### PATIENT RIGHTS & RESTRAINTS

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<td><strong>15.00.00</strong></td>
<td>Condition of Participation: Patient’s Rights.</td>
<td>The facility must protect and promote each patient’s rights. Protection of patient’s rights is demonstrated through a variety of modalities which includes privacy, safety, confidentiality of records, the grievance process, advance directives, participation in the plan of care, and use of restraints or seclusion. These requirements apply to all Medicare or Medicaid participating hospitals including short-term, acute care, surgical, specialty, psychiatric, rehabilitation, long-term, children’s and cancer, whether or not they are accredited. This rule does not apply to critical access hospitals. (See Social Security Act (the Act) §1861(e)) These requirements, as well as the other Conditions of Participation in 42 CFR §482, apply to all parts and locations (outpatient services, provider-based entities, inpatient services) of the Medicare participating hospital.</td>
<td>DOCUMENT REVIEW &amp; OBSERVATION</td>
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<td><strong>15.01.00</strong></td>
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<td><strong>15.01.01</strong></td>
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<td><strong>15.01.02</strong></td>
<td>Notice of Patient Rights.</td>
<td>The hospital must ensure the notice of rights requirements is met. The hospital must inform each patient, or when appropriate, the patient’s representative as allowed by State law, of the patient’s rights.</td>
<td>DOCUMENT REVIEW, INTERVIEW, &amp; OBSERVATION</td>
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1. Determine the hospital’s policy for notifying all patients of their rights, both inpatient and outpatient. |  |  |

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| whenever possible. §482.13(a) §482.13(a)(1) | - Whenever possible, this notice must be provided before providing or stopping care.  
- All patients, inpatient or outpatient, must be informed of their rights as hospital patients.  
- The patient’s rights include all of those discussed in this condition, as well as any other rights for which notice is required under State or Federal law or regulations for hospital patients. (See 42 CFR §482.11.)  
- The patient’s rights should be provided and explained in a language or manner that the patient (or the patient’s representative) can understand. This is consistent with the guidance related to Title VI of the Civil Rights Act of 1964 issued by the Department of Health and Human Services- Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons (August 8, 2003, 68 FR 47311). In accordance with §482.11, hospitals are expected to comply with Title VI and may use this guidance to assist it in ensuring patient’s rights information is provided in a language and manner that the patient understands. Surveyors do not assess compliance with these requirements on limited English proficiency, but may refer concerns about possible noncompliance to the Office for Civil Rights in the applicable Department of Health and Human Services Regional Office.  
Hospitals are expected to take reasonable steps to | 2. Determine that the hospital’s policy provides for determining when a patient has a representative and who that representative is, consistent with this guidance and State law.  
3. Determine that the information provided to the patients by the hospital complies with Federal and State law.  
4. Review records and interview staff to examine how the hospital communicates information about their rights to diverse patients, including individuals who need assistive devices or translation services. Does the hospital have alternative means, such as written materials, signs, or interpreters (when necessary), to communicate patients’ rights?  
5. Review records and interview staff and patients or patients’ representatives (as appropriate) to examine how the hospital determines whether the patient has a representative, who that representative is, and whether notice of patients’ rights is provided as required to patients’ representatives.  
6. Ask patients to tell you what the hospital has told them about their rights.  
7. Does staff know what steps to take to inform a patient about their patients’ rights, including those patients’ with special communication needs? | | |
determine the patient’s wishes concerning designation of a representative. Unless prohibited by applicable State law:

- When a patient who is not incapacitated has designated, either orally to hospital staff or in writing, another individual to be his/her representative, the hospital must provide the designated individual with the required notice of patients’ rights in addition to the patient. The explicit designation of a representative takes precedence over any non-designated relationship and continues throughout the patient’s inpatient stay or outpatient visit, unless expressly withdrawn, either orally or in writing, by the patient.

- In the case of a patient who is incapacitated, when an individual presents the hospital with an advance directive, medical power of attorney or similar document executed by the patient and designating an individual to make medical decisions for the patient when incapacitated, then the hospital must, when presented with the document, provide the required notice of its policies to the designated representative. The explicit designation of a representative takes precedence over any non-designated relationship and continues throughout the patient’s inpatient stay or outpatient visit, unless the patient ceases to be incapacitated and expressly withdraws the designation, either orally or in writing.

- When a patient is incapacitated or otherwise unable to communicate his or her wishes, there

8. Review a sample of inpatient medical records for Medicare beneficiaries, to determine whether the records contain a signed and dated IM provided within 2 days of the admission of the patient.

9. For patients whose discharge occurred more than 2 days after the initial IM notice was issued, determine whether the hospital provided another copy of the IM to the patient prior to discharge in a timely manner.
is no written advance directive on file or presented, and an individual asserts that he or she is the patient’s spouse, domestic partner (whether or not formally established and including a same-sex domestic partner), parent (including someone who has stood in loco parentis for the patient who is a minor child), or other family member and thus is the patient’s representative, the hospital is expected to accept this assertion, without demanding supporting documentation, and provide the required notice to the individual, unless:

- More than one individual claims to be the patient’s representative. In such cases, it would be appropriate for the hospital to ask each individual for documentation supporting his/her claim to be the patient’s representative. The hospital should make its determination of who is the patient’s representative based upon the hospital’s determination of who the patient would most want to make decisions on his/her behalf. Examples of documentation a hospital might consider could include, but are not limited to, the following: proof of a legally recognized marriage, domestic partnership, or civil union; proof of a joint household; proof of shared or co-mingled finances; and any other documentation the hospital considers evidence of a special relationship that indicates familiarity with the patient’s preferences concerning medical treatment;
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- Treating the individual as the patient’s representative without requesting supporting documentation would result in the hospital violating State law. State laws, including State regulations, may specify a procedure for determining who may be considered to be the incapacitated patient’s representative, and may specify when documentation is or is not required; or

- The hospital has reasonable cause to believe that the individual is falsely claiming to be the patient’s spouse, domestic partner, parent or other family member.

Hospitals are expected to adopt policies and procedures that facilitate expeditious and non-discriminatory resolution of disputes about whether an individual is the patient’s representative, given the critical role of the representative in exercising the patient’s rights.

A refusal by the hospital of an individual’s request to be treated as the patient’s representative, based on one of the above-specified familial relationships, must be documented in the patient’s medical record, along with the specific basis for the refusal.

In addition, according to the regulation at 42 CFR §489.27(a), (which cross references the regulation at 42 CFR 405.1205), each Medicare beneficiary who is an inpatient (or his/her representative) must be provided the standardized notice, “An Important Message from Medicare (IM)”, within 2 days of admission.
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- Medicare beneficiaries who have not been admitted (e.g., patients in observation status or receiving other care on an outpatient basis) are not required to receive the IM. The IM is a standardized, OMB-approved form and cannot be altered from its original format. The IM is to be signed and dated by the patient to acknowledge receipt. See Exhibit 16 for a copy of the IM.

Furthermore, 42 CFR §405.1205(c) requires that hospitals present a copy of the signed IM in advance of the patient’s discharge, but not more than two calendar days before the patient’s discharge.

In the case of short inpatient stays, however, where initial delivery of the IM is within 2 calendar days of the discharge, the second delivery of the IM is not required.

The hospital must establish and implement policies and procedures that effectively ensure that patients and/or their representatives have the information necessary to exercise their rights.

Patient’s Rights are posted in clear sight for patients and visitors to view throughout the hospital and all outpatient settings.

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15.01.03 **Patient Grievances.**  
*The hospital must establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance.*

The patient should have reasonable expectations of care and services and the facility should address those expectations in a timely, reasonable, and consistent manner. Although §482.13(a)(2)(ii) and (iii) address documentation of facility time frames

**DOCUMENT REVIEW, OBSERVATION, AND INTERVIEW**

1. Review the hospital’s policies and procedures to assure that its grievance process encourages all personnel to alert

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Compliant  
Not Compliant  
This standard is not met as evidenced by:  
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for a response to a grievance, the expectation is that the facility will have a process to comply with a relatively minor request in a more timely manner than a written response. For example, a change in bedding, housekeeping of a room, and serving preferred food and beverage may be made relatively quickly and would not usually be considered a "grievance" and therefore would not require a written response.

The hospital must inform the patient and/or the patient's representative of the internal grievance process, including whom to contact to file a grievance (complaint).

- As part of its notification of patient rights, the hospital must provide the patient or the patient's representative a phone number and address for lodging a grievance with the State agency.
- The hospital must inform the patient that he/she may lodge a grievance with the State agency (the State agency that has licensure survey responsibility for the hospital) directly, regardless of whether he/she has first used the hospital's grievance process.

A “patient grievance” is a formal or informal written or verbal complaint that is made to the hospital by a patient, or the patient’s representative, regarding the patient’s care (when the complaint is not resolved at the time of the complaint by staff present), abuse or neglect, issues related to the hospital's compliance with the CMS Hospital

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<td>§482.13(a)(2)</td>
<td>for a response to a grievance, the expectation is that the facility will have a process to comply with a relatively minor request in a more timely manner than a written response. For example, a change in bedding, housekeeping of a room, and serving preferred food and beverage may be made relatively quickly and would not usually be considered a &quot;grievance&quot; and therefore would not require a written response. The hospital must inform the patient and/or the patient's representative of the internal grievance process, including whom to contact to file a grievance (complaint). - As part of its notification of patient rights, the hospital must provide the patient or the patient's representative a phone number and address for lodging a grievance with the State agency. - The hospital must inform the patient that he/she may lodge a grievance with the State agency (the State agency that has licensure survey responsibility for the hospital) directly, regardless of whether he/she has first used the hospital's grievance process. A “patient grievance” is a formal or informal written or verbal complaint that is made to the hospital by a patient, or the patient’s representative, regarding the patient’s care (when the complaint is not resolved at the time of the complaint by staff present), abuse or neglect, issues related to the hospital's compliance with the CMS Hospital</td>
<td>appropriate staff concerning any patient grievance. Does the hospital adhere to its policy / procedure established for grievances? 2. Interview patients or the patient’s legal representative to determine if they know how to file a complaint (grievance) and who to contact if they have a complaint (grievance). 3. Is the hospital following its grievance policies and procedures? 4. Does the hospital’s process assure that grievances involving situations or practices that place the patient in immediate danger are resolved in a timely manner? 5. Does the patient or the patient’s representative know that he/she has the right to file a complaint with the State agency as well as or instead of utilizing the hospital’s grievance process? 6. Has the hospital provided the telephone number for the State agency to all patients/patient representatives? 7. Are beneficiaries aware of their right to seek review by the QIO for quality of care issues, coverage decisions, and to appeal a premature discharge?</td>
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Conditions of Participation (CoPs), or a Medicare beneficiary billing complaint related to rights and limitations provided by 42 CFR §489.

- "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, administration, nursing supervisors, patient advocates, etc.) to resolve the patient's complaint.

- If a 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 is considered a grievance.

- A written complaint is always considered a grievance. This includes written complaints from an inpatient, an outpatient, a released/discharged patient, or a patient's representative regarding the patient care provided, abuse or neglect, or the hospital's compliance with CoPs. For the purposes of this
requirement, an email or fax is considered "written."

- Information obtained from patient satisfaction surveys usually does not 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. If an identified patient writes or attaches a complaint to the survey but has not requested resolution, the hospital must treat this as a grievance if the hospital would usually treat such a complaint as a grievance.

- 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
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<td>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.</td>
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<td>Data collected regarding patient grievances, as well as other complaints that are not defined as grievances (as determined by the hospital), must be incorporated in the hospital's Quality Assessment and Performance Improvement (QAPI) Program.</td>
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**15.01.04 Governing Body Responsibility for the Grievance Process.**

*The hospital must establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance.*

- The hospital’s governing body must approve and be responsible for the effective operation of the grievance process and must review and resolve grievances, unless it delegates the responsibility in writing to a grievance committee.

§482.13(a)(2)

The hospital’s grievance process must be approved by the governing body.

The hospital is responsible to address patient concerns in a timely manner.

The hospital’s governing body is responsible for the effective operation of the grievance process. This includes the hospital’s compliance with all of the CMS grievance process requirements.

The hospital’s governing body must review and resolve grievances, unless it delegates this responsibility in writing to a grievance committee.

A committee is more than one person. The committee membership should have adequate numbers of qualified members to review and resolve the grievances the hospital receives (this includes providing written responses) in a manner that complies with the CMS grievance process.

**DOCUMENT REVIEW**

1. Review the hospital’s protocol to determine that it meets the requirement.
2. Determine if the hospital’s governing body approved the grievance process.
3. Is the governing body responsible for the operation of the grievance process, or has the governing body delegated the responsibility in writing to a grievance committee?
4. Determine how effectively the grievance process works. Are patient’s or the patient representative’s concerns addressed in a timely manner? Are patients informed of any resolution to their grievances? Does the hospital apply what it learns from the grievance as part of its continuous quality improvement?

[Compliant] [Not Compliant] This standard is not met as evidenced by:
15.01.05 Timely Referrals. 
[The hospital must establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance.]

- The grievance process must include a mechanism for timely referral of patient concerns regarding quality of care or premature discharge to the appropriate Utilization and Quality Control, Quality Improvement Organization (QIO).

§482.13(a)(2)

Quality Improvement Organizations (QIOs) are CMS contractors charged with reviewing the appropriateness and quality of care rendered to Medicare beneficiaries in the hospital setting. The QIOs are also tasked with reviewing utilization decisions. Part of this duty includes reviewing discontinuation of stay determinations based upon a beneficiary’s request.

The regulations state the functions of the QIOs in order to make Medicare beneficiaries aware of the fact that if they have a complaint regarding quality of care, disagree with a coverage decision, or they wish to appeal a premature discharge, they may contact the QIO to lodge a complaint.

The hospital is required to have procedures for referring Medicare beneficiary concerns to the QIOs; additionally, CMS expects coordination between the grievance process and existing grievance referral procedures so that beneficiary complaints are handled timely and referred to the QIO at the beneficiary’s request.

This regulation requires coordination between the hospital’s existing mechanisms for utilization review notice and referral to QIOs for Medicare beneficiary improvement activities?

5. Is the grievance process reviewed and analyzed through the hospital’s QAPI process or some other mechanisms that provides oversight of the grievance process?

**DOCUMENT REVIEW AND INTERVIEW**

1. Review patient discharge materials. Is the hospital in compliance with 42 CFR §489.27?

2. Does the hospital grievance process include a mechanism for timely referral of Medicare patient concerns to the QIO? What time frames are established?

3. Interview Medicare patients. Are they aware of their right to appeal premature discharge?
concerns (See 42 CFR Part §489.27).

This requirement does not mandate that the hospital automatically refer each Medicare beneficiary’s grievance to the QIO; however, the hospital must inform all beneficiaries of this right, and comply with his or her request if the beneficiary asks for QIO review.

Medicare patients have the right to appeal a premature discharge (see Interpretive Guidelines for 42 CFR §482.13(a)). Pursuant to 42 CFR §412.42(c)(3), a hospital must provide a hospital-issued notice of non-coverage (HINN) to any fee-for-service beneficiary that expresses dissatisfaction with an impending hospital discharge. Medicare Advantage (MA) organizations are required to provide enrollees with a notice of non-coverage, known as the Notice of Discharge and Medicare Appeal Rights (NODMAR), only when a beneficiary disagrees with the discharge decision or when the MA organization (or hospital, if the MA organization has delegated to it the authority to make the discharge decision) is not discharging the enrollee, but no longer intends to cover the inpatient stay.

15.01.06 Grievance Process.

At a minimum:

- The hospital must establish a clearly explained procedure for the submission of a patient’s written or verbal grievance to the hospital.

The hospital’s procedure for a patient or the patient’s representative to submit written or verbal grievances must be clearly explained. The patient or patient’s representative should be able to clearly understand the procedure.

DOCUMENT REVIEW AND INTERVIEW

Review the hospital’s procedure.

1. Review the information provided to patients that explains the hospital’s grievance procedures. Does it clearly explain how the patient is to submit either a verbal or written grievance?
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#### 15.01.07 Grievance Process Response

**Time Frames.**

At a minimum:

- The grievance process must specify time frames for review of the grievance and the provision of a response.

**§482.13(a)(2)(ii)**

The hospital must review, investigate, and resolve each patient's grievance within a reasonable timeframe. For example, grievances about situations that endanger the patient, such as neglect or abuse, should be reviewed immediately, given the seriousness of the allegations and the potential for harm to the patient.

However, regardless of the nature of the grievance, the hospital should make sure that it is responding to the substance of each grievance while identifying, investigating, and resolving any deeper, systemic problems indicated by the grievance.

Document when a grievance is so complicated that it may require an extensive investigation. We recognize that staff scheduling as well as fluctuations in the numbers and complexity of grievances can affect the timeframes for the resolution of a grievance and the provision of a written response. On average, a time frame of 7 days for the provision of the response would be considered appropriate. We do not require that every grievance be resolved during the specified timeframe although most should be resolved. 42 CFR §482.13(a)(2)(iii) specifies information the

#### DOCUMENT REVIEW

Review hospital procedures. Determine:

1. The procedure specifies time frames for responding to grievances.

2. The hospital responds to grievances within those timeframes.

3. What time frames are established to review and respond to patient grievances? Are these time frames clearly explained in the information provided to the patient that explains the hospital's grievance process?

4. On average, does the hospital provide a written response to most of its grievances within the timeframe specified in its policy?

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This standard is not met as evidenced by:
**15.01.08 Patient Notification of the Grievance Process.**

At a minimum:

- In its resolution of the grievance, the hospital must provide the patient with a written notice of its decision that contains the name of the hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the date of completion.

§482.13(a)(2)(iii)

In all cases, the hospital must provide a written response to the patient grievance.

In resolution of the grievance, the written notice must be communicated in a language and manner the patient / representative understands and provides:

1. The hospital’s decision.
2. The name of the hospital contact person.
3. The steps taken on behalf of the patient to investigate the grievance.
4. The date of grievance investigation completion.

The written notice of the hospital’s determination regarding the grievance must be communicated to the patient or the patient’s representative in a language and manner the patient or the patient’s legal representative understands.

The hospital may use additional tools to resolve a

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**DOCUMENT REVIEW**

1. Review the protocol for resolution of the patient’s grievance to assure that it meets the requirement.

2. Review a sampling of grievance response letters to determine whether they include all required components.

3. Review the hospital’s copies of written notices (responses) to patients. Are all patients provided a written notice? Do the notices comply with the requirements?
grievance, such as meeting with the patient and his family. The regulatory requirements for the grievance process are minimum standards, and do not inhibit the use of additional effective approaches in handling patient grievances.

However, in all cases the hospital must provide a written notice (response) to each patient’s grievance(s). The written response must contain the elements listed in this requirement.

When a patient communicates a grievance to the hospital via email the hospital may provide its response via email pursuant to hospital policy. (Some hospitals have policies against communicating to patients over email.) If the patient requests a response via email, the hospital may respond via email. When the email response contains the information stated in this requirement, the email meets the requirement for a written response. The hospital must maintain evidence of its compliance with these requirements.

A grievance is considered resolved when the patient is satisfied with the actions taken on their behalf.

There may be situations where the hospital has taken appropriate and reasonable actions on the patient's behalf in order to resolve the patient's grievance and the patient or the patient’s representative remains unsatisfied with the hospital's actions. In these situations, the hospital may consider the grievance closed for the purposes of these requirements. The hospital must maintain documentation of its efforts and demonstrate compliance with CMS requirements.
In its written response, the hospital is not required to include statements that could be used in a legal action against the hospital, but the hospital must provide adequate information to address each item stated in this requirement. The hospital is not required to provide an exhaustive explanation of every action the hospital has taken to investigate the grievance, resolve the grievance, or other actions taken by the hospital.

The hospital must ensure that the exercise of patients’ rights requirements are met.

The posted and promulgated Patient’s Rights documents may include additional statements of rights. Any rights, which are mandated by state or local jurisdictions, not listed, are included.

Other statements may derive from organizational philosophy or be influenced by hospital ownership or affiliation. Some facilities may wish to include "freedom to unhampered exercise of religious or spiritual practices, within constraint of law" or other similar statements.

### 15.01.09 Exercise of Patient Rights

**The Patient’s Rights document includes, at a minimum, that the patient has:**

**A.** The right to participate in the development and implementation of his or her plan of care; §482.13(b)(1)

**B.** Or his or her representative (as allowed under state law) has the right to make informed decisions regarding his or her care. The patient’s rights include being informed of his or her health status, being involved in care planning and treatment, and being able to request or refuse treatment. This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate; §482.13(b)(2)

**C.** The right to formulate advance directives and to have hospital staff

### OBSERVATION

- Review the posted and promulgated statements of Patient’s Rights to determine that they are congruent with these and any other known requirements.

- Score any noncompliance with patient notification of their rights in this standard. Facility compliance with the rights listed will be scored individually in the standards following.

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and practitioners who provide care in the hospital comply with these directives, in accordance with §489.100 of this part, §489.102 of this part, and §489.104 of this part; §482.13(b)(3)

D. The right to have a family member or representative of his or her choice and his or her own physician notified promptly of his or her admission to the hospital; §482.13(b)(4)

E. The right to personal privacy; §482.13(c)(1)

F. The right to receive care in a safe setting; §482.13(c)(2)

G. The right to be free from all forms of abuse or harassment; §482.13(c)(3)

H. The right to the confidentiality of his or her clinical records; §482.13(d)(1)

I. The right to access information contained in his or her clinical records within a reasonable time frame. The hospital must not frustrate the legitimate efforts of individuals to gain access to their own medical records and must actively seek to meet these requests as quickly as its record keeping system permits. §482.13(d)(2)

J. The right to be free from restraints of
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<td>any form that are not medically necessary or are used as a means of coercion, discipline, convenience, or retaliation by staff; §482.13(e)(1)</td>
<td>K. The right to be fully informed of and to consent or refuse to participate in any unusual, experimental or research project without compromising his/her access to services;</td>
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<td>L. The right to know the professional status of any person providing his/her care / services;</td>
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<td>M. The right to know the reasons for any proposed change in the Professional Staff responsible for his/her care;</td>
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<td>N. The right to know the reasons for his/her transfer either within or outside the hospital;</td>
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<td>O. The relationship(s) of the hospital to other persons or organizations participating in the provision of his/her care;</td>
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<td>P. The right of access to the cost, itemized when possible, of services rendered within a reasonable period of time;</td>
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<td>Q. The right to be informed of the source of the hospital's</td>
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reimbursement for his/her services, and of any limitations which may be placed upon his/her care;

R. Informed of the right to have pain treated as effectively as possible.

S. A hospital must have written policies and procedures regarding the visitation rights of patients, including those setting forth any clinically necessary or reasonable restriction or limitation that the hospital may need to place on such rights and the reason for the clinical restriction or limitation. A hospital must meet the following requirements:

- Inform each patient (or support person, where appropriate) of his or her visitation rights, including any clinical restriction or limitation on such rights, when he or she is informed of his or her other rights under this section. §482.13(h)(1)

- Inform each patient (or support person, where appropriate) of the right, subject to his or her consent, to receive the visitors whom he or she designates, including, but not limited to, a spouse, a domestic partner (including a same sex domestic partner), another family
### PATIENT RIGHTS & RESTRAINTS

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- member, or a friend, and his or her right to withdraw or deny such consent at any time. §482.13(h)(2)
- Not restrict, limit or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation, or disability. §482.13(h)(3)
- Ensure that all visitors enjoy full and equal visitation privileges consistent with patient preferences. §482.13(h)(4)

T. The patient’s family has the right of informed consent for donation of organs and tissues.

#### 15.01.10 Participation in the Plan of Care.

_The patient has the right to participate in the development and implementation of his or her plan of care._

§482.13(b)(1)

This regulation requires the hospital to actively include the patient in the development, implementation and revision of his/her plan of care. It requires the hospital to plan the patient’s care, with patient participation, to meet the patient’s psychological and medical needs.

The patient’s (or patient’s representatives, as allowed by State law) right to participate in the development and implementation of his or her plan of care includes at a minimum, the right to:

- participate in the development and implementation of his/her inpatient treatment / care plan, outpatient treatment / care plan, discharge plan, and pain management plan?

**OBSERVATION, DOCUMENT, CHART REVIEW, & INTERVIEW**

1. Does the hospital have policies and procedures to involve the patient or the patient’s representative (as appropriate) in the development and implementation of his/her inpatient treatment / care plan, outpatient treatment / care plan, discharge plan, and pain management plan?

2. Review records and interview staff and patients, or patients’ representatives (as...
### PATIENT RIGHTS & RESTRAINTS

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<td>outpatient treatment / care plan, participate in the development and implementation of his/her discharge plan, and participate in the development and implementation of his/her pain management plan.</td>
<td>Hospitals are expected to take reasonable steps to determine the patient’s wishes concerning designation of a representative to exercise the patient’s right to participate in the development and implementation of the patient’s plan of care. Unless prohibited by applicable State law:</td>
<td>3. Does the hospital’s policy provide for determining when a patient has a representative who may exercise the patient’s right to participate in developing and implementing his/her plan of care, and who that representative is, consistent with this guidance and State law?</td>
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<td>• When a patient who is not incapacitated has designated, either orally to hospital staff or in writing, another individual to be his/her representative, the hospital must involve the designated representative in the development and implementation of the patient’s plan of care. The explicit designation of a representative by the patient takes precedence over any non-designated relationship and continues throughout the patient’s inpatient stay or outpatient visit, unless expressly withdrawn, either orally or in writing, by the patient.</td>
<td>4. Is there evidence that the patient or the patient’s representative was included or proactively involved in the development and implementation of the patient’s plan of care?</td>
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<td>• In the case of a patient who is incapacitated, when an individual presents the hospital with an advance directive, medical power of attorney or similar document executed by the patient and designating an individual to make medical decisions for the patient when incapacitated, the hospital, when presented with the document, must involve the designated representative in the development</td>
<td>5. Were revisions in the plan of care explained to the patient and/or the patient’s representative (when appropriate)?</td>
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and implementation of the patient’s plan of care. The explicit designation of a representative takes precedence over any non-designated relationship and continues throughout the patient’s inpatient stay or outpatient visit, unless the patient ceases to be incapacitated and expressly withdraws the designation, either orally or in writing.

- When a patient is incapacitated or otherwise unable to communicate his or her wishes, there is no written advance directive on file or presented, and an individual asserts that he or she is the patient’s spouse, domestic partner (whether or not formally established and including a same-sex domestic partner), parent (including someone who has stood in loco parentis for the patient who is a minor child) or other family member and thus is the patient’s representative, the hospital is expected to accept this assertion, without demanding supporting documentation, and must involve the individual as the patient’s representative in the development and implementation of the patient’s plan of care, unless:

  - More than one individual claims to be the patient’s representative. In such cases, it would be appropriate for the hospital to ask each individual for documentation supporting his/her claim to be the patient’s representative. The hospital should make its determination of who is the patient’s representative based upon the hospital’s determination of who the patient would
**PATIENT RIGHTS & RESTRAINTS**

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most want to make decisions on his/her behalf. Examples of documentation a hospital might consider could include, but are not limited to, the following: proof of a legally recognized marriage, domestic partnership, or civil union; proof of a joint household; proof of shared or co-mingled finances; and any other documentation the hospital considers evidence of a special relationship that indicates familiarity with the patient’s preferences concerning medical treatment;

- Treating the individual as the patient’s representative without requesting supporting documentation would result in the hospital violating State law. State laws, including State regulations, may specify a procedure for determining who may be considered to be the incapacitated patient’s representative, and may specify when documentation is or is not required; or

- The hospital has reasonable cause to believe that the individual is falsely claiming to be the patient’s spouse, domestic partner, parent or other family member.

Hospitals are expected to adopt policies and procedures that facilitate expeditious and non-discriminatory resolution of disputes about whether an individual is the patient’s representative, given the critical role of the representative in exercising...
the patient’s rights.

A refusal by the hospital of an individual’s request to be treated as the patient’s representative, based on one of the above-specified familial relationships, must be documented in the patient’s medical record, along with the specific basis for the refusal.

15.01.11 Participation in Decision Making

The patient or his or her representative (as allowed under State law) has the right to make informed decisions regarding his or her care. The patient’s rights include being informed of his or her health status, being involved in care planning and treatment, and being able to request or refuse treatment. This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate.

§482.13(b)(2)

The right to make informed decisions means that the patient or patient’s representative is given the information needed in order to make “informed” decisions regarding his/her care.

Patient’s Representative:

A patient may wish to delegate his/her right to make informed decisions to another person (as allowed under State law).

Hospitals are expected to take reasonable steps to determine the patient’s wishes concerning designation of a representative. Unless prohibited by applicable State law:

- When a patient who is not incapacitated has designated, either orally to hospital staff or in writing, another individual to be his/her representative, the hospital must provide the designated individual with the information required to make an informed decision about the patient’s care.
- The hospital must also seek the written consent of

DOCUMENT, CHART REVIEW, INTERVIEW, & OBSERVATION

1. Is there a hospital policy addressing the patient’s or the patient’s representative (as appropriate) right to make informed decisions? Does it articulate how the hospital assures patients’ ability to exercise this right?

- Does the hospital’s policy provide for determining when a patient has a representative who may exercise the patient’s right to make informed decisions, and who that representative is, consistent with this guidance and State law?
- Is there a hospital policy addressing the patient’s right to have information on his/her medical status, diagnosis, and prognosis? Does it articulate the hospital’s process for assuring that patients have this information?
the patient’s representative when informed consent is required for a care decision. The explicit designation of a representative by the patient takes precedence over any non-designated relationship and continues throughout the patient’s inpatient stay or outpatient visit, unless expressly withdrawn, either orally or in writing, by the patient.

