AHC Media

November 21, 2016

Patient's Bill of Rights CMS CoPs

Speaker

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- 614 791-1468 (Call with questions, No emails)
- sdill1@columbus.rr.com
- CMS questions hospitalscg@cms.hhs.gov

Objectives

- Identify the CMS grievance committee requirement.
- Explain requirements for advance directives.
- Describe the restraint and seclusion training requirements.
- Explain new and revised standards, regulations, and laws put forth by CMS, DNV, TJC and the federal government.
- Evaluate compliance requirements and penalties.

The Conditions of Participation (CoPs)

- Regulations first published in 1986
  - Many revisions since then
  - Manual updated more frequently now
  - Patient rights from tag 115-217
- First regulations are published in the **Federal Register** then CMS publishes the **Interpretive Guidelines** and some have **survey procedures** [2]
  - Hospitals should check this website once a month for changes

[1]www.gpoaccess.gov/fr/index.html [2]www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/list.asp

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How to Keep Up with Changes

- First, periodically check to see if you have the most current CoP manual
- Sign up to get the Federal Register[1]
- Once a month go out and check the survey and certification website [2]
- Once a month check the CMS transmittal page and see if new manual [3]
  - Have one or two person in your facility who has this responsibility

[1] http://www.cms.hhs.gov/manuals/downloads/som107_Appendicestoc.pdf
2http://www.cms.gov/SurveyCertificationGenInfo/PMSR/list.asp#TopOfPage
[3] http://www.cms.gov/Transmittals

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Medicare State Operations Manual

Appendix

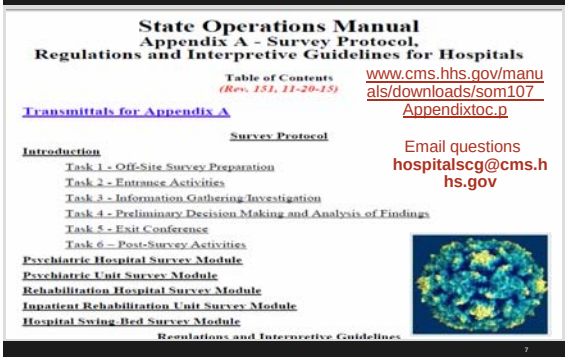
Email questions to CMS hospitalscg@cms.hhs.gov

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

New website at
www.cms.hhs.gov/manuals/downloads/som107_Appendixtoc.pdf

App. No.	Description	PDF File
A	Hospitals	2,185 KB
AA	Psychiatric Hospitals	606 KB

CoP Manual Also Called SOM



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

Table of Contents
(Rev. 151, 11-20-15)

Transmittals for Appendix A

Survey Protocol

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

Psychiatric Hospital Survey Module
Psychiatric Unit Survey Module
Rehabilitation Hospital Survey Module
Inpatient Rehabilitation Unit Survey Module
Hospital Swing-Bed Survey Module
Regulations and Interpretive Guidelines

www.cms.hhs.gov/manuals/downloads/som107_Appendixtoc.p

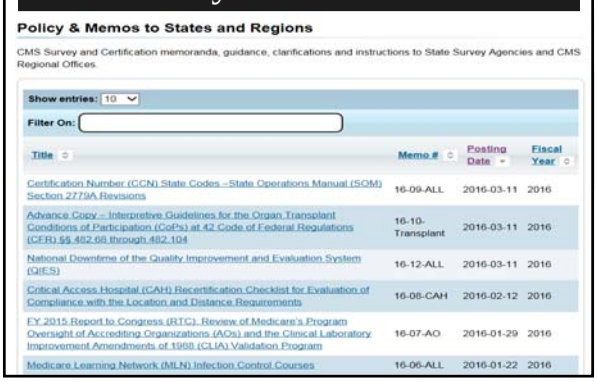
Email questions **hospitalscg@cms.hhs.gov**

CMS Survey and Certification Website

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

Click on Policy & Memos to States

CMS Survey Memos



Policy & Memos to States and Regions

CMS Survey and Certification memoranda, guidance, clarifications and instructions to State Survey Agencies and CMS Regional Offices.

Show entries: 10
Filter On:

Title	Memo #	Posting Date	Fiscal Year
Certification Number (CCN) State Codes –State Operations Manual (SOM) Section 2779A Revisions	16-09-ALL	2016-03-11	2016
Advance Copy – Interpretive Guidelines for the Organ Transplant Conditions of Participation (CoPs) at 42 Code of Federal Regulations (CFR) §§ 482.68 through 482.104	16-10-Transplant	2016-03-11	2016
National Downtime of the Quality Improvement and Evaluation System (QIES)	16-12-ALL	2016-03-11	2016
Critical Access Hospital (CAH) Recertification Checklist for Evaluation of Compliance with the Location and Distance Requirements	16-08-CAH	2016-02-12	2016
FY 2015 Report to Congress (RTC): Review of Medicare's Program Oversight of Accrediting Organizations (AOs) and the Clinical Laboratory Improvement Amendments of 1988 (CLIA) Validation Program	16-07-AO	2016-01-29	2016
Medicare Learning Network (MLN) Infection Control Courses	16-06-ALL	2016-01-22	2016

Spouse Includes Same Sex Marriages

- CMS publishes 6 pages in December 14, 2014 Federal Register
- CMS issues ten page survey memo December 12, 2014
- Manual updated to include this in October 9, 2015
- Recognizes the rights of a spouse in legally valid same sex marriages
- Equal rights to the spouse and treated the same as opposite-sex marriages
- Must honor regardless of where the couple resides

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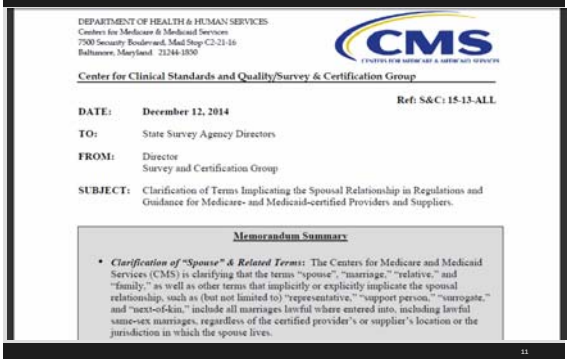
Spouse Includes Same Sex Marriages



DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Center for Clinical Standards and Quality/Survey & Certification Group

Ref: S&C: 15-13-ALL

DATE: December 12, 2014

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Clarification of Terms Implicating the Spousal Relationship in Regulations and Guidance for Medicare- and Medicaid-certified Providers and Suppliers.

Memorandum Summary

- ***Clarification of "Spouse" & Related Terms:*** The Centers for Medicare and Medicaid Services (CMS) is clarifying that the terms "spouse", "marriage," "relative," and "family," as well as other terms that implicitly or explicitly implicate the spousal relationship, such as (but not limited to) "representative," "support person," "surrogate," and "next-of-kin," include all marriages lawful where entered into, including lawful same-sex marriages, regardless of the certified provider's or supplier's location or the jurisdiction in which the spouse lives.

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FR Rights Spouse of Same Sex Marriages

Federal Register / Vol. 79, No. 239 / Friday, December 12, 2014 / Proposed Rules 73873

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 416, 418, 482, 483, and 485

[CMS–3302–P]

RIN 0938–AS29

Medicare and Medicaid Program: Revisions to Certain Patient's Rights Conditions of Participation and Conditions for Coverage

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

ACTION: Proposed rule.

SUMMARY: This proposed rule would revise the applicable conditions of participation (CoPs) for providers, conditions for coverage (CfCs) for suppliers, and requirements for long-term care facilities, to ensure that certain requirements are consistent with the Supreme Court decision in *United States* v. *Windsor*, 570 U.S.12, 133 S.Ct. 2675 (2013), and HHS policy. Specifically, we propose to revise certain definitions and patient's rights provisions, in order to ensure that same-sex spouses in legally-valid marriages are recognized and afforded equal rights

Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *By hand or courier.* Alternatively, you may deliver (by hand or courier) your written comments only to the following addresses prior to the close of the comment period:

a. For delivery in Washington, DC—
Centers for Medicare & Medicaid Services, Department of Health and Human Services, Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue SW., Washington, DC 20201.

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without Federal government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

b. For delivery in Baltimore, MD—
Centers for Medicare & Medicaid Services, Department of Health and Human Services, 7500 Security Boulevard, Baltimore, MD 21244–1850.

If you intend to deliver your comments to the Baltimore address, call

Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1–800–743–3951.

Table of Contents

This proposed rule is organized as follows:

I. Background
A. United States v. Windsor Decision
B. Statutory and Regulatory Authority
II. Provisions of the Proposed Regulation
A. Ambulatory Surgical Centers Condition for Coverage—Patient Rights (§ 416.50)
B. Hospice Care (Part 418)
C. Conditions of Participation for Hospitals (Part 482)
D. Requirements for States and Long-Term Care (LTC) Facilities (Part 483)
E. Conditions of Participation: Community Mental Health Centers (CMHCs) (Part 485, Subpart B)
III. Collection of Information Requirements
IV. Response to Comments
V. Regulatory Impact Statement
Regulations Text

I. Background

A. United States v. Windsor Decision

In *United States* v. *Windsor*, 570 U.S. 12, 133 S. Ct. 2675 (2013), the Supreme Court held that section 3 of the Defense of Marriage Act (DOMA) is unconstitutional because it violates the Fifth Amendment (*See Windsor*, 133 S.

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CMS CoP Manual

Regulations and Interpretive Guidelines
(Rev. 149, Issued: 10-09-15, Effective: 10-09-15, Implementation: 10-09-15)

NOTE: in the regulations or guidance which follow, in every instance where the following terms appear:

- **"spouse" means an individual who is married to another individual as a result of marriage lawful where it was entered into, including a lawful same-sex marriage, regardless of whether the jurisdiction where the hospital is located, or in which the spouse lives, permits such marriages to occur or recognizes such marriages.**
- **"marriage" means a marriage lawful where entered into, including a lawful same-sex marriage, regardless of whether the jurisdiction where the hospital is located, or in which the spouse lives, permits such marriages to occur or recognizes such marriages;**
- **"family" includes, but is not limited to, an individual's "spouse" (see above); and**
- **"relative" when used as a noun, includes, but is not limited to, an individual's "spouse" (see above).**

Furthermore, except where CMS regulations explicitly require an interpretation in accordance with State law, wherever the text of a regulation or associated guidance uses the above terms or includes a reference to a patient's "representative," "surrogate," "support person," "next-of-kin," or similar term in such a manner as would normally implicitly or explicitly include a spouse, the terms are to be interpreted consistent with the guidance above.

