Joint Commission Resources
Quality & Safety Network (JCRQSN)

Resource Guide

Be Prepared: Maximizing Behavioral Healthcare-Related Tracer Activities

April 27, 2017
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Program Summary

This page provides an overview of the program content and learning objectives. Please refer to the Table of Contents and Program Outline for a detailed list of the topics covered. The information included in this Resource Guide is intended to support but not duplicate the video presentation content. There may be additional information available online for this topic.

Program Description

Since 2004, the Tracer Methodology has been an evaluation method where surveyors select a patient, resident, or client and use that person's record as a roadmap to move through an organization to assess and evaluate the organization's compliance with selected standards and the organization's systems of providing care and services.

The Tracer Methodology is a significant component of the accreditation process, providing a framework for Joint Commission surveyors to assess standards compliance and patient safety during on-site surveys. To better address the unique characteristics and relevant issues of each accredited organization, Joint Commission behavioral healthcare surveyors have a wider range of behavioral health-specific tracers to conduct during surveys.

For instance, through the use of Tracer Methodology, surveyors evaluate the effectiveness of processes to prevent elopement, therefore enhancing safety and identifying process, and possibly system-level issues contributing to successful elopements. A surveyor also examines the effectiveness of the organization's suicide prevention strategy and, again, identifies process, and possibly system-level issues contributing to suicide attempts. The surveyor also evaluates the effectiveness of the organization's process to control violence and ensure the safety of others.

Designed for organizations that want a better understanding of tracer implementation and methodologies, this 60-minute live activity provides the information and tools needed to make the most of the opportunities tracers provide related to Behavioral Healthcare.

Program Objectives

After completing this activity, the participant should be able to:

1. Identify various tracers that focus on Behavioral Healthcare.
2. Prioritize tracer data to determine the effectiveness of process design in the delivery of safe, high-quality care in the Behavioral Healthcare setting.
3. Improve processes through use of Tracer Methodology and aggregation of tracer findings data.

Target Audience

This activity is essential for those in your organization who are responsible for assessing the quality and safety of care provided throughout the organization, as well as those responsible for accreditation compliance, including survey coordinators, risk managers, performance improvement (PI) coordinators, department managers, and others who have a hands-on role in The Joint Commission accreditation process or assessing the systems and processes within the organization.
Program Outline

Be Prepared: Maximizing Behavioral Healthcare-Related Tracer Activities
April 27, 2017

I. Introduction
   A. Program Content
   B. Objectives
   C. Faculty
II. Mock Survey – National Patient Safety Goal 15
   A. Assessing and Intervening to Reduce Self-Harm and Suicide Risk in All Settings
   B. Surveying Ligature Risk to Reduce the Potential for Self-harm and Suicide Risk In Inpatient Psychiatric Settings
III. Mock Survey – Effective Monitoring, Assessment and Care Planning
   A. Effective Staff Assessment and Monitoring for Patients Placed in Restraint and Seclusion
   B. Effective Care Planning for Patient at Risk for Self-Harm and/or Suicide
IV. The Survey Analysis for Evaluating Risk (SAFER) Matrix™
V. Conclusion
VI. Post-Program Live Question and Answer Session
   A. Audio only telephone seminar with program faculty – for 30 minutes following the program.
   B. Call 1-888-206-0090; enter conference code: 7925428.
      Or e-mail your questions or comments to: Questions@jcrqsn.com

<table>
<thead>
<tr>
<th>Program Broadcast Time</th>
<th>Eastern: 2:00 p.m. to 3:00 p.m.</th>
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<tr>
<td></td>
<td>Central: 1:00 p.m. to 2:00 p.m.</td>
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<td>Mountain: 12:00 p.m. to 1:00 p.m.</td>
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<tr>
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<td>Pacific: 11:00 a.m. to 12:00 p.m.</td>
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Program Question and Answer Session

During the live airing of this program on April 27, 2017, you may be able to talk directly with the faculty when prompted by the program’s host. After this date, your message will be forwarded to the appropriate personnel.

Immediately following the program, we invite you to join in a live discussion with the program presenters. Call 1-888-206-0090 and enter Conference Code: 7925428 to be included in the teleconference.

To submit your question ahead of time or for additional details, please send an e-mail to questions@jcrqsn.com. If you submit your questions after this date, your message will be forwarded to the appropriate personnel.

You can also receive answers to your questions by calling The Joint Commission’s Standards Interpretation Hotline at 630-792-5900, option 6.
Continuing Education (CE) Credit

After viewing the JCR Quality & Safety Network presentation and reading this Resource Guide, please complete the required online CE/CME credit activities (test and evaluation form). The test measures knowledge gained and/or provides a means of self-assessment on a specific topic. The evaluation form provides us with valuable information regarding your thoughts on the activity’s quality and effectiveness.

Prior to the Program Presentation Day
1. Login to the JCRQSN Learning Management System web site at http://jcrqsn.twnlms.com/
   • Select the course for this program, Be Prepared: Maximizing Behavioral Healthcare-Related Tracer Activities
   • When prompted, choose Access Content to confirm that you would like to access this program.
2. Display and print the desired documents (Resource Guide, etc.).

Online Process for CE/CME Credit
1. Read the course materials and view the entire video presentation.
2. Login to the JCRQSN Learning Management System web site at http://jcrqsn.twnlms.com/
   Note: This assumes you have already been enrolled in the program, as described above.
4. If you did not view the broadcast video presentation, view it online.
5. Complete the online post test (see Appendix E).
   • You have up to three attempts to successfully complete the test with a minimum passing score of 80%.
   • Physicians must take the post test to obtain credit.
6. Complete the program evaluation form.
7. On the top-left corner of the main course page, you will see your completion status in the Status block.
8. Select Get Certificate from within the Status block to print your completion certificate.
   Note: Certificates for other completed courses can be printed from the “My History” tab, as well.
Relevant Standards and Elements of Performance

Program: Hospital

Chapter: Environment of Care

Standard: EC.02.06.01: The hospital establishes and maintains a safe, functional environment.
Note: The environment is constructed, arranged, and maintained to foster patient safety, provide facilities for diagnosis and treatment, and provide for special services appropriate to the needs of the community.

Rationale: (None)

EPs

1. Interior spaces meet the needs of the patient population and are safe and suitable to the care, treatment, and services provided.

11. Lighting is suitable for care, treatment, and services.

20. Areas used by patients are clean and free of offensive odors.

26. The hospital keeps furnishings and equipment safe and in good repair.

Program: Hospital

Chapter: National Patient Safety Goals

Standard: NPSG.15.01.01: Identify patients at risk for suicide.
Note: This requirement applies only to psychiatric hospitals and patients being treated for emotional or behavioral disorders in general hospitals.

Rationale: Suicide of a patient while in a staffed, round-the-clock care setting is a frequently reported type of sentinel event. Identification of individuals at risk for suicide while under the care of or following discharge from a health care organization is an important step in protecting these at-risk individuals.

EPs:

1. Conduct a risk assessment that identifies specific patient characteristics and environmental features that may increase or decrease the risk for suicide.

2. Address the patient's immediate safety needs and most appropriate setting for treatment.

3. When a patient at risk for suicide leaves the care of the hospital, provide suicide prevention information (such as a crisis hotline) to the patient and his or her family.

Program: Hospital

Chapter: Provision of Care, Treatment, and Services

Standard: PC.01.03.01: The hospital plans the patient's care.

