

Standards BoosterPak™ for Use of Restraint and Seclusion for Organizations Using Joint Commission Accreditation for Deemed Status



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Executive Vice President, Accreditation and Certification Operations
The Joint Commission
1 Renaissance Boulevard
Oakbrook Terrace, Illinois 60181

Standards BoosterPak™ for Use of Restraint and Seclusion for Organizations Using Joint Commission Accreditation for Deemed Status

Introduction

In its broadest context, restraint is the direct application of physical force to a patient, with or without the patient's permission to restrict his or her freedom of movement. The physical force may be human, mechanical devices, or a combination of the two. Restraint used for acute medical or surgical care is usually an adjunct to planned care and/or a component of an approved protocol.

A chemical restraint is 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 and is not a standard treatment or dosage for the patient's condition.

Restraint, if used improperly, can cause accidental injury or death. For these reasons, the hospital needs to limit its use of restraint to clinically appropriate and adequately justified situations. A physical and organizational environment that limits restraint use to clinically appropriate and adequately justified situations and that seeks to identify opportunities to reduce the risks associated with restraint use through preventive strategies, innovative alternatives, and process improvements is an environment that helps hospital staff focus on the patient's well-being. This requires planning and frequently new or reallocated resources, thoughtful education, and performance improvement. The result is an organizational approach to restraint that protects the patient's health and safety and preserves his or her dignity, rights, and well-being.*

There are standards in the *Comprehensive Accreditation Manual for Hospitals* related to the use of restraint for violent and/or self-destructive behavior as well as nonviolent/non-self-destructive behavior. Meeting these standards can be challenging. This BoosterPak was designed to offer clarification, implementation suggestions, and tips for those restraint standards with the highest incidence of Requirement for Improvement (RFI) observations.

Scope:

This BoosterPak will look at the following standards from the *Comprehensive Accreditation Manual for Hospitals* and *Comprehensive Accreditation Manual for Critical Access Hospitals 2013* manuals using Joint Commission accreditation for Centers for Medicare & Medicaid Services (CMS) deemed status purposes:

Applicability:

- Hospitals (HAP) using Joint Commission accreditation for deemed status need to follow PC.03.05 standards in the "Provision of Care, Treatment, and Services" (PC) chapter.
- Critical Access Hospitals (CAH) Distinct Part Units (DPUs) need to follow the same PC.03.05 standards.
- CAH without DPU need to follow PC.03.02.01 and PC.03.03.01.
- CAH with long term care (LTC) swing beds need to follow PC.03.02.09.

A. Description of Standard and Implementation Expectations

Section A1: Standard Rationale, Elements of Performance (EPs), Scoring Categories, Implementation Suggestions

Chapter: Provision of Care, Treatment, and Services (PC)

Standard Number: PC.03.05.01

Standard Text: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital uses restraint or seclusion only when it can be clinically justified or when warranted by patient behavior that threatens the physical safety of the patient, staff, or others.

Element of Performance:

1. For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital uses restraint or seclusion only to protect the immediate physical safety of the patient, staff, or others.

Examples:

1. The patient is pulling out his or her tubes and trying to disconnect from a ventilator and is a danger to self.
2. The patient is violent, hitting staff or peers, and is a danger to self or others.

Scoring Categories:

Criticality level: Direct (Δ)

Documentation required: No

Scoring category (A or C): A

Measure of Success: No

Identified risk area: Yes

Implementation Suggestions:

- A hospital policy for restraint/seclusion that includes definitions and examples of terminology may provide clarification and consistency for staff.
- Hospital policy for restraint/seclusion needs to indicate that a drug or medication is considered to be a restraint when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.
- Leaders might assign a nurse or licensed independent practitioner to review episodes of restraint/seclusion for appropriateness, safety, and quality issues.
- The leadership of the organization should constantly monitor performance data and trends in regard to the use of seclusion and restraint and their safe use (*see* PI.01.01.01, EP 4). When the measurement data indicate trends suggesting opportunity for improvement, the organization should respond.
- Each use of restraint or seclusion poses an inherent danger, both physically and psychologically, to the individual who is subject to the interventions and, often, to the staff who are involved in administering the seclusion or restraint. Each implementation of restraint and/or seclusion poses a high risk for the patient.
- Many alternatives to the use of restraint and seclusion have been developed and successfully implemented across a broad range of facilities. Alternatives to restraint might include removing the individual to a separate area away from other patients such as a "quiet room" or "comfort room."

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Tips:

- Train staff to work collaboratively with the patient to identify appropriate coping mechanisms to avoid the use of restraint or seclusion.
- Health care organizations should be proactive in reducing the use of restraint and seclusion. Admission assessments for behavioral health patients may include a psychiatric review of the patient's history such as abuse history, trauma, abandonment issues, psychiatric symptoms, and history of poor impulse control and/or anger management issues. Patients admitted for medical reasons may also have behavioral health issues, and this information should be included in the patient assessment. Understanding the whole patient may help reduce the use of restraint or seclusion. Triggers that may lead to increased agitation and individualized interventions are identified for teaching the patient how to problem-solve, learn relaxation responses, and make choices that will keep him or her and others safe.
- Based on the patient's clinical condition, the practitioner determines if the restraint order is for violent or self-destructive behavior or nonviolent, non-self-destructive behavior.

Health care organizations should be aware of practice parameters identified by professional groups for specific populations in regards to aggressive behavior and seclusion and restraint. These include the following:

- Child & Adolescent:
American Academy of Child & Adolescent Psychiatry: *Practice Parameter for the Prevention and Management of Aggressive Behavior in Child and Adolescent Psychiatric Institutions, With Special Reference to Seclusion and Restraint*
http://www.aacap.org/galleries/PracticeParameters/JAACAP_SR_2002.pdf
- Special Needs Population:
National Association of State Mental Health Program Directors: *Reducing the Use of Seclusion and Restraint PART II: Findings, Principles, and Recommendations for Special Needs Populations*
http://www.nasmhpd.org/docs/publications/archiveDocs/2001/Seclusion_Restraint_2.pdf
- American Psychiatric Nursing Association: *Seclusion & Restraint Position Statement* :
http://www.apna.org/files/public/APNA_SR_Position_Statement_Final.pdf
- National Association of Psychiatric Health Systems: *Learning from Each Other: Success Stories and Ideas for Reducing Restraint/Seclusion in Behavioral Health*
<https://www.naphs.org/resources/home.aspx>

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Chapter: Provision of Care, Treatment, and Services (PC)

Standard Number: PC.03.05.01

Standard Text: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital uses restraint or seclusion only when it can be clinically justified or when warranted by patient behavior that threatens the physical safety of the patient, staff, or others.

Element of Performance:

2. For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital does not use restraint or seclusion as a means of coercion, discipline, convenience, or staff retaliation.

Scoring Categories:

Criticality level: Direct (△)

Documentation required: No

Scoring category (A or C): A

Measure of Success: No

Identified risk area: No

Implementation Suggestions:

- Educate staff in the appropriate use of restraint/seclusion and that it is not used as a means of coercion, discipline, convenience, or staff retaliation.
- Include in the policy for restraint/seclusion examples of when restraint/seclusion would be appropriate.
- Leadership could consider providing behavioral examples of when immediate physical safety of the patient, staff, or others is present.
- Develop clear guidelines for staff in monitoring documentation for each use of restraint or seclusion. This includes the reasons given for the implementation of the restraint and/or seclusion, accurate and complete documentation, and ensuring that all policies and procedures were followed.

Tip:

- Restraint/seclusion is to be used only when the patient is a threat to self and/or others and alternatives are not effective. The reasons for implementation should be clearly documented.

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Chapter: Provision of Care, Treatment, and Services (PC)

Standard Number: PC.03.05.01

Standard Text: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital uses restraint or seclusion only when it can be clinically justified or when warranted by patient behavior that threatens the physical safety of the patient, staff, or others.

Element of Performance:

3. For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital uses restraint or seclusion only when less restrictive interventions are ineffective.

Scoring Categories:

Criticality level: Direct (△)

Documentation required: No

Scoring category (A or C): A

Measure of Success: No

Identified risk area: No

Implementation Suggestions:

- Develop a packet for restraint/seclusion that includes all the paperwork required per hospital policy when initiation of restraint/seclusion takes place. This packet can be used to audit any restraint/seclusion process to ensure that all the requirements for documentation are consistently met. A part of this packet can include a listing of less restrictive interventions that could be tried and found to be successful. This suggestion applies to both paper and electronic records processes.

Examples:

- If a patient has a history of previous seclusion or restraint, it is beneficial to know the patient's perception of what happened, his or her perception of being in restraint or seclusion. Engage the patient in an open and honest dialogue that respects his or her needs, issues, and concerns regarding avoiding the need for seclusion and restraint and keeping him or her safe.
- Engage the patient in a 1:1 dialogue.

Tips:

- The use of restraint/seclusion needs to be a trauma-sensitive approach particularly with children and adolescents, as well as with victims of abuse. Similar sensitivity should be utilized when dealing with the elderly, particularly those with dementia.
- Specific attention is given to risks associated with vulnerable persons, such as those who are obese or frail; those who have medical comorbidities, intellectual or developmental disabilities, or communication difficulties; and those with repeatedly challenging behaviors that may put them at risk for incomplete assessments.
- Consider measures to protect the person's confidentiality, privacy, and dignity.

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Chapter: Provision of Care, Treatment, and Services (PC)

Standard Number: PC.03.05.01

Standard Text: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital uses restraint or seclusion only when it can be clinically justified or when warranted by patient behavior that threatens the physical safety of the patient, staff, or others.

Element of Performance:

4. For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital uses the least restrictive form of restraint or seclusion that protects the physical safety of the patient, staff, or others.

