restraints)
- PC.01.03.03 Hospitals with BH policies for Behavioral Management
TJC Restraint Standards

- Divided into hospitals that use TJC for deemed status and those that do not

- PC.03.05.01, 03.04.03, 03.05.03, 03.05.07, 03.05.09, 03.05.11, 03.05.13, 03.05.15, 03.05.17, 03.05.19,

- Most hospitals follow these 10 which are similar to CMS
CoPs

- Promulgated by Centers for Medicare and Medicaid Services (CMS)
- Contained in the Conditions of Participation (CoPs)
- Any facility seeking reimbursement for Medicaid/Medicare patients must follow
- Must follow even if Joint Commission (TJC), AOA (HFAP), CIHQ, or DNV Healthcare National Integrated Accreditation for Healthcare Organizations (NIAHO) accredited
CMS Complaint Manual

- Amended process 03-17-06 on investigations involving restraint and seclusion.
  - Updated to current R&S CoPs on July 10, 2009 and again on April 19, 2013.
  - CMS may terminate provider agreement and OIG can assess fines.

www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/itemdetail.asp?filterType=dual,%20date&filterValue=2|yyyyy&filterByDID=3&sortByDID=4&sortOrder=ascending&itemId=CMS060962&intNumPerPage=10
CMS Hospital CoPs

- Interpretative guidelines at www.cms.hhs.gov and look under state operations manual
- Appendix A, Tag A-0001 to A 1164 and 422 pages long and R&S starts at tag 154
- CAH hospital is Appendix W and does not have corresponding patient rights section or a section on R&S but must do something
  - CAH can adopt most but not all standards such as do not adopt reporting requirement to regional offices
- Interpretative guidelines updated 12/22/2011


Location of CMS Hospital CoP Manuals

Medicare State Operations Manual
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CMS Hospital CoP Manuals new address

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CMS Issues Final Regulation

- CMS publishes 165 page final regulations changing the CMS CoP and one change on restraints
- Published in the May 16, 2012 Federal Register
  - CMS publishes to reduce the regulatory burden on hospitals-more than two dozen changes
  - States will save healthcare providers over 5 billion over five years
- FR effective 60 days of publication so went into effect on July 16, 2012
- Changes to use of soft wrist restraints and reporting
  - Available at www.ofr.gov/inspection.aspx

May 16, 2012 Federal Register

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
42 CFR Parts 482 and 485
CMS-3244-F1
RIN 0930-AC90
Medicare and Medicaid Programs: Reform of Hospital and Critical Access Hospital Conditions of Participation
AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services.
ACTION: Final rule.

SUMMARY: This final rule revises the requirements that hospitals and critical access hospitals (CAHs) must meet to participate in the Medicare and Medicaid programs. These changes are an integral part of our efforts to reduce procedural burdens on providers. This rule reflects the Centers for Medicare and Medicaid Services (CMS) commitment to the general principles of the President’s Executive Order 13563, released January 18, 2011, entitled

www.federalregister.gov/articles/2012/05/16

- Nursing care plans: We have allowed hospitals the options of having a stand-alone nursing care plan or a single interdisciplinary care plan that addresses nursing and other disciplines.
- Administration of medications: We have allowed hospitals to have an optional program for patients to support persons on self-administration of appropriate medications. The program must address the safe and accurate administration of specified medications; ensure a process for medication dispensing; ensure the appropriate training and supervision; and document medication self-administration.
- Administration of blood transfusions and intravenous medications: We have eliminated the requirement for non-physician personnel to have special training in administering blood transfusions and intravenous medications and have revised the requirement to clarify that those who administer blood transfusions and intravenous medications do so in accordance with State law and approved medical staff policies and procedures. We believe that this clarification will make the requirement consistent with current
Patient Rights Restraint and Seclusion

- This included the use of two points wrist restraints that were used in critical care settings to prevent patients from removing central lines, NG, or ET tubes
- No research to show that this type of use ever caused a patient’s death
- CMS has changed, July 16, 2012, the interpretive guideline that we would not have to report and fill out the worksheet if a patient died in two-point wrist restraints and no use of seclusion was used

The hospital would not need to report to the CMS regional office

- Instead the hospital could just keep an internal log
- The log would include the patient’s name, date of birth, date of death, attending physician, primary diagnosis, and medical record number
- Name of practitioner responsible for patient could be used in lieu of attending if under care on non-physician practitioner
- CMS could request to review the log at anytime
- Would still require reporting of deaths within seven days
CMS Final Changes Memo

Patient Safety Brief
Emergency Medicine Patient Safety Foundation

CMS Final Hospital CoP Changes
Sue Dill Calloway RN MSN JD CPHRM
July 16, 2012

There are important changes that hospitals should know about. These changes were published in the Federal Register on May 16, 2012 and become effective on July 16, 2012 and affect every hospital that receives Medicare or Medicaid reimbursement. They make over two dozen changes to the hospital conditions of participation (CoPs). CMS will publish interpretive guidelines on these at a later date. Many of these standards have some impact on the emergency department.

 CMS said these changes would modernize the CoPs. In fact, CMS states these are the most significant changes in over two decades. CMS published the changes to reduce the regulatory burden on hospitals.

Standing Orders, Protocols, Order Sets

Patient Safety Brief
Emergency Medicine Patient Safety Foundation

CMS Requirements on Order Sets, Protocols, Preprinted Orders, and Standing Orders
Sue Dill Calloway RN MSN JD

There are three separate tag numbers that hospitals must review in order to understand the Center for Medicare and Medicaid Services (CMS) requirements for standing orders, protocols, and order sets. Additionally, CMS included information on this topic in the changes to the hospital CoPs which was published in the Federal Register and which became effective July 16, 2012. Any hospital that accepts Medicare or Medicaid reimbursement must follow the conditions of participation (CoPs) and they must be followed for all patients seen in the hospital.
CMS Changes to CoPs

- CMS publishes memo dated March 15, 2013 that summarizes changes to the CoPs for acute and CAH hospitals and is 228 pages
- Includes the interpretive guidelines to the changes in the Federal Register effective July 16, 2012
  - More than two dozen changes as discussed
- Includes changes to hospital outpatient PPS effective January 1, 2012
  - 76 FR 74122 and notice to patients that do not have a doctor in the hospital at all times, ED signage, clarifications, and changes in some tag numbers
Tag 213 and Tag 214 Amended

A-0213

§482.13(g) Standard: Death Reporting Requirements: - Hospitals must report deaths associated with the use of seclusion or restraint.

(1) With the exception of deaths described under paragraph (g)(2) of this section, the hospital must report the following information to CMS by telephone, facsimile, or electronically, as determined by CMS, no later than the close of business on the next business day following knowledge of the patient’s death:

(i) Each death that occurs while a patient is in restraint or seclusion.

(ii) Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion.

(iii) Each death known to the hospital that occurs within 1 week after restraint or seclusion where it is reasonable to assume that use of restraint or placement in seclusion contributed directly or indirectly to a patient’s death, regardless of the type(s) of restraint used on the patient during this time. “Reasonable to assume” in this context includes, but is not limited to, deaths related to restrictions of movement for prolonged periods of time, or death related to chest compression, restriction of breathing or asphyxiation....

(3) The staff must document in the patient’s medical record the date and time the death was:

Tag 214 Amended

A-0214

(Rev.)

§482.13(g) Standard: Death Reporting Requirements: - Hospitals must report deaths associated with the use of seclusion or restraint.