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Access to Hospital Complaint Data

- CMS issued Survey and Certification memo on March 22, 2013 regarding access to hospital complaint data
- Includes acute care and CAH hospitals
  - Does not include the plan of correction but can request
  - Questions to bettercare@cms.hhs.com
- This is the CMS 2567 deficiency data and lists the tag numbers
  - Highest number is in patient rights in the CoP manual
- Updated the report quarterly
  - Available under downloads on the hospital website at www.cms.gov

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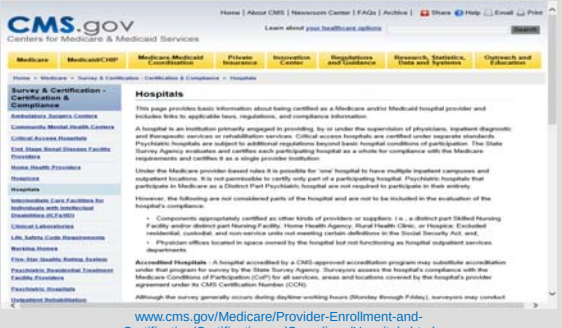
Updated Deficiency Data Reports



www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Hospitals.html

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Number of Deficiencies Patient Rights

- CMS issued its first deficiency report in March 22, 2013 and updating quarterly
- In March 2013 the number of patient rights deficiencies was **950**
- January 28,2016 the total number of patient rights deficiencies was **5,146** with restraints and seclusion being the most common (1,634)
- Reports lists the name and address of all hospitals receiving deficiencies

Number of Deficiencies Nov 3, 2016

Section	Number Of Deficiencies	Tag Number
Restraint and Seclusion	1,938	Tag 154-214
Care in a Safe Setting	985	Tag 144
Grievances	902	Tag 118-123
Consent & Decision Making	429	Tag 131-132
Freedom from Abuse & Neglect	375	Tag 145
Notice of Patient Rights	239	Tag 116 and 117
Care Planning	117	Tag 130

Number of Deficiencies Jan 28, 2016

Section	Number of Deficiencies	Tag Number
Privacy and Safety	175	142 and 143
Confidentiality	76	146 and 147
Visitation	41	215-217
Access to Medical Records Protect Patient Rights	19 556	148 115
Admission Status Notification	27	133
Exercise of Patient Rights	35	129 **Total 6,237**

Patient Rights Standards 0115-0217

- Minimum protections and rights for patients
- Right to notification of rights and exercise of rights
  - Privacy and safety
  - Confidentiality of medical records
  - Restraint issues (50 pages of restraint standards)
  - Grievances, Advance directives
  - Visitation rights

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Standard # 1

- Notice of Patient Rights and Grievance Process
- Hospital must ensure the notice of patient rights are met
- Provide in a manner the patient will understand
  - Remember issue of limited English proficiency (LEP) as with patients who does not speak English and low health literacy
  - 20% of patients read at a sixth grade level but most written at 10th or 11th grade so use read back
- Must have P&P to ensure patients have information necessary to exercise their rights

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Notice of Patient Rights 117

- Rule #1 - A hospital must inform each patient of the patient's rights in advance of furnishing or discontinuing care
  - Must protect and promote each patient's rights
- Must have P&P to ensure patients have information on their rights and this includes inpatients and outpatients
- Must take reasonable steps to determine patient's wishes on designation of a representative
  - Must give Medicare patient IM Notice within two days of admission and in advance of discharge if more than two days

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Designation of Representative 117

- If patient is not incapacitated and has an individual to be their representative then the hospital must provide the representative with the notice of patient rights in addition to the patient
  - Patient can do orally or in writing which author suggests
- If the patient is incapacitated then the notice of patient rights is given to the person who presents with an advance directive such as the DPOA
- If incapacitated and no advance directive then to the person who is spouse, domestic partner, parent of minor child, or other family member

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Designation of Representative 117

- This person is known as the patient representative
- You can not ask for supporting documentation unless more than one individual claims to be their representative
- If hospital refuses the request of an individual to be the patient's representative then must document this in the medical record
- States can specify a state law for doing this
- Hospital must adopt P&P on this

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Notice of Patient Rights

- Confidentiality and privacy
- Pain relief
- Refuse treatment and informed consent
- Advance directives
- Right to get copy for Medicare patients of Important Message from Medicare (IM Notice) or detailed notice)
- Right to be free from unnecessary restraints
- Right to determine who visitors will be

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Notify Patient of Their Rights

- When appropriate, this information is given to the patient's representative
  - Document reason, patient unconscious, guardian, DPOA, parent if minor child et. al.
- Consider having a copy on the back of the general admission consent form and acknowledgment of the NPP
- Have sentence that patient acknowledges receipt of their patient rights
- Right to contact the QIO (BFCC QIO) or state agency of problems

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Interpreters

- Rule #2 - A hospital must ensure interpreters are available
- Make sure communication needs of patients are meet
- Recommend qualified interpreters
- Must comply with Civil Rights law
- Be sure to document that the interpreter was used
  - See TJC Patient Centered Communications Standards

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Limited English Proficiency Resources

OCR Effective Communication

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Interpreters

- Consider posting a sign in several languages (15 languages/taglines) that interpreting services are available
- Include in yearly skills lab for nurses to make sure your staff knows what to do and they understand P&P
- Review your policy and procedure and the five patient centered communication standard TJC requirements
- If hospital owned physician practices ensure interpreters are present in prescheduled appointments

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Section 1557 ACA 2016

- Need to add section to patient rights statement regarding prohibiting sex discrimination
- Cannot segregate, delay, or deny services based on patient's color, race, or national origin
- May not delay or deny effective language assistance services to patients with LEP
- Taglines are short statements in non-English languages to notify the patient of the availability of language assistance services
  - Publish and place in prominent locations
  - Many sections overlap with CMS hospital patient rights

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Section 1557 ACA

- Must offer a timely qualified interpreter when oral interpretation is a reasonable step to provide a patient with meaningful access
- Language services are provided free of charge
  - May not require a patient to have their own interpreter
  - Cannot relay on child to interpret with exception
  - Cannot use low quality video remote interpreting services
- Treat individuals consistent with their gender identity, including with respect to access to facilities, such as bathrooms and patient rooms.

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Sample Language; Patient Rights Policy

- General Hospital respects the dignity and pride of each individual we serve.
- Every patient has the right to have his/her rights respected without regard to age, gender, disability, race, color, ancestry, citizenship, religion, pregnancy, sexual orientation, gender identity or expression, national origin, medical condition, marital status, veteran status, payment source or ability, or any other basis prohibited by federal, state, or local law

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Certification CHI CoreCHI

- **National Council on Interpreting in Health Care** and CCHI or the Certification Commission for Healthcare Interpreters (CCHI Associate Healthcare Interpreter credential and has two credentials)
  - **CHI stands for Certified Healthcare Interpreter** -best (Spanish, Mandarin & Arabic)
  - And entry level **Core Certification Healthcare Interpreter** (CoreCHI)
    - Every interpreter needs to have this today and for hospital to show compliance with TJC and National CLAS standard 7
  - Previously had **AHI** which stands for Associate Healthcare Interpreter and in 2014 decided was core professional certification so changed to CoreCHI

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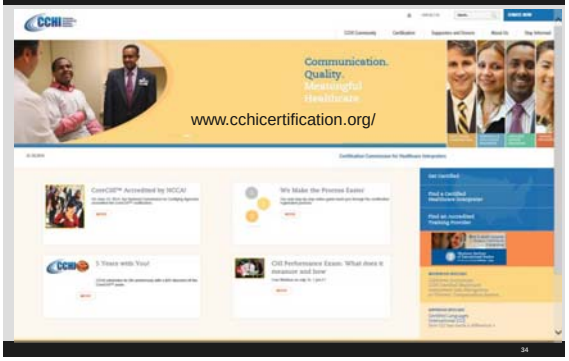
CCHI Certification Commission



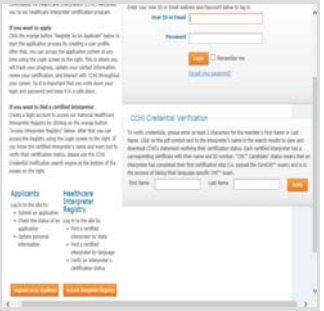
CoreCHI Is Entry Point for Interpreters

CCHI certification of interpreters helps facilitate HR tasks to ensure that individuals who provide language services have specific qualifications and competencies required to perform their job functions in a safe and efficient manner

www.cchicertification.org/healthcare-providers/ensure

CCHI Website

- Hospital can log on to their website and find a certified interpreter
- HR can verify interpreter's certification status
- Click on access interpreter registry



National Board of Certification

- **The National Board of Certification for Medical Interpreters**
  - **CMI or Certified Medical Interpreter** (best)
  - **Qualified Medical Interpreter (QMI)**
    - For minority languages where National Board does not have an exam and an oral exam is done in partnership with another national testing provider
  - Or **Screened Medical Interpreter (SMI)**
    - For newly emerging and indigenous languages and complete written exam
  - Question contact info@certifiedmedicalinterpreters.org

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National Board of Certification for Medical

www.certifiedmedicalinterpreters.org/

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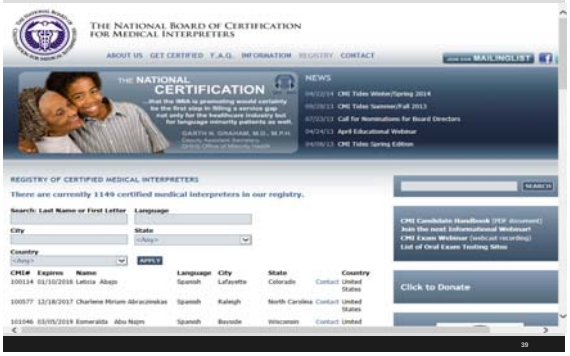
HR Can Check Registry



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Grievance Process 118

- Rule #3 - The hospital must have a process for prompt resolution of patient grievances
- Hospital must inform each patient to whom to file a grievance
- Provides definition which you need to include in your policy
- If TJC accredited combine P&P with complaint section complaint standard at RI.01.07.01 in which is similar to CMS now with one addition
- Use the CMS definition of grievance

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Grievance Process 118

- **Definition:** A patient grievance is a formal or informal written or verbal complaint
  - When the verbal complaint about patient care is not resolved at the time of the complaint by **staff present**
- By a patient, or a patient's representative,
- Regarding the patient's care, abuse, or neglect, issues related to the hospital's compliance with the CMS CoP or a Medicare beneficiary billing complaint related to rights

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Grievances 118

- Hospitals should have process in place to deal with minor request in more timely manner than a written request
  - Examples: change in bedding, housekeeping of room, and serving preferred foods
  - Does not require written response
- If complaint cannot be resolved at the time of the complaint or requires further action for resolution then it is a grievance
- All the CMS requirements for grievances must be met

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Patient or Their Representative

- If someone other than the patient complains about care or treatment
  - Contact the patient and ask if this person is their authorized representative
  - Get the patient's permission to discuss protected health information with designed person because of HIPAA
  - Document in the file that the patient's permission was obtained
    - Some facilities get a HIPAA compliant form signed

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Grievances 0118

- Not a grievance if patient is satisfied with care but family member is not
- Billing issues are not generally grievances unless a quality of care issue
- A written complaint is always a grievance whether inpatient or outpatient (email and fax is considered written)
- Information on patient satisfaction surveys generally not a grievance unless patient asks for resolution or unless the hospital usually treats that type of complaint as a grievance

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Grievances 0118

- If complaint is telephoned in after patient is dismissed then this is also considered a grievance
- All complaints on abuse, neglect, or patient harm will always be considered a grievance
  - Exception is if post hospital verbal communication would have been routinely handled by staff present
  - If patient asks you to treat as grievance it will always be a grievance

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- Patient complaints that are considered grievances also include situations where a patient or a patient's representative telephones the hospital with a complaint regarding the patient's care or with an allegation of abuse or neglect, or failure of the hospital to comply with one or more CoPs, or other CMS requirements. Those post-hospital verbal communications regarding patient care that would routinely have been handled by staff present if the communication had occurred during the stay/visit are not required to be defined as a grievance.
- All verbal or written complaints regarding abuse, neglect, patient harm, or hospital compliance with CMS requirements are considered grievances for the purposes of these requirements.
- Whenever the patient or the patient's representative requests that his or her complaint be handled as a formal complaint or grievance or when the patient requests a response from the hospital, the complaint is considered a grievance and all the requirements apply.