Scoring Categories:

Criticality level: Direct (△)

Documentation required: No

Scoring category (A or C): A

Measure of Success: No

Identified risk area: No

Implementation Suggestions:

- For behavioral health care: Objects should not be placed on or over a patient's face during restraint/seclusion procedures. In situations in which precautions need to be taken to protect staff against biting or spitting during restraint/seclusion episodes, staff should wear bite gloves, masks, or clear face shields when possible for purposes of infection control. Some institutions provide material made from Kevlar for staff to wear on their arms and hands for patients who bite and scratch.
- Patients who are known or reasonably believed to have a history of physical or sexual abuse, or in the case of patients with hearing impairments who would be unable to communicate without the use of their hands, an explanation of why restraint is the most appropriate intervention under the circumstances could be included in the patient's medical record.
- If a patient can communicate only with his or her hands, the patient's hands need to be released periodically to enable the patient to communicate his or her needs. This can be completed every time the patient is assessed by staff.

Example:

- Family may be at the bedside only if a patient is in non-violent, non-self destructive restraints. Families should not be at the bedside of a patient in violent, self destructive restraints. The patient may be moved closer to the nursing station for monitoring. The patient may be placed on 1:1 monitoring.

Tip:

- For behavioral health care: Some state guidelines allow only manual restraint for children less than 9 years of age. Please check your state's laws and regulations and your state's mental health code.

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Chapter: Provision of Care, Treatment, and Services (PC)

Standard Number: PC.03.05.01

Standard Text: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital uses restraint or seclusion only when it can be clinically justified or when warranted by patient behavior that threatens the physical safety of the patient, staff, or others.

Element of Performance:

5. For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital discontinues restraint or seclusion at the earliest possible time, regardless of the scheduled expiration of the order.

Scoring Categories:

Criticality level: Direct (△)

Documentation required: No

Scoring category (A or C): A

Measure of Success: No

Identified risk area: No

Implementation Suggestions:

- For behavioral health care: Patients who are sleeping may be deemed to be no danger to themselves or others. In such situations, the removal of restraints or discontinuation of seclusion might be considered.
- To assist in making the determination to discontinue restraint/seclusion, it is helpful for the physician to note in the order a description of the specific behavior of the patient that resulted in the determination that restraint/seclusion was necessary and the criteria used to discontinue the restraint/seclusion.
- For behavioral health care: Organizations may consider a process in which restraint/seclusion is discontinued based on the assessment that the behavioral criteria for release are met. This can be a single criterion or a group of criteria.

Tips:

- Individualized indicators that merit review and evaluation for release may include behaviors that were not specified in the release criteria but may indicate readiness for release. The evaluation may also include behavior that indicates that the use of restraint/seclusion is increasing agitation or dangerous behavior. Patient assessment and evaluation should focus on determining if the patient is no longer a threat to self or others.
- To assist staff in evaluation, consider developing a restraint/seclusion physician order sheet that includes reasons for restraint/seclusion, time of initiation and maximum duration, type of restraint, and behavioral criteria for release. A key decision factor for release is the reason for initiation of the intervention.

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Chapter: Provision of Care, Treatment, and Services (PC)

Standard Number: PC.03.05.03

Standard Text: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital uses restraint or seclusion safely.

Element of Performance:

1. **For hospitals that use Joint Commission accreditation for deemed status purposes:** The hospital implements restraint or seclusion using safe techniques indentified by the hospital's policies and procedures in accordance with law and regulation.

Scoring Categories:

Criticality level: Direct (△)

Documentation required: No

Scoring category (A or C): A

Measure of Success: No

Identified risk area: Yes

Implementation Suggestions:

- Ensure that the institution has a well-defined policy differentiating use of nonviolent, non-self-destructive restraint that promotes medical recovery versus restraint for violent or self-destructive behavior.
- Refer to Standard PC.03.05.15, EP 1, for more documentation requirements.
- All clinical staff demonstrate competency in alternatives; one alternative may be de-escalation techniques. Staff would be trained in alternative techniques before they participate in a restraint or seclusion episode (*see* PC.03.05.17).
- Education is provided to all new clinical staff and any staff who will participate in a restraint/seclusion procedure and at a periodic interval thereafter (*see* PC.03.05.17).
- Although debriefings are no longer required for deemed hospitals, medical and clinical leaders should consider staff debriefings with implementation of seclusion or restraint. These provide some of the best opportunities for supervision, teaching, and professional growth and improvement.

Tip:

- Organizations may want to review the training course offered to staff to ensure that safe techniques are being taught in the class.

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Chapter: Provision of Care, Treatment, and Services (PC)

Standard Number: PC.03.05.03

Standard Text: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital uses restraint or seclusion safely.

Element of Performance:

2. For hospitals that use Joint Commission accreditation for deemed status purposes: The use of restraint and seclusion is in accordance with a written modification to the patient's plan of care.

Scoring Categories:

Criticality level: Indirect

Documentation required: No

Scoring category (A or C): C

Measure of Success: Yes

Identified risk area: No

Implementation Suggestions:

- The use of restraint and seclusion is in accordance with a written modification to the patient's plan of care. The plan of care needs to be modified as soon as the patient is placed in restraints so all staff are aware of the goals and objectives of the restraint/seclusion episode. The use of restraint/seclusion indicates a change in the patient's plan of care and is based on the assessment and evaluation of the patient.
- A nonphysical response to manage behavioral emergencies is contingent on information in the treatment plan that will assist staff in interventions to avoid the use of physical responses.
- For behavioral health care: Accurate assessments of the evolving behavioral emergency and knowledge of the person's preferred methods to help him or her manage the behavior should be considered.
- For behavioral health care: Consider providing staff with knowledge of an array of communication techniques and de-escalation methods, including use of reduced stimulation, supportive limit setting, problem solving, and physical presence of staff.
- It is important to value the person's perceptions, his or her treatment priorities, and his or her active participation in developing treatment plans.
- For behavioral health care: Apply knowledge of past efforts that were effective to decrease the level of intensity of the person's response to situations that trigger adverse behaviors.

Tips:

- Documentation in the plan of care must include any use of restraint or seclusion at the time they become necessary and at intervals defined by hospital policy.
- Documentation of treatment modifications, alternatives to restraint use, or escalation in type of restraint use must be reflected in the medical record at the time such an assessment is made.
- Update treatment plans whenever a restraint/seclusion episode occurs so that the necessary information is available to staff in assisting with interventions if another episode should occur.
- Plans of care are multidisciplinary. There should be evidence of input from the physician, nurses, and other allied staff involved in the treatment of the patient. When changes are made in treatment planning and interventions for safety management, the staff should attempt to involve the patient in this process and communicate changes to staff involved in patient care.

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Chapter: Provision of Care, Treatment, and Services (PC)

Standard Number: PC.03.05.05

Standard Text: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital initiates restraint or seclusion based on an individual order.

Element of Performance:

1. For hospitals that use Joint Commission accreditation for deemed status purposes: A physician, clinical psychologist, or other authorized licensed independent practitioner primarily responsible for the patient's ongoing care orders the use of restraint or seclusion in accordance with hospital policy and law and regulation.

Note: *The definition of "physician" is the same as that used by the Centers for Medicare & Medicaid Services (CMS).*

Scoring Categories:

Criticality level: Indirect

Documentation required: No

Scoring category (A or C): A

Measure of Success: No

Identified risk area: No

Implementation Suggestions:

- For behavioral health care: When manual restraint is used for the purpose of facilitating the safe administration of court-ordered or emergency medications, the use of force must have a physician's order for the application of the restraint. If physical holding for forced medication is used with a violent patient, the one-hour face-to-face evaluation is required. Please refer to CMS Condition of Participation (CoP) §482.13(e)(1)(i)(C), which indicates that staff are expected to use the least restrictive method of administering medication to avoid or reduce the use of force whenever possible.
- Mechanical supports are devices used to achieve proper body position, balance, or alignment as to allow greater freedom of mobility than would be possible without the use of such a mechanical support and are not considered restraints. Examples include immobilization of a fracture and patients who lack the ability to walk without leg braces or to sit upright without neck, head, or back support. A physician's order would be implemented for any of these devices. A restraint order would not be needed because these devices are not being used as a restraint but as a mechanical support. Please see CoP §482.13(e)(1)(i)(C).

Tips:

- Hospital policy must clearly define who may order restraint or seclusion.
- The order shall specify the type of intervention to be used and the criteria for discontinuation unless the restraint is for violent or self-destructive behavior. The order shall also specify any special care or monitoring instructions. Other required ordering elements may also be considered, with the goal of standardizing the approach to restraint and seclusion in light of the organization's mission and vision.
- Consider requiring orders to specify the conditions for the patient's release prior to the expiration of the order. Examples might include when the patient is asleep (with the understanding that the patient may possibly become violent again when awakening); when there is an absence of verbal threats; and when the patient has stopped struggling against the restraint.

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Chapter: Provision of Care, Treatment, and Services (PC)

Standard Number: PC.03.05.05

Standard Text: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital initiates restraint or seclusion based on an individual order.

Element of Performance:

2. For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital does not use standing orders or PRN (also known as “as needed”) orders for restraint or seclusion.

Scoring Categories:

Criticality level: Indirect

Documentation required: No

Scoring category (A or C): A

Measure of Success: No

Identified risk area: No

Implementation Suggestion:

- Staff need to be educated that restraint/seclusion can be applied only when there is a specific order to do so.

Tips:

- Hospital policy related to the ordering of restraint or seclusion must clearly prohibit the use of PRN or standing orders.
- A trial release constitutes a PRN use of restraint or seclusion and therefore is not permitted by this regulation. When a staff member ends a restraint or seclusion intervention, the staff has no authority to reinstitute the intervention without a new order.
- All staff need education that the use of PRN orders for restraint/seclusion is never allowed.