(2) When no seclusion has been used and when the only restraints used on the patient are those applied exclusively to the patient’s wrist(s), and which are composed solely of soft, non-rigid, cloth-like materials, the hospital staff must record in an internal log or other system, the following information:

(i) Any death that occurs while a patient is in such restraints.

(ii) Any death that occurs within 24 hours after a patient has been removed from such restraints.

(3) [The staff must document in the patient’s medical record the date and time the death was]

(ii) Recorded in the internal log or other system for deaths described in paragraph (g)(2) of this section.

(4) For deaths described in paragraph (g)(2) of this section, entries into the log or other system must be documented as follows:

(i) Each entry must be made not later than seven days after the date of death of the patient.

(ii) Each entry must document the patient’s name, date of birth, date of death, name of attending physician or other licensed independent practitioner who is responsible for the care
Feb 4, 2013 Proposed Changes

- CMS issues 114 pages related to proposed changes to the CMS CoP but none in R&S
- Hospital privileges for RD to write diet orders
- Board must consult with chief medical officer for each individual hospital rea quality of medical care provided in the hospital
- Confirmed each hospital must have separate medical staff
- MS can include PharmD, dieticians, PA, NP, etc.
- No requirement for board to include MD/DO

Feb 4, 2013 Proposed Changes

- Allow practitioners not on MS to order outpatient services
- Allow in-house preparation of radiopharmaceuticals on off hours without a physician or a pharmacist being present
- 3 changes for hospitals that are transplant centers
- ASC change for radiology services incident to the surgery
- Swing beds move to Part D so accreditation organizations can survey
- CAH P&P committee deleted requirement for non staff member requirement
Feb 4, 2013 Proposed Changes

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
42 CFR Parts 416, 447, 482, 483, 485, 486, 488, 491, and 493

[RIN 0938-AR49]

Medicare and Medicaid Programs; Part II - Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Proposed rule.

SUMMARY: This proposed rule would reform Medicare regulations that CMS has identified as unnecessary, obsolete, or excessively burdensome on health care providers and suppliers, as well as certain regulations under the Clinical Laboratory Improvement Amendments of 1988 (CLIA).

Restraints Start at Tag A-0154

A-0154

(Rev. 37, Issued: 10-17-08; Effective/Implementation Date: 10-17-08)

§482.13(e) Standard: Restraint or seclusion. All patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time.

Interpretive Guidelines §482.13(e):

The intent of this standard is to identify patients' basic rights, ensure patient safety, and eliminate the inappropriate use of restraint or seclusion. Each patient has the right to receive care in a safe setting. The safety of the patient, staff, or others is the basis for initiating and discontinuing the use of restraint or seclusion. Each patient has the right to be free from all forms of abuse and corporal punishment. Each patient has the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may not be used unless the use of restraint or seclusion is necessary to ensure the immediate physical safety of the patient, a staff member, or others. The use of restraint or seclusion must be discontinued as soon as possible based on an individualized patient assessment and re-evaluation. A violation of any of these patients' rights constitutes an inappropriate use of restraint or seclusion and would be subject to a condition level deficiency.
Restraints

- CAH do not have a patient rights section in their manual and not required to follow every rule in R&S section except Tag 1000 and 1001 rea visitation in Dec 2011
  - However, CAH must have P&P on R&S so they can either use TJC standards or select some or all of hospital ones
- Some CAH have adopted all of the standards if they are in system with regular hospitals

Restraint Worksheet

- CMS restraint worksheet is available on the internet\(^1\)
  - This is not an official OMB form
  - Cannot mandate hospital fill out but will save time on phone from them asking you for the information
- List of regional offices (to put in your P&P)\(^1\)
  - Must still notify regional office by phone the next business day and document this in medical record

[http://www.cms.hhs.gov/RegionalOffices/01_overview.asp](http://www.cms.hhs.gov/RegionalOffices/01_overview.asp)
Reporting Deaths Unless 2 Soft Wrist Restraints

HOSPITAL RESTRAINT/SECLUSION DEATH REPORT WORKSHEET

A. Hospital Information:
Hospital Name:  
CCN:  
Address:  
City:  State:  Zip Code:  
Person Filing the Report:  
Filer’s Phone Number:  

B. Patient Information:
Name:  Date of Birth:  
Medical Record Number:  Primary Diagnosis(es):  
Date of Admission:  Date of Death:  
Cause of Death:  

C. Restraint Information (check only one):
  While in Restraint, Seclusion, or Both
Patient Rights Restraint and Seclusion

- Currently there are about 50 pages of standards on restraint and seclusion (R&S)
- Currently CMS requires that every death that occurs if the patient is in restraint or within 24 hours of being in a restraint must be reported to CMS
- It also included reporting of any death that occurs within one week after R&S if the restraint is reasonable to assume contributed to or caused the death
- A report form had to be filled out and sent to the regional office
Patient Rights  Restraint and Seclusion

- Reporting section is currently at tag 213 and 214
- Requirement for death reporting still needs to be clarified
- AHA states it is problematic that CMS did not clarify the overall requirement for death reporting
- It makes more sense just to report the number of deaths caused by the restraint
- Some patients near death may be restrained for a number of reasons

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Patient Rights  Restraint and Seclusion

- CMS would keep the reporting of deaths for other types of restraints
  - For example, a patient dies and has a restraint jacket on
  - Note that most hospitals no longer use restraint jackets
- This would include notifying CMS by telephone, fax, or electronic the next business day
- It would include completing the restraint worksheet and sending it to the regional office
- CMS would allow hospital to fax report in or use electronic reporting (including email)
Restraint Guidelines Start at Tag 154

(Rev. 37, Issued: 10-17-08; Effective/Implementation Date: 10-17-08)

§482.13(e) Standard: Restraint or seclusion. All patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time.

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Restraint and Seclusion Rule #1

- Patients have a right to be free from physical or mental abuse, and corporal punishment
- Restraint and seclusion (R&S) will only be used when necessary and not as coercion, discipline, convenience or retaliation
- R&S only used for patient safety and discontinued at earliest possible time
- R&S guidelines from CMS apply to all hospital patients even those in behavioral health unit
Right to be Free from Restraint

- Hospitals should consider adding it to their patient rights statement if not already there
- Hospitals are required to provide a copy of their rights to inpatients
  - Staff must document or
  - Patients sign that they received a copy of their rights
  - Could also include information in admission packet
- If patient falls, do not consider using restraints as routine part of fall prevention (154)

Restraint Chair Used by Law Enforcement

- Emergency restraint chair
- Manufacturer states used for safe transports to hospital or court
- Safely restrains a combative or self destructive person
Rule 2 Hospital Leadership’s Role

- Like TJC, leadership (LD) is responsible for creating a culture that supports right to be free from R&S
- LD must make sure systems and processes are in place to eliminate inappropriate R&S
- LD assesses and monitors use thru PI process
- LD makes sure only used for physical safety of patient or staff
- LD ensures hospital complies with all R&S requirements (154)
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<td>Is there a physician's order for the restraint?</td>
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<td>Does the order identify the reason for the restraint?</td>
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<td>Does the order identify when the restraint is to be used?</td>
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<tr>
<td>Does the resident's chart indicate that restraints are checked every 30 minutes?</td>
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<td>Does the resident's chart indicate that restraints are released for 10 minutes at least every 2 hours?</td>
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<td>Does the resident's chart indicate that the resident is repositioned every 2 hours?</td>
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<td>Does the resident's chart indicate the medical need for the restraint?</td>
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<td>Does the resident's chart indicate that the physical/occupational therapist and interdisciplinary team evaluated the resident for alternative measures?</td>
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<td>Does the resident's chart indicate that all means were exhausted before using the restraint?</td>
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<td>Does the resident's chart contain evidence of any physical/mental decline related to use of the restraint?</td>
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<td>Does the MDS indicate use of the restraint?</td>
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</table>
Restraints Protocols