- In the case of a patient who is incapacitated, when an individual presents the hospital with an advance directive, medical power of attorney or similar document executed by the patient and designating an individual to make medical decisions for the patient when incapacitated, the hospital must, when presented with the document, provide the designated individual the information required to make informed decisions about the patient’s care.

- The hospital must also seek the consent of the designated individual when informed consent is required for a care decision. The explicit designation of a representative takes precedence over any non-designated relationship and continues throughout the patient’s inpatient stay or outpatient visit, unless the patient ceases to be incapacitated and expressly withdraws the designation, either orally or in writing.

- When a patient is incapacitated or otherwise unable to communicate his or her wishes, there is no written advance directive on file or presented, and an individual asserts that he or she is the patient’s spouse, domestic partner (whether or not formally established and including a same-sex

- Is there a hospital policy addressing how the patient will be involved in his/her care planning and treatment?

2. Is there evidence that the hospital routinely complies with its policies?

- Evidence would be obtained through review of medical records, interviewing current patients and/or interviewing hospital personnel to determine their understanding of the hospital’s informed decision-making policies and how they are implemented.

- Review of evidence would be designed to determine whether patients / patient representatives are provided adequate information about the patient’s medical status, diagnosis, and prognosis, and then allowed to make informed decisions about their care planning and treatment.

3. Review records and interview staff and patients or patients’ representatives (as appropriate) to determine how the hospital assures the patient or the patient’s representative (as appropriate) ability to exercise the right to make informed decisions.

**Assessing Required Disclosures:**

**Physician Ownership:**

1. If the hospital indicates that it is physician-
domestic partner), parent (including someone who has stood in loco parentis for the patient who is a minor child), or other family member and thus is the patient’s representative, the hospital is expected to accept this assertion, without demanding supporting documentation, and provide the individual the information required to make informed decisions about the patient’s care. The hospital must also seek the consent of the individual when informed consent is required for a care decision. Hospitals are expected to treat the individual as the patient’s representative unless:

- More than one individual claims to be the patient’s representative. In such cases, it would be appropriate for the hospital to ask each individual for documentation supporting his/her claim to be the patient’s representative. The hospital should make its determination of who is the patient’s representative based upon the hospital’s determination of who the patient would most want to make decisions on his/her behalf. Examples of documentation a hospital might consider could include, but are not limited to, the following: proof of a legally recognized marriage, domestic partnership, or civil union; proof of a joint household; proof of shared or co-mingled finances; and any other documentation the hospital considers evidence of a special relationship that indicates familiarity with the patient’s preferences concerning medical treatment;

2. If the hospital is physician-owned but not exempt from the physician ownership disclosure requirements:

- Verify that appropriate policies and procedures are in place to assure that necessary written notices are provided to all patients at the beginning of an inpatient or outpatient stay.

- Review the notice the hospital issues to each patient to verify that it discloses, in a manner reasonably designed to be understood by all patients, that the hospital meets the Federal definition of “physician-owned,” that a list of owners and investors who are physicians or immediate family members of physicians is available upon request, and that such a list is provided to the patient at the time the
• Treating the individual as the patient’s representative without requesting supporting documentation would result in the hospital violating State law. State laws, including State regulations, may specify a procedure for determining who may be considered to be the incapacitated patient’s representative, and may specify when documentation is or is not required; or

• The hospital has reasonable cause to believe that the individual is falsely claiming to be the patient’s spouse, domestic partner, parent or other family member.

Hospitals are expected to adopt policies and procedures that facilitate expeditious and non-discriminatory resolution of disputes about whether an individual is the patient’s representative, given the critical role of the representative in exercising the patient’s rights.

A refusal by the hospital of an individual’s request to be treated as the patient’s representative, based on one of the above-specified familial relationships, must be documented in the patient’s medical record, along with the specific basis for the refusal.

Informed Decisions

The right to make informed decisions regarding care presumes that the patient has been provided information about his/her health status, diagnosis, and prognosis. Furthermore, it includes the patient's participation in the development of their plan of care, including providing consent to, or refusal of, medical or surgical interventions, and in planning for care after request is made by or on behalf of the patient.

• Determine through staff interviews, observation, and a review of policies and procedures whether the hospital furnishes its list of physician owners and investors at the time a patient or patient’s representative requests it.

• Determine through staff interviews and review of policies, procedures, and staff records whether a physician-owned hospital’s medical staff membership and admitting privileging requirements include a requirement that, as a condition of continued membership or admitting privileges, physician owners who refer patients to the hospital agree to provide written disclosure of their own or any immediate family member’s ownership or investment interest to all patients at the time of the referral to the hospital.

MD/DO 24/7 On-Site Presence:

1. Determine through interviews, observation, and medical record review whether an MD/DO is present in the hospital, at each campus or satellite location providing inpatient services 24 hours/day, seven days/week.

2. For each required location where an MD/DO is not present:
discharge from the hospital. The patient or the patient’s representative should receive adequate information, provided in a manner that the patient or the patient’s representative can understand, to assure that the patient can effectively exercise the right to make informed decisions.

Hospitals must establish processes to assure that each patient or the patient’s representative is given information on the patient’s health status, diagnosis, and prognosis.

Giving informed consent to a treatment or a surgical procedure is one type of informed decision that a patient or patient’s representative may need to make regarding the patient’s plan of care. Hospitals must utilize an informed consent process that assures patients or their representatives are given the information and disclosures needed to make an informed decision about whether to consent to a procedure, intervention, or type of care that requires consent. See the guidelines for 42 CFR §482.51(b)(2) pertaining to surgical services informed consent and the guidelines for 42 CFR §482.24(c)(2)(v) pertaining to medical records for further detail.

Informed decisions related to care planning also extend to discharge planning for the patient’s post-acute care. See the guidelines at 42 CFR §482.43(c) pertaining to discharge planning for discussion of pertinent requirements.

Hospitals must also establish policies and procedures that assure a patient’s right to request or refuse treatment. Such policies should indicate how the patient’s request will be addressed. However,

- Verify that the appropriate policies and procedures are in place to assure written notices that an MD/DO is not present at all times are provided at the beginning of an inpatient stay or outpatient stay to all inpatients and to all outpatients receiving observation services, surgery or another procedure requiring anesthesia.
- Verify that there is signed acknowledgment by patients of such disclosure, obtained by the hospital prior to the patient’s admission or before applicable outpatient services were provided.
- Ask a sample of inpatients and affected outpatients whether they were provided notice about an MD/DO not being present at all times in the hospital.
- Verify that the hospital’s emergency department has signage with the appropriate disclosure information.
- Review the notice the hospital issues to verify that it indicates how the hospital will meet the medical needs of any patient who develops an emergency medical condition at a time when no physician is present at that hospital, including any remote location or satellite.
hospitals are under no obligation to fulfill a patient's request for a treatment or service that the responsible practitioner has deemed medically unnecessary or even inappropriate.

Required Hospital Disclosures to Patients:

**Physician Ownership**

In addition, there are certain provisions of the Medicare provider agreement rules concerning disclosures that certain hospitals are required to make which are enforced under 21 CFR §482.13(b)(2):

- **42 CFR §489.3** defines a “physician-owned hospital” as any participating hospital in which a physician or physicians have an ownership or investment interest, except for those satisfying exception criteria found at 42 CFR §411.356(a) or (b). Surveyors are not required to make an independent determination regarding whether a hospital meets the Medicare definition of “physician-owned,” but they must ask whether the hospital is physician-owned.

- **42 CFR §489.20(u)(1)** requires that all physician-owned hospitals provide written notice to their patients at the beginning of each patient’s hospital inpatient stay or outpatient visit stating that the hospital is physician-owned, in order to assist the patient in making an informed decision about his/her care, in accordance with requirements of §42 CFR §482.13(b)(2).

- A planned inpatient stay or outpatient visit which is subject to the notice requirement begins with the provision of a package of information
regarding scheduled preadmission testing and registration for a planned hospital admission for inpatient care or for an outpatient service subject to notice. An unplanned inpatient stay or outpatient visit subject to the notice requirement begins at the earliest point at which the patient presents to the hospital.

- The notice must disclose, in a manner reasonably designed to be understood by all patients, that the hospital is physician-owned and that the list of physician owners or investors is available upon request. If the patient (or someone on behalf of the patient) requests this list, the hospital must provide it at the time of the request.

- However, the notice requirement does not apply to any physician-owned hospital that does not have at least one referring physician (as defined at §411.351) who has an ownership or investment interest in the hospital or who has an immediate family member who has an ownership or investment interest in the hospital. In such cases, the hospital must sign an attestation statement that it has no referring physician with an ownership or investment interest or whose immediate family member has an ownership or investment interest in the hospital. The hospital must maintain this attestation in its records.

- 42 CFR 489.20(u)2) provides that physician-owned hospitals must require each physician owner who is a member of the hospital’s medical staff to agree, as a condition of obtaining/retaining medical staff membership or admitting privileges, to disclose in writing to all patients they refer to
the hospital their ownership or investment interest in that hospital or that of any immediate family member. The hospital must require that this disclosure be made at the time of the referral and the requirement should be reflected in the hospital’s policies and procedures governing privileges for physician owners.

- The hospital may exempt from this disclosure requirement any physician owner who does not refer any patients to the hospital.

- 42 CFR 489.12 permits CMS to refuse to enter into a provider agreement with a physician-owned hospital applicant that does not have procedures in place to notify patients of physician ownership in the hospital as required under §489.20(u).

- 42 CFR 489.53(c) permits CMS to terminate a provider agreement with a physician-owned hospital if the hospital fails to comply with the requirements at §489.20(u).

**MD/DO 24/7 On-Site Presence**

42 CFR 489.20(w) mandates that if there is no doctor of medicine or osteopathy present in the hospital 24 hours per day, seven days per week, the hospital must provide written notice of this to all inpatients at the beginning of a planned or unplanned inpatient stay, and to outpatients for certain types of planned or unplanned outpatient visits. The purpose of this requirement is to assist the patient in making an informed decision about his/her care, in accordance with 42 CFR 482.13(b)(2). Hospitals that have an MD/DO on-site 24/7 (including residents who are MDs or DOs) do not need to issue any disclosure notice.
about emergency services capability.

- The notice must be provided to all inpatients and to those outpatients who are under observation or who are having surgery or any other procedure using anesthesia.

- The notice must be provided at the beginning of the planned or unplanned inpatient stay, or outpatient visit subject to notice.
  - A planned inpatient stay or outpatient visit which is subject to the notice requirement begins with the provision of a package of information regarding scheduled preadmission testing and registration for a planned hospital admission for inpatient care or for an outpatient service subject to notice. An unplanned inpatient stay or outpatient visit which is subject to the notice requirement begins at the earliest point at which the patient presents to the hospital.

- Individual notices are not required in the hospital’s dedicated emergency department (DED) (as that term is defined in 42 CFR 489.24(b)), but the DED must post a notice conspicuously, in a place or places likely to be noticed by all individuals entering the DED. The posted notice must state that the hospital does not have a doctor of medicine or a doctor of osteopathy present in the hospital 24 hours per day, 7 days per week, and must indicate how the hospital will meet the medical needs of any
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patient with an emergency medical condition, as defined in 42 CFR 489.24(b) [the EMTALA definition], at a time when there is no doctor of medicine or doctor of osteopathy present in the hospital. If an emergency department patient is determined to require admission, then the individual notice requirements of 42 CFR 489.20(w) would apply to that patient.

- Before admitting an inpatient or providing outpatient services requiring notice, the hospital must obtain a signed acknowledgement from the patient stating that he/she understands that a doctor of medicine or doctor of osteopathy may not be present at all times services are furnished to him/her.

- In the event of an unplanned surgery or inpatient admission to treat an emergency medical condition, it may in some cases be necessary in the interest of the patient’s safety to proceed with treatment before the required notice can be given and acknowledgement can be obtained. In such circumstances, the hospital must provide notice and obtain acknowledgement as soon as possible after the patient’s stay or visit begins.

- For a hospital that participates in Medicare with multiple campuses providing inpatient services (e.g., a main provider campus and separate satellite, remote, and/or provider-based locations) under one CMS Certification Number, a separate determination is made for each campus or satellite location with inpatient services as to whether the disclosure notice is required. For example, if a hospital has a main campus and a
15.01.12  **Advance Directives.**

*The patient has the right to formulate advance directives and to have hospital staff and practitioners who provide care in the hospital comply with these directives, in accordance with §489.100 of this part (Definition), §489.102 of this part (Requirements for providers) and §489.104 of this part. (Effective dates).*

An advance directive is defined at §489.100 as “a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated.”

The patient (inpatient or outpatient) has the right to formulate advance directives, and to have hospital staff implement and comply with their advance directive. The regulation at 42 CFR §489.102

**DOCUMENT REVIEW**

1. Review the hospital’s advance directive notice.
   - Does it advise inpatients or applicable outpatients, or their representatives, of the patient’s right to formulate an advance directive and to have hospital staff comply with the advance directive (in accordance with State law)?

   - Does it include a clear, precise and
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<td>§482.13(b)(3)</td>
<td>specifies the rights of a patient (as permitted by State law) to make medical care decisions, including the right to accept or refuse medical or surgical treatment and the right to formulate, at the individual’s option, advance directives. In the advance directive, the patient may provide guidance as to his/her wishes concerning provision of care in certain situations; alternatively the patient may delegate decision-making authority to another individual, as permitted by State law. (In addition, the patient may use the advance directive to designate a support person, as that term is used in §482.13(h), for purposes of exercising the patient’s visitation rights.) When a patient who is incapacitated has executed an advance directive designating a particular individual to make medical decisions for him/her when incapacitated, the hospital must, when presented with the document, provide the designated individual the information required to make informed decisions about the patient’s care. (See also the requirements at §482.13(b) (2).) The hospital must also seek the consent of the patient’s representative when informed consent is required for a care decision. The explicit designation of a representative in the patient’s advance directive takes precedence over any non-designated relationship and continues throughout the patient’s inpatient stay or, as applicable, outpatient visit, unless the patient ceases to be incapacitated and expressly withdraws the designation, either orally or in writing.</td>
<td>valid statement of limitation if the hospital cannot implement an advance directive on the basis of conscience? 2. What mechanism does the hospital have in place to allow patients to formulate an advance directive or to update their current advance directive? Is there evidence that the hospital is promoting and protecting each patient’s right to formulate an advance directive? 3. Determine to what extent the hospital educates its staff regarding advance directives. 4. Determine to what extent the hospital provides education for the patient population (inpatient and outpatient) regarding one’s rights under State law to formulate advance directives.</td>
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CHART REVIEW

Review the records of a sample of patients for evidence of hospital compliance with advance directive notice requirements.

1. Does every inpatient or applicable outpatient record contain documentation that notice of the hospital’s advance directives policy was provided at the time of admission or registration?
2. Is there documentation of whether or not each patient has an advance directive?
3. For those patients who have reported an advance directive, has a copy of the

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Accreditation Requirements for Acute Care Hospitals

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§489.102 also requires the hospital to:

- Provide written notice of its policies regarding the implementation of patients’ rights to make decisions concerning medical care, such as the right to formulate advance directives. If an individual is incapacitated or otherwise unable to communicate, the hospital may provide the advance directive information required under §489.102 to the individual’s “family or surrogate in the same manner that it issues other materials about policies and procedures to the family of the incapacitated individual or to a surrogate or other concerned persons in accordance with State law. (§489.102(e)) The guidance concerning the regulation at §482.13(a)(1) governing notice to the patient or the patient’s representative of the patient’s rights applies to the required provision of notice concerning the hospital’s advance directive policies. Although both inpatients and outpatients have the same rights under §482.13(a)(1), §489.102(b)(1) requires that notice of the hospital’s advance directive policy be provided at the time an individual is admitted as an inpatient. However, in view of the broader notice requirements at §482.13(a)(1), the hospital should also provide the advance directive notice to outpatients (or their representatives) who are in the emergency department, who are in an observation status, or who are undergoing same-day surgery. The notice should be presented at the time of registration. Notice is not required for other outpatients, given that patient’s advance directive been placed in the medical record?

4. Determine to what extent the hospital complies, as permitted under State law, with patient advance directives that delegate decisions about the patient’s care to a designated individual.

**INTERVIEW**

Interview staff to determine their knowledge of the advance directives of the patients in their care.
they are unlikely to become incapacitated.

- The notice must include a clear and precise statement of limitation if the hospital cannot implement an advance directive on the basis of conscience. At a minimum, a statement of limitation should:
  - Clarify any differences between institution-wide conscience objections and those that may be raised by individual physicians or other practitioners;
  - Identify the State legal authority permitting such an objection; and
  - Describe the range of medical conditions or procedures affected by the conscience objection.

It should be noted that this provision allowing for certain conscience objections to implementing an advance directive is narrowly focused on the directive’s content related to medical conditions or procedures. This provision would not allow a hospital or individual physician or practitioner to refuse to honor those portions of an advance directive that designate an individual as the patient’s representative and/or support person, given that such designation does not concern a medical condition or procedure.

Issuance of the written notice of the hospital’s advance directive policies to the
patient or the patient’s representative must be documented in the patient’s medical record.

• Document in a prominent part of the patient’s medical record whether or not the patient has executed an advance directive;

• Not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;

• Ensure compliance with requirements of State law concerning advance directives and inform individuals that complaints concerning the advance directive requirements may be filed with the State survey and certification agency;

• Provide for the education of staff concerning its policies and procedures on advance directives. The right to formulate advance directives includes the right to formulate a psychiatric advance directive (as allowed by State law); and

• Provide community education regarding advance directives and the hospital must document its efforts.

A psychiatric advance directive is akin to a traditional advance directive for health care. This type of advance directive might be prepared by an individual who is concerned that at some time he or she may be subject to involuntary psychiatric commitment or treatment. The psychiatric advance directive may cover a range of subjects, and may name another person who is authorized to make
decisions for the individual if he or she is determined to be legally incompetent to make his/her own choices. It may also provide the patient’s instructions about hospitalization, alternatives to hospitalization, the use of medications, types of therapies, and the patient’s wishes concerning restraint or seclusion. The patient may designate who should be notified upon his/her admission to the hospital, as well as who should not be permitted to visit him or her. State laws regarding the use of psychiatric advance directives vary.

In accordance with State law, a psychiatric advance directive should be accorded the same respect and consideration that a traditional advance directive for health care is given. Hospitals should carefully coordinate how the choices of a patient balance with the rights of other patients, staff, and individuals in the event that a dangerous situation arises.

However, even if State law has not explicitly spoken to the use of psychiatric advance directives, consideration should be given to them inasmuch as this regulation also supports the patient’s right to participate in the development and implementation of his or her plan of care. When the patient is, for whatever reason, unable to communicate his/her wishes, the preferences expressed in the psychiatric advance directive can give critical insight to the Doctor of Medicine / Doctor of Osteopathic Medicine, nurses, and other staff as they develop a plan of care and treatment for the patient.
### 15.01.13 Not Applicable.

### 15.01.14 Admission Notification

The patient has the right to have a family member or representative of his or her choice and his or her own physician notified promptly of his or her admission to the hospital.

§482.13(b)(4)

#### Identifying Who Is to Be Notified

For every inpatient admission, the hospital must ask the patient whether the hospital should notify a family member or representative about the admission.

If the patient requests such notice and identifies the family member or representative to be notified, the hospital must provide such notice promptly to the designated individual. The explicit designation of a family member or representative by the patient takes precedence over any non-designated relationship.

The hospital must also ask the patient whether the hospital should notify his/her own physician. In the case of scheduled admissions, the patient’s own physician likely is already aware of the admission. However, if the patient requests notice to and identifies the physician, the hospital must provide such notice promptly to the designated physician, regardless of whether the admission was scheduled in advance or emergent.

When a patient is incapacitated or otherwise unable to communicate and to identify a family member or representative to be notified, the hospital must

#### CHART REVIEW, DOCUMENT REVIEW, AND INTERVIEW

1. Determine if the hospital has policies that address notification of a patient’s family or representative and physician when the patient is admitted as an inpatient.

2. Ask the hospital who is responsible for providing the required notice.
   - Interview person(s) responsible for providing the notice to determine how they identify the persons to be notified and the means of notification.
   - What do they do in the case of an incapacitated person to identify a family member / representative and the patient’s physician?

3. Review a sample of inpatient medical records.
   - Do the medical records provide evidence that the patient was asked about notifying a family member / representative and his/her physician?

This standard is not met as evidenced by:
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<th>EXPLANATION</th>
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<td>make reasonable efforts to identify and promptly notify a family member or patient’s representative. If an individual who has accompanied the patient to the hospital, or who comes to or contacts the hospital after the patient has been admitted, asserts that he or she is the patient’s spouse, domestic partner (whether or not formally established and including a same-sex domestic partner), parent (including someone who has stood in loco parentis for the patient who is a minor child), or other family member, the hospital is expected to accept this assertion, without demanding supporting documentation, and provide this individual information about the patient’s admission, unless:</td>
<td>- Is there a record of when and how notice was provided? Was notice provided promptly?</td>
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<td>- More than one individual claims to be the patient’s family member or representative. In such cases it would not be inappropriate for the hospital to ask each individual for documentation supporting his/her claim to be the patient’s family member or representative. The hospital should make its determination of who is the patient’s representative based upon the hospital’s determination of who the patient would most want to make decisions on his/her behalf. Examples of documentation a hospital might consider could include, but are not limited to, the following: proof of a legally recognized marriage, domestic partnership, or civil union; proof of a joint household; proof of shared or co-mingled finances; and any other documentation the hospital considers evidence of a special relationship that indicates</td>
<td>- Is there a record of the patient declining to have notice provided to a family member / representative and his/her physician? Is there documentation of whether the patient was incapacitated at the time of admission, and if so, what steps were taken to identify a family member / representative and the patient’s physician?</td>
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familiarity with the patient’s preferences concerning medical treatment;

- Treating the individual as the patient’s family member or representative without requesting supporting documentation would result in the hospital violating State law. State laws, including State regulations, may specify a procedure for determining who may be considered to be the incapacitated patient’s family member or representative, and may specify when documentation is or is not required; or

- The hospital has reasonable cause to believe that the individual is falsely claiming to be the patient’s spouse, domestic partner, parent or other family member.

Hospitals are expected to adopt policies and procedures that facilitate expeditious and non-discriminatory resolution of disputes about whether an individual should be notified as the patient’s family member or representative, given the critical role of the representative in exercising the patient’s rights. Hospitals may also choose to provide notice to more than one family member.

When a patient is incapacitated and the hospital is able through reasonable efforts to identify the patient’s own physician – e.g., through information obtained from a family member, or from review of prior admissions or outpatient encounters, or through access to the patient’s records in a regional system of electronic patient medical records in which the hospital participates – the hospital must
promtly notify the patient’s physician of the admission.

**Prompt Notice**

The hospital must provide the required notice promptly. “Promptly” means as soon as possible after the physician’s or other qualified practitioner’s order to admit the patient has been given. Notice may be given orally in person, by telephone, by e-mail or other electronic means, or by other methods that achieve prompt notification. It is not acceptable for the hospital to send a letter by regular mail.

**Medical Record Documentation**

The hospital must document that the patient, unless incapacitated, was asked no later than the time of admission whether he or she wanted a family member / representative notified, the date, time and method of notification when the patient requested such, or whether the patient declined to have notice provided. If the patient was incapacitated at the time of admission, the medical record must indicate what steps were taken to identify and provide notice to a family member / representative and to the patient’s physician.

15.01.15  Not Applicable.
**15.01.16 Privacy & Safety: Personal Privacy.**

*The patient has the right to personal privacy.*

§482.13(c)
§482.13(c)(1)

The underlying principle of this requirement is the patient’s basic right to respect, dignity, and comfort while in the hospital.

**Physical Privacy**

“The right to personal privacy” includes at a minimum, that patients have physical privacy to the extent consistent with their care needs during personal hygiene activities (e.g., toileting, bathing, dressing), during medical / nursing treatments, and when requested as appropriate.

People not involved in the care of the patient should not be present without his/her consent while he/she is being examined or treated, nor should video or other electronic monitoring / recording methods be used while he/she is being examined without his/her consent. If an individual requires assistance during toileting, bathing, and other personal hygiene activities, staff should assist, giving utmost attention to the individual’s need for privacy.

Privacy should be afforded when the Doctor of Medicine / Doctor of Osteopathic Medicine or other staff visits the patient to discuss clinical care issues or conduct any examination or treatment.

However, audio / video monitoring (does not include recording) of patients in medical-surgical or intensive-care type units would not be considered violating the patient’s privacy, as long as there exists a clinical need, the patient/patient’s representative is aware of the monitoring and the monitors or speakers are located so that the monitor screens are not readily visible or where speakers are not readily audible to visitors or the public.

**OBSERVATION, DOCUMENT REVIEW, AND INTERVIEW**

1. Conduct observations/interview patients or their representatives to determine if patients are provided reasonable privacy during examinations or treatments, personal hygiene activities and discussions about their health status/care and other appropriate situations?

2. Review hospital policy and interview staff concerning their understanding of the use of patient information in the facility directory. Does the policy address the opportunity for the patient or patient’s representative to restrict or prohibit use of patient information in emergent and non-emergent situations?

3. Review hospital policy and conduct observations/interview staff to determine if reasonable safeguards are used to reduce incidental disclosures of patient information.

4. If audio and/or visual monitoring is utilized in the med/surg or ICU setting, conduct observations to determine that monitor screens and/or speakers are not readily visible or audible to visitors or the public.

5. Is the hospital promoting and protecting each patient’s right to privacy?

- Are patient names posted in public view?

Compliant

Not Compliant

This standard is not met as evidenced by:
audible to visitors or the public.

- Video recording of patients undergoing medical treatment requires the consent of the patient or his/her representative.

A patient’s right to privacy may also be limited in situations where a person must be continuously observed to ensure his or her safety, such as when a patient is simultaneously restrained and in seclusion to manage violent or self-destructive behavior or when the patient is under suicide precautions. In most situations, security cameras in non-patient care areas such as stairwells, public waiting areas, outdoor areas, entrances, etc., are not generally affected by this requirements.

**Protecting Patient Personal Information**

The right to personal privacy also includes limiting the release or disclosure of patient information. Patient information includes, but is not limited to, the patient’s presence or location in the hospital; demographic information the hospital has collected on the patient, such as name, age, address, income; or information on the patient’s medical condition. Such patient information may not be disclosed without informing the patient or the patient’s representative in advance of the disclosure and providing the patient or the patient’s representative an opportunity to agree, prohibit, or restrict the disclosure. Below is a summary of privacy issues that surveyors might encounter in hospital settings, and the related privacy requirements.

**Permitted Disclosures:**

- Is patient information posted in public view?
A hospital is permitted to use and disclose patient information, without the patient’s authorization, in order to provide patient care and perform related administrative functions, such as payment and other hospital operations.

- Payment operations include hospital activities to obtain payment or be reimbursed for the provision of health care to an individual.

- Hospital operations are administrative, financial, legal, and quality improvement activities of a hospital that are necessary to conduct business and to support the core functions of treatment and payment. These activities include, but are not limited to:
  - quality assessment and improvement activities,
  - case management and care coordination;
  - competency assurance activities, conducting or arranging for medical reviews, audits, or legal services, including fraud and abuse detection and compliance programs;
  - business planning, development, management, and administration and certain hospital-specific fundraising activities.

Hospitals must develop and implement policies and procedures that restrict access to and use of patient information based on the specific roles of the
members of their workforce.

- These policies and procedures must identify the persons, or classes of persons, in the workforce who need access to protected health information to carry out their duties and the categories of protected health information to which access is needed.

- One example of a permitted disclosure is a Facility Directory. It is common practice in many hospitals to maintain a directory of patient contact information.

- The hospital must inform the patient, or the patient’s representative, of the individual information that may be included in a directory and the persons to whom such information may be disclosed. The patient, or the patient’s representative, must be given the opportunity to restrict or prohibit any or all uses and disclosures. The hospital may rely on a patient’s/representative’s individual’s informal permission to list in its facility directory the patient’s name, general condition, religious affiliation, and location in the provider’s facility. The provider may then disclose the patient’s condition and location in the facility to anyone asking for the patient by name, and also may disclose religious affiliation to clergy. If the opportunity to prohibit or restrict uses and disclosures cannot be provided due to the patient’s incapacity or emergency.

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treatment circumstance, and there is no patient representative available, the hospital may disclose patient information for the facility’s directory if such disclosure is in the patient’s best interest. The hospital must provide the patient or the patient’s representative an opportunity to prohibit or restrict disclosure as soon as it becomes practicable to do so. The hospital may use patient information to notify, or assist in the notification of, a family member, a personal representative of the patient, or another person responsible for the care of the patient of their location, general condition, or death.

- The hospital must have procedures in place, in accordance with State law, to provide appropriate information to patient families or others in those situations where the patient is unable to make their wishes known.

Incidental Uses and Disclosures May be Acceptable:

An incidental use or disclosure is a secondary use or disclosure of patient information that cannot reasonably be prevented, is limited in nature, and that occurs as a result of another use or disclosure that is permitted. Many customary health care communications and practices play an important role in ensuring the prompt delivery of effective care. Due to the nature of these communications and practices, as well as of the hospital environment, the potential exists for a patient’s
information to be disclosed incidentally.

For example, a hospital visitor may overhear a health care professional’s confidential conversation with another health care professional or the patient, or may glimpse a patient’s information on a sign-in sheet or nursing station whiteboard. The regulation protecting patient privacy does not impede these customary and essential communications and practices and, thus, a hospital is not required to eliminate all risk of incidental use or disclosure secondary to a permitted use or disclosure, so long as the hospital takes reasonable safeguards and discloses only the minimum amount of personally identifiable information necessary.