Rationale: (None)

EPs:

1. The hospital plans the patient's care, treatment, and services based on needs identified by the patient's assessment, reassessment, and results of diagnostic testing. (See also RC.02.01.01, EP 2; PC.01.02.13, EP 2)

5. The written plan of care is based on the patient's goals and the time frames, settings, and services required to meet those goals.
   Note: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The patient's goals include both short- and long-term goals.
6. For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The written plan of care includes the following:
   – A substantiated diagnosis (The substantiated diagnosis is the diagnosis identified by the treatment team to be the primary focus upon which treatment planning will be based. It evolves from the synthesis of data from various disciplines. The substantiated diagnosis may be the same as the initial diagnosis or it may differ, based on new information and assessment.)
   – Documentation to justify the diagnosis and the treatment and rehabilitation activities carried out
   – Documentation that demonstrates all active therapeutic efforts are included
   – The specific treatment modalities used to treat the patient

22. Based on the goals established in the patient's plan of care, staff evaluate the patient's progress.

23. The hospital revises plans and goals for care, treatment, and services based on the patient's needs. (See also RC.02.01.01, EP 2)

43. For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The plan of care includes the responsibilities of each member of the treatment team.

**Program:** Hospital  
**Chapter:** Provision of Care, Treatment, and Services  
**Standard:** PC.03.05.01: The hospital uses restraint or seclusion only when it can be clinically justified or when warranted by patient behavior that threatens the physical safety of the patient, staff, or others.  
**Rationale:** (None)  
**EPs:**
1. The hospital uses restraint or seclusion only to protect the immediate physical safety of the patient, staff, or others.
2. The hospital does not use restraint or seclusion as a means of coercion, discipline, convenience, or staff retaliation.
3. The hospital uses restraint or seclusion only when less restrictive interventions are ineffective.
4. The hospital uses the least restrictive form of restraint or seclusion that protects the physical safety of the patient, staff, or others.
5. The hospital discontinues restraint or seclusion at the earliest possible time, regardless of the scheduled expiration of the order.

**Program:** Hospital  
**Chapter:** Provision of Care, Treatment, and Services  
**Standard:** PC.03.05.03: The hospital uses restraint or seclusion safely.  
**Rationale:** (None)  
**EPs:**
1. The hospital implements restraint or seclusion using safe techniques identified by the hospital's policies and procedures in accordance with law and regulation.
2. The use of restraint and seclusion is in accordance with a written modification to the patient's plan of care.
Program: Hospital

Chapter: Provision of Care, Treatment, and Services

Standard: PC.03.05.05: The hospital initiates restraint or seclusion based on an individual order.

Rationale: (None)

EPs:

1. A physician, clinical psychologist, or other authorized licensed independent practitioner primarily responsible for the patient's ongoing care orders the use of restraint or seclusion in accordance with hospital policy and law and regulation. **Note:** The definition of “physician” is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).

2. The hospital does not use standing orders or PRN (also known as “as needed”) orders for restraint or seclusion.

3. The attending physician or clinical psychologist is consulted as soon as possible, in accordance with hospital policy, if he or she did not order the restraint or seclusion.

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

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

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

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

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

6. Orders for restraint used to protect the physical safety of the nonviolent or non-self-destructive patient are renewed in accordance with hospital policy

Program: Hospital

Chapter: Provision of Care, Treatment, and Services

Standard: PC.03.05.07: The hospital monitors patients who are restrained or secluded.

Rationale: (None)

EPs:

1. Trained physicians, clinical psychologists, or other licensed independent practitioners or staff monitor the condition of patients in restraint or seclusion. **(See PC.03.05.17, EPs 2-5 for training requirements)**

   **Note:** For hospitals that use Joint Commission accreditation for deemed status purposes: The training requirements in PC.03.05.17, EPs 2-5, are in accordance with 42 CFR 482.13(f).
Program: Hospital

Chapter: Provision of Care, Treatment, and Services

Standard: PC.03.05.09: The hospital has written policies and procedures that guide the use of restraint or seclusion.

Rationale: (None)

EPs:
1. The hospital's policies and procedures regarding restraint or seclusion include the following:
   - Physician, clinical psychologist, and other authorized licensed independent practitioner training requirements
   - Staff training requirements
   - The determination of who has authority to order restraint and seclusion
   - The determination of who has authority to discontinue the use of restraint or seclusion
   - The determination of who can initiate the use of restraint or seclusion
   - The circumstances under which restraint or seclusion is discontinued
   - The requirement that restraint or seclusion is discontinued as soon as is safely possible
   - A determination of who can assess and monitor patients in restraint or seclusion
   - Time frames for assessing and monitoring patients in restraint or seclusion
   - A definition of restraint
   - A definition of seclusion
   - A definition or description of what constitutes the use of medications as a restraint

For hospitals that use Joint Commission accreditation for deemed status purposes:

Note 1: The hospital's definition of restraint or the use of medications as a restraint is in accordance with 42 CFR 482.13(e)(1)(i)(A-C):
42 CFR 482.13(e)(1) Definitions. (i) A restraint is—(A) Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely; or 42 CFR 482.13(e)(1)(i)(B) (A restraint is—) A drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.
42 CFR 482.13(e)(1)(i)(C) A restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort).

Note 2: The hospital's definition of seclusion is in accordance with 42 CFR 482.13(e)(1)(ii):
Seclusion is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may be used only for the management of violent or self-destructive behavior.

2. Physicians, clinical psychologists, and other licensed independent practitioners authorized to order restraint or seclusion (through hospital policy in accordance with law and regulation) have a working knowledge of the hospital policy regarding the use of restraint and seclusion.

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

Chapter: Provision of Care, Treatment, and Services

Standard: PC.03.05.11: The hospital evaluates and reevaluates the patient who is restrained or secluded.

Rationale: (None)

EPs:

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

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

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

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

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

3. The in-person evaluation, conducted within one hour of the initiation of restraint or seclusion for the management of violent or self-destructive behavior that jeopardizes the physical safety of the patient, staff, or others, includes the following:
   – An evaluation of the patient's immediate situation
   – The patient's reaction to the intervention
   – The patient's medical and behavioral condition
   – The need to continue or terminate the restraint or seclusion

Program: Hospital

Chapter: Provision of Care, Treatment, and Services

Standard: PC.03.05.13: The hospital continually monitors patients who are simultaneously restrained and secluded.

Rationale: (None)

EPs:

1. The patient who is simultaneously restrained and secluded is continually monitored by trained staff either in-person or through the use of both video and audio equipment that is in close proximity to the patient.

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

Program: Hospital

Chapter: Provision of Care, Treatment, and Services

Standard: PC.03.05.15: The hospital documents the use of restraint or seclusion.

Rationale: (None)
EPs:

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

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

Program: Hospital

Chapter: Provision of Care, Treatment, and Services

Standard: PC.03.05.17: The hospital trains staff to safely implement the use of restraint or seclusion.

Rationale: (None)

EPs:

2. The hospital trains staff on the use of restraint and seclusion, and assesses their competence, at the following intervals:
   - At orientation
   - Before participating in the use of restraint and seclusion
   - On a periodic basis thereafter
3. Based on the population served, staff education, training, and demonstrated knowledge focus on the following:
   - Strategies to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of restraint or seclusion
   - Use of nonphysical intervention skills
   - Methods for choosing the least restrictive intervention based on an assessment of the patient's medical or behavioral status or condition
   - Safe application and use of all types of restraint or seclusion used in the hospital, including training in how to recognize and respond to signs of physical and psychological distress (for example, positional asphyxia)
   - Clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary
   - Monitoring the physical and psychological well-being of the patient who is restrained or secluded, including, but not limited to, respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by hospital policy associated with the in-person evaluation conducted within one hour of initiation of restraint or seclusion
   - Use of first-aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic recertification

   *(See also PC.03.05.07, EP 1)*

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

5. The hospital documents in staff records that restraint and seclusion training and demonstration of competence were completed.