- CMS previously did not recognize or allow the use of protocols like Joint Commission (TJC) does
  - Protocols are no longer banned by the new regulations (168)
  - CMS prohibits standing orders for R&S (457)
- Must contain information for staff on how to monitor and apply protocols
  - Example: intubation protocol, specific criteria

Protocols

- If protocol includes use of intervention that meets definition of restraint, then need to have a separate order
  - This is basically the same process hospitals were doing previously
- Medical record must include documentation of individualized assessment, symptoms and diagnosis that triggered protocol
- Need MS involvement in developing and review and quality monitoring of their use
Restraint Standards

- If a patient becomes violent or has self destructive behavior (V/SD) in the ICU or ED, CMS has one set of standards that apply
  - Decision to use R&S is not driven from diagnosis but from assessment of the patient
  - CMS says it is not the department in which the patient is located but the behavior of the patient
  - TJC calls it behavioral health (BH) and non behavioral health (medical surgical patients)

Rule #3 Know Definition Tag A-0159

- New definitions
  - Physical restraint is any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely
  - Mechanical restraints are things like belts, restraint jackets, cuffs, or ties
    - Most hospitals no longer use restraint vests
  - Manual method is holding the patient
Restraint Definition

- A drug or medication when it is used as a restriction to manage the patient's behavior, or restrict the patient's freedom of movement

- Is not a standard treatment or standard dosage for the patient's condition (160)

- Note use of PRN drug is only prohibited if medication meets definition of drug used as a restraint

- Ativan for ETOH withdrawal symptoms is okay
Standard Treatment

- Standard treatment includes all the following:
  - Medication is within pharmacy parameters set by FDA and manufacturer for use
  - Use follows national practice standards
  - Used to treat a specific condition based on patient’s symptoms
  - Enables patient to be effective or appropriate functioning

Definition of Seclusion

- Seclusion is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving (162)
- Seclusion may only be used for the management of violent or self-destructive behavior (V/SD behavior) that jeopardizes the immediate physical safety of the patient, a staff member, or others
- Is not being on a locked unit with others
- Not for time out (162)
- It is not confining a patient to an area
Learning from Each Other

- Learning from Each Other-Success stories and Ideas for Reducing Restraint/Seclusion in Behavioral Health, Tools and forms in appendix

- Tool for behavioral health patients

- Published in 2003 by many organizations such as American Psychiatric Nurses Assn, National Association of Psychiatric Health Systems (NAPHS) with support of AHA
  - See NAPHS and AHA guiding principles

Restraint and Seclusion

- May only be used to manage V/SD behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others
- Time limits on length of order apply
- One hour face-to-face evaluation must be done (183)
- Therapeutic holds to manage V/SD patients are a form of restraint
- CMS eliminated term behavioral management and calls it violent and/or self destructive

Restraints Do Not Include

- Forensic restraints such as handcuffs, shackles, or other restrictive devices applied by law enforcement (0154)
  - Closely monitor and observe for safety reasons
- Prescribed orthopedic devices, surgical dressings or bandages, protective helmets (161)
- Padded side rails put up when on seizure precaution
- Special air mattress like beds with movement to prevent pressure ulcers (can put all four rails)
Restraints Do Not Include

- Methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests (161)
- Protecting the patient from falling out of bed
  - However, cannot use side rails to prevent patient from getting out of bed if patient can not lower
  - Striker beds are narrow carts and their use of side rails is not a restraint
  - Okay to put up side-rails up on bed that constantly moves to improve circulation or prevent skin breakdown

Restraints Do Not Include

- Or to permit the patient to participate in activities without the risk of physical harm
- IV board unless tied down or attached to bed
- Postural support devices for positioning or securing (161)
- Device used to position a patient during surgery or while taking an x-ray
Restraints Do Not Include

- Physically holding a patient to give child a shot to protect them from injury
  - Physically holding a patient for forced medications is a physical restraint but (161)
- Recovery from anesthesia is part of surgical procedure and medically necessary(161)
- Mitts unless tied down or pinned down or unless so bulky or applied so tightly patient can not use or bend their hand (161)
  - Mitts that look like boxing gloves are a restraint

So, Is This a Restraint?
Restraints Do Include

- Sheet tucked in so tightly patient cannot move (159)
- Use of enclosed bed or net bed if the patient cannot freely exit the bed
  - Not a restraint if zipper inside the bed and patient can get out of enclosure bed
- Freedom splint that immobilizes limb or a device that a patient cannot remove
- Physical holds for patients or to force psychotropic medications (161)
  - If patient consents to injection okay to hold if patient requests

Restraints

- Devices with multiple purposes such as side rails or Geri chairs, when they cannot be easily removed by the patient, and restrict the patient’s movement constitute a restraint
- If belt across patient in wheelchair and he can unsnap belt - it is not a restraint (159)
- If patient can lower side rails when she wants then it is not a restraint
  - Document this use of side rails
Restraints  Age Specific

- What about stroller safety belts, swing safety belts, high chair lap belts, raised crib rails, and crib covers (161)
  - Okay as long as age or developmentally appropriate
  - Use of these safety intervention must be addressed in your policy
  - Holding an infant or toddler is not a restraint

Weapons 154

- CMS does not consider the use of weapons on patients by hospital staff as being safe (154)
  - Could use on criminal breaking into building
- Weapons include pepper spray, mace, nightsticks, tazers, stun guns, pistols, etc.
- Okay if patient is arrested and used by law enforcement or non-employed staff according to state and federal laws
**Assessment**

- Should do comprehensive assessment
  - To identify medical problems that could be causing behavioral changes (0154) such as increased temp, hypoxia, low blood sugar, electrolyte imbalance, drug interactions etc.

- Assess to reduce risk of slipping, tripping or falling

- Use of restraint is not considered routine part of a falls prevention program (154)

**Determine Reason for R&S**

- Surveyor will look to see if there is evidence that staff determined the reason for the R&S (154)

- This should be documented and be specific

- Consider including on the order sheet
  - Danger to self
  - To maintain therapeutic environment such as to prevent patient from removing vital equipment
  - Physically attempting to harm others or property
  - Patient demonstrates lack of understanding to comply with safety directions
Reasons to Restrain

- Check all that apply:
  - Unable to follow directions
  - High risk of falls
  - Aggressive
  - Disruptive/combative
  - History of hip fracture/falls
  - Self injury
  - Interference with treatments
  - Removal of medical devices
  - Other: ____________________________
Rule #4

- Restraints can only be used when less restrictive interventions have been determined to be ineffective to protect the patient or others from harm (154, 164, 165,)

- Type or technique used must also be least restrictive

- Is what the patient doing a hazard

- Sundowners okay to walk or wander at night (154)

- Request from patient or family member is not sufficient basis for using if not indicated by condition of patient
Less Restrictive

- Need to make sure restraint intervention is necessary when applying to all patients
- Document that restraint is least restrictive intervention to protect patient safety based on assessment
- Document the effect of least restrictive intervention
- Provide training on this policy