Exceptions:

- Geri chair: If the patient requires the use of a Geri chair with the tray locked in place in order for the patient to safely be out of bed, and given that a patient may be out of bed in a Geri chair several times a day, it is not necessary to obtain a new order each time.
- Raised side rails: If the patient’s status requires that all bedrails be raised while the patient is in bed, it is not necessary to obtain a new order each time the patient is returned to bed after being out of bed. If the patient is on a stretcher, recovering from anesthesia, and the side rails are up, that is not considered a restraint. If the patient is sedated or experiencing involuntary movements, and the side rails are up, that is not considered a restraint. If the side rails are up and they prevent a patient from exiting the bed, it *is* considered a restraint.
- A restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort).
- For behavioral health care: Interventions used to prevent patient from repetitive self-mutilation

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- For behavioral health care: Repetitive self-mutilating behavior: If a patient is diagnosed with a chronic medical or psychiatric condition, such as Lesch-Nyham Syndrome, and the patient engages in repetitive self-mutilating behavior. Specific parameters must be established in the treatment plan. Because the use of restraints to prevent self-injury is needed for these types of rare, severe, medical and psychiatric conditions, the specific requirements (1-hour face-to-face evaluation, time-limited orders, and evaluation every 24 hours before renewal of the order) for the management of violent or self-destructive behavior do not apply.

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Chapter: Provision of Care, Treatment, and Services (PC)

Standard Number: PC.03.05.05

Standard Text: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital initiates restraint or seclusion based on an individual order.

Element of Performance:

3. For hospitals that use Joint Commission accreditation for deemed status purposes: The attending physician or clinical psychologist is consulted as soon as possible, in accordance with hospital policy, if he or she did not order the restraint or seclusion.

Note: *The definition of “physician” is the same as that used by the Centers for Medicare & Medicaid Services (CMS).*

Scoring Categories:

Criticality: Indirect

Documentation required: No

Scoring category (A or C): A

Measure of Success: No

Identified risk area: No

Implementation Suggestions:

- If the application of a restraint is an emergency, the restraint can be applied and a physician order obtained either during the emergency application or immediately afterward (within a few minutes).
- The use of restraint/seclusion is always subject to a physician’s written order. Restraint orders for violent, self-destructive behavior require a one-hour face-to-face examination of the patient. This evaluation may be performed by a specially trained nurse or physician assistant who must then consult with the attending physician, clinical psychologist, or other licensed independent practitioner responsible for the care of the patient as soon as possible after the evaluation, and as determined by hospital policy. The circumstances leading to the restraint/seclusion should be documented in the physician’s notes, along with the preventive measures taken prior to the initiation of restraint/seclusion (*see* PC.03.05.15).
- Whenever any elements of the examination cannot be performed due to the condition of the patient, or the patient’s refusal, an explanation of the omission and the physician’s clinical observations of the patient shall be recorded.

Tips:

- Immediately after the application of the restraint/seclusion, the patient should be assessed to ensure that the intervention was safely and correctly applied without undue harm or pain to the patient.
- The restraint application should be checked to ensure that the restraints are not too tight or obstructing the patient’s respiration and circulation.

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Chapter: Provision of Care, Treatment, and Services (PC)

Standard Number: PC.03.05.05

Standard Text: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital initiates restraint or seclusion based on an individual order.

Element of Performance:

4. For hospitals that use Joint Commission accreditation for deemed status purposes: Unless state law is more restrictive, orders for the use of restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, staff, or others may be renewed with the following limits:
- 4 hours for adults 18 years of age or older
 - 2 hours for children and adolescents 9 to 17 years of age
 - 1 hour for children under 9 years of age

Orders may be renewed according to the time limits for a maximum of 24 consecutive hours.

Scoring Categories:

Criticality level: Indirect

Documentation required: No

Scoring category (A or C): C

Measure of Success: Yes

Identified risk area: No

Implementation Suggestions:

- Restraint/seclusion shall be used only as necessary to protect the patient and/or others. The time limits noted in the standard are maximums, and less time should be the goal whenever possible.
- Check state laws and mental health code regarding time limits on restraint/seclusion for any setting.
- Please *see* maximum time limits above and in PC.03.05.05, EP 5.

Tips:

- Hospital policy must clearly state the process for renewal, which includes reevaluation, as well as by whom these tasks may be performed.
- Documentation of renewal for restraint use must include reevaluation.
- Include and document education of staff regarding the maximum time period of restraint/seclusion.

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Chapter: Provision of Care, Treatment, and Services (PC)

Standard Number: PC.03.05.05

Standard Text: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital initiates restraint or seclusion based on an individual order.

Element of Performance:

5. For hospitals that use Joint Commission accreditation for deemed status purposes: Unless state law is more restrictive, every 24 hours, a physician, clinical psychologist, or other authorized licensed independent practitioner primarily responsible for the patient's ongoing care sees and evaluates the patient before writing a new order for restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, staff, or others in accordance with hospital policy and law and regulation.

Note: *The definition of "physician" is the same as that used by the Centers for Medicare & Medicaid Services (CMS).*

Scoring Categories:

Criticality level: Direct (△)

Documentation required: No

Scoring category (A or C): A

Measure of Success: No

Identified risk area: Yes

Implementation Suggestions:

- If, based on the results of the physician's examination, the physician determines that continued use of restraint or seclusion is indicated, he or she shall write an order for the procedure consistent with hospital policy. Time frames shall not exceed those delineated in EP 4 in this standard for restraint/seclusion for violent/self-destructive behavior.
- The physician reviews the patient's existing medication orders and shall assess the need for modifying such orders during the period of restraint/seclusion. Documentation of this medication review shall be included in the patient's clinical record.

Tips:

- Staff assessment and evaluation are critical to determine if the patient still meets the criteria to remain in restraints.
- Staff need to be educated that, if at any time after application of restraint/seclusion, clinical assessment indicates that the patient no longer represents an imminent danger to self or others, release shall be immediate.

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Chapter: Provision of Care, Treatment, and Services (PC)

Standard Number: PC.03.05.05

Standard Text: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital initiates restraint or seclusion based on an individual order.

Element of Performance:

6. For hospitals that use Joint Commission accreditation for deemed status purposes: Orders for restraint used to protect the physical safety of the nonviolent or non–self-destructive patient are renewed in accordance with hospital policy.

Scoring Categories:

Criticality level: Direct (△)

Documentation required: No

Scoring category (A or C): A

Measure of Success: No

Identified risk area: Yes

Implementation Suggestion:

- The policy for restraint/seclusion contains specific language as to the renewal of the restraint order for nonviolent, non-self-destructive behavior.

Tips:

- Examples of restraints that are used for the nonviolent or non-self-destructive are listed in the hospital's policy.
- Staff are educated in the use and can demonstrate correct application of restraint/seclusion per PC.03.05.17.
- Organizations may want to review performance improvement data to determine how long patients are in restraints, what alternatives have been tried, and what alternatives have been successful. This information can be included in staff education.

Standards BoosterPak™ for Use of Restraint and Seclusion for Organizations Using Joint Commission Accreditation for Deemed Status

Chapter: Provision of Care, Treatment, and Services (PC)

Standard Number: PC.03.05.07

Standard Text: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital monitors patients who are restrained or secluded.

Element of Performance:

1. For hospitals that use Joint Commission accreditation for deemed status purposes: Physicians, clinical psychologists, or other licensed independent practitioners or staff who have been trained in accordance with 42 CFR 482.13(f) monitor the condition of patients in restraint or seclusion. (See also PC.03.05.17, EP 3)

Note: *The definition of “physician” is the same as that used by the Centers for Medicare & Medicaid Services (CMS).*

Scoring Categories:

Criticality level: Direct (A)

Documentation required: No

Scoring category (A or C): A

Measure of Success: No

Identified risk area: Yes

Implementation Suggestions:

- Consider the required education as a part of the orientation process.
- Strategies to accomplish education may include a self-learning packet that contains the hospital’s policy, the expectations of documentation, and the forms that are to be used. A completed sample as required within the organization would help to clarify expectations. One question an organization may ask, How do I know that staff are competent to apply restraints/seclusion to any patient in any setting? (See also PC.03.05.17.)
- Consider a posttest to meet the requirements of demonstrating that the learning has taken place.
- The use of tip cards that the physicians, clinical psychologists, licensed independent practitioners, or staff can refer to when involved in writing an order or documenting an evaluation would be helpful reminders.

Tips:

- Organizations must determine the frequency of monitoring for a patient in restraints/seclusion. The patient may need more frequent monitoring than every 15 minutes or every 2 hours. The monitoring is based on patient assessment, the type of restraint applied, and the safety of the patient.
- Staff must be knowledgeable regarding the time frames for offering fluids and nourishment, providing for other general care needs such as elimination and range-of-motion exercises, and completing assessment and documentation of vitals, skin integrity, intake/output, and mental status of the patient who is being monitored in restraints/seclusion.

Standards BoosterPak™ for Use of Restraint and Seclusion
for Organizations Using Joint Commission Accreditation for Deemed Status

Chapter: Provision of Care, Treatment, and Services (PC)

Standard Number: PC.03.05.09

Standard Text: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has written policies and procedures that guide the use of restraint or seclusion.

Element of Performance:

1. For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital's policies and procedures regarding restraint or seclusion include the following:

- Physician, clinical psychologist, and other authorized licensed independent practitioner training requirements
- Staff training requirements
- The determination of who has authority to order restraint and seclusion
- The determination of who has authority to discontinue the use of restraint or seclusion
- The determination of who can initiate the use of restraint or seclusion
- The circumstances under which restraint or seclusion is discontinued
- The requirement that restraint or seclusion is discontinued as soon as is safely possible
- A definition of restraint in accordance with 42 CFR 482.13(e)(1)(i)(A–C)
- A definition of seclusion in accordance with 42 CFR 482.13(e)(1)(ii)
- A definition or description of what constitutes the use of medications as a restraint in accordance with 42 CFR 482.13(e)(1)(i)(B)
- A determination of who can assess and monitor patients in restraint or seclusion
- Time frames for assessing and monitoring patients in restraint or seclusion

Note 1: *The definition of restraint per 42 CFR 482.13(e)(1)(i)(A–C) is as follows:*

42 CFR 482.13(e)(1) Definitions. (i) A restraint is— (A) 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; or 42 CFR 482.13(e)(1)(i)(B) (A restraint is—) 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 and is not a standard treatment or dosage for the patient's condition. 42 CFR 482.13(e)(1)(i)(C) A restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort).

Note 2: *The definition of seclusion per 42 CFR 482.13(e)(1)(ii) is as follows:*

Seclusion is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may only be used for the management of violent or self-destructive behavior.

