

Restraints or Seclusion Compliance Guide

The CoPs at § 418.110 - Hospices That Provide Inpatient Care Directly, specify a hospice provider's care requirements if restraint or seclusion is used for a patient.

- (m) Standard: Restraint or seclusion.
- (n) Standard: Restraint or seclusion staff training requirements.
- (o) Standard: Death reporting requirements.

The Requirements

Patient rights:

- All patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time.
- The patient has the right to safe implementation of restraint or seclusion by trained staff.
- *(Reference § 418.52 – Condition of Participation: Patient Rights)*

Use as a last resort:

- If a medication is prescribed to manage a patient's symptoms, it not considered a restraint.
- If a medication is prescribed to manage a patient's behavior, it is considered as a restraint.
- Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, a staff member, or others from harm.
- 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.
- Restraint is defined in the CoPs at § 418.3 as -
- 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, not including devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort); or A drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.
- Guidance regarding bedrails
 - CMS suggested that hospice providers consult the language in the current long term care interpretive guidelines about bedrails. The language is as follows:
 - ▶ The use of side rails as restraints is prohibited unless they are necessary to treat a resident's medical symptoms. Residents who attempt to exit a bed through, between, over or around side rails are at risk of injury or death. The potential for serious injury is more likely from a fall from a bed with raised side rails rather than from a fall from a bed where side rails are not used. They also potentially increase the likelihood that the resident will spend more time in bed and fall when attempting to transfer from the bed. As with other restraints, for residents who are restrained by side rails, it is expected that the process facilities employ to reduce the use of side rails as restraints is systematic and gradual to ensure the resident's safety while treating the resident's medical symptom. The same device may have the effect of restraining one individual but not another, depending on the individual resident's condition and circumstances. For example, partial rails may assist one resident to enter and exit the bed independently while acting as a restraint for another.

Policy/procedure and documentation:

- If a hospice decides to use restraints or seclusion, the following must occur:
 - The use of restraint or seclusion must be—
 - ▶ In accordance with a written organizational policy and procedure.
 - ▶ In accordance with a written modification to the patient's plan of care.
 - ▶ Implemented in accordance with safe and appropriate restraint and seclusion techniques as determined by hospice policy in accordance with State law.

Physician orders and the patient plan of care:

- A physician authorized to order restraints or seclusion may do so in accordance with hospice policy and/or accordance with State law.
- Orders for the use of restraint or seclusion must never be written as a standing order or on an as needed basis (PRN).
- The medical director or physician designee must be consulted as soon as possible if the attending physician did not order the restraint or seclusion.
- Unless superseded by State law that is more restrictive—
 - Each order for restraint or seclusion may only be renewed in accordance with the following limits for up to a total of 24 hours:
 - ▶ 4 hours for adults 18 years of age or older;
 - ▶ 2 hours for children and adolescents 9 to 17 years of age; or
 - ▶ 1 hour for children under 9 years of age; and
 - ▶ After 24 hours, before writing a new order, a physician authorized to order restraint or seclusion by hospice policy in accordance with State law must see and assess the patient.
 - ▶ Each order for restraint used to ensure the physical safety of the non-violent or non-self-destructive patient may be renewed as authorized by hospice policy.
- Restraint or seclusion must be discontinued at the earliest possible time, regardless of the length of time identified in the order.
- The condition of the patient who is restrained or secluded must be monitored by a physician or trained staff that have completed the training criteria specified in paragraph (n) of this section at an interval determined by hospice policy.
- Physician, including attending physician, training requirements must be specified in hospice policy. At a minimum, physicians and attending physicians authorized to order restraint or seclusion by hospice policy in accordance with State law must have a working knowledge of hospice policy regarding the use of restraint or seclusion.
 - When restraint or seclusion is used, the patient must be seen face-to-face within 1 hour after the initiation of the intervention by a physician or Registered nurse who has been trained in accordance with the requirements specified in paragraph (n) of this section, to 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.
- States are free to have requirements by statute or regulation that are more restrictive than those contained in paragraph (m)(11)(i) of this section. **Hospice providers must always adhere to the more stringent regulation.**
- If the face-to-face evaluation is conducted by a trained registered nurse, the trained registered nurse must consult the medical director or physician designee as soon as possible after the completion of the 1-hour face-to-face evaluation.
- Simultaneous restraint and seclusion use is only permitted if the patient is continually monitored:
 - Face-to-face by an assigned, trained staff member; or
 - By trained staff using both video and audio equipment. This monitoring must be in close proximity to the patient.