Least Restrictive Restraint to More

<table>
<thead>
<tr>
<th>Side-rails</th>
<th>Net bed</th>
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<tbody>
<tr>
<td>Hand mittens</td>
<td>Soft extremity restraint</td>
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<tr>
<td>Lap board</td>
<td>Geri chair</td>
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<td>Roll belt/lap belt</td>
<td>Vest restraint</td>
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<tr>
<td>2-point soft restraint</td>
<td>3- or 4-point soft</td>
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<tr>
<td>Wrap IV site</td>
<td>Arm board</td>
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<td>Hand mitten</td>
<td>Soft wrist restraint</td>
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<tr>
<td>Freedom splint</td>
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</tbody>
</table>
Rule #5 Alternatives

- Alternatives should be considered along with less restrictive interventions (186)
- What are other things you could do to prevent using restraints?
- Try nonphysical interventions (200) like sitter or family member staying with patient
- Considering having a list of alternatives in the toolkit
- Alternatives include distractions such as watching video games or working on a laptop computer

## Consider Alternatives

<table>
<thead>
<tr>
<th>Bed sensor</th>
<th>Lower chairs</th>
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<tbody>
<tr>
<td>Close to nurse’s station</td>
<td>Allow wandering, if possible</td>
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<tr>
<td>Activity apron</td>
<td>Food/hydration</td>
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<tr>
<td>E-Z release hugger (if can release)</td>
<td>Low beds or mattress on floor</td>
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<tr>
<td>Reality orientation/familiarize patients to room</td>
<td>Encourage family visits</td>
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<tr>
<td>Verbal instructions/support</td>
<td>Pain/discomfort relief</td>
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<tr>
<td>Frequent visits with patient (hourly except night shift)</td>
<td>Diversion activities such as TV, CDs, DVDs, music therapy, picture books, games</td>
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<tr>
<td>Skin sleeves</td>
<td>Provide structured, quiet environment</td>
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<tr>
<td>Sensor alarm</td>
<td>Exercise/ambulate</td>
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<tr>
<td>Posey lateral/wedges</td>
<td>Toiletting routine</td>
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<tr>
<td>Access to call cord</td>
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</tbody>
</table>
Alternatives to Restraints

- Structured, quiet environment
- Exercise/ambulation
- Toileting routine
- Back rubs or massage therapist
- Low beds or mattress on floor
- Lower chairs
- Allow wandering, if possible
- Food/hydration

Alternatives to Restraints

- Be calm and reassuring
- Approach in non-threatening manner
- Wrap around velcro band, wheelchair (if can release then not a restraint)
- Relaxation tapes
- Photo albums
- Wander guard system
- Limit caffeine
Alternatives to Restraints

- Avoid sensory overload
- Fish tanks
- Tapes of families or friends
- Watching TV
- Behavior tracking for trends
- DVD or CD player with movies
- Punching bag
**Restrain Alternatives**

**For the WANDERER:**
1. Wandering stimulates circulation and promotes beneficial muscle activity and oxygenation of the cells. It also channels excess energy and anxiety. When possible allow the patient to wander on the unit observed by nursing personnel.
2. Engaging the patient in a structured, repetitive activity* will keep him busy and burn up restless energy.
3. For confused patient who wander because they become disoriented, hang a plastic picture frame containing familiar items outside room to provide orientation cues.
4. Since wanderers perceive breaks in carpet patterns or tiles as dangerous holes or puddles, place a mat in front of exit doorways or use a different pattern of carpet in front of exits or doorways that are "off limits."
5. Usually a patient wanders into another room in search of a bathroom. Frequent toileting, especially before bedtime and throughout the night. Many patients crawl out of bed because he is wet or his bladder is full.
6. At night, place call bell through the sleeve of the nightgown or pajama top. Place the bedside table, with water I reach. Providing a steady background noise such as a ticking clock, or special music can also help keep patient calm and in their rooms.
7. Make sure the patient's room temperature is comfortable and adjusted to suit the patient's comfort level.

**For the UNSTEADY PATIENT:**
1. Keep the room free from obstacles and make sure the bed is in low position.
2. Provide adequate lighting and night-light to increase the patient's visual perception and/or prevent hallucinations.
3. Check that the patient's walker, cane, or other assistive devices are within reach and are always in the same location. If the patient wears glasses, make sure they are on, and if he wears a hearing aid,
Restraints LIP Can Write Orders

- Rule #6 LIPs can write orders for restraints
- Any individual permitted by both state law and hospital policy, within the scope of their licensure, and consistent with granted privileges, may order restraint, seclusion
  - NP, licensed resident, PA, but not a medical student
  - Must specify who in your P&P (168)

Rule #7 Restraints Notify Doctor ASAP 170

- Any established time frames must be consistent with ASAP (not in three hours or six hours)
- Hospital MS policy determines who is the attending physician
- Hospital P&P should address the definition of ASAP (182,170) such as soon as feasible and in no event will it be over one hour
- RN or PA who does one hour face-to-face must notify attending physician and discuss findings (182)
- Be sure to document if LIP or nurse notifies physician
Rule #8 Restraints Order needed

- An order must be received for the restraint by the physician or other LIP who is responsible for the care of the patient (168)
  - Include in P&P use in an emergency
  - P&P to include category of who can order (PA, NP, resident, can not be med student)
- PRN order prohibited if for medication used as a restraint
- No PRN order for restraints (167, 169)
  - Three exceptions (169)

PRN Order 3 Exceptions

- Repetitive self-mutilating behavior (169), such as Lesch-Nyham Syndrome
- Geri chair - if patients requires tray to be locked in place when out of bed and patient is unable to get out of it without assistance
- Raised side rails if requires all 4 side rails to be up when the patient is in bed and patient unable to lower
- Do not need new order every time but still a restraint
Rule #9 Plan of Care

- Restraints must be used in accordance with a written modification to the patient's plan of care (166)
- Define the goal of the plan of care
- Use of restraint should be in modified plan of care
- Care plan should be reviewed and updated in writing
  - Within time frame specified in P&P 166

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**Physical Restraints: Development of Plan of Care**

<table>
<thead>
<tr>
<th>Key Steps</th>
<th>Key Elements</th>
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<tbody>
<tr>
<td>Establish Medical Necessity</td>
<td>Identify medical symptoms-full risk, behavior problems, and inability to treat a medical condition.</td>
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<tr>
<td>Develop Plan of Care</td>
<td>• Match goals and interventions with specific conditions</td>
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<td>• Coordinate plan and care with health care team, resident, family, caregivers</td>
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<tr>
<td>Implement Care Plan Interventions</td>
<td>• Alternatives to Physical Restraints</td>
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<tr>
<td></td>
<td>• Use of Physical Restraints</td>
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<td></td>
<td>• Least restrictive device</td>
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</tbody>
</table>
Restraints - Plan of Care

- Make sure plan reflects a loop of assessment, intervention, evaluation and reevaluation
- Make sure orders are time limited and is included in the plan of care
- For patient who is V/SD may want to debrief as part of plan of care but not mandated by CMS
- Debriefing not mandated anymore by TJC but may still want to do for behavioral patients only
  - Sometimes required by state law for behavioral health units
- Can add information on debrief to R&S toolkit