**Program:** Hospital

**Chapter:** Provision of Care, Treatment, and Services

**Standard:** PC.03.05.17: The hospital trains staff to safely implement the use of restraint or seclusion.

**Rationale:** (None)

**EPs:**

2. The hospital trains staff on the use of restraint and seclusion, and assesses their competence, at the following intervals:
   - At orientation
   - Before participating in the use of restraint and seclusion
   - On a periodic basis thereafter
3. Based on the population served, staff education, training, and demonstrated knowledge focus on the following:
   – Strategies to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of restraint or seclusion
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   – Methods for choosing the least restrictive intervention based on an assessment of the patient's medical or behavioral status or condition
   – Safe application and use of all types of restraint or seclusion used in the hospital, including training in how to recognize and respond to signs of physical and psychological distress (for example, positional asphyxia)
   – Clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary
   – Monitoring the physical and psychological well-being of the patient who is restrained or secluded, including, but not limited to, respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by hospital policy associated with the in-person evaluation conducted within one hour of initiation of restraint or seclusion
   – Use of first-aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic recertification

(See also PC.03.05.07, EP 1)

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

5. The hospital documents in staff records that restraint and seclusion training and demonstration of competence were completed.

**Program:** Hospital

**Chapter:** Record of Care, Treatment, and Services

**Standard:** RC.02.01.01: The medical record contains information that reflects the patient's care, treatment, and services.

**Rationale:** (None)

**EPs:**

1. The medical record contains the following demographic information:
   – The patient's name, address, and date of birth and the name of any legally authorized representative
   – The patient's sex
   – The legal status of any patient receiving behavioral health care services
   – The patient's communication needs, including preferred language for discussing health care (See also PC.02.01.21, EP 1)

   **Note:** If the patient is a minor, is incapacitated, or has a designated advocate, the communication needs of the parent or legal guardian, surrogate decision-maker, or legally authorized representative is documented in the medical record.
2. The medical record contains the following clinical information:

- The reason(s) for admission for care, treatment, and services
- The patient's initial diagnosis, diagnostic impression(s), or condition(s)
- Any findings of assessments and reassessments *(See also PC.01.02.01, EP 1; PC.03.01.03, EPs 1 and 8)*
- Any allergies to food
- Any allergies to medications
- Any conclusions or impressions drawn from the patient's medical history and physical examination
- Any diagnoses or conditions established during the patient's course of care, treatment, and services (including complications and hospital-acquired infections). For psychiatric hospitals using Joint Commission accreditation for deemed status purposes: The diagnosis includes intercurrent diseases (diseases that occur during the course of another disease; for example, a patient with AIDS may develop an intercurrent bout of pneumonia) and the psychiatric diagnoses.
- Any consultation reports
- Any observations relevant to care, treatment, and services
- The patient's response to care, treatment, and services
- Any emergency care, treatment, and services provided to the patient before his or her arrival
- Any progress notes
- All orders
- Any medications ordered or prescribed
- Any medications administered, including the strength, dose, and route
- Any access site for medication, administration devices used, and rate of administration
- Any adverse drug reactions
- Treatment goals, plan of care, and revisions to the plan of care *(See also PC.01.03.01, EPs 1 and 23)*
- Results of diagnostic and therapeutic tests and procedures
- Any medications dispensed or prescribed on discharge
- Discharge diagnosis
- Discharge plan and discharge planning evaluation

*(See also PC.01.02.03, EP 6)*
Sentinel Event Alert 56: Detecting and Treating Suicide Ideation in All Settings

The rate of suicide is increasing in America.¹ Now the 10th leading cause of death,² suicide claims more lives than traffic accidents³ and more than twice as many as homicides.⁴ At the point of care, providers often do not detect the suicidal thoughts (also known as suicide ideation) of individuals (including children and adolescents) who eventually die by suicide, even though most of them receive health care services in the year prior to death,⁵ usually for reasons unrelated to suicide or mental health.⁵⁻⁷ Timely, supportive continuity of care for those identified as at risk for suicide is crucial, as well.⁸

Through this alert, The Joint Commission aims to assist all health care organizations providing both inpatient and outpatient care to better identify and treat individuals with suicide ideation. Clinicians in emergency, primary and behavioral health care settings particularly have a crucial role in detecting suicide ideation and assuring appropriate evaluation. Behavioral health professionals play an additional important role in providing evidence-based treatment and follow-up care. For all clinicians working with patients with suicide ideation, care transitions are very important. Many patients at risk for suicide do not receive outpatient behavioral treatment in a timely fashion following discharge from emergency departments and inpatient psychiatric settings.⁶ The risk of suicide is three times as likely (200 percent higher) the first week after discharge from a psychiatric facility⁹ and continues to be high especially within the first year⁶,¹⁰ and through the first four years¹¹ after discharge.

This alert replaces two previous alerts on suicide (issues 46 and 7). The suggested actions in this alert cover suicide ideation detection, as well as the screening, risk assessment, safety, treatment, discharge, and follow-up care of at-risk individuals. Also included are suggested actions for educating all staff about suicide risk, keeping health care environments safe for individuals at risk for suicide, and documenting their care.

Some organizations are making significant progress in suicide prevention.¹² The “Perfect Depression Care Initiative” of the Behavioral Health Services Division of the Henry Ford Health System achieved 10 consecutive calendar quarters without an instance of suicide among patients participating in the program. The U.S. Air Force’s suicide prevention initiative reduced suicides by one-third over a six-year period. Over a period of 12 years, Asker and Bærum Hospital near Oslo, Norway implemented continuity-of-care strategies and achieved a 54 percent decline in suicide attempts in a high-risk population with a history of poor compliance with follow-up. Additionally, the hospital’s multidisciplinary suicide prevention team accomplished an 88 percent success rate for getting patients to the aftercare program to which they were referred. Dallas’ Parkland Memorial Hospital became the first U.S. hospital to implement universal screenings to assess whether patients are at risk for suicide. Through preliminary screenings of 100,000 patients from its hospital and emergency department, and of more than 50,000 outpatient clinic patients, the hospital has found 1.8 percent of patients there to be at high suicide risk and up to 4.5 percent to be at moderate risk.¹³
**Who is at risk for suicide?**

Much of what we know about the profile of individuals who have died by suicide and those who have attempted suicide comes from looking in the rearview mirror – at data compiled about suicide victims and attempts. Suicide may affect certain demographics – such as military veterans and men over age 45 – more than others. It’s important to identify the risk factors, rather than membership in a group, when considering suicide risk. Paying attention to risk factors matters because patients may not disclose suicide ideation voluntarily. Risk factors for suicide include:

- Mental or emotional disorders, particularly depression and bipolar disorder. Up to 90 percent of suicide victims suffer from a mental or emotional disorder at the time of death.
- Previous suicide attempts or self-inflicted injury; the risk of suicide is twice as high (100 percent higher) than general suicide rates for one year following a suicide attempt and the higher risk continues beyond that. The risk is even higher the first few weeks immediately following a suicide attempt.
- History of trauma or loss, such as abuse as a child, a family history of suicide, bereavement or economic loss.
- Serious illness, or physical or chronic pain or impairment.
- Alcohol and drug abuse.
- Social isolation or a pattern/history of aggressive or antisocial behavior.
- Discharge from inpatient psychiatric care, within the first year after and particularly within the first weeks and months after discharge. While some depressed patients who attempt or die by suicide inpatient psychiatric hospitalization express suicide ideation before or during hospitalization, other depressed patients who have received inpatient psychiatric treatment develop suicide ideation after discharge.
- Access to lethal means coupled with suicidal thoughts.