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Grievance Process - Survey Procedure

- Review the hospital policy to assure its grievance process encourages all personnel to alert appropriate staff concerning grievances
- Hospital must assure that grievances involving situations that place patients in immediate danger are resolved in a timely manner
- Conduct audits and PI to make sure your facility is following its grievance P&P

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Grievance Process - Survey Procedure

- Surveyor will interview patients to make sure they know how to file a complaint or grievance
  - Including right to notify state agency (state department of health and BFCC QIO with phone numbers)
  - Remember to add email address and address of both
  - Document that this is given to the patient
  - Remember the TJC APR requirements
- Should be in writing in patient rights section

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Grievance Process 119

- Rule #4 – The hospital must establish a process for prompt resolution
- Inform each patient whom to contact to file a grievance by name or title
- Operator must know where to route calls
- Make form accessible to all

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Grievance Process 119

- Rule #5 – The hospital's governing board must approve and is responsible for the effective operation of the grievance process
  - Elevates issue to higher administrative level
- Have a process to address complaints timely
- Coordinate data for PI and look for opportunities for improvement
- Read this section with the next rule
- Most boards will delegate this to hospital staff

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Board Responsibility Rule #6 119-120

- The hospital's board must review and resolve grievances
  - Unless it delegates the responsibility in writing to the grievance committee
- Board is responsible for effective operation of grievance process
  - Grievance process reviewed and analyzed thru hospital's PI program
  - Grievance committee must be more than one person and committee needs adequate number of qualified members to review and resolve

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Grievance Process 120

- Rule #7 – The grievance process must include a mechanism for timely referral of patient concerns regarding the quality of care or premature discharge to the appropriate QIO
- Now two QIOs in the country to handle grievances, called BFCC QIO; KEPRO and Livanta
- QIO are CMS contractors who are charged with reviewing the appropriateness and quality of care rendered to Medicare beneficiaries in the hospital setting

[1]http://www.qualitynet.org/dcs/ContentServer?pagename=Medqic/MQGeneralPage/GeneralPageTemplate&name=QIO%20Listings

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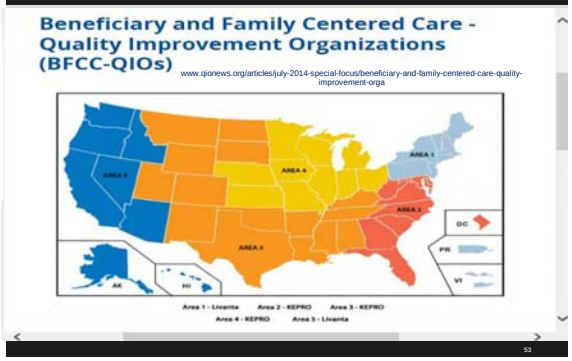
KEPRO and Livanta QIOs



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Beneficiary & Family Centered Care QIOs

- **Area 1 – Livanta**
  9090 Junction Drive, Suite 10
  Annapolis Junction, MD 20701
  Toll-free: 866-815 5440
  www.BFCCQIOAREA1.com
- **Area 2 – KEPRO**
  5201 W. Kennedy Blvd., Suite 900 Tampa, FL 33609
  Toll-free: 844-455-8708
  www.keprogio.com
- **Area 3 – KEPRO**
  5700 Lombardo Center Dr., Suite 100 Seven Hills, OH 44131
  Toll-free: 844-430-9504
  www.keprogio.com
- **Area 4 – KEPRO**
  5201 W. Kennedy Blvd., Suite 900 Tampa, FL 33609
  Toll-free: 855-408-8557
  www.keprogio.com
- **Area 5 – Livanta**
  9090 Junction Drive, Suite 10 Annapolis Junction, MD 20701
  Toll-free: 877-588-1123
  www.BFCCQIOAREA5.com

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Beneficiary & Family Centered Care QIOs

- Beneficiary and Family Centered Care (BFCC)-QIOs will manage:
  - All beneficiary complaints,
  - Quality of care reviews,
  - EMTALA,
  - And other types of case reviews
  - To ensure consistency in the review process while taking into consideration local factors important to beneficiaries and their families

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IM and Detailed Notice Forms

- Hospital to provide a Medicare patient with an Important Message from Medicare (IM notice) within 48 hours of admission
- The hospital must deliver to the patient a copy of this signed form again if more than two days and within 48 hours of discharge
- About 1% of Medicare patients voice concern about being discharge prematurely
  - These patients must be given a more detailed notice and request the QIO to review their case
- New forms IM “You Have the Right” and “Detailed Notice”
- Website for beneficiary notices[1]

[1]www.cms.hhs.gov/bni

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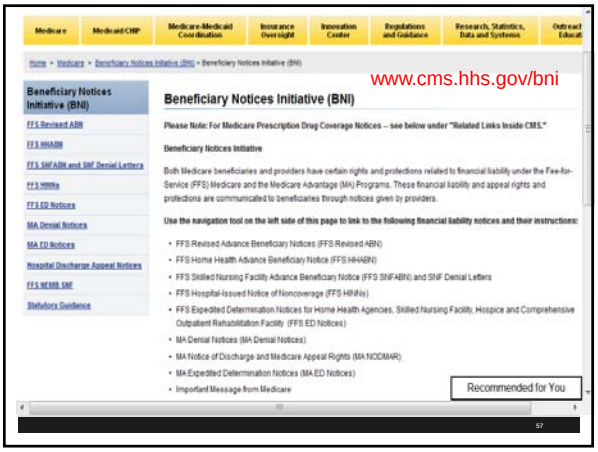

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CMS IM Notice

Department of Health & Human Services
Centers for Medicare & Medicaid Services
OMB Approval No. 0938-0692

Patient Name:
Patient ID Number:
Physician:

An Important Message From Medicare About Your Rights

As A Hospital Inpatient, You Have The Right To:

- Receive Medicare covered services. This includes medically necessary hospital services and services you may need after you are discharged, if ordered by your doctor. You have a right to know about these services, who will pay for them, and where you can get them.
- Be involved in any decisions about your hospital stay, and know who will pay for it.
- Report any concerns you have about the quality of care you receive to the Quality Improvement Organization (QIO) listed here:

Name of QIO

Telephone Number of QIO

Your Medicare Discharge Rights

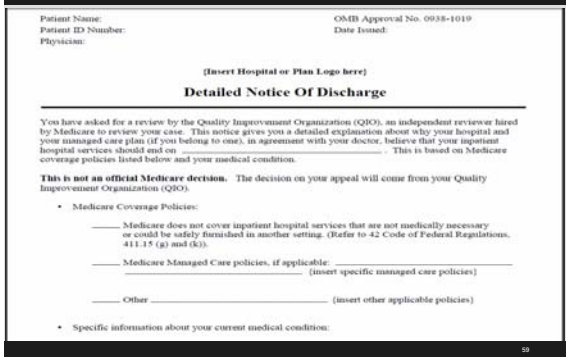
Planning For Your Discharge: During your hospital stay, the hospital staff will be working with you to prepare for your safe discharge and arrange for services you may need after you leave the hospital. When you no longer need inpatient hospital care, your doctor or the hospital staff will inform you of your planned discharge date.

If you think you are being discharged too soon:

- You can talk to the hospital staff, your doctor and your managed care plan (if you belong to one) about your concerns.
- You also have the right to an appeal, that is, a review of your case by a Quality Improvement Organization (QIO). The QIO is an outside reviewer hired by Medicare to look at your case to decide whether you are ready to leave the hospital.

58

Detailed Notice



Patient Name:
Patient ID Number:
Physician:

OMB Approval No. 0938-1019
Date Issued:

{Insert Hospital or Plan Logo here}

Detailed Notice Of Discharge

You have asked for a review by the Quality Improvement Organization (QIO), an independent reviewer hired by Medicare to review your case. This notice gives you a detailed explanation about why your hospital and your managed care plan (if you belong to one), in agreement with your doctor, believe that your inpatient hospital services should end on _____. This is based on Medicare coverage policies listed below and your medical condition.

This is not an official Medicare decision. The decision on your appeal will come from your Quality Improvement Organization (QIO).

- Medicare Coverage Policies:
  - _____ Medicare does not cover inpatient hospital services that are not medically necessary or could be safely furnished in another setting. (Refer to 42 Code of Federal Regulations, 411.15 (g) and (k)).
  - _____ Medicare Managed Care policies, if applicable: _____ {insert specific managed care policies}
  - _____ Other _____ {insert other applicable policies}
- Specific information about your current medical condition:

59

Grievance Procedure 121

- Hospital must have a clear procedure for the submission of a patient's written or verbal grievances
- Surveyor will review your information to make sure it clearly tells patients how to submit a verbal or written grievance
- Surveyor will interview patient to make sure information provided tells them how to submit a grievance
- Must establish process for prompt resolution of grievances

60

Hospital Grievance Procedure 122

- Rule #8 – Hospital must have a P&P on grievance
- Specific time frame for reviewing and responding to the grievance
- Grievance resolution that includes the patient with a written notice of its decision, IN MOST CASES
- The written notice to the patient must include the steps taken to investigate the grievance, the results and date of completion
- Facility must respond to the substance of each and every grievance

61

Grievances 7 Day Rule

- Timeframe of 7 days would be considered appropriate and if not resolved or investigation not completed within 7 days must notify patient still working on it and hospital will follow up
- Most complaints are not complicated and do not require extensive investigation
- Will look at time frames established
- Must document if grievance is so complicated it requires an extensive investigation

62

Grievances 123

- Explanation to the patient must be in a manner the patient or their legal representative would understand
  - Remember the issue of low health literacy
- The written response must contain the elements required in this section - not statements that could be used in legal action against the hospital
- Written response must the steps taken to investigate the complaint
- Surveyors will review the written notices to make sure they comply with this section

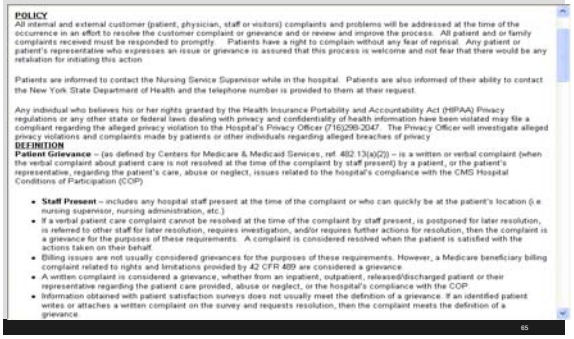
63

Grievances 123

- CMS says if patient emailed you a complaint, you may email back response
  - Be careful as many hospital policy on security do not allow this since email is not encrypted or some would have patient accept the risks of sending unencrypted PHI
- Must maintain evidence of compliance with the grievance requirements
- Grievance is considered resolved when patient is satisfied with action or if hospital has taken appropriate and reasonable action

64

Have a Policy to Hit All the Elements



POLICY

All internal and external customer (patient, physician, staff or visitors) complaints and problems will be addressed at the time of the occurrence in an effort to resolve the customer complaint or grievance and or review and improve the process. All patient and or family complaints received must be responded to promptly. Patients have a right to complain without any fear of reprisal. Any patient or patient's representative who expresses an issue or grievance is assured that this process is welcome and not fear that there would be any retaliation for initiating this action

Patients are informed to contact the Nursing Service Supervisor while in the hospital. Patients are also informed of their ability to contact the New York State Department of Health and the telephone number is provided to them at their request.

Any individual who believes his or her rights granted by the Health Insurance Portability and Accountability Act (HIPAA) Privacy regulations or any other state or federal laws dealing with privacy and confidentiality of health information have been violated may file a compliant regarding the alleged privacy violation to the Hospital's Privacy Officer (716)298-2047. The Privacy Officer will investigate alleged privacy violations and complaints made by patients or other individuals regarding alleged breaches of privacy

DEFINITION

Patient Grievance – (as defined by Centers for Medicare & Medicaid Services, ref. 482.13(a)(2)) – is a written or verbal complaint (when the verbal complaint about patient care is not resolved at the time of the complaint by staff present) by a patient, or the patient's representative, regarding the patient's care, abuse or neglect, issues related to the hospital's compliance with the CMS Hospital Conditions of Participation (COP)

- **Staff Present** – includes any hospital staff present at the time of the complaint or who can quickly be at the patient's location (i.e. nursing supervisor, nursing administration, etc.)
- If a verbal patient care complaint cannot be resolved at the time of the complaint by staff present, is postponed for later resolution, is referred to other staff for later resolution, requires investigation, and/or requires further actions for resolution, then the complaint is a grievance for the purposes of these requirements. A complaint is considered resolved when the patient is satisfied with the actions taken on their behalf.
- Billing issues are not usually considered grievances for the purposes of these requirements. However, a Medicare beneficiary billing complaint related to rights and limitations provided by 42 CFR 489 are considered a grievance.
- A written complaint is considered a grievance, whether from an inpatient, outpatient, released/discharged patient or their representative regarding the patient care provided, abuse or neglect, or the hospital's compliance with the COP.
- Information obtained with patient satisfaction surveys does not usually meet the definition of a grievance. If an identified patient writes or attaches a written complaint on the survey and requests resolution, then the complaint meets the definition of a grievance.