Note 3: *The definition of "physician" is the same as that used by the Centers for Medicare & Medicaid Services (CMS).*

Standards BoosterPak™ for Use of Restraint and Seclusion for Organizations Using Joint Commission Accreditation for Deemed Status

Scoring Categories:

Criticality level: Indirect

Documentation required: Yes

Scoring category (A or C): A

Measure of Success: No

Identified risk area: Yes

Implementation Suggestions:

- Ensure that the policy is readily available to staff for easy reference and to promote compliance and consistency.
- It is helpful if the training or education packet follows policy and highlights documentation requirements.
- Leadership may consider tracking the elements required in the standard with the organization's policy in order to ensure that all elements are clearly addressed.

Tips:

- In the electronic medical record environment, consider having a reminder pop up to identify the policy for easy staff reference.
- Education on the use and documentation of restraint and seclusion could include quick tips and reminders about what information needs to be documented. Some organizations have created an easily accessible checklist for staff reference.
- When completing chart audits, it is helpful to develop a checklist to ensure all required elements for restraint/seclusion are completed, such as the physician order, modification of the plan of care, monitoring of the patient, the face to face evaluation, and assessment of the patient.

Standards BoosterPak™ for Use of Restraint and Seclusion for Organizations Using Joint Commission Accreditation for Deemed Status

Chapter: Provision of Care, Treatment, and Services (PC)

Standard Number: PC.03.05.09

Standard Text: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has written policies and procedures that guide the use of restraint and seclusion.

Element of Performance:

2. For hospitals that use Joint Commission accreditation for deemed status purposes: Physicians, clinical psychologists, and other licensed independent practitioners authorized to order restraint or seclusion (through hospital policy in accordance with law and regulation) have a working knowledge of the hospital policy regarding the use of restraint and seclusion.

Note: *The definition of “physician” is the same as that used by the Centers for Medicare & Medicaid Services (CMS).*

Scoring Categories:

Criticality level: Direct (△)

Documentation required: No

Scoring category (A or C): A

Measure of Success: No

Identified risk area: No

Implementation Suggestions:

- Medical staff may consider adding this as a part of ongoing professional practice evaluation
- Medical staff orientation may include the education on the restraint/seclusion policy during credentialing and privileging.

Tips:

- Periodic concurrent monitoring of required documentation can be effective in demonstrating working knowledge. If improvement opportunities are identified for staff or licensed independent practitioners, mentoring may be effectively used by organizations to improve individual behavior and overall compliance.

Standards BoosterPak™ for Use of Restraint and Seclusion for Organizations Using Joint Commission Accreditation for Deemed Status

Chapter: Provision of Care, Treatment, and Services (PC)

Standard Number: PC.03.05.11

Standard Text: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital evaluates and reevaluates the patient who is restrained or secluded.

Element of Performance:

1. For hospitals that use Joint Commission accreditation for deemed status purposes: A physician, clinical psychologist, or other licensed independent practitioner responsible for the care of the patient evaluates the patient in-person within one hour of the initiation of restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the physical safety of the patient, staff, or others. A registered nurse or a physician assistant may conduct the in-person evaluation within one hour of the initiation of restraint or seclusion; this individual is trained in accordance with the requirements in PC.03.05.17, EP 3.

Note 1: States may have statute or regulation requirements that are more restrictive than the requirements in this element of performance.

Note 2: The definition of “physician” is the same as that used by the Centers for Medicare & Medicaid Services (CMS).

Scoring Categories:

Criticality level: Direct (△)

Documentation required: No

Scoring category (A or C): A

Measure of Success: No

Identified risk area: Yes

Implementation Suggestions:

- Any episode of restraint or seclusion for management of violent or self-destructive behavior requires documentation of a face-to-face assessment by a physician, licensed independent practitioner, or nurse within one hour of application.
- The in-person evaluation includes the following:
 - An evaluation of 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
- The face-to-face evaluation needs to be documented to include the four bullet points listed in PC.03.05.11, EP 3.
- On arrival, the physician must review the original order and revise the type of restraint, duration, or behavioral criteria for the person’s release as indicated by the treatment team review and the person’s response.

Tips:

- The hospital must provide verification that the registered nurse or physician assistant is trained and authorized to complete the one-hour in-person evaluation.
- The training needs to include the type of assessment and documentation that needs to be completed for the one-hour in-person evaluation (*see also* PC.03.05.17).
- The training for the registered nurse or physician assistant needs to be completed and documented (*see* PC.03.05.17).

Standards BoosterPak™ for Use of Restraint and Seclusion for Organizations Using Joint Commission Accreditation for Deemed Status

Chapter: Provision of Care, Treatment, and Services (PC)

Standard Number: PC.03.05.11

Standard Text: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital evaluates and reevaluates the patient who is restrained or secluded.

Element of Performance:

2. For hospitals that use Joint Commission accreditation for deemed status purposes: When the in-person evaluation (performed within one hour of the initiation of restraint or seclusion) is done by a trained registered nurse or trained physician assistant, he or she consults with the attending physician, clinical psychologist, or other licensed independent practitioner responsible for the care of the patient as soon as possible after the evaluation, as determined by hospital policy.

Scoring Categories:

Criticality level: Direct (Δ)

Documentation required: No

Scoring category (A or C): A

Measure of Success: No

Identified risk area: Yes

Implementation Suggestion:

- The registered nurse or physician assistant initiating the restraint/seclusion shall note in the patient's record the name of the physician contacted, the time of the contact, and any correspondence he or she had with the physician.

Tips:

- Documentation must clearly indicate the date and time when the one-hour in-person evaluation was completed and that it was completed and signed by an authorized individual. Refer to PC.03.05.09, EP 1, and PC.03.05.17, EPs 2–3, for training standards.
- Any staff members participating in a restraint/seclusion episode, including application of a restraint, must maintain documented competencies for restraint/seclusion procedures. *See* PC.03.05.17.
- *See* section B3 in this BoosterPak for more information.

Standards BoosterPak™ for Use of Restraint and Seclusion for Organizations Using Joint Commission Accreditation for Deemed Status

Chapter: Provision of Care, Treatment, and Services (PC)

Standard Number: PC.03.05.11

Standard Text: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital evaluates and reevaluates the patient who is restrained or secluded.

Element of Performance:

3. For hospitals that use Joint Commission accreditation for deemed status purposes: The in-person evaluation, conducted within one hour of the initiation of restraint or seclusion for the management of violent or self-destructive behavior that jeopardizes the physical safety of the patient, staff, or others, includes the following:

- An evaluation of 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

Scoring Categories:

Criticality level: Direct (△)

Documentation required: No

Scoring category (A or C): A

Measure of Success : No

Identified risk area: Yes

Implementation Suggestion:

- The organization should ensure that the information in the EP is included in the education provided to whoever is qualified to complete the one-hour face-to-face evaluation after a patient is placed in restraints for violent or self-destructive behavior. After a restraint/seclusion episode, the organization may review the documentation to ensure that it is complete.

Standards BoosterPak™ for Use of Restraint and Seclusion for Organizations Using Joint Commission Accreditation for Deemed Status

Chapter: Provision of Care, Treatment, and Services (PC)

Standard Number: PC.03.05.13

Standard Text: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital continually monitors patients who are simultaneously restrained and secluded.

Element of Performance:

1. **For hospitals that use Joint Commission accreditation for deemed status purposes:** The patient who is simultaneously restrained and secluded is continually monitored by trained staff either in-person or through the use of both video and audio equipment that is in close proximity to the patient.

Note: *In this element of performance “continually” means ongoing without interruption.*

Scoring Categories:

Criticality level: Direct (△)

Documentation required: No

Scoring category (A or C): A

Measure of Success: No

Identified risk area: No

Implementation Suggestions:

- Any staff member who is continually monitoring the patient must be trained to respond to an emergency if one should arise while the patient is simultaneously in restraint and seclusion.
- Using video and audio equipment does not eliminate the need for frequent monitoring and assessment of the patient. The individual’s privacy and dignity should be protected to the extent possible during any intervention. The patient needs to be continually monitored while in restraint and seclusion. Example: If the patient is having trouble breathing, the staff member who is continually monitoring the patient must be able to intervene immediately.

Tips:

- Ensure that staff are aware of the safety issues associated with continually monitoring a patient who is simultaneously in restraint and seclusion.
- The monitor is never left unattended.
- Ensure that any staff assigned to monitor a patient have been trained as per PC.03.05.17.

Standards BoosterPak™ for Use of Restraint and Seclusion for Organizations Using Joint Commission Accreditation for Deemed Status

Chapter: Provision of Care, Treatment, and Services (PC)

Standard Number: PC.03.05.15

Standard Text: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital documents the use of restraint or seclusion.

Element of Performance:

1. For hospitals that use Joint Commission accreditation for deemed status purposes: Documentation of restraint and seclusion in the medical record includes the following:

- Any in-person medical and behavioral evaluation for restraint or seclusion used to manage violent or self-destructive behavior
- A description of the patient's behavior and the intervention used
- Any alternatives or other less restrictive interventions attempted
- The patient's condition or symptom(s) that warranted the use of the restraint or seclusion
- The patient's response to the intervention(s) used, including the rationale for continued use of the intervention
- Individual patient assessments and reassessments
- The intervals for monitoring
- Revisions to the plan of care
- The patient's behavior and staff concerns regarding safety risks to the patient, staff, and others that necessitated the use of restraint or seclusion
- Injuries to the patient
- Death associated with the use of restraint or seclusion
- The identity of the physician, clinical psychologist, or other licensed independent practitioner who ordered the restraint or seclusion
- Orders for restraint or seclusion
- Notification of the use of restraint or seclusion to the attending physician
- Consultations

Scoring Categories:

Criticality level: Indirect

Documentation required: No

Scoring category (A or C): C

Measure of Success: Yes

Identified risk area: No

Implementation Suggestions:

- If a patient is injured, the organization must follow its defined process for patient injury. Such documentation may indicate whether the patient was injured prior to, during, or after placement in restraint/seclusion. In addition, a progress note must be written describing the event, the injury, and the intervention and care provided to the patient per the Record of Care, Treatment, and Services (RC) standard RC.02.01.01, EP 2.
- Suggestions for treatment and care planning updates might include the following:
 - o Risks to the patient
 - Reassessment frequency based on the indication for restraint use
 - Revision of the plan of care as the patient's condition changes

Standards BoosterPak™ for Use of Restraint and Seclusion for Organizations Using Joint Commission Accreditation for Deemed Status

- Documentation of skin integrity
- Frequency of monitoring, hydration, food, range of motion, and toileting
- De-escalation techniques that will be used to help the patient be released from restraints

Tips:

- You may want to consider consulting with your risk manager as to the approved manner in which to document any patient injuries.
- The use of a flow sheet to document monitoring activities and reassessments is helpful to staff in complying with monitoring time frames addressed in the policy.