Rule #10 End at Earliest Time

- Restraints must be discontinued at the earliest possible time (154, 174)
  - Regardless of the time identified in the order
- If you discontinue and still time left on clock and behavior reoccurs, you need to get a new order
- **Temporary release** for caring for patient is okay (feeding, ROM, toileting)
- **A trial release** is a PRN order and not permitted (169)
Restraints - End at Earliest Time

- Restraints only used while unsafe condition exists
- Hospital policy should include who has authority to discontinue restraints (154, 174)
- Policy should describe the circumstances when restraints are to be discontinued and who is allowed to take them off
- Based on determination that patients behavior is no longer a threat to self, staff, or others (put this in your P&P)
- Surveyors will look at hospital policy
- Policy should a include when staff need to apply in an emergency

Rule #11 Assessment of Patient

- Staff must assess and monitor patient’s condition on ongoing basis (0154, 174, 175)
- Physician or LIP must provide ongoing monitoring and assessment also (175)
  - To determine if they can removed
- Took out word “continually” monitored except for V/SD patients
- Monitor at an interval determined by hospital policy
Assessment of Patient

- Intervals are based on patient's need, condition and type of restraint used (violent, SD or not)
- CMS doesn’t specify time frame for assessment nor does TJC now (many hospitals still have it in their P&P to do every two hours for medical patients and every 15 minutes for behavioral health patients)
  - Some state laws may mandate this for behavioral health units
- CMS says this may be sufficient but waking patient up every 2 hours in night might be excessive
- Document nursing assessments to show compliance with standard

Rule #12 Documentation

- Most hospital use special documentation sheet for assessment parameters, including frequency of assessment
  - Hospital policy should address each of these (175, 184)
- If doctor writes a new order or renews order need documentation that describes patients clinical needs and supports continued use (174)
- Fluids offered (hydration needs)
- Vital signs
- Toileting offered (elimination needs)
Removal of restraint and ROM and repositioning
- Mental status
- Circulation
- Attempts to reduce restraints
- Skin integrity
- Level of distress or agitation, etc.
- Behavior in descriptive terms to evaluate the appropriateness of the intervention (185)

Patient’s behavior and interventions used
- Patient states the Martians have landed and attempts to strike the nurses with his fists
- Patient attempts to bite the nurse on her arm
- Patient picks up chair and throws it against the window
- Clinical response to the intervention (188)
- Symptoms and condition that warranted the restraint must be documented (187)
Document Type of Restraint

TYPE OF RESTRAINT OR SECLUSION: (CHECK ALL THAT APPLY)
- □ 4 Side Rails
- □ Elbow Immobilizers
- □ Soft Wrist Restraint(s)
- □ Hand Mitt(s)
- □ Soft Wrist Restraint(s)
- □ Vest
- □ Soft Ankle Restrains(s)
- □ Papoose Board
- □ Other

CATEGORY OF ORDER: (CHECK ALL THAT APPLY)
- □ Initial order
- □ Continuation order
- □ Verbal order

I have assessed the patient, attempted or considered alternative(s), determined the need for restraints, and have notified and have obtained an order for the application of restraints.

Print Name of LIP
RN Signature Date Time
Print Name

LICENSED INDEPENDENT PRACTITIONER (LIP) to COMPLETE
(Physician, Resident, Advanced Practice Nurse, or Physician Assistant)

In accordance with Centers for Medicare and Medicaid (CMS) Conditions of Participation, Standard 482.13(c)(3)(ii) I have personally evaluated this patient (within one hour of application if this is an initial order) and have determined the need to use/continue the use of restraints/seclusion as specified by this order.

I have notified ____________________________ on ____________________________

Print Name of Attending Staff Physician
LIP Signature Date Time
Print Name

RESTRAINT FLOW SHEET

Key: (*) = Observation/intervention  (*) = See nurse's note/comments

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<td>Assent Early Release</td>
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<td>Trail Release</td>
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<td>Restraints Reapplied</td>
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<td>Observe q 15 Minutes (For Behavioral Health)</td>
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Initials of nurse

COMMENTS:

1. 7 Initals and Signature  7-3 Initials and Signature  3-11 Initials and Signature

* Loc/Orientation

Key: (*) = Observation/intervention  (*) = See nurse's note/comments

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Log and QAPI

- Hospitals take action thru QAPI activities
- Hospital leadership should assess and monitor R&S use to make sure medically necessary
- Consider log to record use - shift, date, time, staff who initiated, date and time each episode was initiated, type of restraint used, whether any injuries of patient or staff, age and gender of patient
<table>
<thead>
<tr>
<th>Criteria #</th>
<th>Criteria</th>
<th>Answer</th>
</tr>
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<tbody>
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<td>Documented evidence that non-physical interventions were initiated and ineffective prior to placing patient in restraint. (medication, quiet time, counseling and etc.)&lt;br&gt;Responsible Person:</td>
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<td>A Treatment Team Meeting was held to reassess the patient’s condition after each restraint episode.&lt;br&gt;Responsible Person:</td>
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<td>Documented evidence that the patient was asked for family to be notified, and with consent, staff attempts to contact the family to inform them of the restraint episode.&lt;br&gt;Responsible Person:</td>
<td>Yes / No / NA</td>
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<td>125</td>
<td>Documented evidence that the patient is continuously monitored by an assigned staff while in restraint (Restraint Monitoring Form).&lt;br&gt;Responsible Person:</td>
<td>Yes / No / NA</td>
</tr>
<tr>
<td>126</td>
<td>Any pre-existing medical conditions, physical disabilities and limitations that would place the patient in greater risk during restraint is identified.&lt;br&gt;Responsible Person:</td>
<td>Yes / No / NA</td>
</tr>
<tr>
<td>127</td>
<td>Documented evidence that every hour the limbs of the patient were loosened and are exercised, if necessary while in restraints.&lt;br&gt;Responsible Person:</td>
<td>Yes / No / NA</td>
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Rule #13 Use as Directed

- Restraints and seclusion must be implemented in accordance with safe, appropriate restraining techniques (167)
  - As determined by hospital policy
  - In accordance with state law
  - According to manufacturer’s instructions
- Include in your policy
- Fill out incident reports if there are injuries to patients

Rule #14 One Hour Rule

- The lightning rod for public comment!
- AHA sued CMS over this provision
- Time limits for R&S used to manage violent or self destructive behavioral and drugs used as restraint to manage them (178)
- Must see (face-to-face) and evaluate the need for R&S within one hour after the initiation of this intervention
One Hour Rule 178

- Big change is face-to-face evaluation can be done by physician, LIP or a RN or PA trained under 482.13 (f)
- TJC standards changed to allow RN to do one hour assessment
- Physician does not have to come to the hospital to see patient
  - Telephone conference may be appropriate

One Hour Rule 178

- Training requirements are detailed and discussed later
- Consider having a one hour face to face form that contains all the required elements
- Joint Commission has four-hour period of time for adults
  - To rule out possible underlying causes of contributing factors to the patient’s behavior
One Hour Rule Assessment 482.13 (f)

- Must see the patient face-to-face within one hour after the initiation of the intervention, unless state law more restrictive (179)
- Practitioner must evaluate the patient’s immediate situation
  - The patient’s reaction to the intervention
  - The patient’s medical and behavioral condition
  - The need to continue or terminate the restraint or seclusion
- Must document this information so have form (184)

One Hour Rule Assessment 482.13 (f)

- Include in evaluation, physical and behavioral assessment (179)
- Include a review of systems, behavioral assessment, as well as patient’s history
- Include drugs and medications and most recent lab tests
- Look for other causes such as drug interactions, electrolyte imbalance, hypoxia, sepsis, etc. that are contributing to the V/SD behavior
- Document change in the plan of care
- Train staff in these requirements (196)
Rule #15 Time Limited Orders

- Time limits apply - written order is limited to (171)
  - Four hours for adults
  - Two hours for children (9-17)
  - One hour for children under age 9
- Related to R&S for violent or self-destructive behavior for safety of patient or staff
- Same as for the Joint Commission (TJC)
LICENSING INDEPENDENT PRACTITIONER
ORDER FOR RESTRAINTS OR SECLUSION
USE BALL-PEN ONLY

RESTRAINT/SECLUSION ORDERS
FOR NON VIOLENT/ NON SELF-DESTRUCTIVE PATIENT

This restraint/seclusion order is valid for the duration ordered below and requires either a written or verbal order PRIOR to the application of restraints OR in emergency situations, WITHIN MINUTES after the application of restraints. If restraints are discontinued, for any reason other than to provide medical care, a NEW order must be initiated.