65

Standard #2 Exercise of Rights 130

- Rule #1 – Patients have the right to participate in the development and implementation of their plan of care
- Includes inpatients and outpatients
- Includes discharge planning and pain management
- Requires hospital to actively include the patient in developing their plan of care including changes

66

Patient Representative

- Repeats that hospital expected to take reasonable step to determine patient's wishes on designation of a representative with same requirements
- Same standard and if patient is not incapacitated and has a representative then must involve **both** in development and implementation of a plan of care
- If incapacitated and AD then this person is involved
- If incapacitated and no AD then to who claims to be patient representative and can not ask for supporting documentation unless two claim to be the representative

67

Patient Representative

- Same requirements about documenting any refusals to let someone be the representative in the medical record
- Same requirement to follow any specific state law
- Need P&P on this and should teach staff this section
- Policy must facilitate expeditious and non-discriminatory resolution of disputes about whether the person is the patient's representative

68

Patient Participate in Plan of Care

- If patient refuses to participate, document this
- Include patient's legal representative if patient minor or incompetent
- Plan of care is frequently cited
  - Do not need a separate plan of care for nursing if participates in interdisciplinary plan of care
- Patients needing post-hospital care are given choice home health or nursing homes in writing
- Includes choice to pain management, patient care issues, and discharge planning
  - Section 1802 of SSA guarantees free choice by Medicare patients for LTC or home health

69

Rule #2 - Patients Have a Right:

- To make informed decision regarding their care
- Being informed of their diagnosis
- To request or refuse treatment
  - Right to sign out AMA
  - Remember EMTALA requirements if patient is transferred
  - Have patient sign the transfer agreement

70

Informed Consent 0131

- CMS has 3 sections in the hospital CoP manual on informed consent
  - Section on informed consent in patient rights on informed decisions, medical records and surgical services
- The patient has the right to make informed decisions
- Same provisions related to the patient representative as before so if competent patient has a patient representative then you give information to both regarding the information required to make an informed decision about the care

71

Patient Representative and Consent

- CMS specifically states that the hospital must obtain the written consent of the patient representative of a patient who is not incapacitated
  - Continues throughout the inpatient hospitalization or the outpatient encounter
- Same provisions related to the patient who is incapacitated as to whether they have a DPOA and if not then to their patient representative
- If no advance directives the hospital can not ask the representative for supporting documentation unless two people claim to be the representative

72

Informed Consent 0131

- Right to delegate the right to make informed decisions to another (DPOA, guardian)
- Patient has a right to an informed consent for surgery or a treatment
- Right to be informed of health status and to be involved in care planning and treatment
- Informed decision on discharge planning to post acute care
- Right to request or refuse treatment and P&P to assure patient's right to request or refuse treatment

73

Disclosures to Patients 131

- There are two disclosures that must be in writing
  - If physician owned hospital
  - If a doctor or an ED physician is not available 24 hours a day to assist in emergencies
    - Include in notice to patients and post sign in the ED
    - Must be signed acknowledgement from the patient
- Must provide information at beginning of inpatient stay or visit
  - Physicians who refer patients to the hospital they have an ownership interest must disclose this and hospital requires this as a condition for the physician being credentialed or privileged
  - Give to patients at first opportunity and have P&Ps

74

Patient Rights 0132

- Patient has the right to make and have the advance directives followed when incapacitated
  - Staff must provide care that is consistent with these directives
  - P&P must include delegation of patient rights to representative if patient incompetent
  - In addition patient may designate in the AD a support person to make decision on visitation
- Note rights as inpatient outpatient AD requirements of Joint Commission

75

Advance Directives

- Your policy should have clear statement of any limitations such as conscience
  - At a minimum, clarify any difference between facility wide conscience objections and those raised by individual doctors
  - But can not refuse to honor designation of a DPOA, support person or patient representative
- You must provide written information to the patient on their rights under state law, at time of admission as an inpatient
  - Same notice to **3 types of outpatients**; ED, observation or same day surgery
  - Document whether or not they have an AD

76

Advance Directives 132

- Cannot condition treatment on whether or not they have one
- Not construed as a mechanism to demand inappropriate or medically unnecessary care
- Ensure compliance with state laws on AD
  - Inform patients they may file with state survey and certification agency
- Provide and document advance directives education
- Staff on P&P and community

77

Patient Rights

- Includes the right for DPOA to medical decisions when patient incapacitated such as informed consent or pain management
- Disseminate policy on advance directive, identify state authority permitting an objection
- Includes Psychiatric or behavioral health AD
- The visitation regulations are one of the newest patient rights

78

Family Member & Doctor Notified 133

- The patient has a right to have a family member or representative notified and their physician notified on admission if not aware
  - Must now ask every patient on admission and document
  - Must do so promptly when patient responds affirmatively
- If patient incapacitated must identify a family member or representative to promptly notify
- If someone comes with patient or arrives after and asserts they are the patient's representative then hospital accepts this
  - Same if two people claim to be their representative & follow state law

79

3rd Standard Privacy and Safety 143

- Standard: The patient has a right to personal privacy while within the hospital
- To receive care in a safe setting
- To be free from all forms of abuse or harassment
- Rule #1 – The right to personal privacy
  - Right to respect, dignity, and comfort
  - Privacy during personal hygiene activities (toileting, bathing, dressing, pelvic exam)

80

Personal Privacy 143

- Need consent for video/electronic monitoring
  - Must exist clinical need to do this
  - Make sure patient is aware and can see camera
  - Such as cameras in patient rooms (sleep lab, ED safe room, eICU) and not in hallways or lobbies
  - Include in your general admission consent form that all patients sign on admission or make sure patients are aware such in ICU
  - May use to monitor patients who are violent and or self destructive who are in both restraint and seclusion

81

Personal Privacy & Confidentiality 143

- Person not involved with care may not be present while exam is being done unless consent required (medical students who are observing not those caring for patient)
- Information in directory may not be disclosed without informing patient in advance
  - Visitor must ask for the patient by name
- Can use information for payment and healthcare operation
- Must have P&P that restrict access to MR to those who need to know such as nurse who takes care of patient

82

Personal Privacy & Confidentiality 143

- Discusses incidental uses and disclosures
  - Names on spine of chart
  - Names on outside of rooms
  - Whiteboards that list patient present in OR or PACU
- Take reasonable safeguards
  - Ask waiting patients to stand back a few feet from a counter used for patient registration
  - Speak quietly if patient in semi-private room
  - Passwords on computers
  - Limit access to areas with light boards or white boards

83

Personal Privacy

- Surveyor will conduct observations to determine if privacy provided during exams, treatments, surgery, personal hygiene activities, etc.
- Surveyor will look to see if names with patient information is posted in plain view
- Survey procedure will ask if patient names are posted in public view
  - No white boards with patient names and other PHI such as diagnosis

84

Privacy and Safety 144

- Rule #2 – The right to receive care in a safe setting
  - Includes following standards of care and practice for environmental safety, infection control, and security such as preventing infant abductions, preventing patient falls and medication errors
  - Very broad authority for patient safety issue
- Right to respect for dignity and comfort

85

Care in a Safe Setting

- Includes washing hands between patients - see CDC or WHO hand hygiene and TJC Measuring Hand Hygiene Adherence
- Review and analyze incident or accident reports to identify problems with a safe environment
- Review policies and procedures
- How does facility have P&P to curtail unwanted visitors or contraband materials

86

Privacy and Safety 145

- Rule #3 – The patient has the right to be free from all forms of abuse or harassment and neglect
  - Must have process in place to prevent this
  - Criminal background checks as required by your state law
- Must provide ongoing (yearly) training on abuse, harassment, and neglect

87

Privacy and Safety 145

- Consider annual training in yearly skills lab
- Must have P&P on this
- Adequate staffing section
- Have proactive approach to identify events that could be abuse
- TJC and CMS have definitions of what is abuse and neglect

88

Freedom From Abuse and Neglect

- Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment, with resulting physical harm, pain, or mental anguish
  - Includes staff neglect or indifference to infliction of injury or intimidation of one patient by another
  - Include state laws in your P&P on abuse and neglect
- Remember TJC has standard and definitions, RI.01.06.03

89

Freedom From Abuse and Neglect

- Neglect is defined as the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness
- Investigate all allegations of abuse or neglect
- Do not hire persons with record of abuse or neglect
- Report all incidents to proper authority, board of nursing, etc.

90

Freedom From Abuse and Neglect

- Includes freedom abuse from not just staff but other patients and visitors
- Hospital must have a mechanism in place to prevent this
- Effective abuse program includes prevention
  - Adequate number of staff who have been screened
  - Identify events that could lead to or contribute to abuse
  - Protect during investigation
  - Investigate and report and respond

91

Abuse and Neglect

- Make sure you have a policy in place for investigating allegations of abuse
- Make sure staffing sufficient across all shifts
- Make sure appropriate action taken if substantiated
- Make sure staff know what to do if they witness abuse and neglect
- See reference slides on the TJC standards on abuse and neglect under RI.01.6.03

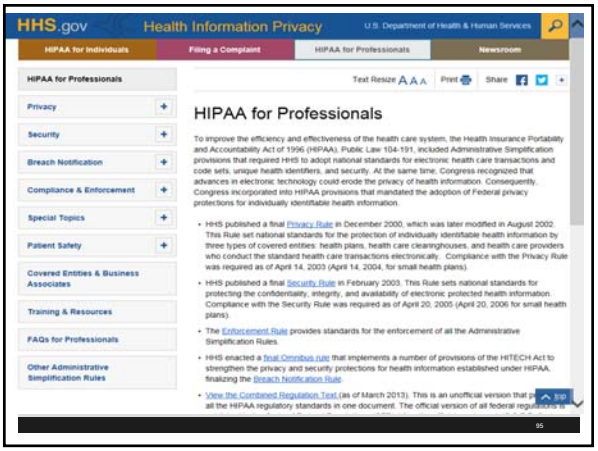
92

Standard #4 Confidentiality 147

- Rule #1 – Patients have a right to confidentiality of their medical records and to access of their medical records (0146)
  - Sufficient safeguards to ensure access to all information
  - HIPPA compliant authorization for release
- Minimal necessary standard such as abstract out information on child abuse and don't give protective services the entire chart
- MR are kept secure and only viewed when necessary by staff involved in care
- Do not post patient information where it can viewed by visitors

93

OCR Privacy Website



Standard #4 Confidentiality 147

- TJC IM.02.01.01 standard requires that hospital protects the privacy of health information, maintain security of same (white boards)
- If white board visible to public hospital consider using first name and first initial of last name
- Must protect patient's medical record information from unauthorized person
  - Must have a policy and procedure on this
- Obtain patient or patient representative written authorization to disclose medical record information

Patient Records

- Rule #2 – Patients have the right to access the information contained within their medical records
- Right to inspect their record or to get a copy
  - 30 day rule under HIPAA unless state law or P&P more stringent
  - HIPAA changes Sept 23, 2013
- Limited exceptions such as psychotherapy notes, prisoners if jeopardize health of themselves or others, information could cause harm to another, under promise of confidentiality, etc.

97

Access to Medical Records (PHI)

- Rule #3 – Access to the medical record must be within a reasonably time frame and hospitals can not frustrate efforts of patients to get records
- If patient is incompetent then to the personal representative and should sign as the personal representative such as guardian, parent, or DPOA
- Reasonable cost for copying, postage or summary
  - No retrieval fee allowed under federal law

98

5th Standard Restraints 0154-0214

- Many changes were made since 1986
- Combined the two sections on medical surgical and behavioral restraints into one section
- Do not need to report death if patient had on only 2 **soft** wrist restraints and deaths not due to the restraints

99

Restraint Patient Safety Brief

EMERGENCY MEDICINE PATIENT SAFETY FOUNDATION

Restraint and Seclusion Patient Safety Briefing
Emergency Medicine Patient Safety Foundation

Written by: Sue Dill Calloway RN MSN JD CPHRM
Michael Gerardi, MD, FAAP, FACEP
John (Jack) Kelly DO, FACEP, FAAEM

March 2012
Revised July 16, 2012

Introduction

Restraint and seclusion is a very important patient safety issue. Appropriately applied restraints can protect patients from harming themselves or others. Paradoxically, improperly applied restraints can result in patient injury and death. It is also an important regulatory issue for accreditation organizations such as the Joint Commission. Likewise, any hospital accredited by DNV Healthcare or by the American Osteopathic Association (AOA) Healthcare Facility Accreditation Program must follow any specific standards they may have.