Suggested Alternative Strategies to Restraint or Seclusion:

- Music
- Television/movies
- Bed alarms
- Patient and family education
- Increased nursing rounding
- Reality orientation
- Companionship in common areas

Standards BoosterPak™ for Use of Restraint and Seclusion for Organizations Using Joint Commission Accreditation for Deemed Status

Chapter: Provision of Care, Treatment, and Services (PC)

Standard Number: PC.03.05.17

Standard Text: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital trains staff to safely implement the use of restraint or seclusion.

Element of Performance:

2. For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital trains staff on the use of restraint and seclusion, and assesses their competence, at the following intervals:

- At orientation
- Before participating in the use of restraint and seclusion
- On a periodic basis thereafter

Scoring Categories:

Criticality level: Indirect

Documentation required: No

Scoring category (A or C): C

Measure of Success: Yes

Identified risk area: No

Implementation Suggestions:

- Contract nurses and security staff should be trained on the use of restraint and seclusion if they are required to participate in a restraint/seclusion procedure.
- Consider evaluating staff perceptions of safety, which may influence their use of restraint and seclusion.

Tips:

- Remember that any staff required to apply restraints or monitor the patient must be trained in the safe application of restraints/seclusion.
- Remember that this standard does not apply to forensic restrictions and restrictions imposed by correction and law enforcement authorities for security purposes.
- If a patient is in forensic restraints, the law enforcement officer who maintains custody and direct supervision of his or her prisoner—the hospital's patient—is responsible for monitoring the prisoner, but the organization is responsible for assessing and evaluating the patient and providing safe care.

Standards BoosterPak™ for Use of Restraint and Seclusion for Organizations Using Joint Commission Accreditation for Deemed Status

Chapter: Provision of Care, Treatment, and Services (PC)

Standard Number: PC.03.05.17

Standard Text: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital trains staff to safely implement the use of restraint or seclusion.

Element of Performance:

3. For hospitals that use Joint Commission accreditation for deemed status purposes: Based on the population served, staff education, training, and demonstrated knowledge focus on the following:

- Strategies to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of restraint or seclusion.
- Use of nonphysical intervention skills
- Methods for choosing the least restrictive intervention based on an assessment of the patient's medical or behavioral status or condition
- Safe application and use of all types of restraint or seclusion used in the hospital, including training in how to recognize and respond to signs of physical and psychological distress (for example, positional asphyxia)
- Clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary
- 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 in-person evaluation conducted within one hour of initiation of restraint or seclusion
- Use of first-aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic recertification

(See also PC.03.05.07, EP 1)

Scoring Categories:

Criticality level: Indirect

Documentation required: No

Scoring category (A or C): C

Measure of Success: No

Identified risk area: No

Implementation Suggestion:

- Consider whether a formalized program such as MANDT, Crisis Prevention Intervention (CPI), or Therapeutic Crisis Intervention should be utilized and is appropriate for the population served as well as your organization.

Tip:

- Although formalized programs such as MANDT, Crisis Prevention Intervention (CPI), and Therapeutic Crisis Intervention exist, they are not required. A training program may be developed by hospital staff in order to meet the needs of the organization's specific patient populations and settings.

Standards BoosterPak™ for Use of Restraint and Seclusion for Organizations Using Joint Commission Accreditation for Deemed Status

Chapter: Provision of Care, Treatment, and Services (PC)

Standard Number: PC.03.05.17

Standard Text: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital trains staff to safely implement the use of restraint or seclusion.

Element of Performance:

4. For hospitals that use Joint Commission accreditation for deemed status purposes: Individuals providing staff training in restraint or seclusion have education, training, and experience in the techniques used to address patient behaviors that necessitate the use of restraint or seclusion.

Scoring Categories:

Criticality level: Indirect

Documentation required: No

Scoring category (A or C): A

Measure of Success: No

Identified risk area: No

Implementation Suggestions:

- Instructors should be familiar with the organization, patient populations served, settings, and challenges regarding restraint/seclusion.
- Ensure that instructors are trained to each of the specific programs the organization uses.
- Training certificates are renewed as per policy and requirements.

Tips:

- Review contracts or personnel files to determine whether individuals providing staff training in restraint or seclusion have education, training, and experience in the techniques used to address patient behaviors that necessitate the use of restraint or seclusion.
- If using contract staff, review the Leadership (LD) standard LD.04.03.09 for contract compliance. Ensure that there are written expectations regarding contracted staff and the educational requirements needed for restraint/seclusion application.

Standards BoosterPak™ for Use of Restraint and Seclusion for Organizations Using Joint Commission Accreditation for Deemed Status

Chapter: Provision of Care, Treatment, and Services (PC)

Standard Number: PC.03.05.17

Standard Text: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital trains staff to safely implement the use of restraint or seclusion.

Element of Performance:

5. For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital documents in staff records that restraint and seclusion training and demonstration of competence were completed.

Scoring Categories:

Criticality level: Indirect

Documentation required: Yes

Scoring category (A or C): C

Measure of Success: Yes

Identified risk area: No

Implementation Suggestions:

- Consider how to document that external law enforcement and security have been oriented regarding distinctions between administrative and clinical seclusion and restraint.
- If staff keep their orientation and training records until they are completed, have a way to determine whether the documentation has been completed and how the documentation becomes a retrievable part of the personnel file.
- After staff are trained on the use of restraint and seclusion at orientation, and before they participate in the use of restraint and seclusion, consider the frequency of the periodic training.
- The organization determines the periodic training intervals. This can be based on patient population and settings. Many organizations conduct annual staff training on restraint and seclusion.

Tips:

- Consider concurrent monitoring of restraint/seclusion use. That way “just in time” training can be done if a staff member needs additional education and support in the restraint and seclusion process.
- Consider identifying “restraint/seclusion reduction champions” as trainers—staff who have been proactive in minimizing the use of restraint and seclusion.
- Consider incorporating programs that help the staff know how it feels to be restrained or secluded.
- If annual education days are scheduled, consider adding restraint/seclusion training to these days.
- If the hospital conducts mock tracers, consider reviewing restraint/seclusion records with staff who cared for a patient in restraints. Ask the staff if the reasons restraints were implemented and continued can be identified in the documentation. This could be another opportunity for just-in-time training.
- Consider alternative ways to educate staff about restraint/seclusion such as case studies and mock scenarios.
- Review staff personnel files and licensed independent practitioner and credential files to validate required training in restraint and seclusion.

Standards BoosterPak™ for Use of Restraint and Seclusion for Organizations Using Joint Commission Accreditation for Deemed Status

Chapter: Provision of Care, Treatment, and Services (PC)

Standard Number: PC.03.05.19

Standard Text: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital reports deaths associated with the use of restraint and seclusion.

Element of Performance :

1. **For hospitals that use Joint Commission accreditation for deemed status purposes:** The hospital reports the following information to the Centers for Medicare & Medicaid Services (CMS) regarding deaths related to restraint or seclusion (this requirement does not apply to deaths related to the use of soft wrist restraints; for more information, refer to EP 3 in this standard):

- Each death that occurs while a patient is in restraint or seclusion
- Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion
- Each death known to the hospital that occurs within one week after restraint or seclusion was used when it is reasonable to assume that the use of the restraint or seclusion contributed directly or indirectly to the patient's death. The types of restraints included in this reporting requirement are all restraints except soft wrist restraints.

Note: *In this element of performance "reasonable to assume" includes, but is not limited to, deaths related to restrictions of movement for prolonged periods of time or deaths related to chest compression, restriction of breathing, or asphyxiation.*

Scoring Categories:

Criticality level: Indirect

Documentation required: No

Scoring category (A or C): A

Measure of Success: No

Identified risk area: No

Implementation Suggestion:

- Organizations should review their policies and procedures to ensure that they are in compliance with law and regulation.

Tips:

- Organizations may choose to have nursing leadership notified when a death occurs while a patient is in restraints or seclusion to ensure that all policies and processes are followed per law and regulation.
- Organizations may wish to review all deaths that occur while a patient is in restraints or seclusion to determine if there are any patterns or trends.

Standards BoosterPak™ for Use of Restraint and Seclusion for Organizations Using Joint Commission Accreditation for Deemed Status

Chapter: Provision of Care, Treatment, and Services (PC)

Standard Number: PC.03.05.19

Standard Text: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital reports deaths associated with the use of restraint and seclusion.

Element of Performance:

2. For hospitals that use Joint Commission accreditation for deemed status purposes: The deaths addressed in PC.03.05.19, EP 1, are reported to the Centers for Medicare & Medicaid Services (CMS) by telephone, by facsimile, or electronically no later than the close of the next business day following knowledge of the patient's death. The date and time that the patient's death was reported is documented in the patient's medical record.

Scoring Categories:

Criticality level: Indirect

Documentation required: Yes

Scoring category (A or C): A

Measure of Success: No

Identified risk area: No

Implementation Suggestions:

- Staff may need reminders in order to heighten awareness that the organization is required to report this information in a timely manner. Explain that the intent is not to be punitive toward staff but rather to collect vital information.
- Encourage staff to report—to an appropriate person at the organization—any death that might be related to the use of restraint or seclusion.
- Consider Joint Commission sentinel event reporting (see the “Sentinel Events” chapter in your accreditation manual).