RN TO COMPLETE

CLINICAL JUSTIFICATION FOR RESTRAINTS OR SECLUSION (CHECK AT LEAST ONE)

☐ To prevent patient from removing vital equipment or therapies
☐ Other:

ALTERNATIVES ATTEMPTED: (MUST CHECK AT LEAST ONE)

☐ Encouragement of family visitation
☐ Repositioned patient
☐ Increased observation by staff
☐ No alternative/imminent risk
☐ Other:

TYPE OF RESTRAINT OR SECLUSION: (CHECK ALL THAT APPLY)

☐ 4 Side Rails
☐ Elbow Immobilizers
☐ Soft Wrist Restrains
☐ Hand Mitt(s)
☐ Vest
☐ Soft Ankle Restrains
☐ Papoose Board
☐ Other:

CATEGORY OF ORDER: (CHECK ALL THAT APPLY)

PHYSICIAN ORDERS

RERAINTS FOR VIOLENT/ SELF-DESTRUCTIVE PATIENT

Date of Restraint Order – Single Episode:

☐ An evaluation of patient’s condition and necessity for restraints must be completed within 1 hour of application of any type of restraint.

Alternatives to restraints attempted:

☐ Family involvement
☐ Relaxation techniques
☐ Verbal de-escalation
☐ Distraction
☐ Decreased stimulation

☐ NO ALTERNATIVES / IMMEDIATE RISK
☐ Anticipated dehydration
☐ Discomfort assessed/ relieved
☐ Sitter/1:1 Observation
☐ Other:

Date/Time of Face-to-Face (must be within 1 hour of restraints initiation):

Pre-existing Conditions that would present greater risk:

☐ Pre-existing medical conditions
☐ History of sexual abuse
☐ History of physical abuse
☐ Other

1. The patient’s immediate situation:

2. The patient’s reaction to intervention:

3. The patient’s medical and behavioral condition:

4. Do restraints need to be continued?  Yes – order will be obtained
☐ No – RN will remove restraint & document discontinuation on flowsheet

Authorized RN/MD/LP:

(Signature) (Date/Time)

☐ Restraint Plan discussed with multidisciplinary team and care plan is modified.
☐ Family notified of restraint policy and intent to apply restraints.

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Rule #16 Renew Order

- The original order for both violent or destructive may be renewed up to 24 hours (not daily but every 24 hours) and then physician needs to reevaluate
  - Each order for non-violent or non-destructive patients may be renewed as authorized by hospital policy (173)
- Nurses evaluate patients and share assessment with practitioner when order to renew is needed (171, 172) Unless state law if more restrictive
- After the original order expires, the MD or LIP must see the patient and assess before issuing a new order

Rule #17 Need Policy on R&S

- Surveyors will interview staff to make sure they know the policy (154)
- Surveyor to look at use of R&S and make sure it is consistent with the policy
- One person should go through R&S section one line at a time and make sure policy contains all sections
Rule #18 Staff Education

- New staff training requirements
- All staff having direct patient contact must have ongoing education and training in the proper and safe use of restraints and able to demonstrate competency (175)
- Yearly education of staff as when skills lab is done including agency nurses
- Document competency and training
- Hospital P&P should identify what categories of staff who are responsible for assessing and monitoring the patient (RN, LPN, Nursing assistant) (175)
Staff Education

- Patients have a right to safe implementation of R&S by trained staff (194)
- Training plays critical role in reducing use (194)
- Staff must not only be trained but must be able to demonstrate competency in:
  - Application of restraints
  - Monitoring of restraints
  - Providing care to patients in restraints

Staff Education

- Training must be done before performing any of these functions (196)
  - Training must occur in orientation
  - Training must occur on periodic basis consistent with hospital policy
  - Consider yearly during skills lab
Staff Education

- TJC PC.03.03.03 and PC.03.02.03 requires staff training and competency
- The hospital must require appropriate staff to have education, training, and demonstrated knowledge based on the specific needs of the patient population in at least the following:
  - Techniques to identify staff behaviors and patient behaviors that can trigger patient reactions
  - Events, and environmental factors that may trigger circumstances that require R&S

De-escalation

- Consider creating a document in your tool kit,
  - Not required by CMS or TJC except note 2013 PC.01.01.01 EP 4 and 24
  - Teach staff about tool kit
  - Use it for V/SD patients especially ones on a behavioral health unit
  - Many state departments of mental health require this on a behavioral health unit
- Methods of de-escalation
  - Avoid confrontation
  - Approach in a calm manner
Methods of De-escalation

- Active listening
- Validate feelings such as “you sound like you are angry”
- Some organizations have personal de-escalation plan that lists triggers such as not being listening to, feeling pressured, being touched, loud noises, being stared at, arguments, people yelling, darkness, being teased, etc.

![Personal De-escalation Plan](image-url)
Staff Education

- The use of non-physical intervention skills (200)
- Choosing the least restrictive intervention based on an individualized assessment of the patient's medical, or behavioral status or condition (201)
- The safe application and use of all types of R&S used in the hospital, including training in how to recognize and respond to signs of physical and psychological distress
  - Example - positional asphyxia, (202)

Staff Education

- Clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary (204)
- Monitoring the physical and psychological well-being of the patient who is restrained or secluded, including but not limited to, respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by hospital policy associated with the 1 hour face-to-face evaluation (205)
Staff Education

- The use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic recertification (206)
  - Patients in R or S are at higher risk for death or injury
  - Render first aid if patient in distress or injured

Staff Education

- Develop scenarios and develop first aid class to address these
- Staff must be qualified as evidenced by education, training, and experience
- Hospital must document in personnel records that the training and competency were successfully completed (208)
- Train security guards who respond to V/SD patients (many give 8 hour CPI course)
Training Cost and Time Spent

- National Association of Psychiatric Health Systems (NAPHS), initial training in de-escalation techniques, R&S P&P
  - Training on restraint and seclusion techniques range from 7 to 16 hours of staff and instructor time
  - Only a recommendation and not a mandate
  - If you can meet and educate on all standards in less time, will not be cited
- Hospitals need to revise their training programs annually which would take 4 hours every year
  - Can do literature search for new articles

Education Physicians and LIPs

- Physician and other LIP training requirements must be specified in hospital policy (176)
  - At a minimum, physicians and other LIPs authorized to order restraint or seclusion by hospital policy in accordance with State law must have a working knowledge of hospital policy regarding the use of restraint or seclusion
- Hospitals have flexibility to determine what other training physicians and LIPs need
Rule #19 Stricter State Laws

- The following requirements will be superceded by existing state laws that are more restrictive (180)
- State laws can be stricter but not weaker or they are preempted
- States are always free to be more restrictive
- Many of the state departments of mental health have state laws for patients that are on a behavioral health unit
  - Many of these state laws mandate de-escalation and debriefing even though CMS and TJC does not

Rule #20 1:1 Monitoring R&S

- For violent or self-destructive behavior that is danger to patient or others
- Can’t use restrain and seclusion together unless the patient is visually monitored in person face-to-face or by an audio and video equipment
- Person to monitor patient face-to-face or via audio & visual
  - Must be assigned and a trained staff member
  - Must be in close proximity to the patient (183)
1:1 Monitoring RS

- There must be documentation of this in the medical record.
- Documentation will include least restrictive interventions, conditions or symptoms that warranted R&S, patient’s response to intervention, and rationale for (continued) use.
  - This needs to be in hospitals P&P.
  - Modify assessment sheets to include this information.