For example, hospitals may:

- Use patient care signs (e.g. “falls risk” or “diabetic diet”) displayed at the bedside or outside a patient room;
- Display patient names on the outside of patient charts; or
- Use “whiteboards” that list the patients present on a unit, in an operating room suite, etc.

Hospitals are expected to review their practices and determine what steps are reasonable to safeguard patient information while not impeding the delivery of safe patient care or incurring undue administrative or financial burden as a result of implementing privacy safeguards.

Examples of reasonable safeguards could include,
but are not limited to:

- Requesting that waiting customers stand a few feet back from a counter used for patient registration;
- Use of dividers or curtains in areas where patient and physician or other hospital staff communications routinely occur;
- Health care staff speaking quietly when discussing a patient’s condition or treatment in a semi-private room;
- Utilizing passwords and other security measures on computers maintaining personally identifiable health information; or
- Limiting access to areas where white boards or x-ray light boards are in use, or posting the board on a wall not readily visible to the public, or limiting the information placed on the board.

15.01.17 Privacy & Safety: Safe Setting.

The patient has the right to receive care in a safe setting.

§482.13(c)(2)

The intention of this requirement is to specify that each patient receives care in an environment that a reasonable person would consider to be safe. For example, hospital staff should follow current standards of practice for patient environmental safety, infection control, and security. The hospital must protect vulnerable patients, including

DOCUMENT REVIEW

1. Review and analyze patient and staff incident and accident reports to identify any incidents or patterns of incidents concerning a safe environment. Expand your review if you suspect a problem with safe environment in the hospitals.

Compliant □ Not Compliant □

This standard is not met as evidenced by:
newborns and children.

Additionally, this standard is intended to provide protection for the patient’s emotional health and safety as well as his/her physical safety. Respect, dignity and comfort would be components of an emotionally safe environment.

2. Review QAPI, safety, infection control and security (or the committee that deals with security issues) committee minutes and reports to determine if the hospital is identifying problems, evaluating those problems and taking steps to ensure a safe patient environment.

3. Review policy and procedures on what the facility does to curtail unwanted visitors or contaminated materials.

**OBSERVATION**

1. Observe the environment where care and treatment are provided.

2. Observe and interview staff at units where infants and children are inpatients. Are appropriate security protections (such as alarms, arm banding systems, etc.) in place? Are they functioning?

3. Access the hospital’s security efforts to protect vulnerable patients including newborns and children. Is the hospital providing appropriate security to protect patients? Are appropriate security mechanisms in place and being followed to protect patients?

**DOCUMENT REVIEW & INTERVIEW**

Examine the extent to which the hospital has a system in place to protect patients from abuse, neglect (as a form of abuse) and harassment whether from staff, other patients or visitors. The patient has the right to be free from abuse, neglect and harassment.

- **Compliant**
- **Not Compliant**

---

**15.01.18 Privacy & Safety: Free From Abuse.**

*The patient has the right to be free from abuse.*

The intent of this requirement is to prohibit all forms of abuse, neglect (as a form of abuse) and harassment whether from staff, other patients or visitors.
The hospital must ensure that patients are free from all forms of abuse, neglect, or harassment. The hospital must have mechanisms/methods in place that ensure patients are free of all forms of abuse, neglect, or harassment.

Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment, with resulting physical harm, pain, or mental anguish. This includes staff neglect or indifference to infliction of injury or intimidation of one patient by another.

Neglect, for the purpose of this requirement, is considered a form of abuse and is defined as the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness.

The following components are suggested as necessary for effective abuse protection:

- **Prevent.** A critical part of this system is that there are adequate staff on duty, especially during the evening, nighttime, weekends and holiday shifts, to take care of the individual needs of all patients. (See information regarding meaning of adequate at those requirements that require the hospital to have adequate staff. Adequate staff would include that the hospital ensures that there are the number and types of qualified, trained, and experienced staff at the hospital and available to meet the care needs of every patient.)

- **Respond.** A critical part of this system is that there are adequate staff on duty, especially during the evening, nighttime, weekends and holiday shifts, to take care of the individual needs of all patients. (See information regarding meaning of adequate at those requirements that require the hospital to have adequate staff. Adequate staff would include that the hospital ensures that there are the number and types of qualified, trained, and experienced staff at the hospital and available to meet the care needs of every patient.)

- **Report.** A critical part of this system is that there are adequate staff on duty, especially during the evening, nighttime, weekends and holiday shifts, to take care of the individual needs of all patients. (See information regarding meaning of adequate at those requirements that require the hospital to have adequate staff. Adequate staff would include that the hospital ensures that there are the number and types of qualified, trained, and experienced staff at the hospital and available to meet the care needs of every patient.)

- **Review.** A critical part of this system is that there are adequate staff on duty, especially during the evening, nighttime, weekends and holiday shifts, to take care of the individual needs of all patients. (See information regarding meaning of adequate at those requirements that require the hospital to have adequate staff. Adequate staff would include that the hospital ensures that there are the number and types of qualified, trained, and experienced staff at the hospital and available to meet the care needs of every patient.)

This standard is not met as evidenced by:

- **Prevent.**
- **Respond.**
- **Report.**
- **Review.**
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<td>Screen. Persons with a record of abuse or neglect should not be hired or retained as employees.</td>
<td>Investigated?</td>
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<td>Identify. The hospital creates and maintains a proactive approach to identify events and occurrences that may constitute or contribute to abuse and neglect.</td>
<td>10. Does the hospital conduct criminal background checks as allowed by State law for all potential new hires?</td>
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<td>Train. The hospital, during its orientation program, and through an ongoing training program, provides all employees with information regarding abuse and neglect, and related reporting requirements, including prevention, intervention, and detection.</td>
<td>11. Is there evidence the hospital employs people with a history of abuse, neglect or harassment?</td>
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<td>Protect. The hospital must protect patients from abuse during investigation of any allegations of abuse or neglect or harassment.</td>
<td>12. Request a copy of the State rules relative to the identification and reporting of abuse (including sexual assault) and neglect.</td>
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<td>Investigate. The hospital ensures, in a timely and thorough manner, objective investigation of all allegations of abuse, neglect or mistreatment.</td>
<td>13. Review education documents. Verify:</td>
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<tr>
<td>Report / Respond. The hospital must assure that any incidents of abuse, neglect or harassment are reported and analyzed, and the appropriate corrective, remedial or disciplinary action occurs, in accordance with applicable local, State, or Federal law.</td>
<td>• Staff education is provided on the prevention, identification, and reporting of suspected abuse (including sexual assault) or neglect.</td>
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As a result of the implementation of this system, changes to the hospital's policies and procedures should be made accordingly.
### PATIENT RIGHTS & RESTRAINTS

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<td>15.01.19</td>
<td>Not Applicable.</td>
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<td>15.01.20</td>
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<tr>
<td>15.01.21 Confidentiality of Patient Records:</td>
<td>The patient has the right to the confidentiality of his or her clinical records.</td>
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| §482.13(d)  
§482.13(d)(1) | The hospital must ensure the confidentiality of patient records requirements are met. | | |
| | The right to confidentiality of the patient’s medical record means the hospital must safeguard the contents of the medical record, whether it is in paper or electronic format, or a combination of the two, from unauthorized disclosure. | | |
| | Confidentiality applies wherever the record or portions thereof are stored, including but not limited to central records, patient care locations, radiology, laboratories, record storage areas, data systems, etc. | | |
| | A hospital is permitted to disclose patient information, without a patient’s authorization, in order to provide patient care and perform related administrative functions, such as payment and other hospital operations. | | |
| | • Payment operations include hospital activities to obtain payment or be reimbursed for the provision of health care to an individual. | | |
| | • Hospital operations are administrative, financial, legal, and quality improvement activities of a hospital that are necessary to conduct business and to support the core functions of treatment and payment. These | | |
| | OBSERVATION | | |
| | 1. Verify that the hospital has policies and procedures addressing the protecting of information in patients’ medical record from unauthorized disclosures. | | |
| | 2. Observe locations where medical records are stored to determine whether appropriate safeguards are in place to protect medical record information. | | |
| | 3. Interview staff to determine their understanding of and compliance with the hospital’s policies and procedures for protecting medical record information. | | |
| | 4. Observe care units. | | |
| | • Is patient information posted where it can be viewed by visitors or other non-hospital staff? | | |
| | • Are medical records accessible to people not involved with the patient’s care? | | |
| | • Is it likely that unauthorized persons could read or remove the clinical record? | | |

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activities include, but are not limited to: quality assessment and improvement activities, case management and care coordination; competency assurance activities, conducting or arranging for medical reviews, audits, or legal services, including fraud and abuse detection and compliance programs; business planning, development, management, and administration and certain hospital-specific fundraising activities.

The hospital must develop policies and procedures that reasonably limit disclosures of information contained in the patient’s medical record to the minimum necessary, even when the disclosure is for treatment or payment purposes, or as otherwise required by State or Federal law.

When the minimum necessary standard is applied, a hospital may not disclose the entire medical record for a particular purpose, unless it can specifically justify that the whole record is the amount reasonably needed for the purpose.

A hospital may make an authorized disclosure of information from the medical record electronically, and may also share an electronic medical record system with other health care facilities, physicians and practitioners, so long as the system is designed and operated with safeguards that ensure that only authorized disclosures are made.

The hospital must obtain the patient’s, or the patient’s representative’s, written authorization for any disclosure of information in the medical record when the disclosure is not for treatment, payment...
**15.01.22 Access to Medical Records.** The patient has the right to access information contained in his or her clinical records within a reasonable time frame. The hospital must not frustrate the legitimate efforts of individuals to gain access to their own medical records and must actively seek to meet these requests as quickly as its record keeping system permits.

§482.13(d)(2)

The requirements of the Department of Health and Human Services with regard to the confidentiality rights of individuals are set forth in the Privacy Rule at 42 CFR §164.500 et seq., pursuant to §264 of the Health Insurance Portability and Accountability Act of 1996. The regulation at 42 CFR §164.524 specifies that patients should be allowed to inspect and obtain a copy of health information about them that is held by providers; and that providers may not withhold information except under limited circumstances.

These circumstances include:

- Psychotherapy notes;
- A correctional institution or a health care provider acting at the direction of a correctional institution may deny an inmate’s request for access, if providing such access would jeopardize the health or security of the individual, other inmates, or officers or employees of the correctional institution;
- The information is about another person (other than a health care provider) and the hospital determines that the patient inspection is reasonably likely to cause sufficient harm to that person to warrant withholding;
- A licensed health care professional has determined that the access requested is

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<td>1. Does the hospital promote and protect the patient’s right to access information contained in his/her clinical record?</td>
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<td>2. Does the hospital have a procedure for providing records to patients within a reasonable time frame?</td>
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<td>3. Does the hospital’s system frustrate the legitimate efforts of individuals to gain access to their own medical record?</td>
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<td>4. Does the procedure include the method to identify what documents were not provided and the reason?</td>
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This standard is not met as evidenced by:
### PATIENT RIGHTS & RESTRAINTS

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<td>reasonably likely to endanger the life or physical safety of the individual or another person;</td>
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<td>- The information contains data obtained under a promise of confidentiality (from someone other than a health care provider), and inspection could reasonably reveal the source;</td>
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<td>- The information is collected in the course of research that includes treatment and the research is in progress, provided that the individual has agreed to the denial of access and the provider informs the individual that his or her right of access will be reinstated when the research is completed;</td>
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<td>- The protected health information is subject to the Clinical Laboratory Improvements Amendments of 1988, 42 CFR §263a, to the extent that providing the requested access would be prohibited by law;</td>
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<td>- The protected health information is exempt from the Clinical Laboratory Improvements Amendments of 1988, pursuant to 42 CFR §493.3(a)(2);</td>
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<td>- The information is compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative action or proceeding; and</td>
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<td>- The request is made by an individual’s personal representative (as allowed under state law) and a licensed health care professional has determined that access is reasonably likely to cause substantial harm to the individual or another person.</td>
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**2014 updated August 2014**

Healthcare Facilities Accreditation Program (HFAP)
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In general, each patient should be able to see and obtain a copy of his/her records. Record holders may not deny access except to a portion of the record that meets criteria specified above. In these cases, the record holder may decide to withhold portions of the record; however, to the extent possible, the patient should be given as much information as possible.

If the patient is incompetent, the patient record should be made available to his or her representative (as allowed under State law). Upon the patient’s request, other designated individuals may access the patient’s records.

The patient has the right to easily access his/her medical records.

- Reasonable cost-based fees may be imposed only to cover the cost of copying, postage, and/or preparing an explanation or summary of patient health information, as outlined in 42 CFR §164.524(c).

- The cost of duplicating a patient’s record must not create a barrier to the individual’s receiving his or her medical record.

15.01.23  Not Applicable.

15.01.24  Not Applicable.

15.01.25  Visitation Rights.  
* A hospital must have written policies and Visitation plays an important role in the care of hospital patients.  

**DOCUMENT REVIEW AND INTERVIEW**

1. Verify that the hospital has written policies  

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- An article published in 2004 in the Journal of the American Medical Association (Berwick, D.M., and Kotagal, M.: Restricted visiting hours in ICUs: time to change. JAMA. 2004; Vol. 292, pp. 736-737) discusses the health and safety benefits of open visitation for patients, families, and intensive care unit (ICU) staff and debunks some of the myths surrounding the issue (physiologic stress for the patient; barriers to provision of care; exhaustion of family and friends). The article ultimately concluded that available evidence indicates that hazards and problems regarding open visitation are generally overstated and manageable, and that such visitation policies do not harm patients but rather may help them by providing a support system and shaping a more familiar environment as they engender trust in families, creating a better working relationship between hospital staff and family members.

Hospitals that unnecessarily restrict patient visitation often miss an opportunity to gain valuable patient information from those who may know the patient best with respect to the patient's medical history, conditions, medications, and allergies, particularly if the patient has difficulties with recall or articulation, or is totally unable to recall or articulate this vital personal information. Many times visitors who may know the patient best act as an intermediary for the patient, helping to communicate the patient's needs to hospital staff.

Although visitation policies are generally considered to relate to visitors of inpatients, visitors also play a

2. Review the policy to determine if there are limitations or restrictions on visitation. If there are, does the policy explain the clinical rationale for the restrictions or limitations? Is the rationale clear and reasonably related to clinical concerns?

3. Is there documentation of how the hospital identifies and trains staff who play a role in facilitating or controlling access of visitors to patients?

4. Are hospital staff aware of the visitation policies and procedures? Can staff on a given unit correctly describe the hospital’s visitation policies for that unit?

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role for outpatients who wish to have a support person present during their outpatient visit. For example, a same-day surgery patient may wish to have a support person present during the pre-operative patient preparation or post-operative recovery. Or an outpatient clinic patient may wish to have a support person present during his or her examination by a physician. Accordingly, hospital visitation policies must address both the inpatient and outpatient settings.

Hospitals are required to develop and implement written policies and procedures that address the patient’s right to have visitors. If the hospital’s policy establishes restrictions or limitations on visitation, such restrictions/limitations must be clinically necessary or reasonable.

• Furthermore, the hospital’s policy must include the reasons for any restrictions/limitations. The right of a patient to have visitors may be limited or restricted when visitation would interfere with the care of the patient and/or the care of other patients.

• The regulation permits hospitals some flexibility, so that health care professionals may exercise their best clinical judgment when determining when visitation is, and is not, appropriate. Best clinical judgment takes into account all aspects of patient health and safety, including the benefits of visitation on a patient’s care as well as potential negative impacts that visitors may have on other patients in the hospital.
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Broad examples of circumstances reasonably related to the care of the patient and/or the care of other patients that could provide a basis for a hospital to impose restrictions or limitations on visitors might include (but are not limited to) when:

- there may be infection control issues;
- visitation may interfere with the care of other patients;
- the hospital is aware that there is an existing court order restricting contact;
- visitors engage in disruptive, threatening, or violent behavior of any kind;
- the patient or patient’s roommate(s) need rest or privacy; and
- in the case of an inpatient substance abuse treatment program, there are protocols limiting visitation; and
- the patient is undergoing care interventions.

However, while there may be valid reasons for limiting visitation during a care intervention, we encourage hospitals to try to accommodate the needs of any patient who requests that at least one visitor be allowed to remain in the room to provide support and comfort at such times.

It may also be reasonable to limit the number of visitors for any one patient during a specific period of time, as well as to establish minimum age requirements for child visitors. However, when a hospital adopts policies that limit or restrict patients’ visitation rights, the burden of proof is...
15.01.26 Patient Visitation Rights. Hospitals are required to inform each patient (or the patient's representative) of visitation restrictions and limitations that are reasonably necessary to provide safe care. Hospitals are expected to provide a clear explanation in their written policy of the clinical rationale for any visitation restrictions or limitations reflected in that policy. Hospitals are not required, however, to delineate each specific clinical reason for policies limiting or restricting visitation, given that it is not possible to anticipate every instance that may give rise to a clinically appropriate rationale for a restriction or limitation. If visitation policies differ by type of unit, e.g., separate policies for intensive care units, or for newborn nurseries, the hospital policy must address the clinical rationale for this differentiation explicitly.

The hospital’s policies and procedures are expected to address how hospital staff who play a role in facilitating or controlling visitor access to patients will be trained to assure appropriate implementation of the visitation policies and procedures and avoidance of unnecessary restrictions or limitations on patients’ visitation rights.
A hospital must have written policies and procedures regarding the visitation rights of patients, including those setting forth any clinically necessary or reasonable restriction or limitation that the hospital may need to place on such rights and the reason for the clinical restriction or limitation.

A hospital must meet the following requirements:

1. Inform each patient (or support person, where appropriate) of his or her visitation rights, including any clinical restriction or limitation on such rights, when he or she is informed of his or her other rights under this section.

2. Inform each patient (or support person, where appropriate) of the right, subject to his or her consent, to receive the visitors whom he or she designates, including, but not limited to, a spouse, a domestic partner (including a same-sex domestic partner), another family member, or a friend, and his or her right to withdraw or deny such consent at any time.

§482.13(h)(1)
§482.13(h)(2)

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.

When a patient is incapacitated or otherwise unable to communicate his or her wishes and an individual provides an advance directive designating an individual as the patient’s support person (it is not necessary for the document to use this exact term), the hospital must accept this designation, provide the required notice of the patient’s visitation rights, and allow the individual to exercise the patient’s visitation rights on the patient’s behalf.

When a patient is incapacitated or otherwise unable to communicate his or her wishes, there is no advance directive designating a representative on file, and no one has presented an advance directive designating himself or herself as the patient’s representative, but an individual asserts that he or she, as the patient’s spouse, domestic partner

REVIEW
1. Determine whether the hospital’s visitation policies and procedures require providing notice of the patient’s visitation rights to each patient or, if appropriate, to a patient’s support person and/or, as applicable, the patient’s representative.

2. Review the hospital’s standard notice of visitation rights. Does it clearly explain the:
   - hospital’s visitation policy, including any limitations or restrictions, such as visiting hours, numbers of visitors, unit-specific restrictions, etc., and the clinical rationale for such limitations or restrictions?
   - right of the patient to have designated visitors, including but not limited to, a spouse, a domestic partner (including a same-sex domestic partner), another family member, or a friend, and the right to withdraw or deny consent to visitation?

3. Review a sample of medical records to determine if there is documentation that the required notice was provided.

4. Ask the hospital to identify how the required notice is provided. Ask staff responsible for providing the notice how they accomplish this. Ask the staff if they are familiar with the concept of a patient’s support person and what it means.

Compliant
Not Compliant
This standard is not met as evidenced by:
(including a same-sex domestic partner), parent or other family member, friend, or otherwise, is the patient’s support person, the hospital is expected to accept this assertion, without demanding supporting documentation, provide the required notice of the patient’s visitation rights, and allow the individual to exercise the patient’s visitation rights on the patient’s behalf. However, if more than one individual claims to be the patient’s support person, it would not be inappropriate for the hospital to ask each individual for documentation supporting his/her claim to be the patient’s support person.

- Hospitals are expected to adopt policies and procedures that facilitate expeditious and non-discriminatory resolution of disputes about whether an individual is the patient’s support person, given the critical role of the support person in exercising the patient’s visitation rights.

- A refusal by the hospital of an individual’s request to be treated as the patient’s support person with respect to visitation rights must be documented in the patient’s medical record, along with the specific basis for the refusal.

Consistent with the patients’ rights notice requirements under the regulation at §482.13(a)(1), the required notice of the patient’s visitation rights must be provided, whenever possible, before the hospital provides or stops care. The notice to the patient, or to the patient’s support person, where appropriate, must be in writing. If the patient also has a representative who is different from the

5. Ask a sample of current hospital patients or patients’ support persons (where appropriate) whether they were provided notice of their right to have visitors.

- Ask if they were able to have visitors when they wanted to. If not, verify whether the restriction/limitation on visitors was addressed in the hospital’s visitation policies and notice, and does not violate the regulations at §482.13(h)(3)&(4). (See interpretive guidelines for the latter provisions.)

6. Ask a sample of current hospital patients or patients’ support persons (where appropriate) whether the hospital did not limit some or all visitors, contrary to the patient’s wishes.
support person, the representative must also be provided information on the patient’s visitation rights, in addition to the support person, if applicable.

In the event that a patient has both a representative and a support person who are not the same individual, and they disagree on who should be allowed to visit the patient, the hospital must defer to the decisions of the patient’s representative. As the individual responsible for making decisions on the patient’s behalf, the patient’s representative has the authority to exercise a patient’s right to designate and deny visitors just as the patient would if he or she were capable of doing so.

The designation of, and exercise of authority by, the patient’s representative is governed by State law, including statutory and case law. Many State courts have addressed the concept of substituted judgment, whereby the patient’s representative is expected to make medical decisions based on the patient’s values and interests, rather than the representative’s own values and interests. State courts have also developed a body of closely related law around the matter of a representative acting in the patient’s best interest. Such case law regarding substituted judgment and best interest may be a resource for hospitals on how to address such conflict situations as they establish visitation policies and procedures. Hospitals may also choose to utilize their own social work and pastoral counseling resources to resolve such conflicts to assure the patient’s well-being.

The required visitation rights notice must address
any clinically necessary or reasonable limitations or restrictions imposed by hospital policy on visitation rights, providing the clinical reasons for such limitations/restrictions, including how they are aimed at protecting the health and safety of all patients. The information must be sufficiently detailed to allow a patient (or the patient’s support person) to determine what the visitation hours are and what restrictions, if any, apply to that patient’s visitation rights.

The notice must also inform the patient (or the patient’s support person, where appropriate) of the patient’s right to:

- Consent to receive visitors he or she has designated, either orally or in writing, including but not limited to, a spouse, a domestic partner (including a same-sex domestic partner), another family member, or a friend;
- Receive the visitors he or she has designated, including but not limited to, a spouse, a domestic partner (including a same-sex domestic partner), another family member, or a friend; and
- Withdraw or deny his/her consent to receive specific visitors, either orally or in writing.

The medical record must contain documentation that the required notice was provided to the patient or, if appropriate, the patient’s support person.

15.01.27   Not Applicable.
15.01.28 Visitation Rights – Discrimination.
A hospital must have written policies and procedures regarding the visitation rights of patients, including those setting forth any clinically necessary or reasonable restriction or limitation that the hospital may need to place on such rights and the reason for the clinical restriction or limitation.

A hospital must meet the following requirements:
- Not restrict, limit or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation, or disability.

- Ensure that all visitors enjoy full and equal visitation privileges consistent with patient preferences.

§482.13(h)(3)
§482.13(h)(4)

The hospital’s visitation policies and procedures may not use the race, color, national origin, religion, sex, gender identity, sexual orientation, or disability of either the patient (or the patient’s support person or representative, where appropriate) or the patient’s visitors (including individuals seeking to visit the patient) as a basis for limiting, restricting, or otherwise denying visitation privileges.

The hospital’s policies and procedures must ensure that all visitors (including individuals seeking to visit the patient) enjoy full and equal visitation privileges, consistent with the preferences the patient (or, where appropriate, the patient’s support person) has expressed concerning visitors. In other words, it is permissible for the patient (or the patient’s support person, where appropriate) to limit the visiting privileges of his/her visitors, including providing for more limited visiting privileges for some visitors than those for others.

But it is not permissible for the hospital, on its own, to differentiate among visitors without any clinically necessary or reasonable basis. This includes visitors designated by the patient who have characteristics not addressed specifically in §482.13(h)(3), when those characteristics do not reasonably relate to a clinically reasonable basis for limiting or denying visitation. For example, it would not be appropriate to prohibit a designated visitor based on that individual’s style of dress, unless there was a clinically reasonable basis for doing so.

The hospital is responsible for ensuring that hospital visitation policies and procedures do not use the race, color, national origin, religion, sex, gender identity, sexual orientation, or disability of either the patient (or the patient’s support person or representative, where appropriate) or the patient’s visitors (including individuals seeking to visit the patient) as a basis for limiting, restricting, or otherwise denying visitation privileges.

DOCUMENT REVIEW AND INTERVIEW

1. Review the hospital’s visitation policies and procedures to determine whether they restrict, limit, or otherwise deny visitation to individuals on a prohibited basis.

2. Interview patients to determine if rights regarding visitation have been explained and enforced.

3. Ask the hospital how it educates staff to assure that visitation policies are implemented in a non-discriminatory manner.

4. Ask hospital staff who plays a role in facilitating or controlling visitors to discuss their understanding of the circumstances under which visitors may be subject to restrictions/limitations.

- Are the restrictions/limitations appropriately based on the hospital’s clinically-based policies?

5. Ask hospital patients (or patients’ support persons, where appropriate) whether the hospital has restricted or limited visitors against their wishes.

- If yes, verify whether the restriction/limitation on visitors was addressed in the hospital’s visitation policies and in the patient notice, and whether it was appropriately based on
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<td>staff treat all individuals seeking to visit patients equally, consistent with the preferences of the patient (or, where appropriate, the patient’s support person) and do not use the race, color, national origin, religion, sex, gender identity, sexual orientation, or disability of either the patient (or the patient’s support person or representative, where appropriate) or the patient’s visitors (including individuals seeking to visit the patient) as a basis for limiting, restricting, or otherwise denying visitation privileges. Hospitals are expected to educate all staff who play a role in facilitating or controlling visitors on the hospital’s visitation policies and procedures, and are responsible for ensuring that staff implement the hospital’s policies correctly. Hospitals are urged to develop culturally competent training programs designed to address the range of patients served by the hospital.</td>
<td>a clinical rationale rather than impermissible discrimination.</td>
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**15.01.29 Not Applicable.**
15.02.00 Restraint or Seclusion.
All patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time.

§482.13(e)

The intent of this standard is to identify patients’ basic rights, ensure patient safety, and eliminate the inappropriate use of restraint or seclusion.

Each patient has the right to receive care in a safe setting. The safety of the patient, staff, or others is the basis for initiating and discontinuing the use of restraint or seclusion. Each patient has the right to be free from all forms of abuse and corporal punishment. Each patient has the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff.

Restraint or seclusion may not be used unless the use of restraint or seclusion is necessary to ensure the immediate physical safety of the patient, a staff member, or others. The use of restraint or seclusion must be discontinued as soon as possible based on an individualized patient assessment and re-evaluation. A violation of any of these patients’ rights constitutes an inappropriate use of restraint or seclusion and would be subject to a condition level deficiency.

The patient protections contained in this standard apply to all hospital patients when the use of restraint or seclusion becomes necessary, regardless of patient location. The requirements contained in this standard are not specific to any treatment setting within the hospital. They are not targeted only to patients on psychiatric units or those with behavioral/mental health care needs. Instead, the requirements are specific to the patient behavior that the restraint or seclusion intervention is being applied to.

DOCUMENT REVIEW, CHART REVIEW, INTERVIEW, & OBSERVATION

1. Review hospital restraint and seclusion policies and procedures to determine if they address, at a minimum:
   - Who has the authority to discontinue the use of restraint or seclusion (based on State law and hospital policies); and
   - Circumstances under which restraint or seclusion should be discontinued. (Also see §482.13(e)(3)).

2. Review a sample of medical records of patients for whom restraints were used to manage non-violent, non-self-destructive behavior, as well as a sample of medical records of patients for whom restraint or seclusion was used to manage violent or self-destructive behavior;

3. Include in the review patients who are currently in restraint or seclusion, as well as those who have been in restraint or seclusion during their hospital stay (include both violent or self-destructive patients as well as non-violent, non-self-destructive patients).

4. What evidence is there that hospital staff identified the reason for the restraint or seclusion, and determined that other less restrictive measures would not be effective before applying the restraint?