Tips:

- The risk manager or health information manager could cross-reference the list of restrained/secluded patients to the list of patient deaths within the seven-day period immediately following the last use of restraint/seclusion to look for any potential matches for further follow-up and review.
- In an EMR environment, an automatic alert may be sent to a specified person in the organization to alert him or her about the use of restraint or seclusion.
- In the EMR, at the time of discharge due to death, a pop-up box could be used to ask if the patient had been restrained or secluded within the last seven days, and automatic notification could be sent to a specified person in the organization.

Standards BoosterPak™ for Use of Restraint and Seclusion for Organizations Using Joint Commission Accreditation for Deemed Status

Chapter: Provision of Care, Treatment, and Services (PC)

Standard Number: PC.03.05.19

Standard Text: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital reports deaths associated with the use of restraint and seclusion.

Element of Performance:

3. For hospitals that use Joint Commission accreditation for deemed status purposes: When no seclusion has been used and when the only restraints used on the patient are wrist restraints composed solely of soft, non-rigid, cloth-like material, the hospital does the following:

- Records in a log or other system any death that occurs while a patient is in restraint. The information is recorded within seven days of the date of death of the patient.
- Records in a log or other system, any death that occurs within 24 hours after a patient has been removed from such restraints. The information is recorded within seven days of the date of death of the patient.
- Documents in the patient record the date and time that the death was recorded in the log or other system
- Documents in the log or other system the patient's name, date of birth, date of death, name of attending physician or other licensed independent practitioner responsible for the care of the patient, medical record number, and primary diagnosis(es)*
- Makes the information in the log or other system available to CMS, either electronically or in writing, immediately upon request

* For law and regulation guidance pertaining to those responsible for the care of the patient, refer to 42 CFR 482.12(c).

Scoring Categories:

Criticality level: Indirect

Documentation required: Yes

Scoring category (A or C): A

Measure of Success: No

Identified risk area: No

Implementation Suggestions:

- Unit managers are notified when a death occurs in restraints or seclusion to ensure that policies and processes are followed.
- Leadership is notified when a patient has died in restraints or seclusion to ensure that the log is completed and accessible to surveyors.

Section A2: Assessing Compliance During the On-Site Survey

Documents for Review:

According to PC.03.05.17, EP 5, the hospital documents in staff records that restraint and seclusion training and demonstration of competence were completed. Competency records need to reflect initial and ongoing training for trainers, for staff, and for only those physician and licensed independent practitioners who participate in applying restraint/seclusion.

In addition, hospitals will provide documentation of the following:

- Orders for use
- Policies and procedures related to restraint
- Results of patient monitoring
- Reassessment
- Unanticipated changes in the patient's condition

Documents Related to Training:

According to PC.03.05.17, EP 2, the hospital trains staff on the use of restraint and seclusion, and assesses their competence, at the following intervals:

- At orientation
- Before participating in the use of restraint and seclusion
- On a periodic basis thereafter

According to PC.03.05.17, EP 3, based on the population served, staff education, training, and demonstrated knowledge focus on the following:

- Strategies to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of restraint or seclusion
- Use of nonphysical intervention skills
- Methods for choosing the least restrictive intervention based on an assessment of the patient's medical or behavioral status or condition
- Safe application and use of all types of restraint or seclusion used in the hospital, including training in how to recognize and respond to signs of physical and psychological distress (for example, positional asphyxia)
- Clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary
- 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 in-person evaluation conducted within one hour of initiation of restraint or seclusion
- Use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic recertification
(*See also* PC.03.05.07, EP 1)

According to PC.03.05.17, EP 4, individuals providing staff training in restraint or seclusion have education, training, and experience in the techniques used to address patient behaviors that necessitate the use of restraint or seclusion.

B. Frequently Asked Questions, Definitions, and Additional Information

Section B1: Frequently Asked Questions (FAQs)

Q. What restraint standards should organizations follow in the *Comprehensive Accreditation Manual for Hospitals* if they are going to use Joint Commission accreditation for deemed status purposes?

A: Effective July 1, 2009, organizations that use Joint Commission accreditation for deemed status purposes must follow Standards PC.03.05.01 through PC.03.05.19.

Q. What standards related to restraint and seclusion will no longer apply as of July 1, 2009, for hospitals that use Joint Commission accreditation for deemed status purposes?

A: Standards PC.03.02.01 through PC.03.03.31 and RC.02.01.05 will no longer apply.

Q. Is the one-hour face-to-face assessment still required if a patient is placed in restraints or seclusion for violent or self-destructive behavior?

A: Yes, in the *Comprehensive Accreditation Manual for Hospitals*, the one-hour face-to-face assessment by a physician or licensed independent practitioner responsible for the care of the patient is required. The physician or licensed independent practitioner evaluates the patient in person within one hour of the initiation of restraint or seclusion. A registered nurse or physician assistant may conduct the in-person evaluation within one hour of the initiation of restraint or seclusion if this person is trained in accordance with requirements in standard PC.03.05.17, EP 3. If the one-hour face-to-face evaluation is completed by a trained nurse or physician assistant, he or she would consult with the attending physician or other licensed independent practitioner responsible for the care of the patient after the evaluation, as determined by hospital policy (PC.03.05.11, EP 2). Some states may have statute or regulation requirements that are more restrictive than the requirements in this standard.

Q. Where can the organization find the definition of what is and is not a restraint?

A: Standard PC.03.05.09 in the *Comprehensive Accreditation Manual for Hospitals* includes the definition of *restraint* and *seclusion* and also what is not a restraint. The definition is also in the update of the glossary in the *Comprehensive Accreditation Manual for Hospitals*. The Joint Commission follows the CMS definition of restraint, which is as follows:

- The 42 CFR (*Code of Federal Regulations*) 482.13(e)(1) Definitions. (i) **A restraint is**—(A) 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; or 42 CFR 482.13(e)(1)(i)(B) 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 and is not a standard treatment or dosage for the patient's condition.
- 42.CFR 482.13(e)(1)(i)(C) **A restraint does not include** devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort).
- 42 CFR 482.13(e)(1)(ii) **Seclusion** is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may only be used for the management of violent or self-destructive behavior.

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Q. Do the new standards require a debriefing process after an episode during which a patient has been placed in restraints for violent or self-destructive behavior?

A: No, the Hospital Accreditation Program restraint/seclusion standards for deemed status purposes do not require a debriefing process to be completed. This does not prohibit the organization from requiring a debriefing process as it sees fit. The debriefing process is often used when the patient has a behavioral health issue and is part of the process.

Q. Do orders for restraints still have definite time limits?

A: A restraint order that is being used for violent or self-destructive behavior still has a definite time limit associated with it. Standard PC.03.05.05, EP 4, states: Unless state law is more restrictive, orders for the use of restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, staff, or others may be renewed within the following limits:

- 4 hours for adults 18 years of age or older
- 2 hours for children and adolescents, 9 to 17 years of age
- 1 hour for children under 9 years of age

Orders may be renewed according to the time limits for a maximum of 24 consecutive hours. Organizations must develop their own guidelines for the time limits on restraints for other than violent or self-destructive behavior. Patient safety, patient assessment, and the type of restraint used will determine the guideline for the time limit for a restraint that is used for nonviolent, non self-destructive behavior.

Q. Are the restraint standards still defined as non-behavioral and behavioral?

A: The new restraint standards are not divided into “non-behavioral” and “behavioral” categories. They do reference “violent or self-destructive behavior” and “nonviolent, non-self-destructive behavior” in the standards that are specific to these types of behaviors. The wording was changed in order to address the framework from which the Medicare requirements are written.

Q. Is the use of a telemedicine link allowed for use by the licensed independent practitioner who conducts the in-person evaluations of the individual in restraint or seclusion?

A: No. A telemedicine link does not fulfill the in-person requirement for the evaluation by a licensed independent practitioner of the individual in restraint or seclusion.

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Section B2: Definitions of Key Terms

Criticality level: The Joint Commission defines *criticality* as the immediacy of risk to patient safety or quality of care as a result of noncompliance with a Joint Commission requirement (for example, an EP, National Patient Safety Goal, Universal Protocol). The four levels of criticality are as follows:

1. Immediate Threat to Health and Safety
2. Situational Decision Rules
3. Direct Impact Requirements
4. Indirect Impact Requirements

Licensed independent practitioner: An individual permitted by law and by the organization to provide care, treatment, and services without direct supervision. A licensed independent practitioner operates within the scope of his or her license, consistent with individually granted clinical privileges. When standards reference the term licensed independent practitioner, this language is not to be construed to limit the authority of a licensed independent practitioner to delegate tasks to other qualified health care personnel (for example, physician assistance and advanced practice registered nurses) to the extent authorized by state law or a state's regulatory mechanism or federal guidelines and organizational policy.

Physician: As defined by the Center for Medicare & Medicaid Services in Sec. 1861 [42 U.S.C. 1395x] of the Social Security Act: (r) the term "physician," when used in connection with the performance of any function or action, means

1. A doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he performs such function or action (including a physician within the meaning of section 1301(a)(7))
2. A doctor of dental surgery or of dental medicine who is legally authorized to practice dentistry by the State in which he performs such function and who is acting within the scope of his license when he performs such functions
3. A doctor of podiatric medicine for the purposes of subsections (k), (m), (p)(1), and (s) of this section and sections 1814(a), 1832(a)(2)(F)(ii), and 1835 but only with respect to functions which he is legally authorized to perform as such by the State in which he performs them
4. A doctor of optometry, but only for purposes of subsection (p)(1) with respect to the provision of items or services described in subsection (s) which he is legally authorized to perform as a doctor of optometry by the State in which he performs them
5. A chiropractor who is licensed as such by the State (or in a state which does not license chiropractors as such, is legally authorized to perform the services of chiropractor in the jurisdiction in which he performs such services), and who meets uniform minimum standards promulgated by the Secretary, but only for the purpose of sections 1861(s)(1) and 1861(s)(2)(A) and only with respect to treatment by means of manual manipulation of the spine (to correct a subluxation) which he is legally authorized to perform by the State or jurisdiction in which such treatment is provided.