- When restraint or seclusion is used, there must be documentation in the patient's clinical record of the following:
 - The 1-hour face-to-face medical and behavioral evaluation if restraint or seclusion is used to manage violent or self-destructive behavior;
 - A description of the patient's behavior and the intervention used;
 - Alternatives or other less restrictive interventions attempted (as applicable);
 - The patient's condition or symptom(s) that warranted the use of the restraint or seclusion; and the patient's response to the intervention(s) used, including the rationale for continued use of the intervention.

Restraint or seclusion staff training requirements.

- Training intervals
 - All patient care staff working in the hospice inpatient facility must be trained and able to demonstrate competency in the application of restraints, implementation of seclusion, monitoring, assessment, and providing care for a patient in restraint or seclusion—
 - ▶ Before performing any of the actions specified in this paragraph;
 - ▶ As part of orientation; and
 - ▶ Subsequently on a periodic basis consistent with hospice policy.
- Training content.
 - The hospice 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 the use of a restraint or seclusion.
 - ▶ The use of nonphysical intervention skills.
 - ▶ Choosing the least restrictive intervention based on an individualized assessment of the patient's medical, or behavioral status or condition.
 - ▶ The safe application and use of all types of restraint or seclusion used in the hospice, including training in how to recognize and respond to signs of physical and psychological distress (for example, positional asphyxia).
 - ▶ Clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary.
 - ▶ Monitoring the physical and psychological well-being of the patient who is restrained or secluded, including but not limited to, respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by hospice policy associated with the 1-hour face-to-face evaluation.
 - ▶ **Direct patient care staff must be trained in the provision of first aid techniques and cardiopulmonary resuscitation, including required periodic recertification.**
- Trainer requirements.
 - Individuals providing staff training must be qualified as evidenced by education, training, and experience in techniques used to address patients' behaviors.
 - **Training documentation.** The hospice must document in the staff personnel records that the training and demonstration of competency were successfully completed.

Death reporting requirements.

- Hospices must report deaths associated with the use of seclusion or restraint.
 - The hospice must report the following information to CMS:
 - ▶ Each unexpected death that occurs while a patient is in restraint or seclusion.
 - ▶ Each unexpected death that occurs within 24 hours after the patient has been removed from restraint or seclusion.
 - ▶ Each death known to the hospice that occurs within 1 week after restraint or seclusion where it is reasonable to assume that use of restraint or placement in seclusion contributed directly or indirectly to a patient's death. "Reasonable to assume" in this context includes, but is not limited to, deaths related to restrictions of movement for prolonged periods of time, or death related to chest compression, restriction of breathing or asphyxiation.

- ▶ Each death referenced in this paragraph must be reported to CMS by telephone no later than the close of business the next business day following knowledge of the patient's death.
- ▶ Staff must document in the patient's clinical record the date and time the death was reported to CMS.

Compliance Suggestions for Hospice Providers

- Know State law and determine whether it is more stringent than Federal requirements.
- Provide training that includes the criteria as defined in § 418.110(n)(2) for all inpatient hospice staff about restraints and seclusion. Document training and competency in staff personnel files. Make a list of trained personnel available at the inpatient IDT station at all times.
- Develop a documentation flow sheet for restraints and seclusion. Educate appropriate staff regarding its use.
- Educate all hospice physicians about the restraint and seclusion requirements and their need to communicate/coordinate with the attending physician ordering restraints and seclusion.
- If a hospice facility chooses to adopt a 'restraint-free' policy, then develop policy/procedure to address the plan for providing these interventions should the need arise.

References

- Part II - Department of Health and Human Services, Centers for Medicare & Medicaid Services
42 CFR Part 418 Medicare Hospice Care Regulations [112 Condition of participation: Hospices that provide hospice care to residents of a SNF/NF or ICF/IID](#)