5. Interview staff who work directly with
### PATIENT RIGHTS & RESTRAINTS

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<td>used to address.</td>
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<td>In summary, these restraint and seclusion regulations apply to:</td>
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<td>• All hospitals (acute care, long-term care, psychiatric, children’s, and cancer);</td>
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<td>• All locations within the hospital (including medical / surgical units, critical care units, forensic units, emergency department, psychiatric units, etc.); and</td>
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<td>• All hospital patients, regardless of age, who are restrained or secluded (including both inpatients and outpatients).</td>
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<td>The decision to use a restraint or seclusion is not driven by diagnosis, but by a comprehensive individual patient assessment. For a given patient at a particular point in time, this comprehensive individualized patient assessment is used to determine whether the use of less restrictive measures poses a greater risk than the risk of using a restraint or seclusion. The comprehensive assessment should include a physical assessment to identify medical problems that may be causing behavior changes in the patient. For example, temperature elevations, hypoxia, hypoglycemia, electrolyte imbalances, drug interactions, and drug side effects may cause confusion, agitation, and combative behaviors. Addressing these medical issues may eliminate or minimize the need for the use of restraints or seclusion.</td>
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<td>Staff must assess and monitor a patient’s condition on an ongoing basis to ensure that the patient is</td>
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<td>patients to determine their understanding of the restraint and seclusion policies. If any patients are currently in restraint or seclusion, ascertain the rationale for use and when the patient was last monitored and assessed.</td>
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<td>6. Is the actual use of restraints or seclusion consistent with hospital restraint and seclusion policies and procedures, as well as CMS requirements?</td>
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<td>7. Review incident and accident reports to determine whether patient injuries occurred proximal to or during a restraint or seclusion intervention. Are incidents and accidents occurring more frequently with restrained or secluded patients?</td>
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<td>8. If record review indicates that restrained or secluded patients sustained injuries, determine what the hospital did to prevent additional injury. Determine if the hospital investigated possible changes to its restraint or seclusion policies.</td>
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<td>9. Obtain data on the use of restraint and seclusion for a specified time period (e.g., 3 months) to determine any patterns in their use for specific units, shifts, days of the week, etc.</td>
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<td>10. Does the number of patients who are restrained or secluded increase on weekends, on holidays, at night, on certain shifts; where contract nurses are used; in one unit more than other units? Such</td>
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released from restraint or seclusion at the earliest possible time. Restraint or seclusion may only be employed while the unsafe situation continues. Once the unsafe situation ends, the use of restraint or seclusion should be discontinued. However, the decision to discontinue the intervention should be based on the determination that the need for restraint or seclusion is no longer present, or that the patient’s needs can be addressed using less restrictive methods.

Hospital leadership is responsible for creating a culture that supports a patient’s right to be free from restraint or seclusion. Leadership must ensure that systems and processes are developed, implemented, and evaluated that support the patients’ rights addressed in this standard, and that eliminate the inappropriate use of restraint or seclusion.

Through their QAPI program, hospital leadership should:

- Assess and monitor the use of restraint or seclusion in their facility;
- Implement actions to ensure that restraint or seclusion is used only to ensure the physical safety of the patient, staff and others; and
- Ensure that the hospital complies with the requirements set forth in this standard as well as those set forth by State law and hospital policy when the use of restraint or seclusion is necessary.

Patients have a right to receive safe care in a safe environment. Patterns of restraint or seclusion use may suggest that the intervention is not based on the patient’s need, but on issues such as convenience, inadequate staffing or lack of staff training. Obtain nursing staffing schedules during time periods in question to determine if staffing levels impact the use of restraint or seclusion.

11. Interview a random sample of patients who were restrained to manage non-violent, non-self-destructive behavior. Were the reasons for the use of a restraint to manage non-violent, non-self-destructive behavior explained to the patient in understandable terms? Could the patient articulate his/her understanding?
environment. However, the use of restraint is inherently risky. When the use of restraint is necessary, the least restrictive method must be used to ensure a patient’s safety. The use of restraint for the management of patient behavior should not be considered a routine part of care.

The use of restraints for the prevention of falls should not be considered a routine part of a falls prevention program. Although restraints have been traditionally used as a falls prevention approach, they have major, serious drawbacks and can contribute to serious injuries. There is no evidence that the use of physical restraint, (including, but not limited to, raised side rails) will prevent or reduce falls. Additionally, falls that occur while a person is physically restrained often result in more severe injuries.¹

FOOTNOTES


- Hanger HC, Ball MC, Wood LA. An analysis of


In fact in some instances reducing the use of physical restraints may actually decrease the risk of falling.²

² University of California at San Francisco (UCSF)-Stanford University Evidence-based Practice Center Subchapter 26.2. Interventions that Decrease the Use of Physical Restraints” of the Evidence Report/Technology Assessment, No. 43.

Consider, for example, a patient who is displaying symptoms of Sundowner’s Syndrome, a syndrome in which a patient’s dementia becomes more apparent at the end of the day than at the beginning of the day. The patient is not acting out or behaving in a violent or self-destructive manner. However, the patient has an unsteady gait and continues to get out of bed even after staff has tried alternatives to
keep the patient from getting out of bed. There is nothing inherently dangerous about a patient being able to walk or wander, even at night. Under the provisions of this regulation, the rationale that the patient should be restrained because he “might” fall does not constitute an adequate basis for using a restraint for the purposes of this regulation.

When assessing a patient’s risk for falls and planning care for the patient, staff should consider whether the patient has a medical condition or symptom that indicates a current need for a protective intervention to prevent the patient from walking or getting out of bed.

A history of falling without a current clinical basis for a restraint intervention is inadequate to demonstrate the need for restraint. It is important to note that the regulation specifically states that convenience is not an acceptable reason to restrain a patient. In addition, a restraint must not serve as a substitute for the adequate staffing needed to monitor patients.

An individualized patient assessment is critical. In this example, an assessment should minimally address the following questions:

- Are there safety interventions or precautions (other than restraint) that can be taken to reduce the risk of the patient slipping, tripping, or falling if the patient gets out of bed?
- Is there a way to enable the patient to safely ambulate?
- Is there some assistive device that will improve
### Patient Rights & Restraints

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the patient’s ability to self ambulate?

- Is a medication or a reversible condition causing the unsteady gait?
- Would the patient be content to walk with a staff person?
- Could the patient be brought closer to the nurse’s station where he or she could be supervised?

If an assessment reveals a medical condition or symptom that indicates the need for an intervention to protect the patient from harm, the regulation requires the hospital to use the least restrictive intervention that will effectively protect the patient from harm. Upon making this determination, the hospital may consider the use of a restraint; however, that consideration should weigh the risks of using a restraint (which are widely documented in research) against the risks presented by the patient’s behavior. If the hospital chooses to use the restraint, it must meet the requirements contained in this standard.

In addition, a request from a patient or family member for the application of a restraint, which they would consider to be beneficial, is not a sufficient basis for the use of a restraint intervention.

- A patient or family member request for a restraint intervention, such as a vest restraint or raising all four side rails, to keep the patient from getting out of bed or falling should prompt a patient and situational assessment to
determine whether such a restraint intervention is needed. If a need for restraint is confirmed, the practitioner must then determine the type of restraint intervention that will meet the patient’s needs with the least risk and most benefit to the patient. If restraint (as defined by the regulation) is used, then the requirements of the regulation must be met.

Patient care staff must demonstrate through their documentation in the patient’s medical record that the restraint intervention used is the least restrictive intervention that protects the patient’s safety, and that the use of restraint is based on individual assessments of the patient. The assessments and documentation of those assessments must be ongoing in order to demonstrate a continued need for restraint. Documentation by the physician or other staff once a day may not be adequate to support that the restraint intervention needs to continue and may not comply with the requirement to end the restraint as soon as possible. A patient’s clinical needs often change over time.

CMS does not consider the use of weapons in the application of restraint or seclusion as a safe, appropriate health care intervention. For the purposes of this regulation, the term “weapon” includes, but is not limited to, pepper spray, mace, nightsticks, tazers, cattle prods, stun guns, and pistols. Security staff may carry weapons as allowed by hospital policy, and State and Federal law. However, the use of weapons by security staff is considered a law enforcement action, not a health care intervention. CMS does not support the use of: | STANDARD / ELEMENT | EXPLANATION | SCORING PROCEDURE | SCORE |
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<td>PATIENT RIGHTS &amp; RESTRAINTS</td>
<td>weapons by any hospital staff as a means of subduing a patient in order to place that patient in restraint or seclusion. If a weapon is used by security or law enforcement personnel on a person in a hospital (patient, staff, or visitor) to protect people or hospital property from harm, we would expect the situation to be handled as a criminal activity and the perpetrator be placed in the custody of local law enforcement. The use of handcuffs, manacles, shackles, other chain-type restraint devices, or other restrictive devices applied by non-hospital employed or contracted law enforcement officials for custody, detention, and public safety reasons are not governed by this rule. The use of such devices are considered law enforcement restraint devices and would not be considered safe, appropriate health care restraint interventions for use by hospital staff to restrain patients. The law enforcement officers who maintain custody and direct supervision of their prisoner (the hospital's patient) are responsible for the use, application, and monitoring of these restrictive devices in accordance with Federal and State law. However, the hospital is still responsible for an appropriate patient assessment and the provision of safe, appropriate care to its patient (the law enforcement officer’s prisoner).</td>
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<td>15.02.01 Restraint Definitions.</td>
<td>This restraint definition applies to all uses of restraint in all hospital care settings. Under this definition, commonly used hospital devices and other practices could meet the definition of a restraint, such as:</td>
<td>DOCUMENT REVIEW, OBSERVATION, AND INTERVIEW</td>
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<td><strong>15.02.02 Medication as a Restraint.</strong>&lt;br&gt;A restraint is –</td>
<td><strong>Drugs or medications that are used as part of a patient’s standard medical or psychiatric treatment, and are administered within the standard dosage for the patient’s condition, would not be subject to the requirements of standard (e).</strong>&lt;br&gt;These regulations are not intended to interfere with the clinical treatment of patients who are suffering from serious mental illness and who need therapeutic doses of medication to improve their level of functioning so that they can more actively participate in their treatment. Similarly, these regulations are not intended to interfere with appropriate doses of sleeping medication prescribed for patients with insomnia, anti-anxiety medication prescribed to calm a patient who is anxious, or analgesics prescribed for pain management. The regulatory language is intended to provide flexibility and recognize the variations in patient conditions.</td>
<td><strong>DOCUMENT REVIEW AND INTERVIEW</strong>&lt;br&gt;1. Determine whether the hospital’s policies and procedures employ a definition or description of what constitutes the use of drugs or medications as a restraint that is consistent with the regulation.&lt;br&gt;2. Interview hospital staff to determine whether they can identify when the use of a drug or medication is considered a chemical restraint.</td>
<td>□ Compliant  □ Not Compliant This standard is not met as evidenced by:</td>
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- Pharmaceutical parameters approved by the Food and Drug Administration (FDA) and the manufacturer for the indications that it is manufactured and labeled to address, including listed dosage parameters;

- The use of the drug or medication follows national practice standards established or recognized by the medical community, or professional medical associations or organizations; and,

- The use of the drug or medication to treat a specific patient’s clinical condition is based on that patient's symptoms, overall clinical situation, and on the physician's or other licensed independent practitioner’s (LIP) knowledge of that patient’s expected and actual response to the medication.

Another component of “standard treatment or dosage” for a drug or medication is the expectation that the standard use of a drug or medication to treat the patient’s condition enables the patient to more effectively or appropriately function in the world around them than would be possible without the use of the drug or medication. If the overall effect of a drug or medication, or combination of drugs or medications, is to reduce the patient's ability to effectively or appropriately interact with the world around the patient, then the drug or medication is not being used as a standard treatment or dosage for the patient’s condition.

As with any use of restraint or seclusion, staff must conduct a comprehensive patient assessment to...
determine the need for other types of interventions before using a drug or medication as a restraint. For example, a patient may be agitated due to pain, an adverse reaction to an existing drug or medication, or other unmet care need or concern.

There are situations where the use of a drug or medication is clearly outside the standard for a patient or a situation, or a medication is not medically necessary but is used for patient discipline or staff convenience (neither of which is permitted by the regulation).

- **EXAMPLE 1:** A patient has Sundowner's Syndrome, a syndrome in which a patient's dementia becomes more apparent at the end of the day rather than at the beginning of the day. The patient may become agitated, angry, or anxious at sundown. This may lead to wandering, pacing the floors, or other nervous behaviors. The staff finds the patient's behavior bothersome, and asks the physician to order a high dose of a sedative to “knock out” the patient and keep him in bed. The patient has no medical symptoms or condition that indicates the need for a sedative. In this case, for this patient, the sedative is being used inappropriately as a restraint for staff convenience. Such use is not permitted by the regulation.

A drug or medication that is not being used as a standard treatment for the patient’s medical or psychiatric condition, and that results in restricting the patient’s freedom of movement
would be a drug used as a restraint.

In addition, the regulation does not permit a drug or medication to be used to restrain the patient for staff convenience, to coerce or discipline the patient, or as a method of retaliation. While drugs or medications can be a beneficial part of a carefully constructed, individualized treatment plan for the patient, drug and medication use should be based on the assessed needs of the individual patient, and the effects of drugs and medications on the patient should be carefully monitored.

• **EXAMPLE 2:** A patient is in a detoxification program. The patient becomes violent and aggressive. Staff administers a PRN medication ordered by the patient’s physician or other LIP to address these types of outbursts. The use of the medication enables the patient to better interact with others or function more effectively. In this case, the medication used for this patient is not considered a “drug used as a restraint.” The availability of a PRN medication to manage outbursts of specific behaviors, such as aggressive, violent behavior is standard for this patient’s medical condition (i.e., drug or alcohol withdrawal). Therefore, this patient’s medication does not meet the definition of “drug used as a restraint” since it is a standard treatment or dosage for the patient’s medical or psychiatric condition. The use of this medication for this patient is not affected by standard (e).

If a drug or medication is used as a standard
treatment (as previously defined) to address the assessed symptoms and needs of a patient with a particular medical or psychiatric condition, its use is not subject to the requirements of this regulation. However, the patient would still need to receive assessments, monitoring, interventions, and care that are appropriate for that patient’s needs.

The regulation supports existing State laws that provide more vigorous promotion of the patient’s choice and rights. Therefore, when a State’s law prohibits the administration of drugs against the wishes of the patient without a court order, the State law applies.

15.02.03 Non-Restraints. A restraint does not include –

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

§482.13(e)(1)(i)(C) The devices and methods listed here would not be considered restraints, and, therefore, not subject to these requirements. These devices and methods are typically used in medical-surgical care.

- Use of an IV arm board to stabilize an IV line is generally not considered a restraint. However, if the arm board is tied down (or otherwise attached to the bed), or the entire limb is immobilized such that the patient cannot access his or her body, the use of the arm board would be considered a restraint.
- A mechanical support used to achieve proper body position, balance, or alignment so as to allow greater freedom of mobility than would be possible without the use of such a mechanical support is not considered a restraint. For example, some patients lack the

**DOCUMENT REVIEW, OBSERVATION, AND INTERVIEW**

1. Determine whether the hospital’s policies and procedures employ a definition or description of what constitutes a restraint that is consistent with the regulation.

2. While touring hospital units look for bed side rail use to determine whether it is consistent with the definition of a restraint. Where bed side rails are being used as a restraint, check the medical record for appropriate documentation.

3. Interview hospital staff to determine whether they know the definition of a restraint, particularly with respect to use of bed side rails.
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- Ability to walk without the use of leg braces, or to sit upright without neck, head, or back braces.

- A medically necessary positioning or securing device used to maintain the position, limit mobility, or temporarily immobilize the patient during medical, dental, diagnostic, or surgical procedures is not considered a restraint.

Recovery from anesthesia that occurs when the patient is in a critical care or postanesthesia care unit is considered part of the surgical procedure; therefore, medically necessary restraint use in this setting would not need to meet the requirements of the regulation.

- However, if the intervention is maintained when the patient is transferred to another unit, or recovers from the effects of the anesthesia (whichever occurs first), a restraint order would be necessary and the requirements of standard (e) would apply.

Many types of hand mitts would not be considered restraint.

- However, pinning or otherwise attaching those same mitts to bedding or using a wrist restraint in conjunction with the hand mitts would meet the definition of restraint and the requirements would apply.

- In addition, if the mitts are applied so tightly that the patient’s hand or fingers are immobilized, this would be considered restraint and the requirements would apply.
Likewise, if the mitts are so bulky that the patient’s ability to use their hands is significantly reduced, this would be considered restraint and the requirements would apply.

**NOTE:** Because this definition of physical restraint does not name each device and situation that can be used to immobilize or reduce the ability of the patient to move his or her arms, legs, body or head freely, it promotes looking at each patient situation on a case-by-case basis.

In addition, if a patient can easily remove a device, the device would not be considered a restraint.

In this context, “easily remove” means that the manual method, device, material, or equipment can be removed intentionally by the patient in the same manner as it was applied by the staff (e.g., side rails are put down, not climbed over; buckles are intentionally unbuckled; ties or knots are intentionally untied; etc.) considering the patient’s physical condition and ability to accomplish the objective (e.g., transfer to a chair, get to the bathroom in time).

Age or developmentally appropriate protective safety interventions (such as stroller safety belts, swing safety belts, high chair lap belts, raised crib rails, and crib covers) that a safety-conscious child care provider outside a health care setting would utilize to protect an infant, toddler, or preschool-aged child would not be considered restraint or seclusion for the purposes of this regulation.

- The use of these safety interventions needs
### Physical Escort

A physical escort would include a “light” grasp to escort the patient to a desired location.

- If the patient can easily remove or escape the grasp, this would not be considered physical restraint.

- However, if the patient cannot easily remove or escape the grasp, this would be considered physical restraint and all the requirements would apply.

### Physical Holding

The regulation permits the physical holding of a patient for the purpose of conducting routine physical examinations or tests.

- However, patients do have the right to refuse treatment. See §482.13(b)(2). This includes the right to refuse physical examinations or tests.

- Holding a patient in a manner that restricts the patient's movement against the patient’s will is considered restraint. This includes holds that some member of the medical community may term “therapeutic holds.” Many deaths have occurred while employing these practices.

- Physically holding a patient can be just as restrictive, and just as dangerous, as restraining methods that involve devices. Physically holding a patient during a forced...
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- Psychotropic medication procedure is considered a restraint and is not included in this exception.
- For the purposes of this regulation, a staff member picking up, redirecting, or holding an infant, toddler, or preschool-aged child to comfort the patient is not considered restraint.

**Physical Holding for Forced Medications**

The application of force to physically hold a patient, in order to administer a medication against the patient’s wishes, is considered restraint.

- The patient has a right to be free of restraint and, in accordance with §482.13(b)(2), also has a right to refuse medications, unless a court has ordered medication treatment.
- A court order for medication treatment only removes the patient’s right to refuse the medication.
- Additionally, in accordance with State law, some patients may be medicated against their will in certain emergency circumstances. However, in both of these circumstances, health care staff is expected to use the least restrictive method of administering the medication to avoid or reduce the use of force, when possible.
  - The use of force in order to medicate a patient, as with other restraint, must have a physician’s order prior to the application of
the restraint (use of force).

- If physical holding for forced medication is necessary with a violent patient, the 1-hour face-to-face evaluation requirement would also apply.

In certain circumstances, a patient may consent to an injection or procedure, but may not be able to hold still for an injection, or cooperate with a procedure.

- In such circumstances, and at the patient’s request, staff may “hold” the patient in order to safely administer an injection (or obtain a blood sample, or insert an intravenous line, if applicable) or to conduct a procedure. This is not considered restraint.

**Side Rails**

A restraint does not include methods that protect the patient from falling out of bed.

- Examples include raising the side rails when a patient is: on a stretcher, recovering from anesthesia, sedated, experiencing involuntary movement, or on certain types of therapeutic beds to prevent the patient from falling out of the bed. The use of side rails in these situations protects the patient from falling out of bed and, therefore, would not be subject to the requirements of standard (e).
• However, side rails are frequently not used as a method to prevent the patient from falling out of bed, but instead, used to restrict the patient’s freedom to exit the bed.

• The use of side rails to prevent the patient from exiting the bed would be considered a restraint and would be subject to the requirements of standard (e).

The use of side rails is inherently risky, particularly if the patient is elderly or disoriented. Frail elderly patients may be at risk for entrapment between the mattress or bed frame and the side rail.

Disoriented patients may view a raised side rail as a barrier to climb over, may slide between raised, segmented side rails, or may scoot to the end of the bed to get around a raised side rail and exit the bed. When attempting to leave the bed by any of these routes, the patient is at risk for entrapment, entanglement, or falling from a greater height posed by the raised side rail, with a possibility for sustaining greater injury or death than if the patient had fallen from the height of a lowered bed without raised side rails. In short, the patient may have an increased risk for a fall or other injury by attempting to exit the bed with the side rails raised. The risk presented by side rail use should be weighed against the risk presented by the patient’s behavior as ascertained through individualized assessment.

When the clinician raises all four side rails in order to restrain a patient, defined in this regulation as immobilizing or reducing the ability of a patient to move his or her arms, legs, body, or head freely to
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ensure the immediate physical safety of the patient, then the requirements of this rule apply.

- Raising fewer than four side rails when the bed has segmented side rails would not necessarily immobilize or reduce the ability of a patient to move freely as defined in the regulation.

- For example, if the side rails are segmented and all but one segment are raised to allow the patient to freely exit the bed, the side rail is not acting as a restraint and the requirements of this rule would not apply.

- Conversely, if a patient is not physically able to get out of bed regardless of whether the side rails are raised or not, raising all four side rails for this patient would not be considered restraint because the side rails have no impact on the patient’s freedom of movement. In this example, the use of all four side rails would not be considered restraint. Therefore, the requirements of this rule would not apply.

Not A Restraint:

- When a patient is on a bed that constantly moves to improve circulation or prevents skin breakdown, raised side rails are a safety intervention to prevent the patient from falling out of bed and are not viewed as restraint.

- When a patient is placed on seizure precautions and all side rails are raised, the use of side rails would not be considered restraint. The use of padded side rails in this situation should protect
the patient from harm; including falling out of bed should the patient have a seizure.

- Placement in a crib with raised rails is an age-appropriate standard safety practice for every infant or toddler. Therefore, placement of an infant or toddler in the crib with raised rails would not be considered restraint.

- If the patient is on a stretcher (a narrow, elevated, and highly mobile cart used to transport patients and to evaluate or treat patients), there is an increased risk of falling from a stretcher without raised side rails due to its narrow width, and mobility. In addition, because stretchers are elevated platforms, the risk of patient injury due to a fall is significant. Therefore, the use of raised side rails on stretchers is not considered restraint but a prudent safety intervention.

- Likewise, the use of a seat belt when transporting a patient in a wheelchair is not considered restraint.

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<td>15.02.04 Definition of Seclusion.</td>
<td>Seclusion is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may only be used for the management of violent or self-destructive behavior.</td>
<td>§482.13(e)(1)(ii)</td>
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**DOCUMENT REVIEW**
- Determine whether the hospital’s policy and procedures employ a definition or description of what constitutes seclusion that is consistent with the regulation.

**OBSERVATION**
- While touring hospital units look for cases where a patient is in seclusion.

Compliant
Not Compliant
This standard is not met as evidenced by:
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| If a patient is restricted to a room alone and staff are physically intervening to prevent the patient from leaving the room or giving the perception that threatens the patient with physical intervention if the patient attempts to leave the room, the room is considered locked, whether the door is actually locked or not. In this situation, the patient is being secluded. | INTERVIEW  
• Interview hospital staff to determine whether they know the definition of seclusion. | | |
| A patient physically restrained alone in an unlocked room does not constitute seclusion. | | | |
| Confinement on a locked unit or ward where the patient is with others does not constitute seclusion. | | | |
| Timeout is not considered seclusion. Timeout is an intervention in which the patient consents to being alone in a designated area for an agreed upon timeframe from which the patient is not physically prevented from leaving. Therefore, the patient can leave the designated area when the patient chooses. | | | |

**15.02.05 Least Restrictive Interventions.**

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.

§482.13(e)(2)

A comprehensive assessment of the patient must determine that the risks associated with the use of the restraint or seclusion is outweighed by the risk of not using the restraint or seclusion.

Less restrictive interventions do not always need to be tried, but less restrictive interventions must be determined by staff to be ineffective to protect the patient or others from harm prior to the introduction of more restrictive measures.

Alternatives attempted or the rationale for not using

**CHART REVIEW**

1. Do physician’s or other LIP’s orders specify the reason for restraint or seclusion, the type of restraint, and the duration of restraint or seclusion?

2. Does the severity of the behavior justify seclusion or restraint usage by identifying an immediate and serious danger to the physical safety of the patient or others?

3. Is there evidence that the hospital
alternatives must be documented.

The underpinning of this regulation is the concept that safe patient care hinges on looking at the patient as an individual and assessing the patient’s condition, needs, strengths, weaknesses, and preferences. Such an approach relies on caregivers who are skilled in individualized assessment and in tailoring interventions to the individual patient’s needs after weighing factors such as the patient’s condition, behaviors, history, and environmental factors.

Resources

Resources are available to assist clinicians in identifying less restrictive interventions. For example, the American Psychiatric Association (APA), American Psychiatric Nurses Association (APNA), and the National Association of Psychiatric Health Systems (NAPHS), with support from the American Hospital Association (AHA), have sponsored the publication of a document entitled, “Learning from Each Other—Success Stories and Ideas for Reducing Restraint / Seclusion in Behavioral Health.” This document, published in 2003, was developed through dialogue with clinicians in the field and included extensive input from behavioral healthcare providers throughout the country who have been working to reduce the use of restraint and seclusion and to improve care within their facilities. To access this document and other useful resources, visit the web sites of the sponsoring organizations: http://www.naphs.org; http://www.psych.org; http://www.apna.org; http://www.aha.org.

4. Does the medical record include documentation of an individual patient assessment and a revision of the plan of care?

5. Does the medical record reflect changes in behavior and staff concerns regarding safety risks to the patient, staff, or others prompting use of seclusion or restraints?

6. Did the patient’s behavior place the patient or others at risk for harm? Was the patient’s behavior violent or self-destructive?

7. Were other, less restrictive interventions tried and documented, or is there evidence that alternatives were considered and determined to be insufficient?

**INTERVIEW**

Interview staff that have been a position to restrain patients.

- How did the staff assess the patient and determine the least restrictive interventions that would be ineffective to protect the patient, staff, or others from harm?
15.02.06 Not Applicable.

15.02.07 Effective Restraints.
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.

§482.13(e)(3)

Resources are available to assist clinicians in identifying less restrictive restraint or seclusion interventions.

For example, the American Psychiatric Association (APA), American Psychiatric Nurses Association (APNA), and the National Association of Psychiatric Health Systems (NAPHS), with support from the American Hospital Association (AHA), have sponsored the publication of a document entitled, “Learning from Each Other—Success Stories and Ideas for Reducing Restraint / Seclusion in Behavioral Health.”

This document, published in 2003, was developed through dialogue with the field and extensive input from behavioral healthcare providers throughout the country who have been working to reduce the use of restraint and seclusion and to improve care within their facilities.

To access this document and other useful resources, visit the web sites of the sponsoring organizations: http://www.naphs.org; http://www.psych.org; http://www.apna.org; http://www.aha.org

CHART REVIEW

1. Is there clear documentation in the patient’s medical record describing the steps or interventions used prior to the use of the needed restraint or seclusion? That is, what documentation is in the medical record to explain the rationale for the use of restraint or seclusion?

2. Is there documentation that less restrictive measures were tried or considered?
   - Is the restraint or seclusion intervention the least restrictive intervention that meets the patient’s clinical needs and protects the safety of the patient, staff, or others?
   - Did the staff determine that less restrictive alternatives would not meet the patient’s clinical needs, or protect the patient’s safety or the safety of others?
   - Do ongoing documented assessments demonstrate that the restraint or seclusion intervention is needed at this time (or at a time in the past) and that the restraint or seclusion intervention remains the least restrictive way to protect
### Modification of the Plan of Care – Restraint or Seclusion

The use of restraint or seclusion must be –

- in accordance with a written modification to the patient’s plan of care.

| §482.13(e)(4) |
| §482.13(e)(4)(i) |

An order for restraint must result in a modification of the individualized plan of care.

The individualized plan of care describes the rationale for restraint or seclusion use. The plan lists the interventions selected, patient monitoring, and re-assessments. The plan addresses the frequency and content of the patient re-assessments including vital signs, safety, comfort, mental status, skin integrity / circulation checks, hydration, toileting, and readiness for release from restraint or seclusion, as outlined by hospital policy.

The use of restraint or seclusion (including drugs or medications used as restraint as well as physical restraint) must be documented in the patient’s plan of care or treatment plan.

- The use of restraint or seclusion constitutes a change in a patient’s plan of care.

The regulation does not require that a modification to the patient’s plan of care be made before initiating or obtaining an order for the use of

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**CHART REVIEW**

Review at least five medical records of patients who required restraint or seclusion.

1. Has the plan of care been modified to reflect the use of restraint or seclusion based on the patient assessment?
2. Has the plan of care been reviewed and updated in writing, according to hospital policy?
3. Are patient safety assessments and monitoring documented in the progress notes linked to the patient care plan, per hospital policy, e.g., vital signs, circulation and skin integrity checks, readiness for release of restraint?
4. Does the plan of care or treatment reflect a process of assessment, intervention, and evaluation when restraint or seclusion is used?
5. Is there evidence of assessment of the patient’s safety?

- If the time of restraint or seclusion use is lengthy, look for evidence that the symptoms necessitating the use of restraint or seclusion have persisted. Is there evidence to indicate that the staff have evaluated whether or not the restraint or seclusion can be safely discontinued?

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This standard is not met as evidenced by:
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<td>restraint or seclusion. The use of a restraint or seclusion intervention should be reflected in the patient’s plan of care or treatment plan based on an assessment and evaluation of the patient. The plan of care or treatment plan should be reviewed and updated in writing within a timeframe specified by hospital policy.</td>
<td>identified problem or of an individual patient assessment?</td>
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<td>6. Does the patient’s plan of care reflect that assessment?</td>
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<td>7. What was the goal of the intervention?</td>
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<td>8. What was the described intervention?</td>
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<td>9. Who is responsible for implementation?</td>
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<td>10. Did the physician or other LIP write orders that included a time limit? Were these orders incorporated into the plan of care?</td>
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<td>11. Was the patient informed of the changes in his or her treatment plan or plan of care?</td>
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<td>12. After the discontinuation of the restraint or seclusion intervention, was this information documented in an update of the plan of care or treatment plan?</td>
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**15.02.09 Safe Application.**

The use of restraint or seclusion must be –

- implemented in accordance with safe and appropriate restraint and seclusion techniques as determined by hospital policy in accordance with State law.