However, there is no typical suicide victim. Most individuals having these risk factors do not attempt suicide, and others without these conditions sometimes do. Therefore, there is a danger in considering only individuals with certain conditions or experiences in certain health care settings as being at risk for suicide. It’s imperative for health care providers in all settings to better detect suicide ideation in patients, and to take appropriate steps for their safety and/or refer these patients to an appropriate provider for screening, risk assessment, and treatment.

**Assessing suicide risk remains a challenge**

The Joint Commission’s Sentinel Event database* has reports of 1,089 suicides occurring from 2010 to 2014 among patients receiving care, treatment, and services in a staffed, around-the clock care setting or within 72 hours of discharge, including from a hospital’s emergency department. The most common root cause documented during this time period was shortcomings in assessment, most commonly psychiatric assessment. In addition, 21.4 percent (165) of Joint Commission-accredited behavioral health organizations and 5.14 percent (65) of Joint Commission-accredited hospitals (for which the requirement was applicable) were rated non-compliant in 2014 with National Patient Safety Goal 15.01.01 Element of Performance 1 – Conduct a risk assessment that identifies specific patient characteristics and environmental features that may increase or decrease the risk for suicide.

**Actions suggested by The Joint Commission**

To accomplish the following suggested actions, The Joint Commission urges all health care organizations to develop clinical environment readiness by identifying, developing and integrating comprehensive behavioral health, primary care and community resources to assure continuity of care for individuals at risk for suicide. Many communities and health care organizations presently do not have adequate suicide prevention resources, leading to the low detection and treatment rate of those at risk. As a result, providers who do identify patients at risk for suicide often must interrupt their workflow and disrupt their schedule for the day to find treatment and assure safety for these patients.

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* The reporting of most sentinel events to The Joint Commission is voluntary and represents only a small proportion of actual events. Therefore, these data are not an epidemiologic data set and no conclusions should be drawn about the actual relative frequency of events or trends in events over time.
DETECTING SUICIDE IDEATION IN NON-ACUTE OR ACUTE CARE SETTINGS
Primary, emergency and behavioral health clinicians all play crucial roles in detecting suicide ideation through the following three steps, which can be taken in non-acute or acute care settings:

1. Review each patient’s personal and family medical history for suicide risk factors. These are listed in the “Who is at risk for suicide?” section of this alert.

2. Screen all patients for suicide ideation, using a brief, standardized, evidence-based screening tool. A waiting room questionnaire including a question specifically asking if the patient has had thoughts about killing him or herself may help identify individuals at risk for suicide who otherwise may not have been identified. Research shows that a brief screening tool can identify individuals at risk for suicide more reliably than leaving the identification up to a clinician’s personal judgment or by asking about suicidal thoughts using vague or softened language. For example, a study using the Patient Health Questionnaire (PHQ-9) found that those who expressed thoughts of death or self-harm were 10 times more likely to attempt suicide than those who did not report those thoughts. Some practices use a shorter version called the PHQ-2, which asks two questions about depression symptoms, and some add an additional question about suicidal thoughts and feelings. If a patient answers “yes” to any of these questions, the PHQ-9 is administered. Other brief screening tools include the Emergency Medicine Network’s ED-SAFE Patient Safety Screener for emergency departments and the Suicide Behaviors Questionnaire-Revised (SBQ-R).

3. Review screening questionnaires before the patient leaves the appointment or is discharged. To determine the proper immediate course of treatment, conduct or refer for secondary screening and assessment patients determined to be at risk for suicide. Useful secondary screeners include the Suicide Prevention Resources Center’s Decision Support Tool and the Emergency Medicine Network’s ED-SAFE Patient Safety Secondary Screener for emergency departments. The SAFE-T20 Pocket Card and the Columbia-Suicide Severity Rating Scale (C-SSRS) can be used for in-depth screening and assessment.

For patients who screen positive for suicide ideation and deny or minimize suicide risk or decline treatment, obtain corroborating information by requesting the patient’s permission to contact friends, family, or outpatient treatment providers. If the patient declines consent, HIPAA permits a clinician to make these contacts without the patient’s permission when the clinician believes the patient may be a danger to self or others.

TAKING IMMEDIATE ACTION AND SAFETY PLANNING
During the following two steps, behavioral health clinicians are generally added to the care team via consultation or referral. The care team should:

4. Take the following actions, using assessment results to inform the level of safety measures needed.
   a. Keep patients in acute suicidal crisis in a safe health care environment under one-to-one observation. Do not leave these patients by themselves. Provide immediate access to care through an emergency department, inpatient psychiatric unit, respite center, or crisis resources. Check these patients and their visitors for items that could be used to make a suicide attempt or harm others. Keep these patients away from anchor points for hanging and material that can be used for self-injury. Some specific lethal means that are easily available in general hospitals and that have been used in suicides include: bell cords, bandages, sheets, restraint belts, plastic bags, elastic tubing and oxygen tubing.
   b. For patients at lower risk of suicide, make personal and direct referrals and linkages to outpatient behavioral health and other providers for follow-up care within one week of initial assessment, rather than leaving it up to the patient to make the appointment.
• For all patients with suicide ideation:
  – **Give every patient** and his or her family members the number to the National Suicide Prevention Lifeline, 1-800-273-TALK (8255), as well as to local crisis and peer support contacts.44
  – **Conduct safety planning**45 by collaboratively identifying possible coping strategies with the patient and by providing resources for reducing risks.12,44 A safety plan is **not** a “no-suicide contract” (or “contract for safety”), which is not recommended by experts in the field of suicide prevention.44 Review and reiterate the patient’s safety plan at every interaction until the patient is no longer at risk for suicide.38
  – **Restrict access to lethal means.** Assess whether the patient has access to firearms or other lethal means, such as prescription medications and chemicals, and discuss ways of removing or locking up firearms and other weapons during crisis periods. Restricting access is important because many suicides occur with little planning during a short-term crisis, and both intent and means is required to attempt suicide.46 The Harvard T.H. Chan School of Public Health’s **Means Matter website** provides helpful advice on means restriction.46

**BEHAVIORAL HEALTH TREATMENT AND DISCHARGE**

Behavioral health clinicians manage the patient’s evidence-based treatments and discharge plans, as well as coordinate care transitions and follow-up care with the patient’s other providers.

5. **Establish a collaborative, ongoing, and systematic assessment and treatment process with the patient involving the patient’s other providers, family and friends as appropriate.**

   Suicide risk, by nature, is very dynamic – changing according to personal events, a person’s level of desperation, and available interventional resources.47 Treatment of individuals at risk for suicide requires a collaborative approach that acknowledges the ambivalence – the desire to find a solution to their pain versus the innate desire to live – that these patients often feel.48 A valuable support to traditional risk assessment is to use a **risk formulation model** – drawn from prevention research49 and violence assessment50 – that can help providers to understand a patient’s current thoughts, plans, access to lethal means, and acute risk factors. This understanding can be used to develop personalized care and both short- and long-term safety plans for patients struggling with thoughts of suicide.