Rule #21 Deaths  213 and 214

- Report any death associated with the use of restraint or seclusion.
  - Reporting to the Joint Commission is optional.
  - However, must still a through and credible root cause analysis.
  - The RCA must be done within 45 days.
- The Safe Medical Devices Act or SMDA also requires reporting if patient injured from a restraint device such as vest restraint.
  - Most hospitals no longer use a vest restraint because of safety concerns.
Rule #21 Deaths 0214  March 15, 2013

- The hospital must report to CMS regional office (not the state department of health) the following;
  - Report by telephone, fax, or electronically
  - No later than the close of business on the next business day after knowledge of the death
  - Each death that occurs while patient is in R&S
  - Report of occurs within 24 hours after the patient has been removed from restraint or seclusion
    - Except two soft wrist restraints as previously discussed

Death Reporting Requirements 213

- Report each death known to the hospital that occurs within one week after restraint or seclusion
  - Where it is reasonable to assume that use of restraint or placement in seclusion contributed directly or indirectly to a patient's death
  - Reasonable to assume” includes, but is not limited to deaths related to restrictions of movement for prolonged periods of time, or death related to chest compression, restriction of breathing or asphyxiation
  - Regardless of the type of restraint use on the patient
  - The staff must document in the medical record the date and time the death was reported to CMS
Death Reporting Requirements

- Hospitals should revise post mortem records to list this requirement
  - Hospital needs to have a process to be able to pick up restraint deaths
  - Need a designated person who can fill out the restraint death form and fax it to CMS
  - Need a process to document that this was done
  - CMS has standard form with information to include; DOB, date of death, patient name, diagnosis, etc.
- Hospitals need to rewrite their P&P to include these requirements

Death with 1 or 2 Soft Wrist Restraints 214

- If patient dies in a soft cloth material wrist restraint or within 24 hours of the death
  - Do not have to report to CMS Regional Office
  - Must document in the MR that the death was recorded in the internal log
  - Must complete internal log ASAP and never more than 7 days after the death
  - Internal log to include patient name, DOB, DOD, name of attending, MR number, and primary diagnosis
  - CMS can come and look at log if they want
Conclusions

- Every nurse, hospital or other healthcare provider should be familiar with these CMS standards, TJC standards and state laws on R&S that are applicable to your facility.
- Governing board should be educated.
- Leadership should be aware of their responsibilities.
- Staff should be well trained on R&S.
- P&P should be revised.
- Audit R&S to be sure you are doing this correctly.
The End! Questions?

- Sue Dill Calloway RN, Esq.
  CPHRM
- AD, BA, BSN, MSN, JD
- President of Patient Safety and
  Education Consulting
- Chief Learning Officer of the
  Emergency Medicine Patient Safety
  Foundation at www.empsf.org
- 614 791-1468
- sdill1@columbus.rr.com

www.naphs.org/rscampaign/Learning.pdf

Leadership and Culture

The Issue
The use of restraint and seclusion within an organization is inevitably tied to the vision and mission of its leadership. Whether adequate resources will be devoted, whether staff training will be prioritized or given true priority, how quickly changes can be instituted — in other words, all the issues that can lead to true change — are related to the priority and understanding of the facility’s clinical and administrative leadership.

Guiding Principle
“Seclusion and restraint use is influenced by the organizational culture of a setting that develops norms for how patients are treated. Seclusion and restraint reduction efforts must include a focus on necessary culture change.” (American Psychiatric Nurses Association Position Statement, May 2006.)

The Challenges
Clinical and administrative leaders have learned that there are enormous challenges associated with initiating and sustaining reduced use of restraint and seclusion. Dealing with potential for violence within a culture that simultaneously demands patient and staff safety, as well as less restrictive interventions, requires highly developed and coordinated clinical and leadership skills. Without careful management, fears about safety, loss of control, and polarization of views can detract from quality care, decrease job satisfaction, and threaten...
Learning from Each Other
Success Stories and Ideas for Reducing Restraint/Seclusion in Behavioral Health

SCDMH DIVISION OF INPATIENT SERVICES
RERAINT/SECLUSION DEBRIEFING FORM

PROGRAM: LODGE/UNIT: DEBRIEFING DATE/TIME

☐ SECLUSION ☐ RESTRAINT ☐ 4 POINT ☐ PERSONAL ☐ AMBULATORY RESTRAINT
This debriefing form must be completely filled out – No items are to be left blank or marked "N/A".

1. When was it noted that the patient's behavior was escalating? What were the first signs?

2. Describe de-escalation/well-being-preference options employed and patient response:

3. Describe the procedure, if any, that staff are to implement to prevent any recurrence of the use of restraint or seclusion.

4. Did patient experience trauma as a result of this incident? ☐ NO ☐ YES (explain)
Draft Example: Policy and Procedure on Debriefing for Seclusion and Restraint Reduction Projects

Policy: The use of seclusion and restraint (S/R) are high risk, problem prone interventions for both consumers and staff and are to be avoided whenever possible. S/R shall only be used in the face of imminent danger and when unavoidable. The use of S/R may cause trauma and re-traumatization in an already vulnerable group of persons and may also cause trauma, stress and injury for staff persons. Preventing the use of S/R is the organizational goal and this includes the mandatory use of debriefing procedures whenever an event of S/R does occur.

Debriefing procedures for the purpose of this policy are defined as two discrete events. The first is titled an “immediate post acute event analysis” and occurs immediately following the S/R episode and with all involved parties including those witnessing the event. The second debriefing procedure is a formal rigorous event analysis that takes place within 24 to 48 working hours following the S/R event and includes the participation of key professional, administrative and support staff as well as the consumer involved.

IMMEDIATE POST ACUTE EVENT ANALYSIS

Procedure:

1. When the S/R event code is called the onsite clinical supervisor or administrator/designee will immediately respond to the site. The responder will need to be an objective mid-level or senior level clinical staff member with training in S/R policy and procedures and should not be someone involved in the S/R event occurring at the time.

Debriefing

The Issue
The debriefing session is a powerful opportunity for everyone (including the patient) involved in a crisis episode to examine and share feelings and perceptions about the incident. It is an opportunity to review clinical data, to review the treatment plan, and to identify opportunities for performance improvement. The debriefing session must be highly individualized to the needs of the patient and must, either at the same time or in a separate session, provide the staff with the opportunity to process and learn from the event.