§482.13(e)(4)(ii)

Restraint or seclusion must be implemented appropriately and safely, and reflect hospital policy in accordance with State law. The use of restraint or seclusion must never act as a barrier to the provision of other interventions to meet the patient’s needs.

**DOCUMENT REVIEW AND CHART REVIEW**

1. Review the hospital’s policies and procedures to determine if they reflect current standards of practice regarding safe and appropriate restraint and seclusion techniques.

   - Are there any references to State law statutes or any indication State laws were reviewed and incorporated?

2. Review a sample of patient medical records

**2014 updated August 2014**

Healthcare Facilities Accreditation Program (HFAP)

Accreditation Requirements for Acute Care Hospitals

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<td>Orders for Restraint or Seclusion.</td>
<td>The use of a restraint or seclusion must be in accordance with the order of a physician or other licensed independent practitioner (LIP) permitted by</td>
<td>CHART REVIEW: Review at least five medical records of patients who required restraint or seclusion. Verify:</td>
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that include patients who required the use of restraint or seclusion for the management of both violent, self-destructive behaviors, and non-violent, non-self-destructive behaviors.

3. After restraints were applied, was an assessment immediately made to ensure that restraints were properly and safely applied?

4. Were the hospital policies and procedures followed?

5. Was the use of restraint or seclusion effective in achieving the purpose for which it was ordered? If not, were timely changes made?

6. Was there any evidence of injury to the patient?
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<td>be –</td>
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<td>1. Each use of restraint or seclusion has been ordered by a physician or LIP authorized by the State and hospital policy.</td>
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<tr>
<td>in accordance with the order of a physician or other licensed independent practitioner who is responsible for the care of the patient as specified under §482.12 (c) and authorized to order restraint or seclusion by hospital policy in accordance with State law.</td>
<td>Hospitals must have policies and procedures for the initiative of restraint or seclusion that identify the categories of LIPs that are permitted to order restraint or seclusion in that hospital, consistent with State law. The regulation requires that a physician or other LIP responsible for the care of the patient to order restraint or seclusion prior to the application of restraint or seclusion. In some situations, however, the need for a restraint or seclusion intervention may occur so quickly that an order cannot be obtained prior to the application of restraint or seclusion. In these emergency application situations, the order must be obtained either during the emergency application of the restraint or seclusion, or immediately (within a few minutes) after the restraint or seclusion has been applied.</td>
<td>2. There are no restraint orders written on a PRN basis or as standing orders.</td>
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<tr>
<td>§482.13(e)(5)</td>
<td></td>
<td></td>
<td>3. Do the medical records reviewed identify the physician or LIP who ordered each use of restraint or seclusion?</td>
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<td>4. During the medical record review, verify that a physician or LIP order was obtained prior to the initiation of restraint or seclusion. When emergency application of restraint or seclusion was necessary, verify that a physician or LIP order was obtained immediately (within a few minutes) after application of the restraint or seclusion.</td>
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<td><strong>This standard is not met as evidenced by:</strong></td>
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**Licensed Independent Practitioner (LIP)**

For the purpose of ordering restraint or seclusion,

1. Each use of restraint or seclusion has been ordered by a physician or LIP authorized by the State and hospital policy.
2. There are no restraint orders written on a PRN basis or as standing orders.
3. Do the medical records reviewed identify the physician or LIP who ordered each use of restraint or seclusion?

**DOCUMENT REVIEW**

1. Review hospital policies and medical staff bylaws to ascertain clinical practice guidelines that describe the responsibilities of medical staff and clinicians who are privileged to order restraint and seclusion.
2. Do the hospital’s written policies identify what categories of practitioners the State recognizes as an LIP or as having the authority to order restraint and seclusion?
3. Does the hospital have written policies indicating which practitioners are permitted to order restraint or seclusion in...
an LIP is any practitioner permitted by State law and hospital policy as having the authority to independently order restraints or seclusion for patients.

- A resident who is authorized by State law and the hospital’s residency program to practice as a physician can carry out functions reserved for a physician or LIP by the regulation.
- A medical school student holds no license, and his/her work is reviewed and must be countersigned by the attending physician; therefore, he or she is not licensed or independent. A medical school student is not an LIP.

Protocols

A protocol cannot serve as a substitute for obtaining a physician’s or other LIP’s order prior to initiating each episode of restraint or seclusion use.

- If a hospital uses protocols that include the use of restraint or seclusion, a specific physician or LIP order is still required for each episode of restraint or seclusion use.
  The philosophy that serves as a foundation for the regulation is that restraint or seclusion use is an exceptional event, not a routine response to a certain patient condition or behavior.
- Each patient must be assessed, and interventions should be tailored to meet the individual patient’s needs. The creation of a protocol can run counter to this

- Do the hospital’s written policies conform to State law?
- Does the hospital have established policies for who can initiate restraint or seclusion?
- Does the hospital utilize protocols for the use of restraint or seclusion? If so, is the use of protocols consistent with the requirements of the regulation?
15.02.11 Use of Standing or PRN Orders.

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

This regulation prohibits the use of standing or PRN (Latin abbreviation for pro re nata - as needed; as circumstances require) orders for the use of restraint or seclusion.

The ongoing authorization of restraint or seclusion is not permitted.

- Each episode of restraint or seclusion must be initiated in accordance with the order of a physician or other LIP.
- If a patient was recently released from restraint or seclusion, and exhibits behavior that can only be handled through the reapplication of restraint or seclusion, a new order would be required. Staff cannot discontinue a restraint or seclusion intervention, and then re-start it under the same order. This would constitute a PRN order.
- A “trial release” constitutes a PRN use of restraint or seclusion, and, therefore, is not permitted by this regulation.

When a staff member ends an ordered restraint or seclusion intervention, the staff member has no philosophy if it sets up the expectation that restraint or seclusion will be used as a routine part of care.

The use of restraint or seclusion is a last resort when less restrictive measures have been determined ineffective to ensure the safety of the patient, staff or others, should not be a standard response to a behavior or patient need.

CHART REVIEW

Review a random sample of medical records for patients that have been restrained or secluded. Review orders, progress notes, flow sheets, and nursing notes to:

1. Verify that there is a physician or other LIP order for each episode of restraint or seclusion.
2. Evaluate patterns of use and verify that orders were obtained when necessary.
3. Verify that the documentation specifically addresses the patients’ behaviors or symptoms.
4. Determine if restraint or seclusion is being improperly implemented on a PRN basis.

This standard is not met as evidenced by:

Compliant
Not Compliant
authority to reinstitute the intervention without a new order. For example, a patient is released from restraint or seclusion based on the staff’s assessment of the patient’s condition. If this patient later exhibits behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others that can only be handled through the use of restraint or seclusion, a new order would be required.

**NOTE:** A temporary, directly-supervised release, however, that occurs for the purpose of caring for a patient's needs (e.g., toileting, feeding, or range of motion exercises) is not considered a discontinuation of the restraint or seclusion intervention. As long as the patient remains under direct staff supervision, the restraint is not considered to be discontinued because the staff member is present and is serving the same purpose as the restraint or seclusion.

The use of PRN orders for drugs or medications is only prohibited when a drug or medication is being used as a restraint.
- A drug or medication is deemed to be a restraint only if it is not a standard treatment or dosage for the patient’s condition, and the drug or medication is a restriction to manage the patient’s behavior or restricts the patient’s freedom of movement.
- Using a drug to restrain the patient for staff convenience is expressly prohibited.

**EXCEPTIONS**
- **Geri chair.** If a patient requires the use of a Geri
Chair with the tray locked in place in order for the patient to safely be out of bed, a standing or PRN order is permitted. Given that a patient may be out of bed in a Geri chair several times a day, it is not necessary to obtain a new order each time.

- **Raised side rails.** If a patient’s status requires that all bedrails be raised (restraint) while the patient is in bed, a standing or PRN order is permitted. It is not necessary to obtain a new order each time the patient is returned to bed after being out of bed.

- **Repetitive self-mutilating behavior.** If a patient is diagnosed with a chronic medical or psychiatric condition, such as Lesch-Nyhan Syndrome, and the patient engages in repetitive self-mutilating behavior, a standing or PRN order for restraint to be applied in accordance with specific parameters established in the treatment plan would be permitted. Since the use of restraints to prevent self-injury is needed for these types of rare, severe, medical and psychiatric conditions, the specific requirements (1-hour face-to-face evaluation, time-limited orders, and evaluation every 24 hours before renewal of the order) for the management of violent or self-destructive behavior do not apply.

**15.02.12 Physician Notification of Restraint Use.**

*The attending physician must be consulted as soon as possible if the:*  

Hospital policy provides practice expectations:  

1. If the attending physician did not order the restraint or seclusion, the attending physician must be consulted as soon as possible. This

**CHART REVIEW, DOCUMENT REVIEW, AND INTERVIEW**  

1. Review the patient’s medical record for documentation that the attending

Compliant  
Not Compliant  
This standard is not met
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<tr>
<td>attending physician did not order the restraint or seclusion.</td>
<td><strong>§482.13(e)(7)</strong> requirement may be achieved through a telephone call. The attending physician is notified to ensure continuity of care, to ensure patient safety, and to obtain other relevant information about the care of the patient. 2. When the attending physician is not available and has delegated patient responsibility to another physician, the covering physician is considered the attending physician. The attending physician is the Doctor of Medicine / Doctor of Osteopathic Medicine who is responsible for the management and care of the patient. Hospital medical staff policies determine who is considered the attending physician. The intent of this requirement is to ensure that the physician who has overall responsibility and authority for the management and care of the patient is aware of the patient’s condition and is aware of the restraint or seclusion intervention. It is important to consult with the attending physician to promote continuity of care, to ensure patient safety, and to elicit information that might be relevant in choosing the most appropriate intervention for the patient. The attending physician may have information regarding the patient’s history that may have a significant impact on the selection of a restraint or seclusion intervention or an alternative intervention, and the subsequent course of treatment. Therefore, consultation should occur as soon as possible. Hospital policies and procedures should address the definition of “as soon as possible” based on the physician was notified immediately if the attending physician did not order the restraint or seclusion. Was the attending physician notified “as soon as possible?” 2. Review the hospital’s policies and procedures regarding consultation with the attending physician if the attending physician did not order the restraint or seclusion. 3. Interview staff to determine if actual practice is consistent with written hospital policies and procedures.</td>
<td>as evidenced by:</td>
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| 15.02.13 Restraint Orders for Management of Violent Behavior. | Patients of all ages are vulnerable and at risk when restrained or secluded to manage violent or self-destructive behavior. Therefore, time limits have been established for each order for restraint or seclusion. | 1. When restraint or seclusion is used to manage violent or self-destructive behavior, do orders contain the appropriate time limits? | }
**PATIENT RIGHTS & RESTRAINTS**

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<td>(i) Each order for restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others may only be renewed in accordance with the following limits for up to a total of 24 hours:</td>
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<td>(A) 4 hours for adults 18 years of age or older;</td>
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<td>(B) 2 hours for children and adolescents 9 to 17 years of age; or</td>
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<td>(C) 1 hour for children under 9 years of age.</td>
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<td>§482.13(e)(8)(i)</td>
<td>seclusion used to manage violent or self-destructive behavior. State law may require more restrictive time limits.</td>
<td>as evidenced by:</td>
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<td>• These time limits do not apply to orders for restraint used to manage non-violent or non-self-destructive behavior. However, the requirement that restraint use be ended at the earliest possible time applies to all uses of restraint.</td>
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<td>In the final rule on the use of restraint or seclusion, CMS did not include specific criteria for differentiating between emergency situations where the patient’s behavior is violent or self-destructive and jeopardizes the immediate physical safety of the patient, a staff member, or others, and non-emergency use of restraint.</td>
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<td>Clinicians are adept at identifying various behaviors and symptoms, and can readily recognize violent and self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others. Asking clinicians to act based on an evaluation of the patient’s behavior is no different than relying on the clinical judgment that they use daily in assessing the needs of each patient and taking actions to meet those individual needs.</td>
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<td>The regulation identifies maximum time limits on the length of each order for restraint or seclusion based on age.</td>
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<td>• The physician or other LIP has the discretion to write the order for a shorter length of time.</td>
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<td>• The length-of-order requirement identifies</td>
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<td>critical points at which there is mandatory contact with a physician or other LIP responsible for the care of the patient. In addition, the time limits do not dictate how long a patient should remain in restraint or seclusion.</td>
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<td>• Staff is expected to continually assess and monitor the patient to ensure that the patient is released from restraint or seclusion at the earliest possible time. Restraint or seclusion may only be employed while the unsafe situation continues.</td>
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<td>• Once the unsafe situation ends, the use of restraint or seclusion should be discontinued.</td>
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<td>The regulation explicitly states that the intervention must be discontinued at the earliest possible time, regardless of the length of time identified in the order.</td>
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<td>• For example, if a patient’s behavior is no longer violent or self-destructive 20 minutes after the intervention is initiated, then the restraint or seclusion should be discontinued, even if the order was given for up to 4 hours.</td>
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<td>• If restraint or seclusion is discontinued prior to the expiration of the original order, a new order must be obtained prior to reinitiating the use of restraint or seclusion.</td>
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<td>At the end of the time frame, if the continued use of restraint or seclusion to manage violent or self-</td>
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destructive behavior is deemed necessary based on an individualized patient assessment, another order is required.

- When the original order is about to expire, an RN must contact the physician or other LIP, report the results of his or her most recent assessment and request that the original order be renewed (not to exceed the time limits established in the regulation).

- Whether or not an onsite assessment is necessary prior to renewing the order is left to the discretion of the physician or other LIP in conjunction with a discussion with the RN who is over-seeing the care of the patient. Another 1-hour face-to-face patient evaluation (see §482.13(e)(12) and the related interpretive guidance) is not required when the original order is renewed.

The original restraint or seclusion order may only be renewed within the required time limits for up to a total of 24 hours. After the original order expires, a physician or other LIP must see and assess the patient before issuing a new order.

**EXCEPTION:** Repetitive self-mutilating behaviors – see interpretive guidance for §482.13(e)(6).

---

**15.02.14 Physician Assessment.**  
*Unless superseded by State law that is more restrictive --*

- **After 24 hours, before writing a new**

At a minimum, if a patient remains in restraint or seclusion for the management of violent or self-destructive behavior 24 hours after the original order, the physician or other LIP must see the patient.

**CHART REVIEW**

1. If restraint or seclusion is used to manage violent or self-destructive behavior for longer than 24 hours, is there
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<td>order for the use of restraint or seclusion for the management of violent or self-destructive behavior, a physician or other licensed independent practitioner who is responsible for the care of the patient as specified under §482.12(c) of this part and authorized to order restraint or seclusion by hospital policy in accordance with State law must see and assess the patient.</td>
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§482.13(e)(8)(ii) | patient and conduct a face-to-face re-evaluation before writing a new order for the continued use of restraint or seclusion.  
Twenty-four hours of restraint or seclusion for the management of violent or self-destructive behavior is an extreme measure with the potential for serious harm to the patient.  
State laws may be more restrictive and require the physician or other LIP to conduct a face-to-face re-evaluation within a shorter timeframe.  
When the physician or other LIP renews an order or writes a new order authorizing the continued use of restraint or seclusion, there must be documentation in the patient’s medical record that describes the findings of the physician’s or other LIP’s re-evaluation supporting the continued use of restraint or seclusion.  
**EXCEPTION:** Repetitive self-mutilating behaviors – see interpretive guidance for §482.13(e)(6). |

documentation of a new written order, patient assessments, and a re-evaluation by a physician or other LIP in the medical record?  
- Does the documentation provide sufficient evidence to support the need to continue the use of restraint or seclusion?  
- Is there evidence in the medical record that the symptoms necessitating the continued use of restraint or seclusion have persisted?  
2. Does the patient’s plan of care or treatment plan address the use of restraint or seclusion?  
3. What is the patient’s documented clinical response to the continued need for restraint or seclusion? |

| 15.02.15 Renewal of Restraint Orders, Unless superseded by State law that is more restrictive -- | | |
| | | as evidenced by: |
| | | 1. Review the hospital policy on renewal of restraint orders for the management of |
| | | 2. Does the patient’s plan of care or treatment plan address the use of restraint or seclusion? |
| | | 3. What is the patient’s documented clinical response to the continued need for restraint or seclusion? |
| | | Hospitals have the flexibility to determine time frames for the renewal of orders for restraint of the non-violent, non-self-destructive patient.  
These time frames should be addressed in hospital documentation of a new written order, patient assessments, and a re-evaluation by a physician or other LIP in the medical record?  
- Does the documentation provide sufficient evidence to support the need to continue the use of restraint or seclusion?  
- Is there evidence in the medical record that the symptoms necessitating the continued use of restraint or seclusion have persisted?  
2. Does the patient’s plan of care or treatment plan address the use of restraint or seclusion?  
3. What is the patient’s documented clinical response to the continued need for restraint or seclusion? |

| 2014 updated August 2014 | Healthcare Facilities Accreditation Program (HFAP) Accreditation Requirements for Acute Care Hospitals | 15-108 |
**PATIENT RIGHTS & RESTRAINTS**

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<td>ensure the physical safety of the non-violent or non-self-destructive patient may be renewed as authorized by hospital policy.</td>
<td>policies and procedures.</td>
<td>non-violent, non-self-destructive patient behavior.</td>
<td>as evidenced by:</td>
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<td>§482.13(e)(8)(iii)</td>
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**15.02.16 Discontinuation of Restraints.**
Restraint or seclusion must be discontinued at the earliest possible time, regardless of the length of time identified in the order.

§482.13(e)(9)

Restraint or seclusion may only be employed while the unsafe situation continues. Once the unsafe situation ends, the use of restraint or seclusion must be discontinued.

Staff members are expected to assess and monitor the patient’s condition on an ongoing basis to determine whether restraint or seclusion can safely be discontinued.

- The regulation requires that these interventions be ended as quickly as possible.
- However, the decision to discontinue the intervention should be based on the determination that the patient’s behavior is no longer a threat to self, staff members, or others.

When the physician or LIP renews an order or writes a new order authorizing the continued use of restraint or seclusion, there must be documentation in the medical record that describes the patient’s clinical needs and supports the continued use of restraint or seclusion.

The hospital policies and procedures should address, at a minimum:

**DOCUMENT REVIEW, CHART REVIEW, AND INTERVIEW**

1. Does the hospital have policies and procedures for ending restraint or seclusion?

2. Do the policies include a requirement to end the restraint or seclusion as soon as is safely possible?

3. Does the medical record contain evidence that the decision to continue or discontinue the use of restraint or seclusion was based on an assessment and re-evaluation of the patient’s condition?

4. Interview staff to determine whether they are aware that use of a restraint or seclusion must be discontinued as soon as is safely possible.

2014 updated August 2014
Healthcare Facilities Accreditation Program (HFAP)
Accreditation Requirements for Acute Care Hospitals
15-109
### 15.02.17 Monitoring of the Patient

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

§482.13(e)(10)

Ongoing assessment and monitoring of the patient's condition by a physician, other LIP or trained staff is crucial for prevention of patient injury or death, as well as ensuring that the use of restraint or seclusion is discontinued at the earliest possible time.

Hospital policies are expected to guide staff in determining appropriate intervals for assessment and monitoring based on the individual needs of the patient, the patient's condition, and the type of restraint or seclusion used.

The selection of an intervention and determination of the necessary frequency of assessment and monitoring should be individualized, taking into consideration variables such as the patient's condition, cognitive status, risks associated with the use of the chosen intervention, and other relevant factors.

- In some cases, checks every 15 minutes or vital signs taken every 2 hours may not be sufficient to ensure the patient's safety.
- In others, it may be excessive or disruptive to patient care (e.g., it may be unnecessary to mandate that a patient with wrist restraints, and who is asleep, be checked every 15 minutes.

#### DOCUMENT REVIEW

Review hospital policies regarding assessment and monitoring of a patient in restraint or seclusion.

1. What evidence do you find that the hospital's monitoring policies are put into practice for all restrained or secluded patients?
2. Do hospital policies identify which categories of staff are responsible for assessing and monitoring the patient?
3. Do hospital policies include time frames for offering fluids and nourishment, toileting / elimination, range of motion, exercise of limbs and systematic release of restrained limbs? Is this documented in the patient's medical record?

#### CHART REVIEW

Review patient medical records:

1. Was there a valid rationale for the decision regarding the frequency of patient assessment and monitoring documented in the medical record?
2. Was documentation consistent, relevant,
and awakened every 2 hours to take the patient’s vital signs.

- Similarly, depending on the patient’s needs and situational factors, the use of restraint or seclusion may require either periodic (e.g., every 15 minutes, every 30 minutes, etc.) or continual (i.e., moment to moment) monitoring and assessment.

Hospital policies should address:
1. frequencies of monitoring and assessment;
2. assessment content (e.g., vital signs, circulation, hydration needs, elimination needs, level of distress and agitation, mental status, cognitive functioning, skin integrity, etc.);
3. providing for nutritional needs, range of motion exercises, and elimination needs; and
4. mental status and neurological evaluations.

With the exception of the simultaneous use of restraint and seclusion, one-to-one observation with a staff member in constant attendance is not required by this regulation unless deemed necessary based on a practitioner’s clinical judgment.

- For example, placing staff at the bedside of a patient with wrist restraints may be unnecessary.

- However, for a more restrictive or risky intervention and/or a patient who is suicidal, self injurious, or combative, staff may determine that continual face-to-face and reflective of the patient’s condition?

3. Are time frames described for how often a patient is monitored for vital signs, respiratory and cardiac status, and skin integrity checks?

4. Is there documentation of ongoing patient monitoring and assessment (e.g., skin integrity, circulation, respiration, intake and output, hygiene, injury, etc.)?

5. Is the patient’s mental status assessed? Is this documented in the medical record?

6. Is the patient assessed regarding continued need for the use of seclusion or restraint?

7. Is there adequate justification for continued use and is this documented?

8. Is the level of supervision appropriate to meet the safety needs of the patient who is at a higher risk for injury (e.g., self-injurious, suicidal),

9. Is the patient’s mental status assessed? Is this documented in the medical record?

10. Is the patient assessed regarding continued need for the use of seclusion or restraint?

11. Is there adequate justification for continued use and is this documented?

12. Is the level of supervision appropriate to meet the safety needs for the patient who is at a higher risk for injury (e.g., self-injurious, suicidal)?
monitoring is needed.

- The hospital is responsible for providing the level of monitoring and frequency of reassessment that will protect the patient's safety.

Hospitals have flexibility in determining which staff performs the patient assessment and monitoring.

- This determination must be in accordance with the practitioner’s scope of clinical practice and State law.

- For example, assessment and monitoring are activities within a registered nurse’s scope of practice.

- However, some trained, unlicensed staff may perform components of monitoring (e.g., checking the patient’s vital signs, hydration and circulation; the patient’s level of distress and agitation; or skin integrity), and may also provide for general care needs (e.g., eating, hydration, toileting, and range of motion exercises). Section §482.13(f) requires that before applying restraints, implementing seclusion, or performing associated monitoring and care tasks, staff must be trained and able to demonstrate competency in the performance of these actions.

15.02.18 Physician Training.
Physician and other licensed independent practitioner training requirements must be specified in hospital policy. At a minimum, physicians and other LIPs authorized to order restraint and seclusion must have a working knowledge of hospital policy regarding the use of restraint and seclusion.

**DOCUMENT REVIEW**
Review the hospital policy regarding restraint and seclusion training requirements for physicians and other LIPs.

□ Compliant
□ Not Compliant
This standard is not met
minimum, physicians and other licensed independent practitioners authorized to order restraint or seclusion by hospital policy in accordance with State law must have a working knowledge of hospital policy regarding the use of restraint or seclusion.

§482.13(e)(11)

Hospitals have the flexibility to identify training requirements above this minimum requirement based on the competency level of their physicians and other LIPs, and the needs of the patient population(s) that they serve.

Physicians receive training in the assessment, monitoring, and evaluation of a patient’s condition as part of their medical school education.

• However, physicians generally do not receive training regarding application of restraint or implementation of seclusion as part of their basic education.

• Depending on the level and frequency of involvement that a physician or other LIP has in the performance of these activities, additional training may or may not be necessary to ensure the competency of these individuals in this area.

The hospital is in the best position to determine if additional physician or other LIP training is necessary based on the model of care, level of physician competency, and the needs of the patient population(s) that the hospital serves.

15.02.19 One Hour Face-to-Face
When restraint or seclusion is used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient,

When restraint or seclusion is used to manage violent or self-destructive behavior, a physician or other LIP, or a registered nurse (RN) or physician assistant (PA) trained in accordance with the requirements specified under §482.13(f), must see

• Are the minimum training requirements addressed?

FILE REVIEW
Review medical staff credentialing and privileging files to determine if physicians or other LIPs involved in restraint and seclusion activities have completed the required training.

DOCUMENT REVIEW AND INTERVIEW
1. Review the hospital policy regarding the 1-hour face-to-face evaluation.

• What categories of practitioners does the hospital policy authorize

Compliant
Not Compliant

This standard is not met as evidenced by:
### Standard / Element

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<td>a staff member, or others, the patient must be seen face-to-face within 1 hour after the initiation of the intervention.</td>
<td>to conduct the 1-hour face-to-face evaluation?</td>
<td>2. Interview staff to determine if practice is consistent with hospital policy.</td>
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#### (i) By a –

(A) Physician or other licensed independent practitioner; or

(B) Registered nurse or physician assistant who has been trained in accordance with the requirements specified in paragraph (f) 42 Code of Federal Regulations.

§482.13(e)(12)(i)

the patient face-to-face within 1-hour after the initiation of the intervention.

This requirement also applies when a drug or medication is used as a restraint to manage violent or self-destructive behavior.

The 1-hour face-to-face patient evaluation must be conducted in person by a physician or other LIP, or trained RN or PA.

- A telephone call or telemedicine methodology is not permitted.

If a patient’s violent or self-destructive behavior resolves and the restraint or seclusion intervention is discontinued before the practitioner arrives to perform the 1-hour face-to-face evaluation, the practitioner is still required to see the patient face-to-face and conduct the evaluation within 1 hour after the initiation of this intervention. The fact that the patient’s behavior warranted the use of a restraint or seclusion indicates a serious medical or psychological need for prompt evaluation of the patient behavior that led to the intervention. The evaluation would also determine whether there is a continued need for the intervention, factors that may have contributed to the violent or self-destructive behavior, and whether the intervention was appropriate to address the violent or self-destructive behavior.

**EXCEPTION:** Repetitive self-mutilating behaviors:

See Explanation for §482.13(e)(6).
15.02.20  Physician Assessment Requirements.

The patient must be seen face-to-face within 1 hour after the initiation of the intervention to evaluate –
(A) The patient’s immediate situation;
(B) The patient’s reaction to the intervention;
(C) The patient’s medical and behavioral condition; and
(D) The need to continue or terminate the restraint or seclusion.

§482.13(e)(12)(ii)

The 1-hour face-to-face evaluation includes both a physical and behavioral assessment of the patient that must be conducted by a qualified practitioner within the scope of their practice.

An evaluation of the patient’s medical condition would include a complete review of systems assessment, behavioral assessment, as well as review and assessment of the patient’s history, drugs and medications, most recent lab results, etc. The purpose is to complete a comprehensive review of the patient’s condition to determine if other factors, such as drug or medication interactions, electrolyte imbalances, hypoxia, sepsis, etc., are contributing to the patient’s violent or self-destructive behavior.

Training for an RN or PA to conduct the 1-hour face-to-face evaluation would include all of the training requirements at §482.13(f) as well as content to evaluate the patient’s immediate situation, the patient’s reaction to the intervention, the patient’s medical and behavioral condition (documented training in conducting physical and behavioral assessment); and the need to continue or terminate the restraint or seclusion.

CHART REVIEW, DOCUMENT REVIEW, AND FILE REVIEW

1. Was the 1-hour face-to-face evaluation conducted by a practitioner authorized by hospital policy in accordance with State law to conduct this evaluation?

2. Does documentation of the 1-hour face-to-face evaluation in the patient’s medical record include all the listed elements of this requirement?

3. Did the evaluation indicate whether changes in the patient’s care were required, and, if so, were the changes made?

4. If the 1-hour face-to-face evaluations are conducted by RNs who are not advanced practice nurses (APN), verify:
   • that those RNs have documented training that demonstrates they are qualified to conduct a physical and behavioral assessment of the patient that addresses 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.

5. Is practice consistent with hospital policy and State law?
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<tr>
<td><strong>15.02.21 State Requirements.</strong></td>
<td>States are free to have requirements that are more restrictive regarding the types of practitioners who may conduct the 1-hour face-to-face evaluation. Generally, States may have more restrictive requirements as long as they do not conflict with Federal requirements.</td>
<td><strong>DOCUMENT REVIEW</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>States are free to have requirements by statute or regulation that are more restrictive than those contained in paragraph (e)(12)(i) of this section.</td>
<td>1. When preparing for the hospital survey, determine whether there are State provisions governing the use of restraint or seclusion that are more restrictive than those found in this section.</td>
<td>Compliant</td>
</tr>
<tr>
<td></td>
<td>§482.13(e)(13)</td>
<td>2. When State requirements are more restrictive, apply those requirements instead of those found in this section.</td>
<td>Not Compliant</td>
</tr>
<tr>
<td><strong>15.02.22 Physician Notification.</strong></td>
<td>When a trained RN or PA conducts the required face-to-face evaluation, he or she must consult the attending physician or other LIP responsible for the patient’s care as soon as possible after the completion of the evaluation.</td>
<td><strong>DOCUMENT REVIEW AND CHART REVIEW</strong></td>
<td>This standard is not met as evidenced by:</td>
</tr>
<tr>
<td></td>
<td>If the face-to-face evaluation specified in paragraph (e)(12) of this section is conducted by a trained registered nurse or physician assistant, the trained registered nurse or physician assistant must consult the attending physician or other licensed independent practitioner who is responsible for the care of the patient as specified under §482.12(c) as soon as possible after the completion of the 1 hour face-to-face evaluation.</td>
<td>1. Review the relevant hospital restraint and seclusion policy.</td>
<td>Compliant</td>
</tr>
<tr>
<td></td>
<td>§482.13(e)(14)</td>
<td>2. Does the hospital policy clarify expectations regarding the requirement, “as soon as possible”?</td>
<td>Not Compliant</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. Does documentation in the patient’s medical record indicate consultation with the attending physician or other LIP when the 1-hour face-to-face evaluation was conducted by a trained RN or PA?</td>
<td>This standard is not met as evidenced by:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4. Is practice consistent with hospital policy?</td>
<td></td>
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A consultation that is not conducted prior to a...
15.02.23 Simultaneous Use of Restraint and Seclusion.
All requirements specified under this paragraph are applicable to the simultaneous use of restraint and seclusion. Simultaneous restraint and seclusion use is only permitted if the patient is continually monitored:

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

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

§482.13(e)(15)

When the simultaneous use of restraint and seclusion is employed, there must be adequate documentation that justifies the decision for simultaneous use as well as vigilance in continuously monitoring the patient so that the patient’s care needs are met.