For the purposes of section 1862(a)(4) and subject to the limitations and conditions provided in the previous sentence, such term includes a doctor of one of the arts, specified in such previous sentence, legally authorized to practice such art in the country in which the inpatient hospital services (referred to in such section 1862(a)(4)) are furnished.

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Restraint,* definition of per 42 CFR 482.13(e)(1)(i)(A-C) is as follows:

- 42 CFR 482.13(e)(1) Definitions. (i) A restraint is—(A) 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
- 42 CFR 482.13 (e)(1)(i)(B) (A restraint is—) 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 and is not a standard treatment or dosage for the patient’s condition.
- 42 CFR 482.13(e)(1)(i)(C) A restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort).

Seclusion,* definition of per 42 CFR 482.13(e)(1)(ii) is as follows:

Seclusion is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may only be used for the management of violent or self-destructive behavior.

Scoring categories: The performance expectations for determining if a standard is in compliance are included in its EPs. EPs are divided into two scoring categories: Category A EPs and Category C EPs.

Category A EPs have the following characteristics:

- Usually relate to structural requirements (for example, policies or plans) that either exist or do not exist, and are scored either 2 for satisfactory compliance or 0 for insufficient compliance
- May address an issue that must be fully compliant even though it focuses on performance or outcome (for example, National Patient Safety Goals)
- May be related to a Medicare Condition of Participation that must always be fully compliant

Category C EPs have the following characteristics:

- Frequency-based EPs that are scored based on the number of times an organization is found not to be compliant with a particular EP
- Scored 2 if there are one or no occurrences of noncompliance
- Scored 1 if there are two occurrences of noncompliance
- Scored 0 if there are three or more occurrences of noncompliance

Definitions from CMS Interpretive Guidelines:

1. An arm board, if used to stabilize an IV line, is generally not considered a restraint. If the arm board is tied down or attached to the bed or the entire limb is immobilized, the use would be considered a restraint.
2. A mechanical support used to achieve body position, balance, or alignment to allow greater freedom of mobility than would be possible without the use of such a mechanical support is not a restraint.
3. A positioning or securing device used to maintain the position or limit mobility during medical, dental, diagnostic, or surgical procedures is not a restraint.

* See section B3 for additional information.

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4. Recovery from anesthesia. The use of a medically necessary restraint in this setting would not need to meet the requirements of a restraint. However, if the device continues to be used when the patient is transferred to another unit or recovers from the effects of the anesthesia, a restraint order would be necessary and the requirements would apply.
5. Many types of **hand mitts** would not be considered restraint. However, pinning or otherwise attaching those same mitts to bedding or using a wrist restraint in conjunction with the hand mitts would meet the definition of restraint and the requirements would apply. In addition, if the mitts are applied so tightly that the patient's hand or fingers are immobilized, this would be considered restraint and the requirements would apply. Likewise, if the mitts are so bulky that the patient's ability to use their hands is significantly reduced, this would be considered restraint and the requirements would apply.
NOTE: Because this definition of physical restraint does not name each device and situation that can be used to immobilize or reduce the ability of the patient to move his or her arms, legs, body or head freely, it promotes looking at each patient situation on a case-by-case basis.
In addition, if a patient can easily remove a device, the device would not be considered a restraint. In this context, "**easily remove**" means that the manual method, device, material, or equipment can be removed intentionally by the patient in the same manner as it was applied by the staff (e.g., side rails are put down, not climbed over; buckles are intentionally unbuckled; ties or knots are intentionally untied; etc.) considering the patient's physical condition and ability to accomplish the objective (e.g., transfer to a chair, get to the bathroom in time).
6. Physical hold of a patient for the purpose of conducting routine physical examinations or tests. Patients do have the right to refuse treatments. This includes the right to refuse physical examinations or tests. Holding a patient in a manner that restricts the patient's movement against the patient's will is considered restraint.
7. Physical hold in order to administer a medication against the patient's wishes is considered restraint. A court order for medication treatment only removes the patient's right to refuse the medication.
8. Physical hold when a patient consents to an injection or procedure but may not be able to hold still for the safe administration of the medication or procedure and requests the staff to "hold" is not considered restraint.
9. Side rails used as a measure to prevent the patient from exiting the bed would be considered a restraint and subject to the requirements.
10. When a patient is on a bed that constantly moves to improve circulation or prevent skin breakdown, raised side rails are a safe intervention and not viewed as a restraint.
11. When a patient is placed on seizure precautions and all side rails are raised, the use would not be considered restraint.
12. If a patient is on a stretcher, there is an increased risk of falling without raised side rails due to its narrow width. Therefore, the use of raised side rails on stretchers is not considered restraint.
13. Time-out is not considered seclusion. It is an intervention in which the patient consents to being alone in a designated area for an agreed-upon time frame, and the patient may leave the room if he or she chooses.
14. Tucking a patient's sheets in so tightly that the patient cannot move is restraint.
15. Use of a "net bed" or an "enclosed bed" that prevents the patient from freely exiting the bed is restraint.
16. Use of "Freedom" splints that immobilize a patient's limb is restraint.
17. A Geri chair or recliner is a restraint only if the patient cannot easily remove the restraint appliance and get out of the chair on his or her own.
18. Seat belts are a restraint only if the patient cannot easily remove the restraint appliance and remove the belt on his or her own .
19. The use of handcuffs, shackles, or other chain-type restraint devices applied by non-hospital employed or contracted law enforcement officials for custody, detention, and public safety reasons are not governed by the Conditions of Participation.

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Section B3: Additional Information

Additional standards to consider regarding restraint/seclusion:

- EC.01.01.01 The hospital plans activities to minimize risks in the environment of care.
- HR.01.01.01 The hospital has the necessary staff to support the care, treatment, and services it provides.
- HR.01.02.01 The hospital defines staff qualifications.
- HR.01.02.07 The hospital determines how staff function within the organization.
- HR.01.04.01 The hospital provides orientation to staff.
- HR.01.05.03 Staff participate in ongoing education and training.
- HR.01.06.01 Staff are competent to perform their responsibilities.
- HR.01.07.01 The hospital evaluates staff performance.
- LD.01.03.01 The governing body is ultimately accountable for the safety and quality of care, treatment, and services.
- LD.02.01.01 The mission, vision, and goals of the hospital support the safety and quality of care, treatment, and services.
- LD.02.03.01 The governing body, senior managers and leaders of the organized medical staff regularly communicate with each other on issues of safety and quality.
- LD.03.01.01 Leaders create and maintain a culture of safety and quality throughout the hospital.
- LD.03.02.01 The hospital uses data and information to guide decisions and to understand variation in the performance of processes supporting safety and quality.
- LD.03.05.01 Leaders implement changes in existing processes to improve the performance of the hospital.
- LD.03.06.01 Those who work in the hospital are focused on improving safety and quality.
- LD.04.01.01 The hospital complies with law and regulation.
- LD.04.01.05 The hospital effectively manages its programs, services, sites, or departments.
- LD.04.01.07 The hospital has policies and procedures that guide and support patient care, treatment, and services.
- LD.04.03.09 Care, treatment, and services provided through contractual agreement are provided safely and effectively
- LD.04.04.01 Leaders establish priorities for performance improvement.
- LD.04.04.05 The hospital has an organizationwide, integrated patient safety program within its performance improvement activities.
- PI.01.01.01 The hospital collects data to monitor its performance.
- RI.01.01.01 The hospital respects, protects, and promotes patient rights.

C: Supporting Documentation, Evidence, Value, Historical Information, and Additional References and Links

Section C1: Supporting Documentation and Evidence

CoP §482.13(e) Standard: Restraint or seclusion

A-0154(e) 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.

A-0164(e)(2) Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, a staff member, or others from harm.

A-0165(e)(3) The type or technique of restraint or seclusion used must be the least restrictive intervention that will be effective to protect the patient, a staff member, or others from harm.

A-0174(e)(9) Restraint or seclusion must be discontinued at the earliest possible time, regardless of the length of time identified in the order.

CoP §482.13(e) Standard: Restraint or seclusion

A-0166(e)(4) The use of restraint or seclusion must be—

A-0166(e)(4)(i) in accordance with a written modification to the patient's plan of care.

A-0166(e)(4)(ii) implemented in accordance with safe and appropriate restraint and seclusion techniques as determined by hospital policy in accordance with State law.

CoP §482.13(e) Standard: Restraint or seclusion

A-0168(e)(5) The use of restraint or seclusion must be in accordance with the order of a physician or other licensed independent practitioner who is responsible for the care of the patient as specified under §482.12(c) and authorized to order restraint or seclusion by hospital policy in accordance with state law.

A-0169(e)(6) Orders for the use of restraint or seclusion must never be written as a standing order or on an as needed basis (PRN).

A-0170(e)(7) The attending physician must be consulted as soon as possible if the attending physician did not order the restraint or seclusion.

A-0171(e)(8) Unless superseded by State law that is more restrictive—

A-0171(e)(8)(i) Each order for restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others may only be renewed in accordance with the following limits for up to a total of 24 hours:

A-0171(e)(8)(i)(A) 4 hours for adults 18 years of age or older;

A-0171(e)(8)(i)(B) 2 hours for children and adolescents 9 to 17 years of age; or

A-0171(e)(8)(i)(C) 1 hour for children under 9 years of age; and

A-0172(e)(8)(ii) [Unless superseded by State law that is more restrictive—] After 24 hours, before writing a new order for the use of restraint or seclusion for the management of violent or self-destructive behavior, a physician or other licensed independent practitioner who is responsible for the care of the patient as specified under §482.12(c) of this part and authorized to order restraint or seclusion by hospital policy in accordance with State law must see and assess the patient.

A-0173(e)(8)(iii) [Unless superseded by State law that is more restrictive—] Each order for restraint used to ensure the physical safety of the non-violent or non-self-destructive patient may be renewed as authorized by hospital policy.

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CoP §482.13(e) Standard: Restraint or seclusion

A-0175(e)(10) The condition of the patient who is restrained or secluded must be monitored by a physician, other licensed independent practitioner or trained staff that have completed the training criteria specified in paragraph (f) of this section at an interval determined by hospital policy.