Guiding Principle
A debriefing should follow each episode of seclusion or restraint. The debriefing should include an examination of the factors leading to the use of seclusion or restraint, steps to reduce the potential future need for the seclusion or restraint of the patient, and the clinical impact of the intervention on the patient. (American Psychiatric Association/ American Academy of Child & Adolescent Psychiatry/National Association of Psychiatric Health Systems Joint Statement of General Principles on Seclusion and Restraint, May 1999.)

The Challenges
Regulatory and accrediting standards set prescriptive requirements that must be met without losing sight of the individualized needs of the patient. Clinical judgment is essential in determining the composition of the group involved in the debriefing sessions, timing, focus of the discussion, and goals. Ways of incorporating all involved persons (including, when appropriate, the patient community) must be considered. The special needs of children and patients with disabilities must also be considered.
**Six Core Strategies for Reducing Seclusion and Restraint Use®**

**Draft Example: Policy and Procedure on Debriefing for Seclusion and Restraint Reduction Projects**

**Kevin Huckshorn**

Policy: The use of seclusion and restraint (S/R) are high risk, problematic interventions for both consumers and staff and are to be avoided whenever possible. S/R shall only be used in the face of imminent danger and when unavoidable. The use of S/R may cause trauma and re-traumatization in an already vulnerable group of persons and may also cause trauma, stress and injury for staff persons. Preventing the use of S/R is the organizational goal and this includes the mandatory use of debriefing procedures whenever an event of S/R does occur.

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**IMMEDIATE POST ACUTE EVENT ANALYSIS**

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<td>Upon observation, does the resident match the assessment?</td>
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<td>If applicable, has a quarterly assessment been performed?</td>
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<td>Has the need for the restraint been reevaluated?</td>
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<td></td>
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<td></td>
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**Restraint Evaluation Worksheet/Data Collection Tool**

[Table showing structured data collection and assessment criteria]
### Restraint Review Form

**Medical Record Number:** _________  **Restraint Date:** _________  **Review Date** _________

**Complex/Unit:** ____________  **Review By:** ____________

**Restraint Time In:** _________  **Restraint Time Out:** _________

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<td>124</td>
<td>Documented evidence that the patient was asked for family to be notified,</td>
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<tr>
<td></td>
<td>and with consent, staff attempts to contact the family to inform them of</td>
<td></td>
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<tr>
<td></td>
<td>the restraint episode.</td>
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<td>125</td>
<td>Documented evidence that the patient is continuously monitored by an</td>
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<tr>
<td></td>
<td>assigned staff while in restraint (Restraint Monitoring Form).</td>
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<td>Yes /</td>
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<td>126</td>
<td>Any pre-existing medical conditions, physical disabilities and limitations</td>
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<td>that would place the patient in greater risk during restraint is identified.</td>
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<tr>
<td>127</td>
<td>Documented evidence that every hour the limbs of the patient were</td>
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<tr>
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<td>loosened and are exercised, if necessary while in restraints.</td>
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### Crisis Stabilization Unit
#### SECLUSION/RERAINT REPORT

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### Physical Restraints Crossword

**Answers on back page**

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81
Down
1. There are many ___ factors to using physical restraints.
2. Increased ___ can be an outcome of restraint use.
3. If a restraint is used, the ___ needs to be on the assessment.
4. Initiation of restraints occurs more frequently to residents that have some type of ___ impairment.
5. Residents are less ___ and less fatigued when not restrained.
6. Serious ___ can occur from restraint use.
7. Unrestrained residents exhibit greater ___ with ADLs.
8. If devices and restraints varied from shift to shift, the ___ must capture the differences.
9. ___ necessity needs to be established when using a physical restraint.
10. Restraints should never be used as a ___ for observation.

Across
2. Interdisciplinary documentation needs to support the ___ of Item 4.
11. Prior to implementing a restraint, all ___ need to be considered.
12. Facilities should ___ the restraint elimination process.
13. A resident’s ___ improves with no restraint use.
14. If a restraint needs to be used, ___ the possible interventions that have been attempted.
15. Awareness regarding physical restraint use in nursing homes has ___ over the past few years.
16. Staff should ___ on the use of physical restraints.
17. Residents with physical restraints need to be ___ at least monthly.
18. The success of restraint elimination program is dependent upon support from the ___.
19. Assessments need to reflect a ___ approach.
Provision of Care, Treatment, and Services (CAMH / Hospitals)

Restraint and Seclusion for Organizations that Do Not Use Joint Commission Accreditation for Deemed Status

Revised | December 24, 2009

Q. There seems to be some confusion regarding where the Acute Medical and Surgical (Nonpsychiatric) Care restraint standards, and the Behavioral Health Care Restraint and Seclusion Standards apply in a hospital. What determines which set of standards would apply?

A. The decision to use restraints for medical/surgical reasons or for behavioral health care reasons is not based on the treatment setting but on the situation the restraint is being used to address. The Behavioral Health Care Restraint and Seclusion Standards apply to all behavioral health settings in which restraint and seclusion is used for behavioral reasons, such as free-standing psychiatric hospitals, psychiatric units in general hospitals, and residential treatment centers that are owned by the hospital. Further, these standards also apply to restraint or seclusion that is applied for behavioral health reasons, regardless of where these patients are in the organization, ED, medical/surgical units, etc.

In the latter cases only select Behavioral Health Care Restraint and Seclusion Standards would apply if behavioral restraint was applied anywhere in a hospital, other than a psychiatric unit. The select standards are PC.03.03.11, PC.03.03.13, PC.03.03.15, PC.03.03.17, PC.03.03.19, PC.03.03.23, PC.03.03.25.

The acute medical and surgical care restraint standards would apply to medical care, post-surgical care, and in situations in which behavior changes are caused by medical conditions or symptoms, for example, for confusion or agitation. In such cases protective interventions may be necessary.

Q. If the Behavioral Health Care Restraint and Seclusion Standards, (or select standards if the patient is not on a psychiatric unit in a hospital), apply only when restraint or seclusion is for behavioral health reasons. How is behavioral health reason defined?

A. The simplest way to determine what is a behavioral health reason is first to determine what it is not. When restraints

TJC FAQ Restraint Standards

Provision of Care, Treatment, and Services (CAMH / Hospitals)

Restrain Standards for Hospitals Using The Joint Commission for Non-Deemed Status purposes

Updated | October 06, 2009

Q. What restraint standards apply to an organization that is not using Joint Commission accreditation for deemed status purposes?

A. Hospitals that do not use Joint Commission accreditation for deemed status purposes will comply with the restraint and seclusion Standards PC.03.02.01 through PC.03.03.31 in the Comprehensive Accreditation Manual for Hospitals. If an organization is a Critical Access Hospital or an organization is surveyed under the Behavioral Health Manual, they would follow the restraint/seclusion standards in those specific manuals.
Risk of Restraint Use

- During education consider discussing the risks of using restraints
- Death by strangulation or suffocation
- Pressure ulcer formation
- UTI, pneumonia, loss of muscle tone
- Decreased mobility with inability to stand or turn
- Stiffness, incontinence and constipation
- Reduced bone mass from lack of pressure on long bones

CMS Resources

- Comments and background information on the restraint and seclusion standard were published in the Federal Register on December 8, 2006
- Can be accessed off the internet at http://www.access.gpo.gov/su_docs/fedreg/a061208c.html
- Was effective January 8, 2007
- Additional changes October 2008 and June 5, 2009 are in the interpretive guidelines
Are you up to the challenge?