All requirements specified under standard (e) apply to the simultaneous use of restraint and seclusion. The simultaneous use of restraint and seclusion is not permitted unless the patient is continually monitored by trained staff, either through face-to-face observation or through the use of both video and audio equipment.

Monitoring with video and audio equipment further requires that staff perform the monitoring in close proximity to the patient. For the purposes of this requirement, “continually” means ongoing without interruption. The use of video and audio equipment does not eliminate the need for frequent monitoring and assessment of the patient.

An individual who is physically restrained alone in his or her room is not necessarily being simultaneously secluded.

The individual’s privacy and dignity should be protected to the extent possible during any intervention.

- In fact, the purpose of restraining a patient renewal of the order would not be consistent with the requirement, “as soon as possible.”

### DOCUMENT REVIEW, OBSERVATION, AND INTERVIEW

1. Review the hospital’s policy regarding simultaneous use of restraint and seclusion to determine whether it provides for continual monitoring and otherwise complies with all requirements of §482.13.

2. Conduct document review and staff interviews to determine if practice is consistent with the hospital policy and required uninterrupted audio and visual monitoring is provided as required.

3. Is the staff member monitoring the patient with video and audio equipment trained and in close proximity to ensure prompt emergency intervention if a problem arises?

4. Does the video equipment cover all areas of the room or location where the patient is restrained or secluded?

5. Is the audio and video equipment located in an area that assures patient privacy?
alone in his or her room may be to promote privacy and dignity versus simultaneously using seclusion and restraint. While this distinction may be difficult to make, it is helpful to consider whether the patient would, in the absence of the physical restraint, be able to voluntarily leave the room. If so, then the patient is not also being secluded.

- However, if the physical restraint was removed and the patient was still unable to leave the room because the door was locked or staff were otherwise physically preventing the patient from doing so, then the patient is also being secluded.

Staff must take extra care to protect the safety of the patient when interventions that are more restrictive are used. Monitoring must be appropriate to the intervention chosen, so that the patient is protected from possible abuse, assault, or self injury during the intervention.

6. Is the equipment appropriately maintained and in working condition?
restraint or seclusion is used to manage violent or self-destructive behavior;

§482.13(e)(16)(i)

**15.02.25 Requirements for Documentation.**

When restraint or seclusion is used, there must be documentation in the patient’s medical record of:

(ii) A description of the patient’s behavior and the intervention used;

§482.13(e)(16)(ii)

Documentation that must be included in the patient’s medical record when the patient is restrained or secluded includes a description of the patient’s behavior and the intervention used. The patient’s behavior should be documented in descriptive terms to evaluate the appropriateness of the interventions used.

The documentation should include a detailed description of the patient’s physical and mental status assessments, and of any environmental factors (e.g., physical, milieu, activities, etc.) that may have contributed to the situation at the time of the intervention.

**CHART REVIEW**

1. Does the patient’s medical record include a clear description of the patient’s behavior that warranted the use of restraint or seclusion?

2. Was the intervention employed appropriate for the identified behavior?

3. What was the patient’s clinical response to the intervention(s)?

**15.02.26 Requirements for Documentation.**

When restraint or seclusion is used, there must be documentation in the patient’s medical record of:

(iii) Alternatives or other less restrictive interventions

The use of restraint or seclusion must be selected only when less restrictive measures have been judged to be ineffective to protect the patient or others from harm. It is not always appropriate for less restrictive alternatives to be attempted prior to the use of restraint or seclusion.

When a patient’s behavior presents an immediate

**CHART REVIEW**

1. Does the patient’s medical record document any alternatives or less restrictive interventions attempted by staff, if appropriate?

2. What was the effect of less restrictive
### Patient Rights & Restraints

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| attempted (as applicable); §482.13(e)(16)(iii) | and serious danger to his- or herself, or others, immediate action is needed.  
- For example, when a patient physically attacks someone, immediate action is needed.  
- While staff should be mindful of using the least intrusive intervention, it is critical that the intervention selected be effective in protecting the patient or others from harm. interventions, if attempted by staff?  
3. Were the interventions selected appropriate to the targeted patient behaviors?  
4. When an immediate and serious danger to the patient or others occurred, was the more restrictive intervention(s) effective?  
- Could a less restrictive intervention have been used to ensure the safety of the patient, staff or others? | | |

#### 15.02.27 Requirements for Documentation.
When restraint or seclusion is used, there must be documentation in the patient’s medical record of:

- The patient’s condition or symptom(s) that warranted the use of the restraint or seclusion; and

§482.13(e)(16)(iv)

- A comprehensive, individualized patient assessment is necessary to identify the most appropriate intervention to effectively manage a patient’s condition or symptom(s).

- When using a restraint or seclusion intervention, the patient’s condition or symptom(s) must be identified and documented in the patient’s medical record.

#### 15.02.28 Requirements for Documentation.
When restraint or seclusion is used, there must be documentation in the patient’s medical record of:

- The patient’s response to the interventions(s) used, including the rationale for continued use

§482.13(e)(16)(v)

- When using a restraint or seclusion intervention, the patient’s response to the intervention must be documented in the patient’s medical record.

**CHART REVIEW**

- Does the patient’s medical record include descriptions of the patient’s condition or symptom(s) that warranted the use of restraint or seclusion?

- Does the patient’s medical record include descriptions of the impact of the intervention on the patient behavior that resulted in the use of restraint or seclusion?

- Does the patient’s medical record include a...
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**15.02.29 Staff Training Requirements – Use of Restraints or Seclusion.**

The patient has the right to safe implementation of restraint or seclusion by trained staff.

§482.13(e)(16)(v)

Without adequate staff training and competency, the direct care staff, patients, and others are placed at risk. Patients have a right to the safe application of restraint or seclusion by trained and competent staff. Staff training and education play a critical role in the reduction of restraint and seclusion use in a hospital.

**SCORING PROCEDURE**

1. Determine whether the hospital has staff training and education program that protects the patient’s right to safe implementation of restraint or seclusion.

2. Observe patients in restraint or seclusion to verify safe application of the restraint or seclusion.

**DOCUMENT REVIEW AND OBSERVATION**

1. Does the hospital have a documented training program for the use of restraint and seclusion interventions employed by the hospital?

2. Does the hospital have documented evidence that all levels of staff, including agency or contract staff, that have direct patient care responsibilities and any other individuals who may be involved in the application of restraints (e.g., security guards) have been trained and are able to demonstrate competency in the safe use of restraint or seclusion?

**DOCUMENT REVIEW**

1. Does the hospital have a documented program for the use of restraint and seclusion interventions employed by the hospital?

2. Does the hospital have documented evidence that all levels of staff, including agency or contract staff, that have direct patient care responsibilities and any other individuals who may be involved in the application of restraints (e.g., security guards) have been trained and are able to demonstrate competency in the safe use of restraint or seclusion?

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<td>§482.13(f)(1)(i)</td>
<td>Staff competency, and the needs of the patient population(s) served.</td>
<td>seclusion and the safe application and use of restraints?</td>
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<tr>
<td>§482.13(f)(1)(ii)</td>
<td>Training for an RN or PA to conduct the 1-hour face-to-face evaluation would include all of the training requirements at §482.13(f) as well as content to:</td>
<td>3. Review and verify restraint and seclusion education staff training documentation for all new employees and contract staff.</td>
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<td>§482.13(f)(1)(iii)</td>
<td>• evaluate the patient’s immediate situation,</td>
<td>4. Does the training include demonstration of required competencies?</td>
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<td>• the patient’s reaction to the intervention,</td>
<td>5. What areas were included in this training program?</td>
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<td>• the patient's medical and behavioral condition, and</td>
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<td>• the need to continue or terminate the restraint or seclusion.</td>
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<td>An evaluation of the patient’s medical condition would include a</td>
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<td>• complete review of systems assessment,</td>
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<td>• behavioral assessment, as well as</td>
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<td>• review and assessment of the patient’s history, medications, most recent lab results, etc.</td>
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<td>The purpose of the 1-hour face-to-face evaluation is to complete a comprehensive review of the patient’s condition and determine if other factors, such as drug or medication interactions, electrolyte imbalances, hypoxia, sepsis, etc., are contributing to the patient’s violent or self-destructive behavior.</td>
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<td>Once initial training takes place, training must be provided frequently enough to ensure that staff possesses the requisite knowledge and skills to safely care for restrained or secluded patients in accordance with the regulations.</td>
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The results of skills and knowledge assessments, new equipment, or QAPI data may indicate a need for targeted training or more frequent or revised training. Hospitals are required to have appropriately trained staff for the proper and safe use of seclusion and restraint interventions.

- It would not be appropriate for a hospital to routinely call upon a law enforcement agency or agencies as a means of applying restraint or initiating seclusion.

- If hospital security guards, or other non-healthcare staff, as part of hospital policy, may assist direct care staff, when requested, in the application of restraint or seclusion, the security guards, or other non-healthcare staff, are also expected to be trained and able to demonstrate competency in the safe application of restraint and seclusion (in accordance with §482.13(f)).

**15.02.31 Training Content.**

The term “appropriate staff” includes all staff that apply restraint or seclusion, monitor, assess, or otherwise provide care for patients in restraint or seclusion.

- All staff, including contract or agency personnel, designated by the hospital as having direct patient care responsibilities are required to

**DOCUMENT REVIEW AND INTERVIEW**

1. Does the hospital educational program include techniques related to the specific patient populations being served?

2. Does the hospital educational program include techniques to identify staff and
Techniques to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of a restraint or seclusion.

§482.13(f)(2)(i)

- Receive training in the areas of clinical techniques used to identify patient and staff behaviors, events and environmental factors that may trigger circumstances that require the use of restraint or seclusion.

This training should be targeted to the specific needs of the patient populations being served, and to the competency level of staff.

Staff needs to be able to employ a broad range of clinical interventions to maintain the safety of the patient and others.

The hospital is expected to provide education and training at the appropriate level to the appropriate staff based upon the specific needs of the patient population being served.

- For example, staff routinely providing care for patients who exhibit violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others (such as in an emergency department or on a psychiatric unit) generally require more in-depth training in the areas included in the regulation than staff routinely providing medical / surgical care.

- Hospitals may develop and implement their own training programs or use an outside training program.

- However, standard (f) specifies that individuals providing staff training must be qualified as evidenced by education.

3. Does the hospital educational program provide more in-depth training in the areas included in the regulation for staff members who routinely provide care to patients who exhibit violent or self-destructive behavior (e.g., staff who work in the emergency department or psychiatric unit)?

4. Interview staff to assess their knowledge of the restraint and seclusion techniques addressed in this requirement.
Hospitals have the flexibility to develop their own training program to meet the staff training requirements at §482.13(f) or purchase a training program from the outside.

- CMS does not specify that any particular outside vendor must be used to provide the required training.

- Each hospital must assess the learning needs and competency of their staff to determine how extensive periodic training and staff competency demonstration must be subsequent to initial training. The training program must be provided to all appropriate staff.

- Any person monitoring or providing care to a restrained patient must demonstrate the knowledge and abilities required by the regulations.

At a minimum, physicians and other LIPs authorized to order restraint or seclusion by hospital policy in accordance with State law must have a working knowledge of hospital policy regarding the use of restraint and seclusion.

- Hospitals have the flexibility to identify training requirements above this minimum based on the competency level of their physicians and other LIPs and the needs of the patient population that they serve.
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| **15.02.32 Training Requirements: Nonphysical Intervention.** The hospital must require appropriate staff to have education, training, and demonstrated knowledge based on the specific needs of the patient population in at least the following:  
- The use of nonphysical intervention skills. §482.13(f)(2)(ii) | Although we recognize that there may be circumstances in which the use of restraint or seclusion may be necessary to prevent a patient situation from escalating, staff often skilfully intervene with alternative techniques to redirect a patient, engage the patient in constructive discussion or activity, or otherwise help the patient maintain self-control and avert escalation. The use of nonphysical intervention skills does not mean attempting a complex series of interventions or a lengthy checklist of steps to initiate before restraining or secluding a patient. Rather, a whole toolbox of possible interventions can be implemented during the course of a patient’s treatment based upon the assessment of an individual patient’s responses. | **DOCUMENT REVIEW AND INTERVIEW** 1. Does the hospital educational program address the use of nonphysical intervention skills?  
2. Does the hospital’s training program comply with the regulatory requirements?  
3. Interview staff to assess their non-physical intervention skills. | □ Compliant  
□ Not Compliant |  
This standard is not met as evidenced by: |
| **15.02.33 Training Requirements: Least Restrictive Intervention.** The hospital must require appropriate staff to have education, training, and demonstrated knowledge based on the specific needs of the patient population in at least the following:  
- Choosing the least restrictive intervention based on an individualized assessment of the patient’s medical, or behavioral status or condition. §482.13(f)(2)(iii) | The underpinning of this regulation is the concept that safe patient care hinges on looking at the patient as an individual and assessing the patient’s condition, needs, strengths, weaknesses, and preferences. Such an approach relies on caregivers who are skilled in individualized assessment and in tailoring interventions to individual patient’s needs after weighing factors such as the patient’s condition, behaviors, history, and environmental factors. **Resources** Resources are available to assist clinicians in identifying less restrictive interventions. For example, the American Psychiatric Association | **DOCUMENT REVIEW AND INTERVIEW** 1. Does the hospital educational program address choosing the least restrictive intervention based on an individualized assessment of the patient’s medical or behavioral status or condition?  
2. Does the hospital educational program address how to conduct an assessment of a patient’s medical and behavioral conditions?  
3. Does the hospital educational program address types of interventions appropriate to the specific needs of the patient | □ Compliant  
□ Not Compliant |  
This standard is not met as evidenced by: |
### 15.02.34 Training Requirements: Safe Application

**The hospital must require appropriate staff to have education, training, and demonstrated knowledge based on the specific needs of the patient population in at least the following:**

- The safe application and use of all types of restraint or seclusion used in the hospital, including training in how to recognize and respond to signs of physical and psychological distress.

**Patients have a right to the safe application of restraint or seclusion by trained and competent staff.**

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<td>(APA), American Psychiatric Nurses Association (APNA), and the National Association of Psychiatric Health Systems (NAPHS), with support from the American Hospital Association (AHA), have sponsored the publication of a document entitled, “Learning from Each Other—Success Stories and Ideas for Reducing Restraint / Seclusion in Behavioral Health.” This document, published in 2003, was developed through dialogue with the field and extensive input from behavioral healthcare providers throughout the country who have been working to reduce the use of restraint and seclusion, and to improve care within their facilities.</td>
<td>- Interview staff to determine if they are able to demonstrate the abilities addressed in this requirement.</td>
<td>- Visit the websites of the sponsoring organizations: <a href="http://www.naphs.org">http://www.naphs.org</a>; <a href="http://www.psych.org">http://www.psych.org</a>; <a href="http://www.apna.org">http://www.apna.org</a>; <a href="http://www.aha.org">http://www.aha.org</a></td>
<td>- Compliant</td>
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<td>§482.13(f)(2)(iv)</td>
<td>Distress (for example, positional asphyxia).</td>
<td>3. Review hospital data (i.e., incident reports, patient injury or death reports, etc.) to identify any patterns of patient injuries or death that may indicate that staff are not adequately trained to recognize and respond to patient signs of physical and psychological distress.</td>
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</tr>
<tr>
<td>§482.13(f)(2)(v)</td>
<td>The use of restraint or seclusion must be ended at the earliest possible time regardless of the length of time identified in the order. Staff must be trained and demonstrate competency in their ability to identify specific patient behavioral changes that may indicate that restraint or seclusion is no longer necessary and can be safely discontinued.</td>
<td>4. Is staff able to identify signs of physical and psychological distress in a timely manner? 5. Is staff able to respond to and appropriately treat signs of physical and psychological distress?</td>
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#### 15.02.35 Training Requirements: Restraint Removal.

The hospital must require appropriate staff to have education, training, and demonstrated knowledge based on the specific needs of the patient population in at least the following:

- Clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary.

§482.13(f)(2)(v)

#### DOCUMENT REVIEW AND INTERVIEW

1. Does the hospital educational program address identification of specific behavioral changes that may indicate that restraint or seclusion is no longer necessary?
2. Interview staff to determine if they are able to demonstrate the abilities addressed in this requirement.

Compliant  
Not Compliant  
This standard is not met as evidenced by:

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### 15.02.36 Training Requirements: Patient Monitoring

The hospital must require appropriate staff to have education, training, and demonstrated knowledge based on the specific needs of the patient population in at least the following:

- Monitoring the physical and psychological well-being of the patient who is restrained or secluded, including but not limited to, respiratory and circulatory status, skin integrity, vital signs, and as well as any special requirements specified by hospital policy associated with the 1-hour face-to-face evaluation.

§482.13(f)(2)(vi)

Staff must be trained and demonstrate competency in monitoring the physical and psychological well-being of a patient who is restrained or secluded, including but not limited to, respiratory and circulatory status, skin integrity, vital signs, and as well as any special requirements specified by hospital policy associated with the 1-hour face-to-face evaluation.

**DOCUMENT REVIEW AND INTERVIEW**

1. Does the hospital educational program address monitoring the physical and psychological needs of patients who are 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?

2. Does the hospital educational program address the specific requirements for the training of RNs and PAs that the hospital authorizes to conduct the 1-hour face-to-face evaluation?

3. Interview staff to determine if they are able to demonstrate the competencies addressed in this regulation.

### 15.02.37 Training Requirements: CPR Training

The hospital must require appropriate staff to have education, training, and demonstrated knowledge based on the specific needs of the patient population in Hospitals are required to provide a safe environment for the patients in their care. When restraint or seclusion techniques are used, patients are placed at a higher risk for injuries or even death.

**DOCUMENT REVIEW AND FILE REVIEW**

1. Does the hospital educational program address first aid techniques?

2. Does the hospital educational program include, or provide for, staff training and

Compliant  
Not Compliant

This standard is not met as evidenced by:

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<td>at least the following:</td>
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<tr>
<td>- The use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic recertification.</td>
<td>Hospitals must require appropriate staff (all staff who apply restraint or seclusion, monitor, access or provide care for a patient in restraint or seclusion) to receive education and training in the use of first aid techniques as well as training and certification in the use of cardiopulmonary resuscitation.</td>
<td>certification in cardiopulmonary resuscitation (including provisions for recertification)?</td>
<td></td>
</tr>
<tr>
<td>§482.13(f)(2)(vii)</td>
<td></td>
<td>3.</td>
<td>Is appropriate staff certified in cardiopulmonary resuscitation?</td>
</tr>
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</table>

15.02.38 **Trainer Requirements.**

**Trainer Requirements.**

- Individuals providing staff training must be qualified as evidenced by education, training, and experience in techniques used to address

| **FILE REVIEW, DOCUMENT REVIEW AND INTERVIEW** | | | |
| 1. Review personnel files of individuals responsible for providing staff education and training. | | | |

**This standard is not met as evidenced by:**

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2014 updated August 2014

Healthcare Facilities Accreditation Program (HFAP)

Accreditation Requirements for Acute Care Hospitals

15-130
### PATIENT RIGHTS & RESTRAINTS

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<td><strong>patients' behaviors.</strong></td>
<td>• However, individuals providing the training must be qualified as evidenced by education, training and experience in techniques used to address patients' behaviors for the patient populations being served.</td>
<td>2. Do the individuals providing the education and training possess education, training, and experience to qualify them to teach the staff?</td>
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<tr>
<td>§482.13(f)(3)</td>
<td>Trainers should demonstrate a high level of knowledge regarding all the requirements of these regulations as well as the hospital's policies and procedures that address these requirements.</td>
<td>3. Are they qualified to identify and meet the needs of the patient population(s) being served?</td>
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<td><strong>15.02.39  Training Documentation.</strong></td>
<td>Staff personnel records must contain documentation that the training and demonstration of competency were successfully completed initially during orientation and on a periodic basis consistent with hospital policy.</td>
<td>4. Does the hospital have a system for documenting and ensuring that the individuals providing education and training have the appropriate qualifications required by this regulation?</td>
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<tr>
<td>Training Documentation.</td>
<td>• The hospital must document in the staff personnel records that the training and demonstration of competency were successfully completed.</td>
<td><strong>FILE REVIEW</strong></td>
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<tr>
<td>§482.13(f)(4)</td>
<td><strong>DOCUMENT REVIEW</strong></td>
<td>• Review a sample of staff personnel records, including contract or agency staff, to determine if the training and demonstration of competency have been completed during orientation and on a periodic basis consistent with hospital policy.</td>
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<td><strong>15.02.40  Not Applicable.</strong></td>
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<tr>
<td><strong>15.02.41  Death Related to Restraint or Seclusion – Reporting Requirements.</strong></td>
<td>The hospital must report to its CMS Regional Office each death that occurs: (1) While a patient is in restraint or in seclusion, except when no seclusion has been used and the only restraint used was a soft, cloth-like</td>
<td><strong>COMPLIANT</strong></td>
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<td>Hospitals must report deaths associated with the use of seclusion or restraint.</td>
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<tr>
<td>(1) With the exception of deaths</td>
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described under paragraph (g)(2) of this section, the hospital must report the following information to CMS by telephone, facsimile, or electronically, as determined by CMS, no later than the close of business on the next business day following knowledge of the patient’s death:

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

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

(iii) Each death known to the hospital that occurs within 1 week after restraint or seclusion where it is reasonable to assume that the use of restraint or seclusion contributed directly or indirectly to the patient’s death, regardless of the type(s) of restraint used on the patient during this time.

“Reasonable to assume” applies only to those deaths that occur on days 2-7 after restraint or seclusion has been discontinued.

This criterion applies regardless of the type of restraint that was used on the patient. In other words, it applies to all uses of restraint or seclusion where the patient has died on days 2-7 after the restraint or seclusion was discontinued, and it is reasonable to assume the use of the restraint or seclusion contributed to the patient’s death. In a case where only two-point soft wrist restraints were used and there was no seclusion, it may reasonably be presumed that the patient’s death was not caused by the use of restraints.

2. Can the hospital provide examples of restraint/seclusion-associated deaths that were reported to CMS?

   o If yes, review the report and medical records to determine whether:
     • The reports met the criteria for reporting to CMS;
     • Were submitted timely to CMS;
     • Were complete; and
     • The date and time the death reported to CMS was entered into the patient’s medical record.

   o If no:
     • Ask the hospital how it ensures that there were no reportable restraint/seclusion-associated deaths.
     • If the hospital’s system relies upon staff identification of reportable deaths, interview several applicable staff members to determine whether they are aware of the hospital’s policy and know when and where to report...
**PATIENT RIGHTS & RESTRAINTS**

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<td>compression, restriction of breathing or asphyxiation.</td>
<td>• In cases involving death within one week after the use of restraint or seclusion where the intervention may have contributed to the patient’s death, it is possible that the patient’s death might occur outside the hospital and that the hospital might not learn of the patient’s death, or that there might be a delay in the hospital’s learning of the patient’s death.</td>
<td>• Ask if there have been any patient deaths that meet the reporting requirements.</td>
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<td>§482.13(g)(1)</td>
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<td>§482.13(g)(1)(i)(ii)(iii)</td>
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<td>(2) When no seclusion has been used and when the only restraints used on the patient are those applied exclusively to the patient’s wrist(s), and which are composed solely of soft, non-rigid, cloth-like materials, the hospital staff must record in an internal log or other system, the following information:</td>
<td>See the guidance for §482.13(g)(2) for handling of deaths while a patient was in, or within 24 hours after removal of a soft, two-point wrist restraint, when no other restraint or seclusion was used.</td>
<td>3. Interview staff in various types of inpatient units, including a psychiatric unit if applicable, to determine whether they are aware of any patients who died while in restraints or seclusion or within one day of restraint or seclusion discontinuation, excluding cases involving only the use of two-point soft wrist restraints and no seclusion.</td>
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<tr>
<td>(i) Any death that occurs while a patient is in such restraints.</td>
<td>(1) The reports required under §482.13(g)(1) must be submitted to the CMS Regional Office by telephone, facsimile, or electronically, as determined by the Regional Office no later than close of the next business day following the day in which the hospital knows of the patient’s death.</td>
<td>• If yes, check whether the hospital has any evidence that these cases were reported to CMS.</td>
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<td>(ii) Any death that occurs within 24 hours after a patient has been removed from such restraints.</td>
<td>(2) The report must include basic identifying information related to the hospital, the patient’s name, date of birth, date of death, name of attending physician/practitioner, primary diagnosis(es), cause of death (preliminary, in case a final, official cause of death is not yet available), and type(s) of restraint or seclusion used. CMS makes a standard form available for hospitals to use in internally a restraint / seclusion-associated death.</td>
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<td>§482.13(g)(2)</td>
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<tr>
<td>§482.13(g)(2)(i)(ii)</td>
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<td>(3) The staff must document in the patient’s medical record the date and time the death was:</td>
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<tr>
<td>(i) Reported to CMS for deaths described in paragraph (g)(1) of this section, or</td>
<td></td>
<td></td>
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<td>(ii) Recorded in the internal log or other system for deaths</td>
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PATIENT RIGHTS & RESTRAINTS

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§482.13(g)(3)  
§482.13(g)(3)(i)(ii)

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

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

(ii) Each entry must document the patient’s name, date of birth, date of death, name of attending physician or other licensed independent practitioner who is responsible for the care of the patient as specified under §482.12(c), medical record number and primary diagnosis(es).

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

§482.13(g)(4)
§482.13(g)(4)(i)(ii)(iii)

submitting the required reports.

Hospitals must document in the patient’s medical record the date and time each reportable death associated with the use of restraint or seclusion was reported to the CMS Regional Office.

CMS Regional Office

After reviewing the submitted information, the Regional Office will determine whether an on-site investigation of the circumstances surrounding the patient’s death is warranted and will direct the State Survey Agency to conduct a survey if applicable.

Hospital Restraint Death Log

Hospitals must maintain an internal log or other type of tracking system for recording information on each death that occurs:

- While a patient is in only 2-point soft, cloth-like non-rigid wrist restraints and there is no use of seclusion; and
- Within 24 hours of the patient being removed from 2-point soft, cloth-like non-rigid wrist restraints where there was no use of any other type of restraint or seclusion.

Use of the log or tracking system is limited only to patient deaths meeting one of these two criteria. Examples of patient deaths associated with restraints that must still be reported to CMS include:

- Deaths occurring during or within 24 hours of discontinuation of 2-point soft, cloth-like non-rigid wrist restraints used in combination with whether they have had patients who die while 2-point soft wrist restraints are being used without seclusion or within 24 hours of their discontinuance.
  - If yes, ask the hospital to demonstrate that it has recorded such deaths.

4. If the hospital’s log or tracking system relies upon staff identification of reportable deaths, interview several applicable staff members to determine whether they are aware of the hospital’s policy and know when and where to report internally a restraint/seclusion-associated death.

5. Review the log/tracking system for patient deaths associated with use of only 2-point soft wrist restraints to determine if:
  - Each entry was made within 7 days of the patient’s death; and
  - Each entry contains all the information required under the regulation.

6. Is the hospital able to make the log or tracking system available immediately on request?

7. Review a sample of medical records of patients whose deaths were entered in the log or tracking system.
  - Does the medical record indicate that only soft, 2-point wrist restraints were used?
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<tr>
<td>any other restraint device or with seclusion; or</td>
<td>• Deaths associated with the use of other types of wrist restraints, such as 2-point rigid or leather wrist restraints. These cases would not be included in this internal log or tracking system and would require reporting the death to CMS using telephone, fax, or electronically. The two-point soft wrist restraint death report must be entered into the internal log or tracking system within 7 days of the patient’s death. The death report log or tracking system entry must include: • The patient’s name; • Patient’s date of birth; • Patient’s date of death; • Name of the attending physician or other licensed independent practitioner who is responsible for the care or the patient; • Patient’s medical record number; and • Primary diagnosis(es). Depending on the size and nature of the patient population the hospital serves and the types of services it provides, there will likely be variations in the frequency of restraint use as well as in the incidence of patient deaths. • Surveyors should adjust their expectations for the volume of log or tracking system</td>
<td>8. Is there documentation in the medical record of the entry into the log or tracking system?</td>
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</table>
For example, hospitals with intensive care units might be more likely to use both soft, 2-point wrist restraints and to have seriously ill patients who die as a result of their disease while such restraints are being used or within 24 hours after their discontinuance.

On the other hand, a rehabilitation hospital would be expected to use such restraints less frequently, and to have patients who die less frequently while hospitalized.