6. **To improve outcomes for at-risk patients, develop treatment and discharge plans that directly target suicidality.**12 Traditionally, behavioral health clinicians often have treated the underlying depression or other mental health disorders in patients but have not directly addressed suicide risk. Providing direct treatment of suicide risk using evidence-based interventions is vital. Hospitalization is often necessary for a patient’s immediate safety, but hospitalization used solely as a containment strategy may be ineffective or counterproductive51-53 and considered by the patient as a disincentive or penalty for expressing suicidal thoughts.54 Evidence-based clinical approaches that help to reduce suicidal thoughts and behaviors include: 1) Cognitive Therapy for Suicide Prevention (CBT-SP),55-56 2) the Collaborative Assessment and Management of Suicide (CAMS),19,57 and 3) Dialectical Behavior Therapy (DBT).58 In addition, Caring Contacts59-61 has a growing body of evidence as a post-discharge suicide prevention strategy. See an overview of these and other evidence-based interventions, which emphasize patient engagement, collaborative assessment and treatment planning, problem-focused clinical intervention to target suicidal “drivers,” skills training, shared service responsibility,12 and proactive and personal clinician involvement in care transitions and follow-up care, such as:

   • Engaging the patient and family members/significant others in collaborative discharge planning to promote effective coping strategies.
   • Discussing the treatment and discharge plan with the patient and sharing the plan with other providers having responsibility for the patient’s well-being.
• Determining how often patients will be called and seen.
• Establishing real-time telephone or live contact with at-risk patients who don't stay in touch or show up for an appointment, rather than having staff or resources just leave reminder messages or emails.
• Directly addressing patients’ thoughts about suicide at every interaction.62
• Using motivational enhancement to increase the likelihood of engagement in further treatment.44

EDUCATION AND DOCUMENTATION
These recommendations are relevant to all care providers and settings.

7. **Educate all staff in patient care settings about how to identify and respond to patients with suicide ideation.** Develop a process for how staff can sensitively respond to a patient with suicidal thoughts and feelings in a way that is appropriate to their role and professional training.63 Education for staff should cover environmental risk factors; finding help in emergencies; and policies for screening, assessment, referral, treatment, safety and support of patients at risk for suicide. The Clinical Workforce Preparedness Task Force of the National Action Alliance for Suicide Prevention developed “Suicide Prevention and the Clinical Workforce: Guidelines for Training.”64 “Caring for Adult Patients with Suicide Risk: A Consensus Guide for Emergency Departments,”38 The Joint Commission’s Standards BoosterPak™ Suicide Risk for National Patient Safety Goal 15.01.01, the QPR Institute and the VA/DoD Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide (2013)14 also are good resources.

8. **Document decisions regarding the care and referral of patients with suicide risk.** Thoroughly document every step in the decision-making process and all communication with the patient, his or her family members and significant others, and other caregivers. Document why the patient is at risk for suicide and the care provided to patients with suicide risk in as much detail as possible, including the content of the safety plan and the patient’s reaction to and use of it; discussions and approaches to means reduction; and any follow-up activities taken for missed appointments, including texts, postcards, and calls from crisis centers. Be generous in documentation, as it becomes the main method of communication among providers. For a documentation checklist, see Page 21 of *Caring for Adult Patients with Suicide Risk: A Consensus Guide for Emergency Departments.*38

Related Joint Commission requirements
The advice provided in this alert applies universally to all patients in all settings. In addition, since the risk of suicide increases after discharge from emergency departments and inpatient settings, it’s important for health care organizations to incorporate appropriate transition and follow-up actions in accordance with Provision of Care, Treatment, and Services accreditation requirement PC.04.01.01 – The organization has a process that addresses the patient’s need for continuing care, treatment, and services after discharge or transfer.
See the content of these standards on The Joint Commission website, posted with this alert.

Resources
Zero Suicide Toolkit, from the Suicide Prevention Resource Center and the National Action Alliance for Suicide Prevention
ED-SAFE Materials, from the Emergency Medicine Network
Caring for Adult Patients with Suicide Risk – A Consensus Guide for Emergency Departments, and Quick Guide for Clinicians, from the Suicide Prevention Resource Center
Means Matter website, from the Harvard T.H. Chan School of Public Health
Mental Health Environment of Care Checklist – For reviewing inpatient mental health units for environmental hazards, from the VA National Center for Patient Safety.
QPR Institute – Suicide prevention courses and training for professionals, institutions, and the public, on site or through a self-study program.
SAFE-T Pocket Card for Clinicians – Five-step evaluation and triage for suicide assessment
Suicide Prevention and the Clinical Workforce: Guidelines for Training, from the Clinical Workforce Preparedness Task Force of the National Action Alliance for Suicide Prevention
VA/DoD Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide, from the Department of Veterans Affairs, Department of Defense, June 2013.

References
20. SAFE-T: Suicide Assessment Five-step Evaluation and Triage for Mental Health Professionals. Originally conceived by Douglas Jacobs, MD, and developed as a collaboration between Screening for Mental Health, Inc. and the Suicide Prevention Resource Center (accessed Aug. 17, 2015).


38. Caring for Adult Patients with Suicide Risk. A consensus guide for emergency departments. Suicide Prevention Resource Center. 2015 Education Development Center, Inc. All rights reserved.


54. Freedenthal S. **Will I be committed to a mental hospital if I tell a therapist about my suicidal thoughts?** Speaking of Suicide website (accessed July 28, 2015).


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**Patient Safety Advisory Group**

The Patient Safety Advisory Group informs The Joint Commission on patient safety issues and, with other sources, advises on topics and content for *Sentinel Event Alert*. Members: James P. Bagian, MD, PE (chair); Frank Federico, BS, RPh (vice chair); Jane H. Barnsteiner, RN, PhD, FAAN; James B. Battles, PhD; William H. Beeson, MD; Bona E. Benjamin, BS, Pharm; Patrick J. Brennan, MD; Todd Bridges, RPh; Michael Cohen, RPh, MS, ScD; Cindy Dougherty, RN, BS, CPHQ; Michael El-Shammaa; Marilyn Flack; Steven S. Fountain, MD; Tejal Gandhi, MD, MPH, CPPS; Martin J. Hallie, Esq; Robin R. Hemphill, MD, MPH; Jennifer Jackson, BSN, JD; Paul Kelley, CBET; Heidi B. King, MS, FACHE, BCC, CMC, CPPS; Ellen Makar, MSN, RN-BC, CCM, CPHIMS, CENP; Jane McCaffrey, MHSA, DFASHRM; Mark W. Milner, RN, MBA, MHS; Grena Porto, RN, MS, ARM, CPHRM; Matthew Scanlon, MD; Ronni P. Solomon, JD; Dana Swenson, PE, MBA

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Effective Immediately: Surveying, Scoring of: Ligature, Suicide, Self-Harm in Inpatient Psychiatric Setting

Effective immediately, The Joint Commission will place added emphasis on the assessment of ligature, suicide and self-harm observations in psychiatric hospitals and inpatient psychiatric patient areas in general hospitals. This comes at a time when there is national concern about the number of suicides in hospitals. Also, the “Zero Suicide” campaign has set a new bar to eliminate suicides in health care facilities. Suicide is second on the list of The Joint Commission's sentinel event database.

Research has shown that many suicide attempts are impulsive. There is little disagreement that a facility that can eliminate environmental risks is reducing the means and opportunities for patients to commit suicide and/or harm themselves.