CoP §482.13(e) Standard: Restraint or seclusion

A-0159(e)(1) Definitions.

A-0159(e)(1)(i) A restraint is—

A-0159(e)(1)(i)(A) 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; or

A-0160(e)(1)(i)(B) [A restraint is—] 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 and is not a standard treatment or dosage for the patient's condition.

A-0161(e)(1)(i)(C) A restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort).

A-0162(e)(1)(ii) Seclusion is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may only be used for the management of violent or self-destructive behavior.

A-0176(e)(11) Physician and other licensed independent practitioner training requirements must be specified in hospital policy. At a minimum, physicians and other licensed independent practitioners 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.

CoP §482.13(e) Standard: Restraint or seclusion

A-0178(e)(12) When restraint or seclusion is used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others, the patient must be seen face-to-face within 1 hour after the initiation of the intervention—

A-0178(e)(12)(i) By a—

A-0178(e)(12)(i)(A) Physician or other licensed independent practitioner; or

A-0178(e)(12)(i)(B) Registered nurse or physician assistant who has been trained in accordance with the requirements specified in paragraph (f) of this section.

A-0179(e)(12)(ii) [the patient must be seen face-to-face within 1 hour after the initiation of the intervention—] To evaluate—

A-0179(e)(12)(ii)(A) The patient's immediate situation;

A-0179(e)(12)(ii)(B) The patient's reaction to the intervention;

A-0179(e)(12)(ii)(C) The patient's medical and behavior condition; and

A-0179(e)(12)(ii)(D) The need to continue or terminate the restraint or seclusion.

A-0180(e)(13) States are free to have requirements by statute or regulation that are more restrictive than those contained in paragraph (e)(12)(i) of this section.

A-0182(e)(14) If the face-to-face evaluation specified in paragraph (e)(12) of this section is conducted by a trained registered nurse or physician assistant, the trained registered nurse or physician assistant must consult the attending physician or other licensed independent practitioner who is responsible for the care of the patient as specified under §482.12(c) as soon as possible after the completion of the 1-hour face-to-face evaluation.

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CoP §482.13(e) Standard: Restraint or seclusion

A-0183(e)(15) All requirements specified under this paragraph are applicable to the simultaneous use of restraint and seclusion. Simultaneous restraint and seclusion use is only permitted if the patient is continually monitored—

A-0183(e)(15)(i) Face-to-face by an assigned, trained staff member; or

A-0183(e)(15)(ii) By trained staff using both video and audio equipment. This monitoring must be in close proximity to the patient.

CoP §482.13(e) Standard: Restraint or seclusion

A-0184(e)(16) When restraint or seclusion is used, there must be documentation in the patient's medical record of the following:

A-0185(e)(16)(i) The 1-hour face-to-face medical and behavioral evaluation if restraint or seclusion is used to manage violent or self-destructive behavior;

A-0185(e)(16)(ii) [When restraint or seclusion is used, there must be documentation in the patient's medical record of the following:] A description of the patient's behavior and the intervention used.

A-0186(e)(16)(iii) [When restraint or seclusion is used, there must be documentation in the patient's medical record of the following:] Alternatives or other less restrictive interventions attempted (as applicable).

A-0187(e)(16)(iv) [When restraint or seclusion is used, there must be documentation in the patient's medical record of the following:] The patient's condition or symptom(s) that warranted the use of the restraint or seclusion.

A-0188(e)(16)(v) [When restraint or seclusion is used, there must be documentation in the patient's medical record of the following:] The patient's response to the intervention(s) used, including the rationale for continued use of the intervention.

CoP §482.13(f) Standard: Restraint or seclusion: Staff training requirements

A-0194(f) The patient has the right to safe implementation of restraint or seclusion by trained staff.

A-0196(f)(1) Training intervals. Staff must be trained and able to demonstrate competency in the application of restraints, implementation of seclusion, monitoring, assessment, and providing care for a patient in restraint or seclusion—

A-0196(f)(1)(i) Before performing any of the actions specified in this paragraph;

A-0196(f)(1)(ii) As part of orientation; and

A-0196(f)(1)(iii) Subsequently on a periodic basis consistent with hospital policy.

A-0199(f)(2) Training Content. 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:

A-0199(f)(2)(i) Techniques to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of a restraint or seclusion.

A-0200(f)(2)(ii) [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:] The use of nonphysical intervention skills.

A-0201(f)(2)(iii) [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:] Choosing the least restrictive intervention based on an individualized assessment of the patient's medical, or behavioral status or condition.

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A-0202(f)(2)(iv) [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:] The safe application and use of all types of restraint or seclusion used in the hospital, including training in how to recognize and respond to signs of physical and psychological distress (for example, positional asphyxia).

A-0204(f)(2)(v) [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:] Clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary.

A-0205(f)(2)(vi) [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:] 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.

A-0206(f)(2)(vii) [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:] The use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic recertification.

A-0207(f)(3) Trainer requirements. Individuals providing staff training must be qualified as evidenced by education, training, and experience in techniques used to address patients' behaviors.

A-0208(f)(4) Training documentation. The hospital must document in the staff personnel records that the training and demonstration of competency were successfully completed.

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

A-0214(g) Hospitals must report deaths associated with the use of seclusion or restraint.

A-0214(g)(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:

A-0214(g)(1)(i) Each death that occurs while a patient is in restraint or seclusion.

A-0214(g)(1)(ii) Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion.

A-0214(g)(1)(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.

A-0214(g)(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:

A-0214(g)(2)(i) Any death that occurs while a patient is in such restraints.

A-0214(g)(2)(ii) Any death that occurs within 24 hours after a patient has been removed from such restraints.

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A-0214(g)(3) The staff must document in the patient's medical record the date and time the death was:

A-0214(g)(3)(i) Reported to CMS for deaths described in paragraph (g)(1) of this section; or

A-0214(g)(3)(ii) Recorded in the internal log or other system for deaths described in paragraph (g)(2) of this section.

A-0214(g)(4) For deaths described in paragraph (g)(2) of this section, entries into the internal log or other system must be documented as follows:

A-0214(g)(4)(i) Each entry must be made not later than seven days after the date of death of the patient.

A-0214(g)(4)(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 of the patient as specified under §482.12(c), medical record number, and primary diagnosis(es).

A-0214(g)(4)(iii) The information must be made available in either written or electronic form to CMS immediately upon request.

Section C2: Value to Field and Related Initiatives

The restraint and seclusion requirements at PC.03.05.01 through PC.03.05.19 use language that is closely associated with the CMS Condition of Participation regarding restraint and seclusion. The Joint Commission reviewed these requirements during the proposed rule commentary period. The Joint Commission believes that these requirements contribute to a minimum level of quality and safety regarding patients in restraint and/or seclusion. The Joint Commission believes that these requirements, which were developed using the CMS framework of addressing restraint and seclusion from a behavior-driven perspective will promote the safe use of restraint and seclusion and promote a reduction in the use of restraint when it is not necessary.

The intent of these standards is to promote a patient's basic rights, ensure safety, and eliminate the inappropriate use of restraint or seclusion. The requirements specify that restraint and seclusion may be used only to make certain that the immediate physical safety of the patient, staff, or others is protected. The requirements promote the discontinuation of restraint and/or seclusion at the earliest possible time. The requirements also promote a thorough assessment and reassessments of the patient to ensure that restraints are discontinued when the patient no longer needs them and that they are properly used according to a patient's plan for care and an order. The competency of staff responsible for providing care, treatment, and services to patients who may be restrained or secluded is addressed in these standards. Proper documentation is expected to ensure that information is available to staff and practitioners in order to make a thorough assessment of the patient and to provide continuity in care and as a tool to help base decisions on.

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Section C3: Historical Information and Changes

In December 2006 the Centers for Medicare & Medicaid Services (CMS) published its final rule on patient's rights for the hospital Conditions of Participation, which included requirements regarding restraint and seclusion in Medicare-certified hospitals. The CMS requirements for restraint and seclusion are behavior driven, whereas the Joint Commission requirements are purpose driven. The Joint Commission determined that these two concepts could not be integrated into a single set of standards for these hospitals.

As a result, in 2009, The Joint Commission adopted requirements based on the CMS requirements *only for hospitals that use Joint Commission accreditation for deemed status purposes*. It is important to note that as of July 1, 2009:

- Hospitals that use Joint Commission accreditation for deemed status purposes must comply with standards PC.03.05.01–PC.03.05.19; these hospitals do not have to follow standards PC.03.02.01–PC03.03.031 and RC.02.01.05 in the “Record of Care, Treatment, and Services” (RC) chapter.
- Hospitals that do not use Joint Commission accreditation for deemed status purposes must continue to comply with current Joint Commission standards PC.03.02.01–PC.03.03.31 and RC.02.01.05.

Changes with restraint and seclusion requirements under the Conditions of Participation, which took effect July 2009, are aligned between The Joint Commission and CMS requirements.

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Section C4: Additional References and Links

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Links

For up-to-date information, please visit your Joint Commission extranet webpage to access the Joint Commission Leading Practice Library.

Follow this link to read about preventing restraint deaths:
http://www.jointcommission.org/assets/1/18/SEA_8.pdf

Follow this link to read about bed rail-related deaths:
http://www.jointcommission.org/assets/1/18/SEA_27.pdf

Follow this link to read *Improving America's Hospitals: The Joint Commission's Annual Report on Quality and Patient Safety 2010*:
http://www.jointcommission.org/assets/1/18/2010_Annual_Report.pdf

Follow this link to *The Physician's Guide to the Joint Commission's Hospital Standards and Accreditation Process*:
<http://www.jointcommission.org/assets/1/18/Physicians%20guide%20WEB1.PDF>

Centers for Medicare & Medicaid Services Medicare Learning Network: Advanced Practice Nurses and Physician Assistants Web page:
https://www.cms.gov/MLNProducts/70_APNPA.asp

Joint Commission Resources offers several educational products and services to fit the needs of any health care organization:
<http://store.jcinc.com/>

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