100

CMS Proposed Changes to R&S

- CMS proposes changes in June 16, 2016 FR
- Would change LIP (licensed independent practitioner) to LP (licensed practitioner)
  - This would allow a Physician Assistant (PA) to order R&S
- If patient is V/SD an assessment must be done after 24 hours by a physician or LP who is responsible for the care of the patient
- Physician and other LP training requirements must be specified in the hospital policy
- After 1 hour face to face must contact physician or LP

101

Proposed Changes June 16, 2016 FR

www.gpo.gov/fdsys/pkg/FR-2016-06-16/pdf/2016-13925.pdf

FEDERAL REGISTER

Vol. 81 Thursday,
No. 116 June 16, 2016

Part IV

Department of Health and Human Services

Centers for Medicare & Medicaid Services
42 CFR Parts 482 and 485
Medicare and Medicaid Programs; Hospital and Critical Access Hospital (CAH) Changes To Promote Innovation, Flexibility, and Improvement in Patient Care; Proposed Rule

102

Restraint Changes

- Will need to include information in internal log
- Log must be done asap and never any later than 7 days
  - Log must include patient's name, date of birth, date of death, attending physician, primary diagnosis, and medical record number
  - Name of practitioner responsible for patient could be used in lieu of attending if under care on non-physician practitioner
  - CMS could request to review the log at anytime
- Would still require reporting of deaths within seven
- Need to rewrite policies and procedures and train all staff

103

Restraint Worksheet

- CMS has restraint worksheet[1] which is now an official OMB form
  - Revised form June 2013
- Must notify regional office by phone the next business day except for soft limb restraints
  - Document this in medical record
  - CMS has manual to address complaint surveys
  - Put regional office contact information in your P&P[1]
  - [1]www.cms.hhs.gov/SurveyCertificationGenInfo/downloads/SCLetter06-31.pdf

[1]www.cms.hhs.gov/RegionalOffices/01_overview.asp

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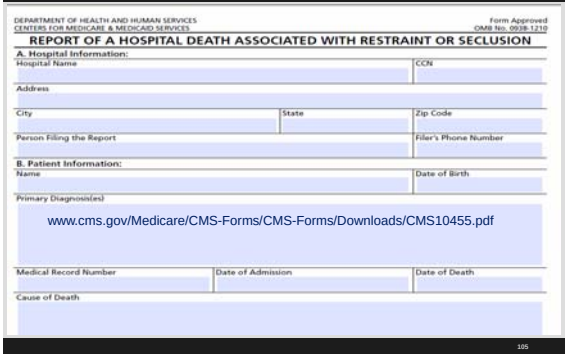
Type In Information and Print Off



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-1210

REPORT OF A HOSPITAL DEATH ASSOCIATED WITH RESTRAINT OR SECLUSION

A. Hospital Information:

Hospital Name | CCN

Address

City | State | Zip Code

Person Filing the Report | Filer's Phone Number

B. Patient Information:

Name | Date of Birth

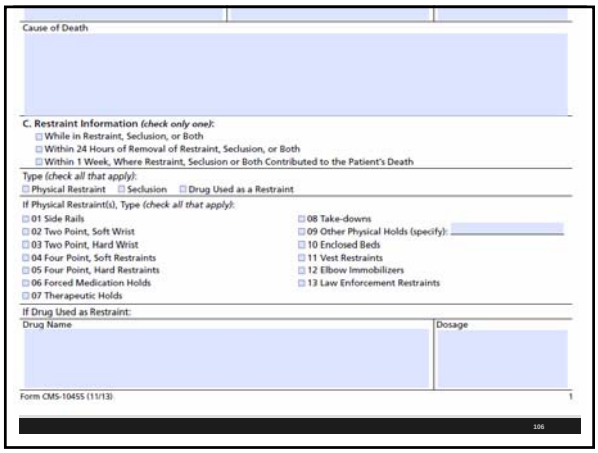
Primary Diagnosis(es)

www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS10455.pdf

Medical Record Number | Date of Admission | Date of Death

Cause of Death

105



Cause of Death

C. Restraint Information *(check only one)*:
- ☐ While in Restraint, Seclusion, or Both
- ☐ Within 24 Hours of Removal of Restraint, Seclusion, or Both
- ☐ Within 1 Week, Where Restraint, Seclusion or Both Contributed to the Patient's Death

Type *(check all that apply)*:
☐ Physical Restraint ☐ Seclusion ☐ Drug Used as a Restraint

If Physical Restraint(s), Type *(check all that apply)*:
- ☐ 01 Side Rails
- ☐ 02 Two Point, Soft Wrist
- ☐ 03 Two Point, Hard Wrist
- ☐ 04 Four Point, Soft Restraints
- ☐ 05 Four Point, Hard Restraints
- ☐ 06 Forced Medication Holds
- ☐ 07 Therapeutic Holds
- ☐ 08 Take-downs
- ☐ 09 Other Physical Holds (specify): _____
- ☐ 10 Enclosed Beds
- ☐ 11 Vest Restraints
- ☐ 12 Elbow Immobilizers
- ☐ 13 Law Enforcement Restraints

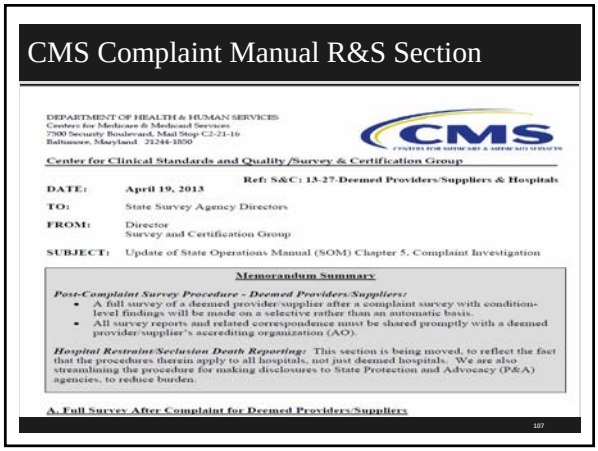
If Drug Used as Restraint:

Drug Name	Dosage

Form CMS-10455 (11/13) 1

106

CMS Complaint Manual R&S Section



DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

Center for Clinical Standards and Quality /Survey & Certification Group

Ref: S&C: 13-27-Deemed Providers/Suppliers & Hospitals

DATE: April 19, 2013

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Update of State Operations Manual (SOM) Chapter 5, Complaint Investigation

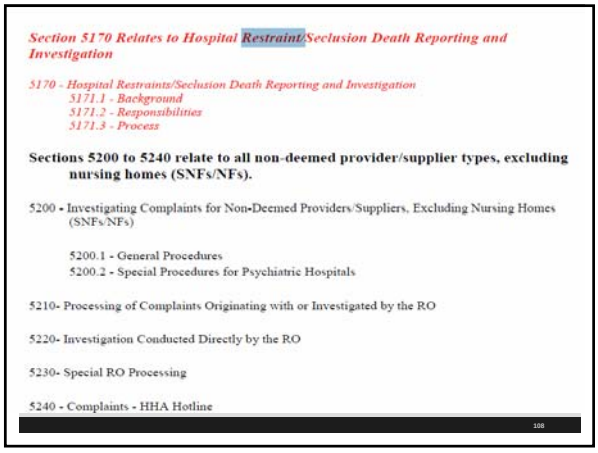
Memorandum Summary

Post-Complaint Survey Procedure - Deemed Providers/Suppliers:
- A full survey of a deemed provider/supplier after a complaint survey with condition-level findings will be made on a selective rather than an automatic basis.
- All survey reports and related correspondence must be shared promptly with a deemed provider/supplier's accrediting organization (AO).

Hospital Restraint/Seclusion Death Reporting: This section is being moved, to reflect the fact that the procedures therein apply to all hospitals, not just deemed hospitals. We are also streamlining the procedure for making disclosures to State Protection and Advocacy (P&A) agencies, to reduce burden.

A. Full Survey After Complaint for Deemed Providers/Suppliers

107



Section 5170 Relates to Hospital Restraint/Seclusion Death Reporting and Investigation

5170 - Hospital Restraints/Seclusion Death Reporting and Investigation
- *5171.1 - Background*
- *5171.2 - Responsibilities*
- *5171.3 - Process*

Sections 5200 to 5240 relate to all non-deemed provider/supplier types, excluding nursing homes (SNFs/NFs).

5200 - Investigating Complaints for Non-Deemed Providers/Suppliers, Excluding Nursing Homes (SNFs/NFs)

- 5200.1 - General Procedures
- 5200.2 - Special Procedures for Psychiatric Hospitals

5210- Processing of Complaints Originating with or Investigated by the RO

5220- Investigation Conducted Directly by the RO

5230- Special RO Processing

5240 - Complaints - HHA Hotline

108

Restraints

- Changes only affect regular hospitals and Critical Access Hospitals have own manual
- CAH do not have a patient rights section which addresses R&S
- CAH must have P&P so they can either use TJC standards or select some or all of hospital ones
  - Some CAH have adopted all if in system with regular hospitals
  - Suggest use same ones except for reporting requirements

109

Standard #5 Restraints

- Rule #1 – Patients have a right to be free from physical or mental abuse, and corporal punishment
- This includes that restraint and seclusion (RS)
  - Will only be used when necessary
  - Not as coercion, discipline, convenience or retaliation
  - Only used for patient safety and discontinued at earliest possible time
- R&S guidelines from CMS apply to all hospital patients even those in behavioral health

110

Right to be Free From Restraint

- Hospitals should consider adding it to their patient rights statement if not already there
- Patients are required to be provided a copy of their rights (staff must document or have patient sign that they received their rights)
  - Could include information in admission packet
- If patient falls do not consider using R&S as routine part of fall prevention (154)

111

Rule #2 Hospital Leadership's Role

- Like TJC, leadership is responsible for creating a culture that supports right to be free from R&S
- LD must make sure systems and processes in place to eliminate inappropriate R&S and monitors use thru PI process
- LD makes sure only used for physical safety of patient or staff
- LD ensure hospital complies with all R&S requirements (154)

112

Restraints Protocols

- CMS previously did not recognize or allow the use of protocols like Joint Commission does
- Protocols are now not banned by the new regulations (168) but still need separate order for R&S so didn't really help
- Must contain information for staff on how to monitor and apply like intubation protocol
  - Must document individualized assessment, symptoms and diagnosis that triggered protocol
  - Need MS involvement in developing and review and quality monitoring of their use

113

Restraint Standards

- If a patient becomes violent or has self destructive behavior (V/SD) in the ICU or ED, CMS has one set of standards that apply
- Decision to use R&S is not driven from diagnosis but from assessment of the patient
- TJC standards changed July 1, 2009
  - 10 new standards in the PC Chapter
  - TJC eliminated the rest of the preexisting R&S standards except two (forensic and one on behavioral management) for hospital who use TJC for deemed status

114

Restraint Standards Medical Patients

- Joint Commission calls it behavioral health and non-behavioral health
- CMS calls it violent and or self destructive (V/SD) and non-violent and non-self destructive
- CMS says it is not the department in which the patient is located but the behavior of the patient

115

Rule #3 Know Definition 159

- New definition: Physical restraint is any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely
  - Mechanical restraints include belts, restraint jackets, cuffs, or ties
  - Manual method of holding the patient is a restraint

116

DEFINITIONS OF RESTRAINT and SECLUSION

A restraint is:

- Any manual method, physical or mechanical device, material, or equipment that restricts, immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely that cannot be removed easily by the patient;
- A drug or medication used as a restraint is a medication used to control behavior or restrict a patient's movement and is not a standard treatment or dosage for the patient's condition.
- If all four side rails are up, or if belts are being used to keep a **patient in bed or from getting up**, they are considered to be a restraint and all the policy/procedure and documentation guidelines apply.

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 (including stroller safety belts, swing safety belts, high chair lap belts, raised crib rails, crib covers, if age specific), or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort).