The log or tracking system must be available in written, i.e., hard copy, or electronic form immediately upon CMS’s request.

CMS will specify the form in which the information is to be provided.

Generally CMS would request access to the log or tracking system during an on-site survey by CMS staff or State surveyors acting on CMS’s behalf when assessing compliance with restraint/seclusion requirements.

However, CMS may also request that a copy of portions or the entire log or tracking system be provided, even though no survey is in progress. Accreditation organizations conducting hospital inspections in accordance with a CMS-approved Medicare hospital accreditation program are also entitled to immediate...
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<tr>
<td>access to the log or tracking system.</td>
<td>The hospital is not required to make the contents of the log or tracking system available to any other outside parties, unless required to do so under other Federal or State law. The hospital must document in the patient's medical record the date and time the death report entry was made into the log or tracking system. Refer to CMS Form 353 “HOSPITAL RESTRAINT/SECLUSION DEATH REPORT WORKSHEET”</td>
</tr>
</tbody>
</table>
15.03.00  **Condition of Participation:**
**Discharge Planning.**
The hospital must have an effective discharge planning process that applies to all patients. The hospital’s policies and procedures must be specified in writing.

§482.43

Hospital discharge planning is a process that involves determining the appropriate post-hospital discharge destination for a patient; identifying what the patient requires for a smooth and safe transition from the hospital to his/her discharge destination; and beginning the process of meeting the patient’s identified post-discharge needs. Newer terminology, such as “transition planning” or “community care transitions” is preferred by some, since it moves away from a focus primarily on a patient’s hospital stay to consideration of transitions among the multiple types of patient care settings that may be involved at various points in the treatment of a given patient. This approach recognizes the shared responsibility of health care professionals and facilities as well as patients and their support persons throughout the continuum of care, and the need to foster better communication among the various groups.

Much of the interpretive guidance for this CoP has been informed by newer research on care transitions, understood broadly. At the same time,
the term “discharge planning” is used both in Section 1861(ee) of the Social Security Act as well as in §482.43. In this guidance, therefore, we continue to use the term “discharge planning.”

When the discharge planning process is well executed, and absent unavoidable complications or unrelated illness or injury, the patient continues to progress towards the goals of his/her plan of care after discharge. However, it is not uncommon in the current health care environment for patients to be discharged from inpatient hospital settings only to be readmitted within a short timeframe for a related condition. Some readmissions may not be avoidable. Some may be avoidable, but are due to factors beyond the control of the hospital that discharged the patient. On the other hand, a poor discharge planning process may slow or complicate the patient’s recovery, may lead to readmission to a hospital, or may even result in the patient’s death.

Jencks\textsuperscript{1} et al. analyzed Medicare claims data for a two-year period in an attempt to more accurately identify readmission (called “rehospitalization”) rates and associated costs. They found approximately 19.6% of Medicare fee-for-service beneficiaries were rehospitalized within 30 days of discharge and 34.0% within 60 days of discharge. 70.5% of those surgical patients subsequently readmitted within 30 days had a medical cause for the readmission. Only approximately 10% of rehospitalizations were estimated to have been planned.

Reducing the number of preventable hospital readmissions is a major priority for patient safety,
and holding hospitals accountable for complying with the discharge planning CoP is one key element of an overall strategy for reducing readmissions.

With respect to the causes of the high rate of preventable readmissions, “Multiple factors contribute to the high level of hospital readmissions in the U.S.... They may result from poor quality care or from poor transitions between different providers and care settings. Such readmissions may occur if patients are discharged from hospitals or other health care settings prematurely; if they are discharged to inappropriate settings; or if they do not receive adequate information or resources to ensure a continued progression of services. System factors, such as poorly coordinated care and incomplete communication and information exchange between inpatient and community-based providers, may also lead to unplanned readmissions.”

The discharge planning CoP requirements address all of these factors. While hospitals are not solely responsible for the success of their patients’ post-hospital care transitions, under the discharge planning CoP hospitals are expected to employ a discharge planning process that improves the quality of care for patients and reduces the chances of readmission.

The plain language of the regulation requires hospitals to have a discharge planning process in effect for “all” patients. However, the preamble to the adoption of this regulation on December 13, 1994 makes it clear that this “all patients” language was meant to distinguish the final rule from the
proposed rule, which would have applied only to hospital inpatients who were Medicare beneficiaries. It was not intended to apply the discharge planning process to outpatients as well as inpatients. Specifically, the preamble stated, “Discharge planning presupposes hospital admission and section 9305(c) of OBRA ‘86 specifically indicates that discharge planning follows hospitalization.” (59 FR at 64141, December 13, 1994).

Accordingly, under the regulation,

- hospitals are required to have a discharge planning process that applies to all inpatients;
- discharge planning is not required for outpatients.

The discharge planning CoP (and Section 1861(ee) of the Act on which the CoP is based) provides for a four-stage discharge planning process:

1. Screening all inpatients to determine which ones are at risk of adverse health consequences post-discharge if they lack discharge planning;
2. Evaluation of the post-discharge needs of inpatients identified in the first stage, or of inpatients who request an evaluation, or whose physician requests one;
3. Development of a discharge plan if indicated by the evaluation or at the request of the patient’s physician; and
4. Initiation of the implementation of the discharge plan prior to the discharge of an inpatient.

The hospital is required to specify in writing its discharge planning policies and procedures. The policies and procedures must address all of the requirements of 42 CFR 482.43(a) – 482.43(e). The hospital must take steps to assure that its discharge planning policies and procedures are implemented consistently.

The discharge planning CoP specifically addresses the role of the patient, or the patient’s representative, by requiring the hospital to develop a discharge planning evaluation at the patient’s request, and to discuss the evaluation and plan with the patient. This is consistent with the regulations at 42 CFR 482.13(b)(1) & (2), that provide the patient has the right to participate in the development and implementation of his/her plan of care, and to make informed decisions regarding his/her care.

Accordingly, hospitals must actively involve patients or their representatives throughout the discharge planning process.

Further, the specific discharge planning evaluation requirement to assess a patient’s capability for post-discharge self-care requires the hospital, as needed, to actively solicit information not only from the patient or the patient’s representative, but also from family/friends/support persons.


2. Modifications to the Maryland Hospital Preventable Readmissions (MHPR) Draft Recommendations, Staff Report, Maryland Health Services Cost Review Commission, December 1, 2010, accessed via the agenda for the December 8, 2010 Commission meeting.

Note: While not a requirement, due to the increasing complexity of services offered in the outpatient setting, hospitals may wish to consider an abbreviated post-hospital planning process for certain categories of outpatients, such as patients discharge from observation services, same day surgery, and certain emergency department discharges.

15.03.01 Discharge Planning – Identification of Patients in Need.

The hospital must identify at an early stage of hospitalization all patients who are likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning.

§482.43(a)

If a hospital does not voluntarily adopt a policy of developing a discharge plan for every inpatient, then the hospital must evaluate all inpatients to identify those patients for whom the lack of an adequate discharge plan is likely to result in an adverse impact on the patient’s health.

While there is no one nationally accepted tool or criteria for identifying those patients who require discharge planning, the following factors have been identified as important:

- the patient’s functional status and cognitive ability;
- the type of post-hospital care the patient

**DOCUMENT REVIEW AND CHART REVIEW**

1. Determine whether hospital policy addresses:
   - Hospital must identify at an early stage of hospitalization all patients who are likely to suffer adverse health consequences upon discharge or readmission if there is inadequate discharge planning.

2. In every inpatient unit surveyed is there evidence of timely screening to determine if a discharge planning evaluation is needed? (Not applicable in hospitals that require a discharge planning evaluation for
requires, and whether such care requires the services of health care professionals or facilities;

- the availability of the required post-hospital health care services to the patient; and
- the availability and capability of family and/or friends to provide follow-up care in the home.

For hospitals that do not develop a discharge plan for every inpatient, the hospital’s discharge planning policies and procedures must document the criteria and screening process it uses to identify patients likely to need discharge planning, including the evidence or basis for the criteria and process. They must also identify which staff are responsible for carrying out the evaluation to identify patients likely to need discharge planning.

The regulation requires that the identification of patients must be made at an early stage of the patient’s hospitalization. This is necessary in order to allow sufficient time to complete discharge planning evaluations and develop appropriate discharge plans, for those patients who need them. (See §482.43((b)(5))) Ideally the identification process will be completed when the patient is admitted as an inpatient, or shortly thereafter. However, no citations will be made if the identification of patients likely to need discharge planning is completed at least 48 hours in advance of the patient’s discharge and there is no evidence that the patient’s discharge was delayed due to the hospital’s failure to complete an appropriate discharge planning evaluation on a timely basis or that the patient was placed unnecessarily in a

3. Conduct discharge tracers for several open and closed inpatient records to determine:

(a) When was the screening done to identify inpatients needing a discharge planning evaluation?

- If the hospital conducts an evaluation for all inpatients, or if it documents in the medical record screening of an inpatient before or at time of admission, or at least 48 hours prior to discharge, it is in compliance.
- For patients whose stay was less than 48 hours is there any evidence of a screening to determine if discharge planning was needed?

(b) Can hospital staff demonstrate that the hospital’s criteria and screening process for a discharge planning evaluation are correctly applied?

4. For patients not initially identified as in need of a discharge plan, is there a process for updating this determination based on changes in the patient’s condition or circumstances?

(a) Does the discharge planning policy address changes in patient condition that would call for a discharge planning evaluation of patients not previously
setting other than where he/she was admitted from primarily due to a delay in discharge planning. For example, a delay in identification of a patient in need of discharge planning might result in discharging the patient to a nursing facility, because such placements can be arranged comparatively quickly, when the patient preferred to return home, and could have been supported in the home environment with arrangement of appropriate community services.

If the patient’s stay is for less than 48 hours, hospitals must nevertheless ensure that they are screened so that, if needed, the discharge planning process is completed before the patient’s discharge.

Changes in the patient’s condition may warrant development of a discharge plan for a patient not identified during the initial screening process. The hospital’s discharge planning policies and procedures must address how the staff responsible for discharge planning will be made aware of changes in a patient’s condition that require a discharge planning evaluation.

In the event that a patient is transferred to another hospital, any pertinent information concerning the identification of the patient’s post-hospital needs should be in the patient’s medical record that is transferred with the patient. The receiving hospital then becomes responsible for the discharge planning process for the patient.
### 15.03.02 Discharge Planning Evaluation

(1) The hospital must provide a discharge planning evaluation to the patients identified in paragraph (a) of this section, and to other patients upon the patient’s request, the request of a person acting on the patient’s behalf, or the request of the physician.

(3) The discharge planning evaluation must include an evaluation of the likelihood of a patient needing post-hospital services and of the availability of the services.

(4) The discharge planning evaluation must include an evaluation of the likelihood of a patient’s capacity for self-care or of the possibility of the patient being cared for in the environment from which he or she entered the hospital.

For every inpatient identified under the process required at §482.43(a) as at potential risk of adverse health consequences without a discharge plan, a discharge planning evaluation must be completed by the hospital.

In addition, an evaluation must also be completed if the patient, or the patient’s representative, or the patient’s attending physician requests one.

Unless the hospital has adopted a voluntary policy of developing an evaluation for every inpatient, the hospital must also have a process for making patients, including the patient’s representative, and attending physicians aware that they may request a discharge planning evaluation, and that the hospital will perform an evaluation upon request.

Hospitals must perform the evaluation upon request, regardless of whether the patient meets the hospital’s screening criteria for an evaluation.

In contrast to the screening process, the evaluation entails a more detailed review of the individual patient’s post-discharge needs, in order to identify the specific areas that must be addressed in the discharge plan.

§482.43(b)(3) requires the evaluation to consider the patient’s likelihood of needing post-hospital services and the availability of such services.

If neither the patient nor the patient’s family or informal caregiver(s) are able to address all of the required care needs, then the evaluation must determine whether there are community-based

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<td>1. Determine whether hospital policy addresses:</td>
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<tr>
<td>- Processes to provide discharge planning evaluation to patients identified by admission screening, upon patient/family request, and upon request of the physician.</td>
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<tr>
<td>2. In every unit with inpatient beds surveyed, is there evidence of discharge planning evaluation activities?</td>
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<tr>
<td>3. Are staff members who are responsible for discharge planning evaluation correctly following the hospital’s policies and procedures?</td>
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<tr>
<td>4. If the hospital does not require a discharge planning evaluation for all inpatients:</td>
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<tr>
<td>- Does the hospital have a standard process for notifying patients, their representative, and physicians that they may request a discharge planning evaluation and that the hospital will conduct an evaluation upon request?</td>
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<tr>
<td>- Can discharge planning and unit nursing staff describe the process for a patient or the patient’s representative to request a discharge planning evaluation?</td>
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<td>- Interview patients and their representatives. If they say they were not aware they could request a</td>
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Compliant  
Not Compliant  
This standard is not met as evidenced by:
services that are available to meet the patient’s needs while allowing the patient to continue living at home.

Such health care services include, but are not limited to:

- Home health, attendant care, and other community-based services;
- Hospice or palliative care;
- Respiratory therapy;
- Rehabilitation services (PT, OT, Speech, etc.);
- End Stage Renal Dialysis services;
- Pharmaceuticals and related supplies;
- Nutritional consultation/supplemental diets; and/or
- Medical equipment and related supplies.

However, services may also include those that are not traditional health care services, but which may be essential to a patient’s ongoing ability to live in the community, including, but not limited to:

- Home and physical environment modifications;
- Transportation services;
- Meal services; and/or
- Household services, such as housekeeping,

discharge planning evaluation, can the hospital provide evidence they received notice of their right?

- Interview attending physicians to see if they are aware they can request a discharge planning evaluation. If they are not aware, can the hospital provide evidence of how they inform the medical staff about this?

5. Review a sample of cases to determine if the discharge planning evaluation documents the patient’s (or the patient’s representatives) goals and preferences for post-discharge placement and care.

6. Review a sample of cases to determine if the discharge planning evaluation includes an assessment of:

- The patient’s post-discharge care needs being met in the environment from which he/she entered the hospital? What the patient’s care needs will be immediately upon discharge, and whether those needs are expected to remain constant or lessen over time?
- The patient’s insurance coverage (if applicable) and how that coverage might or might not provide for necessary services post-hospitalization?
- For patients admitted from home --
Some of the information related to needed services will emerge from the required evaluation of the patient’s ability to receive care in the home, either as self-care or provided by someone else. All patients, even those with a high capability for self-care, are likely to require some follow-up ambulatory health care services, e.g., a post-discharge appointment with their surgeon, specialist or primary care physician, or a series of appointments for physical or occupational therapy. Some patients might have more complex care needs which nevertheless may still be met in the home setting, depending on the specific clinical needs and the services available in the patient’s community.

For example, some patients require wound care that exceeds the capabilities of their family or others who act as informal caregivers. But they may be able to receive sufficient care in the home setting through a home health service, if such services are available. Some patients with chronic conditions may prefer to remain in their home and would be able to do so using available community-based services, but also require financial supports, such as Medicaid-financed home and community-based waiver services. If such supports are not immediately available at the time of discharge while an application for waiver services is pending, the evaluation should consider the availability of other short term supports that would allow the patient to be discharged home.

If the result of the evaluation is that the patient cannot receive required care if he/she returns to the hospital:

- Whether the patient can perform activities of daily living (personal hygiene and grooming, dressing and undressing, feeding, voluntary control over bowel and bladder, ambulation, etc.)?
- The patient’s or family/other support person’s ability to provide self-care?
- Whether the patient will require specialized medical equipment or home modification?
  - If yes, did the evaluation include an assessment of whether the equipment is available or if the modifications can be made to safely discharge the patient to that setting?
- If the patient or family/support person is unable to meet care needs or there are additional care needs above their capabilities, did the evaluation include an assessment of available community-based services to meet post-hospital needs?
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<td>home, then an assessment must be made of options for transfer to another inpatient or residential health care facility that can address the patient’s needs, including other types of hospitals, such as rehabilitation hospitals; skilled nursing facilities; assisted living facilities; nursing homes; or inpatient hospice facilities. If prior to the hospital admission the patient was a resident in a facility that he or she wishes to return to, such as an assisted living or nursing facility or skilled nursing facility, the evaluation must address whether that facility has the capability to provide the post-hospital care required by the patient. The post-discharge care requirements may be different than the care that was previously provided. This requires dialogue and cooperation between hospitals and post-hospital care facilities in the area served by the hospital, as well as with the physicians who provide care to patients in either or both of these settings. Long term care facilities often express concern that hospitals discharge patients to their facilities with care needs that exceed their care capabilities, necessitating sending the patient to the emergency department for care and possible readmission. On the other hand, hospitals often express concern that long term care facilities send patients to the emergency department with ambulatory care-sensitive conditions, i.e., conditions that either do not require an acute level of care, or which could have been prevented from escalating to an acute level had appropriate primary care been provided in a timely manner. 6. For patients admitted from a nursing facility, skilled nursing facility or assisted living facility did the evaluation assess whether the prior facility has the capability to provide necessary post-hospital services to the patient (i.e. is the same, higher, or lower level of care required and can those needs be met?) • If yes, is there any documentation that the patient’s care needs fall within the capabilities of the facility? 7. Are the results of the discharge planning evaluation documented in the medical record?</td>
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While hospitals cannot address these concerns in isolation, they are expected to be knowledgeable about the care capabilities of area long term care facilities and to factor this knowledge into the discharge planning evaluation.

Hospitals are expected to have knowledge of the capabilities and capacities of not only of long term care facilities, but also of the various types of service providers in the area where most of the patients it serves receive post-hospital care, in order to develop a discharge plan that not only meets the patient’s needs in theory, but also can be implemented.

- This includes knowledge of community services, as well as familiarity with available Medicaid home and community-based services (HCBS), since the State’s Medicaid program plays a major role in supporting post-hospital care for many patients.

If the hospital is one with specialized services that attract a significant number of patients who will receive their post-hospital care in distant communities, the hospital is expected to take reasonable steps to identify the services that will be available to the patient.

Once the determination has been made that services will be necessary post-discharge, the team must then determine availability of those services or identify comparable substitutions. Included in the evaluation is coordination with insurers and other payors, including the State Medicaid agency, as
necessary to ensure resources prescribed are approved and available.

For Information—Not Required/Not to be Cited

Although not required under the regulations, hospitals would be well advised to develop collaborative partnerships with post-hospital care providers to improve care transitions of care that might support better patient outcomes. This includes not only skilled nursing facilities and nursing facilities, but also providers of community-based services. For example, Centers for Independent Living (CIL) and Aging and Disability Resource Centers (ADRC) are resources for community-based services and housing available to persons with disabilities and older adults. Hospitals can find local CIL’s at http://www.ilru.org/html/publications/directory/index.html and ADRC’s and other resources at http://www.adrc-tae.org/tiki-index.php?page=HomePage.

- The ability to pay out of pocket for services must also be discussed with the family or other support persons.
- Although hospitals are not expected to have definitive knowledge of the terms of any given patient’s insurance coverage or eligibility for community-based services, or
for Medicaid coverage, they are expected to have a general awareness of these matters and their impact on the patient’s post-discharge needs and prospects for recovery. For example, if the patient is a Medicare beneficiary, the hospital is expected to be aware of Medicare coverage requirements for home health care or admission to a rehabilitation hospital, a skilled nursing facility, or a long term care hospital, etc. and to make the beneficiary aware that they may have to pay out of pocket for services not meeting the coverage requirements.

- Similarly, for Medicaid, they should know coverage options for home health, attendant care, and long term care services or have contacts at the State Medicaid agency that can assist with these issues. As noted above, hospitals are also expected to have knowledge of community resources to assist in arranging services. Some examples include Aging and Disability Resource Centers and Centers for Independent Living (see box above).

The hospital CoP governing patients’ rights at §482.13(b) provides that “The patient has the right to participate in the development and implementation of his or her plan of care.” (CMS views discharge planning as part of the patient’s plan of care). “The patient or his/her representative (as allowed under State law) has the right to make informed decisions regarding his/her care” and “The
patient’s rights include...being involved in care planning and treatment.”

- Accordingly, hospitals are expected to engage the patient, or the patient’s representative, actively in the development of the discharge evaluation, not only as a source of information required for the assessment of self-care capabilities, but also to incorporate the patient’s goals and preferences as much as possible into the evaluation.

- A patient’s goals and preferences may be, in the hospital’s view, unrealistic. Identifying divergent hospital and patient assessments of what is realistic enables a discussion of these differences and may result in an assessment and subsequent development of a discharge plan that has a better chance of successful implementation.

§482.43(b)(4) requires that the evaluation include assessment of the patient’s capacity for self-care or, alternatively, to be cared for by others in the environment, i.e., the setting, from which the patient was admitted to the hospital. In general, the goal upon discharge is for a patient to be able to return to the setting in which they were living prior to admission. This may be the patient’s home in the community or residence in a nursing home. In the case of transfer from another hospital, generally the preferred goal is to return the patient to the setting.
The patient’s discharge planning evaluation must be developed by a registered nurse, social worker, or other appropriately qualified personnel, or by a person who is supervised by such personnel. State law governs the qualifications required to be met.

**15.03.03 Discharge Planning – Staff Qualifications.**

*A registered nurse, social worker, or other appropriately qualified personnel must develop or supervise the discharge planning evaluation.*

**DOCUMENT REVIEW AND INTERVIEW**

1. Review a sample of cases to determine if the discharge planning evaluation was developed by an RN, Social Worker, or other qualified personnel, as defined in the state law.

- [ ] Compliant
- [x] Not Compliant

**This standard is not met as evidenced by:**
considered a registered nurse or a social worker. The hospital’s written discharge planning policies and procedures must specify the qualifications for personnel other than registered nurses or social workers who develop or supervise the development of the evaluation.

The qualifications must include such factors as previous experience in discharge planning, knowledge of clinical and social factors that affect the patient’s functional status at discharge, knowledge of community resources to meet post-discharge clinical and social needs, and assessment skills.

All personnel performing or supervising discharge planning evaluations, including registered nurses and social workers, must have knowledge of clinical, social, insurance/financial and physical factors that must be considered when evaluating how a patient’s expected post-discharge care needs can be met.

It is acceptable for a hospital to include new staff who may not have had previous discharge planning experience, but who are being trained to perform discharge planning duties and whose work is reviewed by qualified personnel.

hospital discharge planning policies and procedures, or someone they supervise? In order to assess this:
• Review the hospital’s written policy and procedure governing who is responsible for developing or supervising the development of the discharge planning evaluation.
• Does the policy permit someone other than a RN or social worker to be responsible for developing or supervising such evaluations?
  o If yes, does the policy specify the qualifications of the personnel other than a RN or social worker to perform this function?

2. Determine which individual(s) is (are) responsible for developing or supervising discharge planning evaluations.
• Review their personnel folders to determine if they are a RN, social worker, or meet the hospital’s criteria for developing/supervising the discharge planning evaluation.
• If they are not, are they supervised by an individual who is an RN, social worker or is qualified according to the hospital’s policies?
• Are their discharge planning

2014 updated August 2014
### 15.03.04 **Not Applicable.**

### 15.03.05 **Not Applicable.**

### 15.03.06 **Timeliness of Assessment.**

The hospital personnel must complete the evaluation on a timely basis so that appropriate arrangements for post-hospital care are made before discharge, and to avoid unnecessary delays in discharge.

§482.43(b)(5)

After a patient has been identified as needing an evaluation, or after a request for an evaluation has been made by the physician, patient and/or patient’s representative, the evaluation must be completed timely.

This means there must be sufficient time after completion to allow arrangements for post-hospital care to be made, without having to delay the patient’s discharge in order to do so, or requiring the patient to transfer to a different setting from where he/she was admitted from primarily due to the delay in making appropriate arrangements.

- The comparatively short average length of stay of a short term acute care hospital

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**DOCUMENT REVIEW AND CHART REVIEW**

Determine whether hospital policy addresses:

1. **Timely completion of the discharge planning evaluation so arrangements for post-hospital care can be made before discharge and to avoid unnecessary delays in discharge.**

2. **Review a sample of cases to determine if the discharge planning evaluation was completed on a timely basis to allow for appropriate arrangements to be made for post-hospital care and to avoid delays in discharge. In order to assess this:**

3. **Determine when the discharge planning evaluations reviewed by their supervisor before being finalized?**

- Ask personnel who supervise or develop discharge planning evaluations to give examples illustrating how they apply their knowledge of clinical, social, insurance/financial and physical factors when performing an evaluation.
### 15.03.07 Patient Involvement & Documentation Requirements.

**The hospital must:**

- Include the discharge planning evaluation in the patient’s medical record for use in establishing an appropriate discharge plan and

#### Chart Review

1. Review a sample of cases to determine if the discharge planning evaluation results are included in the medical record.

2. Review a sample of cases to determine if the discharge planning evaluation results were discussed with the patient or the evaluation was initiated. If the evaluation was not begun within 24 hours of the request or identification of the need for an evaluation, ask why.

4. Is there a pattern of delayed start or completion of the evaluation? If so, is the delay due to circumstances beyond the hospital’s control (e.g., inability to reach the beneficiary’s support person(s), continuing changes in the patient’s condition) and/or is the delay due to the hospital’s failure to develop timely discharge planning evaluations?
• Must discuss the results of the evaluation with the patient or individual acting on his/her behalf.

§482.43(b)(6)

participate in a multidisciplinary process to develop and implement the discharge plan. The evaluation and subsequent planning process may be a continuous one and hospitals may choose not to divide the process into distinct documents. The key requirement is that the evaluation results are included in the patient’s medical record and are used in the development of the features of the discharge plan.

The results of the discharge planning evaluation must be discussed with the patient or the patient’s representative.

• Documentation of this communication must be included in the medical record, including if the patient rejects the results of the evaluation.

• It is not necessary for the hospital to obtain a signature from the patient (or the patient’s representative, as applicable) documenting the discussion.

The patient or the patient’s representative must be actively engaged in the development of the plan, so that the discussion of the evaluation results represents a continuation of this active engagement. It would not be appropriate for a hospital to conduct an evaluation without the participation of the patient or the patient’s representative, and then present the results of the evaluation to the patient as a finished product, since this would place the patient in a passive position that is not consistent with the requirements of the patients’ rights CoP at §482.13(b).
15.03.08 Not Applicable.

15.03.09 Discharge Planning: Required Supervision.
A registered nurse, social worker, or other appropriately qualified personnel must develop, or supervise the development of, a discharge plan if the discharge planning evaluation indicates a need for a discharge plan.

§ 482.43(c)
§ 482.43(c)(1)

The discharge plan that is based on the findings of the discharge planning evaluation must be developed by a registered nurse, social worker, or other appropriate qualified personnel, or by a person who is supervised by such personnel. State law governs the qualifications required to be considered a registered nurse or a social worker.

The hospital’s written discharge planning policies and procedures must specify the qualifications for personnel other than registered nurses or social workers who develop or supervise the development of the plan.

The qualifications should include such factors as:

- previous experience in discharge planning,
- knowledge of clinical and social factors that affect the patient’s functional status at discharge,
- knowledge of community resources to meet post-discharge clinical and social needs, and
- assessment skills.

All personnel performing or supervising

CHART REVIEW, DOCUMENT REVIEW, AND INTERVIEW
Review a sample of cases to determine if the discharge plan was developed by an RN, Social Worker, or other qualified personnel, as defined in the hospital discharge planning policies and procedures, or someone they supervise? In order to assess this:

1. Review the hospital’s written policy and procedure governing who is responsible for developing or supervising the development of the discharge plan.
   - Does the policy permit someone other than a RN or social worker to be responsible for developing or supervising development of such plans?
     - If yes, does the policy specify the qualifications of the personnel other than a RN or social worker to perform this function?

2. Determine which individual(s) are
development of discharge plans, including registered nurses and social workers, must have knowledge of clinical, social, insurance/financial and physical factors that must be considered when evaluating how a patient’s expected post-discharge care needs can be met.

The hospital CoP governing patients’ rights at §482.13(b) provides that “The patient has the right to participate in the development and implementation of his or her plan of care.” (CMS views discharge planning as part of the patient’s plan of care). “The patient or his/her representative (as allowed under State law) has the right to make informed decisions regarding his/her care” and “The patient’s rights include...being involved in care planning and treatment.” Accordingly, hospitals are expected to engage the patient, or the patient’s representative, actively in the development of the discharge plan, not only to provide them the necessary education and training to provide self-care/care, but also to incorporate the patient’s goals and preferences as much as possible into the plan. A patient will be more likely to cooperate in the implementation of a discharge plan that reflects his/her preferences, increasing the likelihood of a successful care transition and better health outcomes.

A patient’s goals and preferences may be, in the hospital’s view, unrealistic. A hospital is not obligated to develop a discharge plan that cannot be implemented. However, the fact that a plan incorporating the patient’s goals and preferences might be more time-consuming for the hospital to responsible for developing or supervising the development of discharge plans.

- Review their personnel folders to determine if they are a RN, social worker, or meet the hospital’s criteria for developing/supervising the discharge plan.
  - If they are not, are they supervised by an individual who is an RN, social worker or qualified according to the hospital’s policies?
  - Are their discharge plans reviewed by their supervisor before being finalized?

3. Ask personnel who supervise or develop discharge plans to give examples illustrating their knowledge of healthcare and other resources available in the community that could be utilized to meet patients’ expected post-discharge care needs.

4. Ask the discharge planner how the patient or patient’s representative is engaged to participate in the development of the discharge plan. Does the discharge plan identify the patient’s or patient’s representative discharge preferences?