**During the on-site survey** – Joint Commission surveyors will document all observations of ligature or self-harm risks in the environment and will:
- Determine if the facility has previously identified these risks
- Evaluate existing plans the facility has for removing these risks
- Evaluate the organization's environmental risk assessment process

Surveyors will assess and/or evaluate:
- Plans and policies on mitigation of harm posed by risks while removal occurs
- Adequacy of staffing patterns to support these mitigation plans
- The patient suicide risk assessment process
- Organization policies and practices related to actions needed for patients identified at risk
- Policies and processes of ensuring staff awareness of a patient's level of risk
- The organization's internal processes for improvement, including:
  - The history of patient safety events and the process for root cause analysis of these events
  - The organization's process for monitoring its compliance with its policies
  - Actions taken when noncompliance was identified

**Documentation of findings and follow-up** – Each observation of a ligature or self-harm risk in the inpatient psychiatric patient area will be:
- Considered a requirement for improvement (RFI)
- Documented, according to standard procedure, using quantification, precise description and all required elements of documentation
- Scored at Environment of Care (EC) 02.06.01, element of performance (EP) 1
- Rated on the **Survey Analysis for Evaluating Risk (SAFER) Matrix™**, in terms of Likelihood to Harm a Patient/Staff/Visitor (low, medium, high) and the number of occurrences (limited, pattern, widespread)

In addition, the findings will be cited at the appropriate Condition of Participation (CoP) 482.41 - and, if in the highest risk areas, will be cited at the Condition level and noted as high risk on the SAFER Matrix™. In multi-purpose hospital areas – such as common rooms where there are always staff, emergency rooms or medical inpatient units where psychiatric patients may temporarily reside – the survey team will assess the organization's awareness of risks, efforts to mitigate, reliability of mitigation efforts, and the surveyor(s) will routinely engage the Standards Interpretation Group in the discussion. The decision on the SAFER Matrix™, as well as the consideration of Standard versus Condition level, will take all of this information into account. The post-survey process for these observations will follow standard procedure in which the organization has a 60-day timeframe to correct the physical environmental risks or have the option of applying for a survey-related waiver.
Survey findings at the highest level of risk may trigger consideration of whether an Immediate Threat to Life (ITL) exists while the surveyors are on-site. Determination of an ITL is only done by the senior leadership at The Joint Commission, who review all the data presented by the survey team. Hospital leadership would be notified immediately if an ITL was under consideration.

Joint Commission-accredited hospitals that treat psychiatric patients are encouraged to become familiar with the “Design Guide for the Built Environment of Behavioral Health Facilities,” as it includes solutions for environmental hazards to patients.

For more information on suicide risk, prevention and resources, see the Sentinel Event Alert published by The Joint Commission.
Bathroom Door Hanging Hazards in Inpatient Psychiatric Hospital

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Inpatient Suicides and Hanging
• 1,500 inpatient US hospital suicides in 2003 with 1/3 occurring while patient was on 15-minute checks
• 5-80 suicides per 100,000 US psychiatric admissions
• Veterans Affairs (VA) inpatient suicide study revealed 2.3 per 100,000 psychiatric admissions
• The Joint Commission (TJC) inpatient suicide review found 75% involved hanging
• VA inpatient suicide study indicated doors and cabinets accounted for 41% of anchor points when hanging was method of self-harm
• 50% of all hanging suicides have a ligature point below the head

What is SO Special About a Bathroom Door as Opposed to Other Doors?
• Fundamentally NOT much; however, bathroom door alternatives do exist and can be implemented without compromising fire safety requirements nor patient dignity.
• Consequently, TJC is requiring environmental change where change can be made.
• Traditional arguments regarding assessment and patient observations are NO longer sufficient without environmental change.

Is It Reasonable to Think a Patient Will Have Access to:

<table>
<thead>
<tr>
<th>Pressure to Close Off</th>
<th>Jugular v.</th>
<th>Carotid a.</th>
<th>Trachea</th>
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</thead>
<tbody>
<tr>
<td>kg (lbs)</td>
<td>2 (4.4)</td>
<td>5 (11)</td>
<td>15 (33)</td>
</tr>
</tbody>
</table>
Then a Patient Could:

What Are Hospitals Doing to Decrease Risk?

**Assessment**
- COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS)
  - Recent Screener
  - Since Last Visit Screener
  - Risk Assessment
  - Lifetime/Recent
  - Military Version
  - Frequent Screener – Psychiatric Inpatient

**Environmental Changes:**
- Removing Bathroom Doors
- “Saloon” Doors with Non-Traditional Door Hardware
- Soft Suicide Prevention Door
- Curtain

The focus of this Presentation is Environmental Risks and Changes.
Please research Columbia-Suicide Severity Rating Scale for assessment improvement opportunities.
Saloon Door with Non-Traditional Hardware

Soft Suicide Prevention Door

SuicideProofing.com

- Magnetic hinge breaks away with vertical pressure
- Shred proof
- Non-flammable
- Cleanable to hospital standards

- Potential safety shield for staff?
- Potential for patient destruction/misuse?
Privacy Curtain

Medline.com
- Velcro tabs pull from curtain and/or track with vertical pressure
- Non-flammable
- Launder able to hospital standards

Consider, a curtain is another implement of ligature but so is the shower curtain and the sheets and towels. Removal of anchor points warrants addition of another ligature element?

<table>
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<th>“Bathroom Door Options”</th>
<th>Privacy of Sight</th>
<th>Privacy of Sound</th>
<th>Privacy of Smell</th>
<th># of Bathroom Door Anchor Points</th>
<th>Retro Correct Per Door $ / Time</th>
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<td>Yes</td>
<td>7</td>
<td>n/a</td>
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<td>No Door: Single Occupancy Room with Hallway Door</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>0</td>
<td>$0 / 5 min</td>
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<td>No Door: Multi-Occupancy Room with Hallway Door</td>
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<td>No</td>
<td>No</td>
<td>0</td>
<td>$0 / 5 min</td>
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<td>No</td>
<td>4</td>
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<td>Soft Suicide Prevention Door</td>
<td>Yes</td>
<td>No</td>
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<td>0</td>
<td>$495 / 5 min</td>
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<tr>
<td>Curtain</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>0 - 1</td>
<td>$45 / 15 min</td>
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Track close up. A possible anchor point? Breakaway screws vs. Velcro strip?
References


The American Psychiatric Nurses Association Position Statement: The Use of Seclusion and Restraint

Introduction

Psychiatric-mental health nursing has a 100-year history of caring for persons in psychiatric facilities. Currently, nurses serve as front-line care providers as well as unit-based and executive level administrators in virtually every organization providing inpatient psychiatric treatment. Therefore, as the professional organization for psychiatric-mental health nurses, the American Psychiatric Nurses Association (APNA) recognizes that the ultimate responsibility for maintaining the safety of both individuals and staff in the treatment environment and for maintaining standards of care in the day-to-day treatment of individuals rests with nursing and the hospital leadership or behavioral health care organization leadership that supports the unit.

Thus, APNA supports a sustained commitment to the reduction and ultimate elimination of seclusion and restraint and advocates for continued research to support evidence-based practice for the prevention and management of behavioral emergencies. Furthermore, we recognize the need for and are committed to working together with physicians, clients and families, advocacy groups, other health providers and our nursing colleagues in order to achieve the reality of eliminating seclusion and restraint.