Restraint Definition

- A drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or standard dosage for the patient's condition (160)
- Use of PRN drug is only prohibited if medication meets definition of drug
  - Ativan for ETOH withdrawal symptoms is okay

118

When Drug is not a Restraint

- Medication is within pharmacy parameters set by FDA and manufacturer for use
- Use follows national practice standards
- Used to treat a specific condition based on patient's symptoms
- Standard treatment would enable patient to be effective or appropriate functioning

119

Definition of Seclusion

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

120

Seclusion

- It is when they are alone in a room and physically prevented from leaving
- May only use seclusion for management of V/SD behavior that is danger to patient or others
- Time limits on length of order apply such as four hours for an adult
- One hour face to face evaluation must be done (183)
- Therapeutic holds to manage V/SD patients are a form of restraint

121

Restraints Do Not Include

- Forensic restraints such as handcuffs, shackles, or other restrictive devices applied by law enforcement or police are not R&S (0154)
  - Closely monitor and observe for safety reasons
- Orthopedically prescribed devices, surgical dressings or bandages, protective helmets (161)
- Methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests (161)

122

Restraints Do Not Include

- Protecting the patient from falling out of bed
  - Cannot use side rails to prevent patient from getting out of bed if patient can not lower
- Striker beds or the narrow carts and their use of side rails are not a restraint
- IV board unless tied down or attached to bed
- Postural support devices for positioning or securing (161)
- Device used to position a patient during surgery or while taking an x-ray

123

Restraints Do Not Include

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

124

Restraints Do Include

- Tucking in a sheet so tight patient could not move (159)
- Use of enclosed bed or net bed unless the patient can freely exit the bed such as zipper inside the bed
- Freedom splint that immobilizes limb
- Remember that is it not the thing but what the thing does to the patient in which their movement is restricted

125

So, Is This a Restraint?

126

Restraints

- Devices with multiple purposes - such as side rails or Geri chairs, when they cannot be easily removed by the patient
  - Restrict the patient's movement constitute a restraint
- If belt across patient in wheelchair and he can unsnap belt or Velcro then it is not a restraint (159)
- If patient can lower side rails when she wants then it is not a restraint but document this
- If a patient can remove a device it is not a restraint

127

Restraints

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

128

Weapons 154

- CMS does not consider the use of weapons by hospital staff on patients as safe in the application of restraint (154)
- Could use on criminal breaking into building
- Weapons include pepper spray, mace, nightsticks, tazers, stun guns, pistols, etc.
- Okay if patient is arrested and use by law enforcement such as non-employed staff like police as state and federal laws

129

Assessment

- Should do comprehensive assessment and assess to reduce risk of slipping, tripping or falling
  - To identify medical problems that could be causing behavioral changes (0154) such as increased temp, hypoxia, low blood sugar, electrolyte imbalance, drug interactions, etc.
  - Use of restraint is not considered routine part of a falls prevention program (154)

130

Determine Reason for R&S

- Surveyor will look to see if there is evidence that staff determined the reason for the R&S (154)
- This should be documented and be specific
- Consider a field on the order sheet to include this
- Usually to prevent danger to the patient or others
- Danger to self, maintain therapeutic environment such as to prevent patient from removing vital equipment, physically attempting to harm others or property, patient demonstrated lack of understanding to comply with safety directions

131

Reasons to Restrain

(Check all that apply)

- Unable to follow directions
- High risk of falls
- Aggressive
- Disruptive/combative
- History of hip fracture/falls
- Self injury
- Interference with treatments
- Removal of medical devices
- Other: _____

132

Rule #4 Less Restrictive

- Restraints can only be used when less restrictive interventions have been determined to be ineffective to protect the patient or others from harm (154, 164, 165,)
- Type or technique used must also be least restrictive
- Is what the patient doing a hazard?
  - Allowing sundowners to walk or wander at night (154)
- Request from patient or family member is not sufficient basis for using if not indicated by condition of patient

133

Less Restrictive

- Must do an assessment of patient
- Must document that restraint is least restrictive intervention to protect patient safety based on assessment
- What was the effect of least restrictive intervention
- You must train on what is least restrictive interventions

134

Least Restrictive Restraint to More

▪ Side-rails……..	▪ Net bed
▪ Hand mittens…….	▪ Soft extremity restraint
▪ Lap board……..	▪ Geri chair
▪ Roll belt/lap belt……	▪ Vest restraint
▪ 2-point soft restraint,,	▪ 3- or 4-point soft
▪ Wrap IV site …….	▪ Arm board
▪ Hand mitten…….	▪ Soft wrist restraint
▪ Freedom splint is a restraint!	

Rule # 5 Alternatives

- Alternatives should be considered along with less restrictive interventions (186)
- What are other things you could do to prevent using R&S such as sitter or family member stays with patient
- Distractions such as watching video games or working on a laptop computer
- Try nonphysical intervention skills (200)
- Considering having a list of alternatives in the toolkit

136

Consider Alternatives

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

Restraints LIP Can Write Orders

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

138

Restraints Notify Doctor ASAP 170

- Rule #7 - Any established time frames must be consistent with asap (not in 1 or 3 hours)
- Hospital MS policy determine who is the attending physician
- Hospital P&P should address the definition of asap (182,170)
- RN or PA who does 1 hour face-to-face must notify attending physician and discuss findings (182)
- Be sure to document if LIP or nurse notifies physician

139

Restraints Order Needed

- Rule #8 An order must be received for the restraint by the physician or other LIP who is responsible for the care of the patient (168)
- Include in P&P use in an emergency
- P&P to include category of who can order (PA, NP, resident, can not be med student)
- PRN order prohibited if for medication used as a restraint, okay if not a restraint
- No PRN order for restraints either (167, 169), except for 3 exceptions (169)

140

PRN Order 3 Exceptions

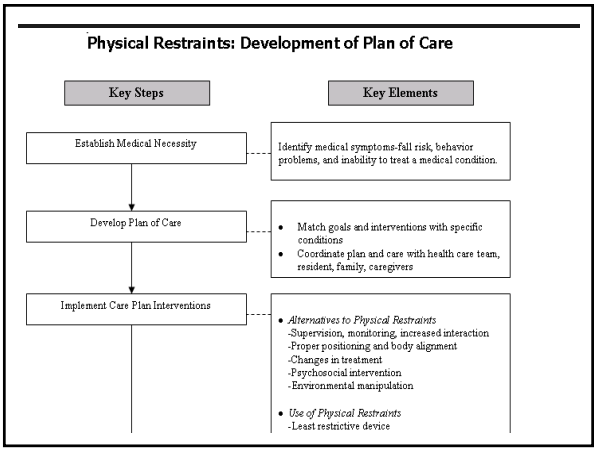
- Repetitive self-mutilating behavior (169), such as Lesch-Nyham Syndrome
- Geri chair if patients requires tray to be locked in place when out of bed
- Raised side rails if requires all 4 side rails to be up when the patient is in bed
- Do not need new order every time but still a restraint

141

Rule #9 Plan of Care

- Restraints must be used in accordance with a written modification to the patient's plan of care (166)
  - What was the goal of the plan of care
  - Use of restraint should be in modified plan of care
- Care plan should be reviewed and updated in writing
  - Within time frame specified in P&P (166)
  - Plan reflects a loop of assessment, intervention, evaluation and reevaluation

142



Restraints - Plan of Care

- Orders are time limited and this is included in the plan of care
- For patient who is V/SD may want to debrief as part of plan of care but not mandated by CMS
- Debriefing no longer mandated by TJC for behavioral patients (deemed status)
  - TJC requires de-escalation under PC.01.01.01
- Can add information on debrief to R&S toolkit

144

Rule #10 End at Earliest Time

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

145

Restraints - End at Earliest Time

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

146

Rule #11 Assessment of Patient

- Staff must assess and monitor patient's condition on ongoing basis (0154, 174, 175)
- Physician or LIP must provide ongoing monitoring and assessment also (175)
- One reason to determine is if R&S can be removed
- Took out word continually monitored except for V/SD patients and says at an interval determined by hospital policy

147

Rule #11 Assessment of Patient

- Intervals are based on patient's need, condition and type of restraint used (V/SD or not)
- CMS doesn't specify time frame for assessment like TJC use to (TJC use to say every 2 hours for medical patients and every 15 minutes for behavioral health patients)
- CMS says this may be sufficient or waking patient up every 2 hours in night might be excessive
- This must be in your hospital P&P frequency of evaluations and assessments (175) and document to show compliance

148

Rule #12 Documentation

- Most hospital use special documentation sheet for assessment parameters, including frequency of assessment, and hospital policy should address each of these (175, 184)
- If doctor writes a new order or renews order need documentation that describes patients clinical needs and supports continued use (174)
- Document; fluids offered (hydration needs), vital signs
- Toileting offered (elimination needs)
- Removal of restraint and ROM and repositioning
- Mental status, circulation

149

Rule #12 Documentation

- Attempts to reduce restraints, skin integrity, and level of distress or agitation, et. al.
- Document the patient's behavior and interventions used
- Behavior should be documented in descriptive terms to evaluate the appropriateness of the intervention (185)
  - Example, patient states the Martians have landed and attempting to strike the nurses with his fists. Patient attempting to bite the nurse on her arm. Patient picked up chair and threw it against the window

150

Rule #12 Documentation

- Document clinical response to the intervention (188)
- Symptoms and condition that warranted the restraint must be documented (187)
- Have the restraint toolkit where you have the documentation sheet with the requirements, the order sheet, manufacturer instructions for the restraints, articles, etc.
  - Many have separate order sheets for V/SD (behavioral health) and non V/SD (non behavioral health)

151

Document Type of Restraint

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

☐ 4 Side Rails ☐ Elbow Immobilizers ☐Soft Wrist Restraint(s) ☐Hand Mitt(s)

☐ Soft Wrist Restraint(s) ☐Vest ☐Soft Ankle Restraint(s) ☐ Papoose Board

☐Other_____

CATEGORY OF ORDER: (CHECK ALL THAT APPLY)

☐ Initial order ☐ Continuation order ☐Verbal order

I have assessed the patient, attempted or considered alternative(s), determined the need for restraints, and have notifie

_____ and have obtained an order for the application of restraints.

Print Name of L.I.P.

RN Signature _____Date:_____ Time: _____

Print Name_____

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

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

I have notified _____on Date _____Time_____

Print Name of Attending Staff Physician

L.I.P. Signature_____ Date_____ Time _____

Print Name _____

Log and QAPI

- Hospital take actions thru QAPI activities
- Hospital leadership should assess and monitor use to make sure medically necessary
- Consider log to record use-shift, date, time, staff who initiated, date and time each episode was initiated, type of restraint used, whether any injuries of patient or staff, age and gender of patient

153

Restraint Review Form

Medical Record Number: _____ Restraint Date: _____ Review Date: _____

Complex/Unit: _____ Review By: _____

Restraint Time In: _____ Restraint Time Out: _____

Criteria #	Criteria	Answer
117	All episodes of restraints are ordered/ countersigned by the physician Responsible Person:	Yes / No / NA
118	When emergency use of restraint is ordered, the physician visits within one (1) hour to authorize continued use. Responsible Person:	Yes / No / NA
119	Each episode of restraint has a specific time limit documented in the order by the physician. Responsible Person:	Yes / No / NA
120	Each episode of restraint has a written order limited to one (1) hour by the physician. Responsible Person:	Yes / No / NA
121 (A)	Each episode and re-evaluation of restraint is documented in the patient's medical record by the physician. Responsible Person:	Yes / No / NA
121 (B)	Each episode and re-evaluation of restraint is documented in the patient's medical record by the nurse. Responsible person:	Yes / No / NA

Rule #13 Use as Directed

- Restraints and seclusion must be implemented in accordance with safe, appropriate restraining techniques (167)
- As determined by hospital policy in accordance with state law
- Use according to manufacturer's instructions and include in your policy as attachment
- Follow any state law provision or standards of care and practice
- Was there any injury to patient and if so fill out incident report

155

Rule #14 One Hour Rule

- The lighting rod for public comment and AHA sued CMS over this provision
- Standard for behavioral health patients or V/SD
- Time limits for R&S used to manage V/SD behavioral and drugs used as restraint to manage them(178)
- Must see (face to face visit) and evaluate the need for R&S within one hour after the initiation of this intervention

156

One Hour Rule 178

- Big change is face to face evaluation can be done by physician, LIP or a RN or PA trained under 482.13 (f)
- Physician does not have to come to the hospital to see patient now, telephone conference may be appropriate
- Training requirements are detailed and discussed later
- To rule out possible underlying causes of contributing factors to the patient's behavior

157

One Hour Rule Assessment 482.13 (f)

- Must see the patient face-to-face within 1-hour after the initiation of the intervention, unless state law more restrictive (179)
- Practitioner must evaluate the patient's immediate situation
- The patient's reaction to the intervention
- The patient's medical and behavioral condition
- And the need to continue or terminate the restraint or seclusion
- Must document this (184) and change documentation form to capture this information