5. Does the discharge plan match the identified needs as determined by the discharge planning evaluation?
### 15.03.10 Discharge Plan — Physician Request

*In the absence of a finding by the hospital that a patient needs a discharge plan, the patient’s physician may request a discharge plan. In such case, the hospital must develop a discharge plan for the patient.*

§482.43(c)(2)

If a patient is not identified through the hospital’s discharge planning evaluation process as requiring a discharge plan, the patient’s physician may nevertheless request a discharge plan. The hospital must develop a discharge plan when requested to do so by the patient’s physician.

If the hospital’s policies and procedures call for a discharge plan for every hospital inpatient, then it is not necessary to include a separate provision in those policies requiring development of a plan upon physician request, since such a provision would be superfluous.

#### DOCUMENT REVIEW AND INTERVIEW

1. Review the hospital’s discharge planning policies and procedures to determine whether it requires the development of a discharge plan for all inpatients, or only for those identified as needing a plan through a risk-based identification and evaluation process.

2. If the hospital does not require a discharge planning evaluation for all inpatients:
   - Does the hospital have a standard process for notifying physicians that they may request a discharge plan evaluation and that the hospital will develop a plan upon request?
   - Interview attending physicians to see if they are aware they can request a discharge plan. If they are not aware they can request a discharge plan, can the hospital provide evidence of how they inform the medical staff about this?
15.03.11 Implementation of the Discharge Plan.
The hospital must arrange for the initial implementation of the patient’s discharge plan.

As needed, the patient and family members or interested persons must be counseled to prepare them for post-hospital care.

§482.43(c)(3)
§482.43(c)(5)

The hospital is required to arrange for the initial implementation of the discharge plan. This includes providing in-hospital education/training to the patient for self-care or to the patient’s family or other support person(s) who will be providing care in the patient’s home. It also includes arranging:

- Transfers to rehabilitation hospitals, long term care hospitals, or long term care facilities;
- Referrals to home health or hospice agencies;
- Referral for follow-up with physicians/practitioners, occupational or physical therapists, etc.;
- Referral to medical equipment suppliers; and
- Referrals to pertinent community resources that may be able to assist with financial, transportation, meal preparation, or other post-discharge needs.

(See §482.43(d) for more discussion about the hospital’s transfer or referral obligations and the initial implementation of the plan relating to transfer/referral.)

The discharge planning process is a collaborative one that must include the participation of the patient and the patient’s informal caregiver or representative, when applicable. In addition, other family or support persons who will be providing care

DOCUMENT REVIEW AND CHART REVIEW
Determine whether hospital policy addresses:

- The initial implementation of the patient’s discharge plan.

Review cases of discharged patients to determine if the hospital arranges initial implementation of the discharge plan by providing:

For patients discharged to home:

1. In-house training to patient and family/support persons, using recognized methods;
2. Written discharge instructions that are legible and use non-technical language;
3. A legible, complete, reconciled medication list that highlights changes from the post hospital regimen;
4. Referrals as applicable to specialized ambulatory services, e.g. physical therapy, occupational therapy, home health, hospice, mental health, etc.;
5. Referrals as applicable to community-based resources other than health services, e.g. Departments of Aging, elder services, transportation services, Centers for Independent Living, Aging and Disability Resource Centers, etc.;

Compliant
Not Compliant
This standard is not met as evidenced by:
to the patient after discharge need to be engaged in the process. Keeping the patient, and, when applicable, the patient’s representative and other support persons informed throughout the development of the plan is essential for its success. Providing them with information on post-discharge options, what to expect after discharge and, as applicable, instruction and training in how to provide care is essential.

The patient needs clear instructions regarding what to do when concerns, issues, or problems arise, including who to call and when they should seek emergency assistance. Although it may be an important component of the discharge instructions, it is not acceptable to only advise a patient to “return to the ED” whenever problems arise.

There are a variety of tools and techniques that have focused on improving the support provided to patients who are discharged back to their homes. A comprehensive approach employing combinations of these techniques has been found to improve patient outcomes and reduce hospital readmission rates, including, but not limited to:

- Improved education to patients and support persons regarding disease processes, medications, treatments, diet and nutrition, expected symptoms, and when and how to seek additional help. Teaching methods must be based on recognized methodologies. CMS does not prescribe any specific methodologies, but examples include the teach-back, repeat-back approach and simulation laboratories;

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<td>6.</td>
<td>Arranging essential durable medical equipment, e.g. oxygen, wheel chair, hospital bed, commode, etc.;</td>
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<td>7.</td>
<td>Sending necessary medical information to providers that the patient was referred to prior to the first post-discharge appointment or within 7 days of discharge, whichever comes first.; and</td>
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<td>1.</td>
<td>Were there portions of the plan the hospital failed to begin implementing, resulting in delays in discharge?</td>
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PATIENT RIGHTS & RESTRAINTS

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- Written discharge instructions, in the form of checklists when possible, that are legible, in plain language, culturally sensitive and age appropriate;

- Providing supplies, such as materials for changing dressings on wounds, needed immediately post-discharge; and

- A list of all medications the patient should be taking after discharge, with clear indication of changes from the patient’s pre-admission medications;

The education and training provided to the patient or the patient’s caregiver(s) by the hospital must be tailored to the patient’s identified needs related to medications, treatment modalities, physical and occupational therapies, psychosocial needs, appointments, and other follow-up activities, etc. Repeated review of instructions with return demonstrations and/or repeat-backs by the patient, and their support persons will improve their ability to deliver care properly. This includes providing instructions in writing as well as verbally reinforcing the education and training.

It is also necessary to provide information to patients and their support persons when the patient is being transferred to a rehabilitation or a long term care hospital, or to a long term care setting, such as a skilled nursing facility or nursing facility. The information should address questions such as: the goal of treatment in the next setting and prospects for the patient’s eventual discharge home.
The hospital must document in the patient’s medical record the arrangements made for initial implementation of the discharge plan, including training and materials provided to the patient or patient’s informal caregiver or representative, as applicable.

**For Information – Not Required/Not to be Cited**

Additional actions hospitals might consider taking to improve the patient’s post-discharge care transition:

- Scheduling follow-up appointments with the patient’s primary care physician/practitioner and in-home providers of service as applicable;
- Filling prescriptions prior to discharge;
- If applicable, arranging remote monitoring technologies, e.g., pulse oximetry and daily weights for congestive heart failure (CHF) patients; pulse and blood pressure monitoring for cardiac patients; and blood glucose levels for diabetic patients; and
- Follow-up phone calls within 24 -72 hours by the hospital to the patient after discharge.

The communication with the patient to ensure implementation of the discharge plan does not stop at discharge. An initiative showing significant success in reducing preventable readmissions involves the hospital contacting the patient by phone in the first 24 to 72 hours after discharge. The phone contact provides an opportunity for the patient to pose questions and for the hospital
### 15.03.12 Plan Reassessment.

The hospital must reassess the patient’s discharge plan if there are factors that may affect continuing care needs or the appropriateness of the discharge plan.

§482.43(c)(4)

Changes in a patient’s condition may warrant adjustments to the discharge plan.

Hospitals must have in place either a routine reassessment of all plans or a process for triggering a reassessment of the patient’s post-discharge needs, capabilities and discharge plan when significant changes in the patient’s condition or available supports occur.

#### DOCUMENT REVIEW, CHART REVIEW, AND INTERVIEW

1. Determine whether hospital policy addresses the reassessment of the discharge plan as indicated for changes in the patient’s condition.
2. Review a sample of cases to determine if any significant changes in the patient’s condition were noted in the medical record that changed post-discharge needs, and if
### PATIENT RIGHTS & RESTRAINTS

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#### 15.03.14 Selection of Discharge Care Providers.

The hospital must include in the discharge plan a list of home health agencies (HHA) or skilled nursing facilities (SNF) that are available to the patient, that are participating in the Medicare program, and that serve the geographic area (as defined by the HHA) in which the patient resides, or in the case of the SNF, in the geographic area requested by the patient. HHAs must request to be listed by the hospital as available.

(i) This list must only be presented to patients for whom home health care is indicated.

The hospital must include a list of Medicare-participating home health agencies (HHAs) and skilled nursing facilities (SNFs) in the discharge plan for those patients for whom the plan indicates home health or post-hospital extended care services are required.

- "Extended care services" are defined at sections 1861(h) and (i) of the Social Security Act as items or services furnished in a skilled nursing facility (SNF). SNFs included on the list must be located in a geographic area that the patient or patient’s representative indicated he/she prefers.

- For Home Health Agencies (HHAs) the list must consist of Medicare-participating HHAs that

### CHART REVIEW AND DOCUMENT REVIEW

1. Review a sample of cases of patients discharged to HHAs or SNFs to determine if, when applicable, the hospital provided the patient with lists of Medicare-participating HHAs or SNFs. In making this determination:

- Is there documentation of a list of multiple HHAs or SNFs being provided (including electronically) to the patient?

- If not, is there documentation for an acceptable rationale for providing only one option, e.g., the patient’s home is included in the service area?
or post hospital extended care services are indicated and appropriate as determined by the discharge planning evaluation.

(ii) For patients enrolled in managed care organizations, the hospital must indicate the availability of home health and post hospital extended care services through individuals and entities that have a contract with the managed care organizations.

(iii) The hospital must document in the patient’s medical record that the list was presented to the patient or to the individual acting on the patient’s behalf.

§482.43(c)(6)
§482.43(c)(6)(i)
§482.43(c)(6)(ii)
§482.43(c)(6)(iii)

The hospital, as part of the discharge planning process, must inform the patient or the patient’s family of their freedom to choose among participating Medicare providers of post-hospital care services and must, when possible, respect patient and family preferences when they are expressed. The hospital must not specify or otherwise limit the qualified providers that are available to the patient.

have requested the hospital to be listed and which serve the geographic area where the patient lives. Hospitals may expect the HHA to define its geographic service area when it submits its request to be listed.

During the discharge planning process the hospital must inform the patient of his/her freedom to choose among Medicare-participating post-hospital providers and must not direct the patient to specific provider(s) or otherwise limit which qualified providers the patient may choose among.

Hospitals have the flexibility either to develop their own lists or to print a list of skilled nursing facilities and home health agencies in the applicable geographic areas from the CMS websites, Nursing Home Compare (www.medicare.gov/NHcompare) and Home Health Compare (www.medicare.gov/homehealthcompare).

- If hospitals develop their own lists, they are expected to update them at least annually. (69 FR 49226, August 11, 2004).

For Information – Not Required/Not to be Cited

Hospitals may also refer patients and their families to the Nursing Home Compare and Home Health Compare websites for additional information regarding Medicare-certified skilled nursing facilities and home health agencies, as well as Medicaid-participating nursing facilities.

The data on the Nursing Home Compare website include an overall performance rating, nursing of only one Medicare-participating HHA that requested to be included on hospital lists, or there is only one Medicare-participating SNF in the area preferred by the patient?

2. Ask to see examples of lists of HHAs and SNFs provided to patients prior to discharge.

3. Ask the hospital if it has any disclosable financial interests in any HHA or SNF on its lists, or if an HHA or SNF has a disclosable financial interest in the hospital.

- If yes, is this stated clearly on the lists?

4. Interview staff members involved with the discharge planning process.

- Ask them to describe how patient preferences are taken into account in the selection of post-hospital HHA or SNF services.

5. Ask the hospital to identify current patients for whom HHA or SNF services are planned. Interview the patient or the patient’s family to ask them:

- Were they presented with a list of HHAs or SNFs, as applicable, to choose from?

- Did the hospital emphasize their freedom of choice?

- Did the hospital arrange for their
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<td>§482.43(c)(7)</td>
<td>The discharge plan must identify any HHA or SNF to which the patient is referred in which the hospital has a disclosable financial interest, as specified by the Secretary, and any HHA or SNF that has a disclosable financial interest in a hospital under Medicare. Financial interests that are disclosable under Medicare are determined in accordance with the provisions of Part 420, Subpart C, of this chapter.</td>
<td>referral/transfer to an HHA or SNF reflecting their preferences? If not, did the hospital explain why their choice was not feasible?</td>
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<td>§482.43(c)(8)</td>
<td>Home Health Compare provides details about every Medicare-certified home health agency in the country. Included on the website are quality indicators such as managing daily activities, managing pain and treating symptoms, treating wounds and preventing pressure sores, preventing harm, and preventing unplanned hospital care. The hospital might also refer the patient and their representatives to individual State agency websites, Long-Term Care Ombudsmen Program, Protection and Advocacy Organizations, Citizen Advocacy Groups, Area Agencies on Aging, Centers for Independent Living, and Aging and Disability Resource Centers for additional information on long term care facilities and other types of providers of post-hospital care. Having access to the information found at these sources may assist in the decision making process regarding post-hospital care options.</td>
<td>If applicable, were they made aware of disclosable financial interest?</td>
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If the patient is enrolled in a managed care insurance program that utilizes a network of exclusive or preferred providers, the hospital must make reasonable attempts, based on information from the insurer, to limit the list to HHAs and SNFs that participate in the insurer’s network of providers.
If the hospital has a disclosable financial interest in a HHA or SNF on a patient’s list, or an HHA or SNF on the list has a disclosable financial interest in the hospital, these facts must also be stated on the list provided to the patient. Surveyors are not expected to know the requirements for a disclosable financial interest under Part 420, Subpart C, but hospitals are expected to know and comply with these requirements, and to identify for the surveyor whether there are such disclosable financial interests between the hospital and any specific HHAs or SNFs to which they refer/transfer patients.

When the patient or the patient’s family has expressed a preference, the hospital must attempt to arrange post-hospital care with an HHA or SNF, as applicable, which meets these preferences. If the hospital is unable to make the preferred arrangement, e.g., if there is no bed available in the preferred SNF, it must document the reason the patient’s preference could not be fulfilled and must explain that reason to the patient.

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### PATIENT RIGHTS & RESTRANTS

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| 15.03.23          | **Transfer or Referral.**  
The hospital must transfer or refer patients, along with necessary medical information, to appropriate facilities, agencies, or outpatient services, as needed, for follow-up or ancillary care. §482.43(d)  
**“Appropriate facilities, agencies, or outpatient services”** refers to entities such as:  
- skilled nursing facilities,  
- nursing facilities,  
- home health agencies,  
- hospice agencies,  
- mental health agencies,  
- dialysis centers,  
- suppliers of durable medical equipment,  
- suppliers of physical and occupational therapy, physician offices, etc. which offer post-acute care services that address the patient’s post-hospital needs identified in the patient’s discharge planning evaluation.  
| **CHART REVIEW**  
1. Determine whether hospital policy addresses:  
   - The hospital will transfer or refer patients along with necessary medical information to appropriate facilities, agencies, or outpatient services, as needed.  
2. Review a sample of records for discharged patients who had a discharge plan to determine if:  
a. For patients discharged home:  
   - Necessary medical information was sent to a practitioner with which the patient has an established relationship prior to the first post-discharge appointment or within 7 days of discharge, whichever comes first;  
   - For patients without an established relationship with a practitioner,  
| Compliant  
| Not Compliant  
This standard is not met as evidenced by: |
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| The term does not refer to non-healthcare entities, but hospitals also are encouraged to make appropriate referrals to community-based resources that offer transportation, meal preparation, and other services that can play an essential role in the patient’s successful recovery. “Appropriate facilities” may also include other hospitals to which a patient is transferred for follow-up care, such as:  
  • rehabilitation hospitals,  
  • long term care hospitals, or  
  • even other short-term acute care hospitals. Necessary medical information must be provided not only for patients being transferred, but also for those being discharged home, to make the patient’s physician aware of the outcome of hospital treatment or follow-up care needs. This is particularly important since the increasing use of hospitalists in the inpatient hospital setting means the patient’s physician may have had no interaction with the patient throughout the hospital stay. When the hospital provides the patient’s physician with necessary medical information promptly, among other things, this provides an opportunity for the patient’s physician to discuss with the hospital care team changes to the patient’s preadmission medication regimen or other elements of the post-discharge care plan about which the physician may have questions. Facilitating opportunities for such communication and dialogue enhances the information was provided on potential primary care providers, such as health clinics, if available.  
  b. For patients transferred to another inpatient facility, was necessary medical information ready at time of transfer and sent to the receiving facility with the patient?  
  c. When applicable, there is documentation in the medical record of providing the results of tests, pending at time of discharge, to the patient and/or post-hospital provider of care? |
The “medical information” that is necessary for the transfer or referral includes, but is not limited to:

1. Brief reason for hospitalization (or, if hospital policy requires a discharge summary for certain types of outpatient services, the reason for the encounter) and principal diagnosis;
2. Brief description of hospital course of treatment;
3. Patient’s condition at discharge, including cognitive and functional status and social supports needed;
4. Medication list (reconciled to identify changes made during the patient’s hospitalization) including prescription and over-the-counter medications and herbal. (Note, an actual list of medications needs to be included in the discharge information, not just a referral to an electronic list available somewhere else in the medical record.);
5. List of allergies (including food as well as drug allergies) and drug interactions;
6. Pending laboratory work and test results, if applicable, including information on how the results will be furnished;
7. For transfer to other facilities,
   - a copy of the patient’s advance
**STANDARD / ELEMENT** | **EXPLANATION** | **SCORING PROCEDURE** | **SCORE**
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   **directive, if the patient has one.**

8. For patients discharged home:
   - Brief description of care instructions reflecting training provided to patient and/or family or other informal caregiver(s);
   - If applicable, list of all follow-up appointments with practitioners with which the patient has an established relationship and which were scheduled prior to discharge, including who the appointment is with, date and time.
   - If applicable, referrals to potential primary care providers, such as health clinics, if available, for patients with no established relationship with a practitioner.

The regulation requires transfer or referral “along” with necessary medical information.

   - In the case of a patient being transferred to another inpatient or residential health care facility, the necessary information must accompany the patient to the facility.

However, in the case of a patient discharged home who is being referred for follow-up ambulatory care, the transmittal of the information to the patient’s physician may take place up to 7 days after discharge or prior to the first appointment for ambulatory care services that may have been scheduled, whichever comes first.
• If the patient’s physician is not yet able to accept the information electronically from the hospital, the hospital may provide the information to the patient with instructions to give this information to the physician at their next appointment.

For Information – Not Required/Not to be Cited

Scheduling of follow-up appointments for ambulatory care services by the hospital prior to discharge has been found to be an effective tool to ensure prompt follow-up and reduce the likelihood of a preventable readmission. This follow-up visit shortly after discharge provides an opportunity for the patient to address any issues or concerns experienced after the inpatient stay. It also provides an opportunity for the primary care physician or practitioner to review and reinforce the post-hospital plan of care with the patient, for rehabilitation therapy to begin in a timely manner, to clarify any concerns related to medication reconciliation or other adjustments to the patient’s pre-hospital regimen, etc.

It is recognized that hospitals have certain constraints on their ability to accomplish patient transfers and referrals:

• They must operate within the constraints of their authority under State law;
15.03.24 Discharge Plan Reassessment.

The hospital must reassess the discharge planning process on an ongoing basis. The reassessment must include a review of discharge plans to ensure that they are responsive to the patient’s discharge needs.

§482.43(e)

The hospital must reassess the effectiveness of its discharge planning process on an ongoing basis. Since the QAPI CoP at §482.21 requires the QAPI program to be hospital-wide, the discharge planning reassessment process is considered an integral component of the overall hospital QAPI program.

The hospital must have a mechanism in place for ongoing reassessment of its discharge planning process.

- The reassessment process must include a review of discharge plans in closed medical

**DOCUMENT REVIEW AND INTERVIEW**

1. Review hospital policies and procedures to determine whether the discharge planning process is reassessed on an ongoing basis, i.e., at least quarterly.

2. Does the hospital’s discharge planning reassessment policy include tracking and analysis of readmissions?

- Do staff know how to obtain data on readmissions that enables them to review the discharge plans for the

**Score**

- Compliant
- Not Compliant

This standard is not met as evidenced by:

**EXPLANATION**

- A patient may refuse transfer or referral; or
- There may be financial barriers limiting a facility’s, agency’s, or ambulatory care service provider’s willingness to accept the patient. In such cases the hospital does not have financial responsibility for the post-acute care services. However, hospitals are expected to be knowledgeable about resources available in their community to address such financial barriers, such as Medicaid services, availability of Federally Qualified Health Centers, Area Agencies on Aging, etc., and to take steps to make those resources available to the patient. For example, in most states hospitals work closely with the Medicaid program to expedite enrollment of patients eligible for Medicaid.
records to determine whether they were responsive to the patient’s post-discharge needs.

- One indicator of the effectiveness of the discharge plan is whether or not the discharge was followed by a preventable readmission.

- Accordingly, hospitals are expected to track their readmission rates and identify potentially preventable readmissions. Typically readmissions at 7, 15, 30 days, or even longer, after discharge are tracked by analysts studying readmissions to short-term acute care hospitals.

- Hospitals must choose at least one interval to track. Since there are National Quality Forum-endorsed readmissions measures that use a 30-day interval, and since such measures are permitted by law to be used by CMS for payment-related purposes, it might be prudent for a hospital to track its 30-day readmissions rate, but other intervals are permissible. It is understood that information on post-discharge admissions to other hospitals may not be readily available to hospitals, but all hospitals are expected to track readmissions to their own hospital, and to do so on an ongoing basis, i.e., at least quarterly. Hospitals may employ various methodologies to identify potentially preventable readmissions. There are proprietary products that, for example, use claims data to identify such cases. Hospitals are expected to document their methodology for initial admission?

- Ask them to identify medical records for patients who were readmitted and to show you the documentation of the review of the discharge planning process for the initial admission.

3. Does the hospital QAPI program include an ongoing re-assessment of the discharge planning process including:
   - Rate of re-admissions?
   - The effectiveness of the discharge planning process for patient readmissions?

4. Does the assessment of readmissions include an evaluation of whether the readmissions were potentially preventable?
   - Is there evidence of in-depth analysis of a sample of discharge plans in cases where preventable readmissions were identified?
   - Is there evidence that the hospital took action to address factors identified as contributing to preventable readmissions?
tracking their readmissions rates.

- Once the hospital has identified potentially preventable readmissions, it is expected to conduct an in-depth review of the discharge planning process for a sample of such readmissions (at least 10% of potentially preventable readmissions, or 15 cases/quarter, whichever is larger is suggested but not required) in order to determine whether there was an appropriate discharge planning evaluation, discharge plan, and implementation of the discharge plan.

- Hospitals are also expected to follow up on trends identified through analysis of their readmissions, such as:
  - a concentration of readmissions related to post-surgical infections,
  - discharges from a particular service or unit,
  - discharges to a particular extended care facility or home health agency,
  - discharges with the same primary diagnosis on the first admission, etc. Such clustering or concentration may identify areas requiring more follow-up analysis and potential remedial actions.

- Having identified factors that contribute to preventable readmissions, hospitals are expected to revise their discharge planning and

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<td>related processes to address these factors.</td>
<td>- Consistent with the requirements under the QAPI CoP, the hospital’s governing body, medical leadership and administrative leadership are all expected to ensure that identified problems are addressed, with further ongoing reassessment to achieve improvement.</td>
<td>OBSERVATION, INTERVIEW, AND CHART REVIEW</td>
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<td>The hospital’s discharge planning process must be integrated into its QAPI program.</td>
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#### 15.03.26 Discharge Instructions.
The hospital must provide the patient or representative with discharge instructions written in lay terminology at time of discharge. The discharge instructions must include the following elements:

1. **Reason for hospitalization and condition at the time of discharge.**

2. **Medications to be taken after discharge including, resuming pre-admission medications, how and when to take medications, and how to obtain medications.**

3. **Complications which may occur and actions to take should these happen.**

Inconsistent practices in the discharge process may result in unsafe outcomes. The discharge process is intended to provide patients with adequate information and necessary resources to improve or maintain their health during the post-hospital period and to prevent adverse events and unnecessary re-hospitalization.

It has been reported that 50% of patients readmitted within 30-days of discharge had not seen their physician since the date of discharge. One strategy to reduce readmissions is for the hospital to make the first follow-up appointment for the patient prior to discharge.

The facility is responsible for making appointments with the appropriate provider for follow-up clinical visits and tests after hospitalization. These

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post-discharge.

4. A list of follow-up appointments for tests and clinic visits, with dates, times and locations.

5. Organized services to be initiated following discharge.

6. Tests completed in the hospital with results pending at time of discharge and name of the clinician responsible for the results.

7. List of relevant contact information (e.g., primary care providers, specialists, the pharmacy, and home health agencies, etc.). (NQF, #15, 2009)

appointments must be communicated, in writing, to the patient / caregiver at the time of discharge. Patient / caregiver understanding of the discharge instructions must be assessed and documented in the patient record.

Research has shown that the use of a checklist for planning discharge activities has decreased adverse events post-discharge and reduced the number of readmissions within 30 days after discharge. (Jack, Brian, et al. (2009). A Reengineered hospital discharge program to decrease re-hospitalization. *Annals of Internal Medicine*, 150(3): 178.) Further, studies report that one in five hospitalizations is complicated by a post-discharge adverse event as patients are often unprepared for patient / caregiver understanding of the discharge instructions must be assessed and documented in the patient record.

15.03.27 Discharge Checklist.
The discharge process must include a checklist of the following activities:

1. Educate patients and families about their diagnosis throughout the hospital stay.

2. Assess the patient’s understanding of the discharge plan in their own words.

3. Organized services to be initiated following discharge.

4. A list of follow-up appointments for tests and clinic visits, with dates, times and locations.

5. Tests completed in the hospital with results pending at time of discharge and name of the clinician responsible for the results.

6. Discharge checklist:

   - Patients that may potentially benefit from a post-discharge telephone call;

CHART REVIEW AND DOCUMENT REVIEW

1. Determine whether the facility utilizes a discharge checklist, which includes the identified eleven (11) elements.

2. Determine whether hospital policy has identified:

   - Patients that may potentially benefit from a post-discharge telephone call;

Comment:
3. Inform the patient and family of any tests completed in the hospital that have results pending at time of discharge; identify the clinician who will be responsible for results.

A review of the literature has identified factors that contribute to hospital readmission including, but not limited to:
- Lack of a medication reconciliation resulting in unexplained medication discrepancies between pre-admission and post-discharge medication lists
- Discharge medication prescription errors
- Lack of information regarding pending tests results or the need for follow-up tests
- Availability of the discharge summary has been received by the clinician at time of the first post-discharge visit

Multiple initiatives have been published offering suggestions to reduce the rate of readmissions.
- With the Project RED (Reengineered Hospital Discharge Program) initiative, clinical pharmacists telephone patients 2–4 days after discharge to discuss medication-related concerns. Upon identification of problems, the patient’s primary care physician is notified.

With pending payment penalties intended to reduce readmission rates, hospitals may elect to develop medical staff approved discharge protocols for specific disease processes known to be high-risk for adverse events or readmission, such as:

4. Schedule follow-up appointments and tests to be done following discharge.

5. Organize services to be initiated following discharge.

6. Confirm the medication plan.

7. Reconcile the discharge plan with national guidelines and critical pathways when relevant.

8. Review with the patient what to do if a problem occurs.

9. Communicate the discharge summary to the healthcare providers who will be accepting responsibility for the patient’s care.

10. Give the patient written discharge instructions.

11. Provide telephone follow-up two to three days after discharge for patients identified to be at risk for adverse health consequences upon discharge or do not understand their medications.

- Persons “qualified” to conduct the discharge follow-up telephone call.

3. Has the hospital developed discharge protocols for high-risk disease processes or medications?

4. If yes, has the protocol:
- Been approved by the medical staff
- Included follow-up visits, tests, medication reconciliation
- Developed a script for the caller to identify conditions that require immediate evaluation including referral to the primary care physician or the Emergency Department?

5. Review the medical record to ensure attempts have been made to contact the patient 2–3 days post-discharge. It is appropriate to leave a generic message asking patient to return call when able. There should be documentation supporting this activity.
Facilities may also consider development of medical staff discharge protocols for patients discharged with medications known to be a high-risk factor associated with adverse events or re-admission, such as:

- Corticosteroids
- Antibiotics
- Anticoagulants
- Analgesics
- Cardiovascular drugs

Hospital policy identifies those patients that would potentially benefit from a follow-up telephone call post discharge to avoid adverse health consequences or readmission.

The medical staff approved discharge protocol should assign professionals qualified to conduct the discharge follow-up telephone call to the patient / patient’s representative. Staff placing the calls should be familiar with the patient’s discharge plan.

The medical staff approved protocol should include:

- A list of inquiries regarding medications, diet, activity, wound care, follow-up appointments.
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- Reinforcement of education that was provided during the course of hospitalization.
- A script for the caller to use to identify conditions that require immediate evaluation, including a referral to the primary care physician or a return to the Emergency Department.

National guidelines and critical pathways, regarding evidence-based practice for patient diagnosis and presentation should be used, when appropriate. The facility must reconcile the discharge plan with national guidelines and critical pathways when relevant.

The discharge planning process may include representatives from nursing, care management, social work, dietary, pharmacy, rehabilitation therapies, respiratory therapy, and other health care professionals along with the medical staff. The team approach ensures all post-discharge needs are identified.

The facility discharge planning policy identifies the individuals that are qualified by education, title, experience, and training to perform the follow-up telephone calls. Often, a registered nurse, case manager, or a social worker is responsible for the follow-up telephone call. It is not mandatory that the bedside RN make the follow-up patient phone calls. However, this individual should be an RN with experience, knowledge and training to recognize
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<td>potentially emergent situations when speaking with the patient.</td>
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<td>As the follow-up call is an assessment of high-risk patients, it would not be appropriate to have a secretary, unit clerk, or pharmacy technician to conduct the discharge follow-up telephone call.</td>
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<td>Recognizing the high volume of patients that experience medication-related adverse drug events or readmissions, facilities may include a well-qualified clinical pharmacist to conduct medication counseling and reconciliation at time of discharge with a follow-up telephone call within 48 hours of discharge.</td>
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