Background

In the mid-1800’s proponents of “moral treatment” of psychiatric patients advocated the elimination of the practice of restraining patients. Despite the relative success of this movement in England and Europe, psychiatrists in the United States concluded that restraints could never be eliminated in the United States (Bockoven, 1963; Deutsch, 1949; Rogers & Bocchino, 1999; Strumpf & Tomes, 1993). Until recently, belief in the necessity for continuing the practice of secluding and restraining patients persisted. For example, in 1994, Fisher concluded from his review of the literature that not only was it nearly impossible to operate a program for severely symptomatic individuals without some form of seclusion or physical or mechanical restraint” (p. 1584) but that these methods were effective in preventing injury and reducing agitation. Others, however, concluded that the practice of restraining and secluding patients was not grounded in research that supported the therapeutic efficacy of this intervention, but upon the observation that these measures interrupted and controlled the patient’s (Steinert et al. 2010, Scanlan 2010, Sailas & Fenton 2000, Paterson & Duxbury 2007).

Reports of patient death and injury while in (Rakhmatullina, Taub and Jacob 2013, Berzlanovich, Schöpfer & Keil, 2012, Cecchi et al. 2012) and studies of patients’ experiences in restraint and (Kontio 2011, Steinert et al. 2013, Soininen et al. 2013) have prompted psychiatric-mental health nurses to question the benefit of secluding and restraining psychiatric patients. These studies bring to the fore the ethical dilemmas inherent in the use of seclusion and (Cleary, Hunt and Walter 2010, Mohr, 2010, APNA Janssen Scholars, 2012). On the one hand, this practice has the potential for physically and/or psychologically harming (Evans, Wood and Lambert 2003, Mohr, Petti and Mohr 2003, Georgieva, Mulder & Whittington 2012) and for violating the patient’s right to autonomy and self-determination (Bower et. al 2003, Ezeobele et al. 2013). On the other hand, studies of violence on inpatient units underscore the reality that violence often cannot be predicted. Since the nursing staff are held responsible for maintaining the safety of all of the patients, they often see seclusion and restraint as a necessary last-resort intervention to maintain that (Lee, et. al 2003, Barton et al. 2009). Therefore, studies of the impact of
assault on those who care for patients must be taken into consideration when developing standards for practice and when addressing organizational strategies to assure equal commitment to worker as well as patient safety. (Flannery et al. 2011, Happell & Koehn 2011).

Research has highlighted the influence of unit philosophy and culture, treatment philosophy, staff attitudes, staff availability, staff training, ratios of patients to staff and location in the United States on either the disparity in the incidence of seclusion and restraint or the perpetuation of the practice of secluding and restraining psychiatric (Ashcraft, Bloss & Anthony, 2012, Chang et al. 2013, Happell & Koehn 2011, Azeem et al. 2011, Chandler 2012). From the research, it appears that the key to seclusion and restraint reduction is prevention of aggression by (a) maintaining a presence on the unit and noticing early changes in the patient and the milieu (Johnson & Delaney 2007, Taylor et al. 2012, Ward et. al. 2011) (b) assessing the patient and intervening early with less restrictive measures such as verbal and non-verbal communication, reduced stimulation, active listening, diversionary techniques, limit setting and prn medication (Bak et al. 2012, Sivak 2012, Bostwick & Hallman 2012, Chalmers et al. 2012, Bowers et al. 2012) and (c) changing aspects of the unit to promote a culture of structure, calmness, negotiation and collaboration rather than control (Kontio et al. 2012, Bowen, Privitera, and Bowie 2011, Jones 2012).

To date, there is some evidence that changes in a unit’s treatment philosophy can lead to changes in patient behavior that will ultimately impact the incidence of the use of seclusion and/or restraints (Delaney and Johnson 2012, Goetz and Taylor-Trujillo 2012). There is also growing awareness that inpatient treatment must be shaped by the principles of trauma-informed care and the recovery movement and that these philosophies will create a collaborative spirit that is essential to restraint reduction and elimination efforts (Hammer et al. 2011, Hardy & Patel 2011, Subica, Claypoole & Wylie 2012, Bowen, Privitera & Bowie 2011, Azeem et al. 2011, SAMHSA 2013).

Despite the best efforts at preventing the use of seclusion and restraint, there may be times that these measures are used. Thus, it is important to be cognizant of the vulnerability of individuals who are secluded or restrained and the risks involved in using these measures (Huf & Adams 2012, Hollins & Stubbs 2011, Mohr& Nunno 2011, Georgieva et. al 2012). Moreover, the dangers inherent in the use of seclusion and restraint include the possibility that the persons behavior is a manifestation of an organic or physiological problem that requires medical intervention and may therefore, secluded or restrained. Therefore, skilled assessments of individuals who are restrained or secluded will not only ensure the safety of individuals in these vulnerable conditions but also will ensure that the measures are discontinued as soon as the individual is able to be safely released.

**Position Statement**

APNA believes that psychiatric-mental health nurses play a critical role in the provision of care to persons in psychiatric settings. This role requires that nurses provide effective treatment and milieu leadership to maximize the individual’s ability to effectively manage potentially dangerous behaviors. To that end, we strive to assist the individual in minimizing the circumstances that give rise to seclusion and restraint use. Therefore:

- **We advocate for policies at the federal, state, and other organizational levels that will protect individuals from needless trauma associated with seclusion and restraint use while supporting both individual and staff safety.**
- **We take responsibility for providing ongoing opportunities for professional growth and learning for the psychiatric-mental health nurse whose treatment promotes individual safety, as well as autonomy and a sense of personal control.**
- **We promulgate professional standards that apply to all populations and in all settings where behavioral emergencies occur and that provide the framework for quality care for all individuals whose behaviors constitute a risk for safety to themselves or others.**
- **We advocate and support evidence-based practice through research directed toward examining the variables associated with the prevention of and safe management of behavioral emergencies.**
• We recognize that organizational characteristics have substantial influence on individual safety and call for shared ownership among leaders to create a work culture that supports minimal seclusion and restraint use and that will enable the vision of elimination to be realized.

• We articulate the following fundamental principles to guide action on the issue of seclusion and restraint:
  – Individuals have the right to be treated with respect and dignity and in a safe, humane, culturally sensitive and developmentally appropriate manner that respects individual choice and maximizes self-determination.
  – Seclusion or restraint must never be used for staff convenience or to punish or coerce individuals.
  – Seclusion or restraint must be used for the minimal amount of time necessary and only to ensure the physical safety of the individual, other patients or staff members and when less restrictive measures have proven ineffective.
  – Individuals who are restrained must be afforded maximum freedom of movement while assuring the physical safety of the individual and others. The least number of restraint points must be utilized and the individual must be continuously observed.
  – Seclusion and restraint reduction and elimination requires preventative interventions at both the individual and milieu management levels using evidence based practice.
  – Seclusion and restraint use is influenced by the organizational culture that develops norms for how persons are treated. Seclusion and restraint reduction and elimination efforts must include a focus on necessary culture change.
  – Effective administrative and clinical structures and processes must be in place to prevent behavioral emergencies and to support the implementation of alternatives.
  – Hospital and behavioral healthcare organizations and their nursing leadership groups must make commitments of adequate professional staffing levels, staff time and resources to assure that staff are adequately trained and currently competent to perform treatment processes, milieu management, de-escalation techniques and seclusion or restraint.
  – Oversight of seclusion and restraint must be an integral part of an organization’s performance improvement effort and these data must be open for inspection by internal and external regulatory agencies. Reporting requirements must be based on a common definition of seclusion and restraint. Specific data requirements must be consistent across regulatory agencies.
  – Movement toward future elimination of seclusion and restraint requires instituting and supporting less intrusive, preventative, and evidence-based interventions in behavioral emergencies that aid in minimizing aggression while promoting safety.