158

One Hour Rule Assessment

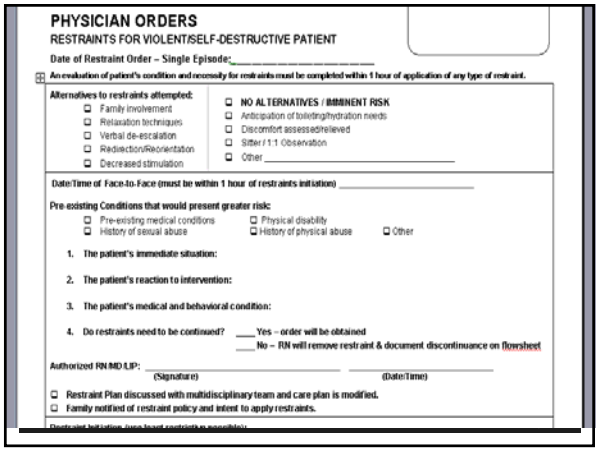
- Include in form evaluation includes physical and behavioral assessment (179)
- This would include a review of systems, behavioral assessment, as well as
- Patient's history, drugs and medications and most recent lab tests
- Look for other causes such as drug interactions, electrolyte imbalance, hypoxia, sepsis etc. that are contributing to the V/SD behavior
- Document change in the plan of care
- Must be trained in all the above (196)

159

Rule #15 Time Limited Orders

- Time limits apply- written order is limited to (171)
  - 4 hours for adults
  - 2 hours for children (9-17)
  - 1 hour for under age 9
- Related to R&S for violent or self destructive behavior and for safety of patient or staff
- Standard same now for Joint Commission time frame for how long the order is good for and closely aligned now

160



PHYSICIAN ORDERS

RESTRAINTS FOR VIOLENT/SELF-DESTRUCTIVE PATIENT

Date of Restraint Order – Single Episode:_____

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

Alternatives to restraints attempted:

- ☐ Family involvement
- ☐ Relaxation techniques
- ☐ Verbal de-escalation
- ☐ Redirection/Reorientation
- ☐ Decreased stimulation

- ☐ **NO ALTERNATIVES / IMMINENT RISK**
- ☐ Anticipation of toileting/hydration needs
- ☐ Discomfort assessed/relieved
- ☐ Sitter / 1:1 Observation
- ☐ Other _____

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

Pre-existing Conditions that would present greater risk:

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

1. **The patient's immediate situation:**
2. **The patient's reaction to intervention:**
3. **The patient's medical and behavioral condition:**
4. **Do restraints need to be continued?** ___ Yes – order will be obtained
   ___ No – RN will remove restraint & document discontinuance on flowsheet

Authorized RN/MD/LIP: _____ _____
(Signature) **(Date/Time)**

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

Rule #16 Renew Order

- The original order for both violent or destructive may be renewed up to 24 hours then physician reevaluates
- Nurse evaluates patient and shares assessment with practitioner when need order to renew (171, 172)
- Unless state law if more restrictive
- After the original order expires, the MD or LIP must see the patient and assess before issuing a new order

162

Rule #16 Renew Order

- Each order for non violent or non-destructive patients may be renewed as authorized by hospital policy (173)
- Remember TJC requires an order to renew restraints on medical patients (which they now call non-behavioral health patients) every 24 hours
  - Not daily but every 24 hours
  - CMS and TJC the same

163

Rule #17 Need Policy on R&S

- Will interview staff to make sure they know the policy (154)
- Consider training on policy in orientation and during the annual in-service and when changes made
- Remember hitting restraints hard in the survey process
- Surveyor to look at use of R&S and make sure it is consistent with the policy

164

POLICY

In keeping with the philosophy of St. Mary's Hospital, the goal is to become a restraint free facility. Every patient has the right to be treated with dignity and respect and the right to be free from any physical restraint unless their safety or the safety of others is in jeopardy.

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 use 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.

APPROVED TYPES OF RESTRAINTS

Soft limb restraints
Hard restraints (4-point - may only be used in ICU or ED)
Four Side Rails (see description below)
Medication / chemical unless it is used as a therapy for a patient's medical condition

ALTERNATIVES TO RESTRAINTS

Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, staff members or others from harm. 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.

Examples of items that are not restraints include side rails, lap boards, mitts that are not tied down, lap or roll belts, etc. if a patient can remove them.

DEFINITIONS OF RESTRAINT and SECLUSION

A restraint is:

- Any manual method, physical or mechanical device, material, or equipment that restricts

Rule #18 Staff Education

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

166

Rule #18 Staff Education

- Patients have a right to safe implementation of RS by trained staff (194)
- Training plays critical role in reducing use (194)
- Staff, including agency nurses, must not only be trained but must be able to demonstrate competency in the following:
- The application of restraints (how to put them on), monitoring, and how to provide care to patients in restraints

167

Rule #18 Staff Education

- This must be done before performing any of these functions (196)
- Training must occur in orientation before new staff can use them on a patient
- Training must occur on periodic basis consistent with hospital policy
- Have a form to document that each of the education requirements have been met

168

Rule #18 Staff Education

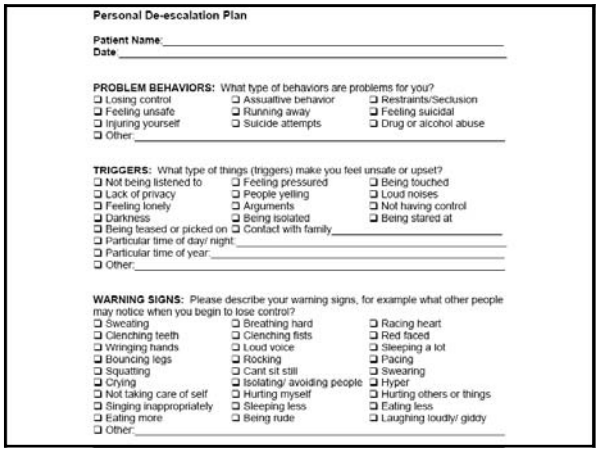
- Again consider yearly during skills lab
- Remember that the Joint Commission PC.03.03.03 and 03.02.03 requires staff training and competency
- The hospital must require appropriate staff to have education, training, and demonstrated knowledge based on the specific needs of the patient population in at least the following
- Techniques to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require RS

169

De-escalation

- Consider document in your tool kit although not required by CMS but TJC does now (deemed status) under PC.01.01.01
- Teach staff what is de-escalation and not just staff on the behavioral health unit
- Avoid confrontation and approach in a calm manner
- Active listening
- Valid feelings such as “you sound like you are angry”
- Some have personal de-escalation plan that lists triggers such as not being listening to, feeling pressured, being touched, loud noises, being stared at, arguments, people yelling, darkness, being teased, etc.

170



Personal De-escalation Plan

Patient Name: _____
Date _____

PROBLEM BEHAVIORS: What type of behaviors are problems for you?

❑ Losing control	❑ Assualtive behavior	❑ Restraints/Seclusion
❑ Feeling unsafe	❑ Running away	❑ Feeling suicidal
❑ Injuring yourself	❑ Suicide attempts	❑ Drug or alcohol abuse

❑ Other: _____

TRIGGERS: What type of things (triggers) make you feel unsafe or upset?

❑ Not being listened to	❑ Feeling pressured	❑ Being touched
❑ Lack of privacy	❑ People yelling	❑ Loud noises
❑ Feeling lonely	❑ Arguments	❑ Not having control
❑ Darkness	❑ Being isolated	❑ Being stared at
❑ Being teased or picked on	❑ Contact with family: _____	

❑ Particular time of day/ night: _____
❑ Particular time of year: _____
❑ Other: _____

WARNING SIGNS: Please describe your warning signs, for example what other people may notice when you begin to lose control?

❑ Sweating	❑ Breathing hard	❑ Racing heart
❑ Clenching teeth	❑ Clenching fists	❑ Red faced
❑ Wringing hands	❑ Loud voice	❑ Sleeping a lot
❑ Bouncing legs	❑ Rocking	❑ Pacing
❑ Squatting	❑ Cant sit still	❑ Swearing
❑ Crying	❑ Isolating/ avoiding people	❑ Hyper
❑ Not taking care of self	❑ Hurting myself	❑ Hurting others or things
❑ Singing inappropriately	❑ Sleeping less	❑ Eating less
❑ Eating more	❑ Being rude	❑ Laughing loudly/ giddy

❑ Other: _____

Staff Education

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

172

Staff Education

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

173

Staff Education

- Including respiratory and circulatory status, skin integrity, VS, and special requirements of 1 hour face to face
- The use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic recertification (206) Patients in R&S are at higher risk for death or injury
- All staff who apply, monitor, access, or provide care to patient in R must have education and training in first aid technique and certified in CPR
- To render first aid if patient in distress or injured
- Develop scenarios and develop first aid class to address these

174

Staff Education

- Staff must be qualified as evidenced by education, training, and experience
- Hospital must document in personnel records that the training and competency were successfully completed (208)
- Security guards respond to V/SD patients would need to train
  - Many give a 8 hour CPI course
  - Don't want someone going into the room of a V/SD patient without training to prevent injury to staff and patient

175

Training Cost

- Individuals doing training program must be qualified (207)
- Trainers must have high level of knowledge and need to document their qualifications
- Train the trainer programs are done by many facilities
- CMS said need to revise your training program every year which should take person 4 hours to do
  - Can have librarian do literature search for new articles on evidenced based restraint research

176

Training Time and Time Spent

- National Association of Psychiatric Health Systems (NAPHS), initial training in de-escalation techniques, restraint and seclusion policies and procedures
- Recommended 7-16 hours of training but number of hours **not** mandated by CMS
- In fact, in Federal Register recommended sending one person to CPI training class as a train the trainer

▪ [1]http://www.crisisprevention.com

177

Education Physicians and LIPs

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

178

Rule #19 Stricter State Laws

- The following requirements will be superseded by existing state laws that are more restrictive (180)
- State laws can be stricter but not weaker or they are preempted
- States are always free to be more restrictive
  - Many states have a state department of mental health which has standards for patients that are in a behavioral health unit

179

Rule #20 1:1 Monitoring R&S 183

- For behavioral health patients- which CMS now calls violent or self destructive behavioral that is a danger to self or others
- Can't use R&S together unless the patient is visually monitored in person face to face or by an audio and video equipment
- Person to monitor patient face to face or via audio & visual must be assigned and a trained staff member
- Must be in close proximity to the patient (183)
- There must be documentation of this in the medical record

180

Rule #20 1:1 Monitoring RS

- Documentation will include least restrictive interventions, conditions or symptoms that warranted RS, patient's response to intervention, and rationale for continued use
- This needs to be in hospitals P&P
- Modify assessment sheets to include this information
- Consider sitter policy to ensure does not leave patient unsupervised

181

Rule #21 Deaths

- Report any death associated with the use of restraint or seclusion
- Remember, the SMDA also requires reporting
- Sentinel event reporting to Joint Commission is voluntary but need to do RCA within 45 days
- See Hospital Reporting of Deaths Related to RS, OIG Report, September 2006, OEI-09-04-00350[1]

[1]www.oig.hhs.gov

182

Rule #21 Deaths 0214 2013

- The hospital must report to CMS each death that occurs while a patient is in restraint or in seclusion at the hospital
- Must report every death that occurs within 24 hours after the patient has been removed from R&S
- Except if patient dies in two soft wrist restraints then complete internal log as discussed previously
  - Be sure to document this in the medical record also
- Each death known to the hospital that occurs within 1 week after R&S where it is reasonable to assume that use of restraint or placement in seclusion contributed directly or indirectly to a patient's death

183

Rule #21 Deaths 0214

- "Reasonable to assume" includes, but is not limited to, deaths related to restrictions of movement for prolonged periods of time, or death related to chest compression, restriction of breathing or asphyxiation
- Must be reported to CMS regional office by telephone no later than the close of business the next business day following knowledge of the patient's death
  - This is in the regulation even though some of the regional offices are telling hospitals just to fax in the form

184

Rule #21 Deaths 0214

- Staff must document in the patient's medical record the date and time the death was reported to CMS
- This includes patients in soft wrist restraints
- Hospitals should revise post mortem records to list this requirement
- Hospitals need to rewrite their policies and procedures to include these requirements

185

Visitation 215

- A hospital must have written P&P regarding the visitation rights of patient
  - Must include any reasonable or clinically necessary restrictions
- Does not recommend restricting visitation in ICU
- Same day surgery patients may wish to have a support person present during pre-op and post-op recovery
- An outpatient may wish to have a support person present during examination by the physician

186

Visitation 215

- Need written P&P to address patient's right to have visitors
- Any restrictions must be clinically necessary or reasonable
- Can be restricted if interferes with the care of the patient or others
- Restrictions for child visitors
- Restrictions may include; infection control issue, court order, disruptive visitor, patient or room mate needs rest, inpatient substance abuse program, patient is having a procedure, etc.

187

Visitation Rights Notice 216

- Hospital must have written P&P on visitation rights
- Policy includes the restrictions
- Hospital must inform each patient of any restrictions to visitation and must document it was given
- Inform patient of the right to receive visitors their choose and they can change their mind
  - This includes spouse, same sex partner, friend, or family
- Support person may be the same or different from the patient representative
  - Any refusal to honor must be documented in the chart

188

Patient Visitation Rights 217

- The hospital policy must ensure that all visitors enjoy full and equal visitation rights no matter who they are
- Can not discriminate based on sex, gender, sexual orientation, race, or disability
- Surveyor will ask patients if visitors restricted against their wishes and if so was it in the P&P
- Hospital needs to educate the staff
  - Consider in orientation and periodically
  - Should have a culturally competent training program

189

Support Person

Interpretive Guidelines §482.13(h)(1) & (2)

Hospitals are required to inform each patient (or the patient's support person, where appropriate) of his/her visitation rights. A patient's "support person" does not necessarily have to be the same person as the patient's representative who is legally responsible for making medical decisions on the patient's behalf. A support person could be a family member, friend, or other individual who supports the patient during the course of the hospital stay. Not only may the support person visit the patient, but he or she may also exercise a patient's visitation rights on behalf of the patient with respect to other visitors when the patient is unable to do so. Hospitals must accept a patient's designation, orally or in writing, of an individual as the patient's support person.

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The End! Questions??

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RI.01.07.01 Complaints & Grievances

- Standard: Patient and or her family has the right to have a complaint reviewed,
- EP1 Hospital must establish a complaint and grievance (C&G) resolution process
  - See also MS.09.01.01, EP1
- EP2 Patient and family is informed of the grievance resolution process
- EP4 Complaints must be reviewed and resolved when possible

192

RI.01.07.01 Complaints & Grievances

- EP6 Hospital acknowledges receipt of C&G that cannot be resolved immediately
  - Hospital must notify the patient of follow up to the C&G
- EP7 Must provide the patient with the phone number and address to file the C&G with the relevant state authority
- EP10 The patient is allowed to voice C&G and recommend changes freely with out being subject to discrimination, coercion, reprisal, or unreasonable interruption of care (Deleted July 1, 2016)

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RI.01.07.01 Complaints and Grievances

- EP 17 Board reviews and resolves grievances unless it delegates this in writing to a grievance committee (eliminated but still CMS requirement)
- EP 18 Hospital provides individual with a written notice of its decision which includes (DS);
  - Name of hospital contact person
  - Steps taken on behalf of the individual to investigate the grievance
  - Results of the process
  - Date of completion of the grievance process

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RI.01.07.01 Complaints

- EP19 Hospital determines the time frame for grievance review and response(DS)
- EP20 Process for resolving grievances includes a timely referral of patient concerns regarding quality of care or premature discharge to the QIO
- EP21 Board approves the C&G process (eliminated but still CMS standard)

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TJC Complaint Standard

- TJC has complaint standard RI.01.07.01 with changes 7-01-09 and 2010 and continued in 2013
- Will not cover but provided for reference
  - TJC calls them complaints
  - CMS calls them grievances
  - TJC has eliminated several standards in 2011 that are still CMS standards
  - More closely cross walked now
  - See reference slides

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TJC Abuse and Neglect

- Remember to include Joint Commission's standard, RI.01.06.03, and definitions of abuse and neglect into your policy also if accredited
- Patients have the right to be free from abuse, neglect, and exploitation
  - This includes physical, sexual, mental, or verbal abuse and Joint Commission has definitions for all of these terms

197

TJC Abuse and Neglect

- Determine how you will protect patients while they are receiving care from abuse and neglect
- Evaluate all allegations that occur within the hospital
- Report to proper authorities as required by law

198

TJC PC.01.02.03 H&P

- EP4 requires H&P no more than 30 days old and done within 24 hours
- EP5 if done within 24 hours update, update prior to surgery (also RC.01.03.01)
- EP7 that requires an update to a history and physical (H&P) at the time of the admission
- RC.02.01.03 EP3 document H&P in MR for operative or high risk procedure and for moderate and deep sedation
- MS.01.01.01 requires H&P process be in MS bylaws

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TJC MS.03.01.01 H&P

- EP6 Specifies minimal content (can vary by setting, level of service, tx & services
- EP7 MS must monitor the quality of the H&Ps
- EP8 Medical staff requires person be privileged to do H&P and requires updates
- EP9 As permitted by state law, allow individuals who are not LIPs to perform part or all of the H&P
- EP10 MS defines when it must be validated and countersigned by LIP with privileges
- MS defines scope of H&P for non inpatient services

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Consider Alternatives to Restraints

- Skin sleeves
- Sensor alarm
- Posey lateral wedges
- Access to call cord
- Lower chairs
- Allow wandering, if possible
- Food/hydration
- Low beds or mattress on floor
- Encourage family visits
- Pain/discomfort relief
- Diversion activities such as TV, CDs, DVDs, music therapy, picture books, games
- Provide structured, quiet environment
- Exercise/ambulate
- Toileting routine

201

Alternatives to Restraints

- Be calm and reassuring
- Approach in non-threatening manner
- Wrap around Velcro band while in wheelchair (if can release)
- Relaxation tapes
- Do photo album
- Back rubs or massage therapist
- Wanderguard system
- Limit caffeine

202

Alternatives to Restraints

- Watching TV
- Massage or family can hire massage therapist
- Punching bag
- Avoid sensory overload
- Fish tanks
- Tapes of families or friends

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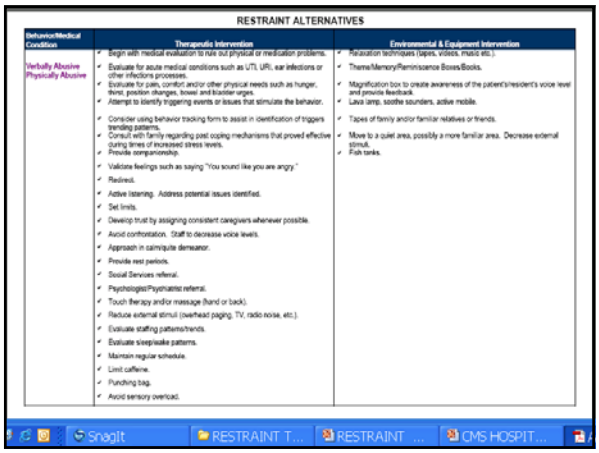
RESTRAINT ALTERNATIVES

Behavior/Medical Condition	Therapeutic Intervention	Environmental & Equipment Intervention
Unsafe Mobility Unsteady Gait	✓ Evaluate medications that may produce gait disturbances. ✓ Evaluate for orthostatic hypertension and change positions slowly. ✓ Evaluate visual system and proper correction of eye glasses. ✓ Evaluate vestibular system - making sure ears are clear & balance system is intact. ✓ Reevaluate physical needs such a as toileting program, comfort, pain. ✓ Exercise peddles while sitting. ✓ Generalized activity programs. ✓ Ambulation and/or exercise programs. ✓ Group ambulation and/or accompanied walks in or out of doors. ✓ 1:1 visitations. ✓ Encourage repositioning frequently. ✓ Identify customary routines (late sleepers and early risers) and allow for preferences. ✓ Evaluate for a restorative program. ✓ PT/OT referral for screening.	✓ Evaluate for proper fitting and appropriate condition of footwear. ✓ Non-skid socks. ✓ Evaluate ambulation devices for good working condition. ✓ Adequate lighting, especially at night. ✓ Remove wheeled furniture used for support. ✓ Bed lowered so resident can touch toes to the floor. ✓ Place glasses on daily to enhance visual acuity. ✓ Call bell in reach at all times. ✓ Evaluate need for bedside commode at night. ✓ Avoid use of throw rugs. ✓ Floor alarm. ✓ Motion detectors. ✓ Bed &/or chair alarms. ✓ Hip protectors. ✓ Merry Walker - fade use as strength increases.
Falling/Climbing Out of Bed	✓ Evaluate medications that may produce gait or balance disturbances. ✓ Evaluate for orthostatic hypotension and change positions slowly. ✓ Reevaluate physical needs such as toileting, comfort, pain, thirst & timing of needs. ✓ Provide h.s. snack. ✓ 1:1 conversation. ✓ Touch if appropriate while recognizing personal body space. ✓ Anticipate customary schedules and accommodate personal preferences. ✓ Evaluate balance for sub-clinical disturbances such as inner ear infections. ✓ Validate feelings and mobilize the patient/resident. For instance "I want to get up." - - "You want to get up?" - - then get the patient/resident up. ✓ Evaluate hearing and vision. ✓ Evaluate for appropriate shoes/foot apparel. ✓ Evaluate for appropriate size and length of clothing. ✓ Check blood sugar levels. ✓ Evaluate sleep/wake patterns. ✓ Evaluate for a Restorative Program. ✓ PT/OT referral for screening.	✓ Low bed. ✓ Remove siderails. ✓ Put mat on floor at bed side. ✓ Bed or chair alarm. ✓ Evaluate accessibility of call lights. ✓ Nightlight. ✓ Visual cues for staff on the patient's/resident's door to identify patients/residents at risk for falling. ✓ Scoop mattress. ✓ Evaluate physical environment for excessive furniture, cluttered hallways, rooms. ✓ Visual cues to direct to toilet, use of gait devices, use call bell. ✓ Light, protective headgear. ✓ Use a trapeze for bed mobility.



RESTRAINT ALTERNATIVES

Behavior/Medical Condition	Therapeutic Intervention	Environmental & Equipment Intervention
Verbally Abusive Physically Abusive	✔ Begin with medical evaluation to rule out physical or medication problems. ✔ Evaluate for acute medical conditions such as UTI, URI, ear infections or other infections processes. ✔ Evaluate for pain, comfort and/or other physical needs such as hunger, thirst, position changes, bowel and bladder urges. ✔ Attempt to identify triggering events or issues that stimulate the behavior. ✔ Consider using behavior tracking form to assist in identification of triggers trending patterns. ✔ Consult with family regarding past coping mechanisms that proved effective during times of increased stress levels. ✔ Provide companionship. ✔ Validate feelings such as saying "You sound like you are angry." ✔ Redirect. ✔ Active listening. Address potential issues identified. ✔ Set limits. ✔ Develop trust by assigning consistent caregivers whenever possible. ✔ Avoid confrontation. Staff to decrease voice levels. ✔ Approach in calm/quite demeanor. ✔ Provide rest periods. ✔ Social Services referral. ✔ Psychologist/Psychiatrist referral. ✔ Touch therapy and/or massage (hand or back). ✔ Reduce external stimuli (overhead paging, TV, radio noise, etc.). ✔ Evaluate staffing patterns/trends. ✔ Evaluate sleep/wake patterns. ✔ Maintain regular schedule. ✔ Limit caffeine. ✔ Punching bag. ✔ Avoid sensory overload.	✔ Relaxation techniques (tapes, videos, music etc.). ✔ Theme/Memory/Reminiscence Boxes/Books. ✔ Magnification box to create awareness of the patient's/resident's voice level and provide feedback. ✔ Lava lamp, soothe saunders, active mobile. ✔ Tapes of family and/or familiar relatives or friends. ✔ Move to a quiet area, possibly a more familiar area. Decrease external stimuli. ✔ Fish tanks.

Restraint Alternatives

For the WANDERER:

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

For the UNSTEADY PATIENT:

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

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Thanks for attending!

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