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2007 APNA Seclusion and Restraint Steering Committee: Lynn DeLacy (Chair), Amy Rushton (Co-Chair), Diane Allen, Hyman Beshansky, Laura Curtis, Kathleen Delaney, Germaine Edinger, Carole Farley-Toombs, Kathryn Fritsche, Susan Griffin, Lyons Hardy, Mary E. Johnson, William Koehler, Georganne Kuberski, Lee Liles. Kathleen McCann, Marlene Nadler-Moodie, Pamela Nold, Douglas Olsen, Kathleen Regan, Theodora Sirota, Joan van der Bijl, Karen Vergano, Theresa Warfield.

References


Approved by the APNA Board of Directors April 8, 2014
The Joint Commission has developed the **Survey Analysis for Evaluating Risk (SAFER)™ matrix** to provide healthcare organizations with the information they need to prioritize resources and focus corrective action plans in areas that are most in need of compliance activities and interventions. Each Requirement for Improvement (RFI) noted within your final report will be plotted on the SAFER™ matrix according to the likelihood the RFI could cause harm to patient(s), staff, and/or visitor(s) and the scope at which the RFI was observed. As the risk level of a RFI increases the placement of the standard and EP moves from the bottom left corner (lowest risk level) to the upper right (highest risk level).

**SAFER™** will help your organization to:
- More easily identify RFIs with higher risk
- Identify potential for widespread quality initiatives
- Better organize survey findings by level of potential patient impact
- Have one, comprehensive visual representation of survey findings

**SAFER™ Impacts**
- SAFER™ matrix will be included in all survey reports and will drive the level of post survey follow up required.
- All RFIs will be addressed in a 60 day Evidence of Standards Compliance Report.
- For higher risk level RFIs, additional detail is required regarding corrective action sustainment.
- RFIs of a higher risk level will be highlighted for surveyors, for potential review on subsequent surveys.

![SAFER™ Matrix and Follow-Up Activity](image)

<table>
<thead>
<tr>
<th>SAFER™ Matrix Placement</th>
<th>Required Follow-Up Activity</th>
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</table>
| HIGH/LIMITED, HIGH/WIDESPREAD | • 60 day Evidence of Standards Compliance (ESC)  
• ESC will include Who, What, When, and How sections |
| MODERATE/LIMITED, MODERATE/WIDESPREAD | • Finding will be highlighted for potential review by surveyors on subsequent onsite surveys up to and including the next full survey or review |
| MODERATE, LOW/PATTERN, LOW/WIDESPREAD | • 60 day Evidence of Standards Compliance (ESC)  
- ESC will include Who, What, When, and How sections |
| LIMITED | |

Note: The Joint Commission's survey process includes a hipaa-compliant process to ensure confidentiality. The process includes reviewing, scoring, and de-identifying survey results. A risk assessment identifies areas requiring additional surveillance. Follow-up activities are documented and tracked to ensure compliance.
### Operational Definitions

#### Scope

<table>
<thead>
<tr>
<th>Category</th>
<th>Definition</th>
<th>Further Guidance</th>
</tr>
</thead>
<tbody>
<tr>
<td>LIMITED</td>
<td>Unique occurrence that is not representative of routine/regular practice, and has the potential to impact only one or a very limited number of patients, visitors, staff</td>
<td></td>
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<tr>
<td></td>
<td>• An outlier.</td>
<td>• Scope is isolated when one or a very limited number of patients are affected and/or one or a very limited number of staff are involved, and/or the deficiency occurs in a very limited number of locations.</td>
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<tr>
<td>PATTERN</td>
<td>Multiple occurrences of the deficiency, or a single occurrence that has the potential to impact more than a limited number of patients, visitors, staff</td>
<td></td>
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<tr>
<td></td>
<td>• Process Variation.</td>
<td>• Scope is pattern when more than a very limited number of patients are affected, and/or more than a very limited number of staff are involved, and/or the situation has occurred in several locations, and/or the same patient(s) have been affected by repeated occurrences of the same deficient practice.</td>
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<tr>
<td>WIDESPREAD</td>
<td>Deficiency is pervasive in the facility, or represents systemic failure, or has the potential to impact most/all patients, visitors, staff</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Process Failure.</td>
<td>• Scope is widespread when the deficiency affects most/all patients, is pervasive in the facility or represents systemic failure. Widespread scope refers to the entire organization, not just a subset of patients or one unit.</td>
</tr>
</tbody>
</table>

#### Likelihood to Harm

<table>
<thead>
<tr>
<th>Category</th>
<th>Definition</th>
<th>Further Guidance</th>
</tr>
</thead>
<tbody>
<tr>
<td>LOW</td>
<td>Harm could happen, but would be rare</td>
<td>• Undermines safety/quality or contributes to an unsafe environment, but very unlikely to directly contribute to harm.</td>
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<tr>
<td></td>
<td></td>
<td>• It would be rare for any actual patient harm to occur as a result of the deficiency.</td>
</tr>
<tr>
<td>MODERATE</td>
<td>Harm could happen occasionally</td>
<td>• Could cause harm directly, but more likely to cause harm as a contributing factor in the presence of special circumstances or additional failures.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• If the deficiency continues, it would be possible that harm could occur but only in certain situations and/or patients.</td>
</tr>
<tr>
<td>HIGH</td>
<td>Harm could happen at any time</td>
<td>• Could directly lead to harm without the need for other significant circumstances or failures.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• If the deficiency continues, it would be likely that harm could happen at any time to any patient (or did actually happen)</td>
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</table>
Survey Analysis for Evaluating Risk (SAFER) Matrix™ FAQs

1. Why are we changing our process?
   a. As time has gone on, The Joint Commission’s scoring processes have slowly become more and more complex, resulting in several layers of identifying impact of a finding to an organization based on which standard and element of performance the finding is cited under. These layers include, but are not limited to, Indirect vs. Direct, A vs. C, and risk categories. Because of this complexity, and the focus of Project Refresh to simplify processes, research began in the beginning of 2015 to determine a better process to identify the potential impact of a finding to patient safety and quality. This analysis included research across several industries to determine best practices to potentially implement within the regulatory healthcare realm.
   b. In addition, this model seeks to provide healthcare organizations with the information necessary to prioritize resources and focus corrective action plans in areas that are in most need of compliance activities and interventions through providing a visual, at an aggregate level, of areas of non-compliance through scope and severity of the deficiencies cited.

2. What is the Survey Analysis for Evaluating Risk (SAFER) Matrix?
   a. In the new SAFER matrix™, findings are evaluated to determine the likelihood the issue has to harm a patient, visitor, or staff member (low, moderate, and high) in addition to the scope of the issue within the organization (limited, pattern, widespread) and are illustrated through a visual matrix. This determination is completed by surveyor(s) onsite and will result in the standard, EP being noted within the matrix below.
b. As the risk of a finding rises, then the placement of the standard, EP moves from the bottom left corner (lowest risk level) to the upper right (highest risk level). The Immediate Threat to Health and Safety process remains the same, and if cited during survey, will be placed in the Immediate Threat to Health and Safety Row located at the top of the matrix.

c. Placement of finding will be determined by surveyor(s) while onsite and will be based upon the risk of the finding itself, not the pre-designation of the standard, EP (A vs C or Indirect vs Direct) under which the finding resides. As a result, the same standard, EP for one organization can be placed in a different area of the matrix than for another organization.

3. How will surveyors use the SAFER matrix during a survey?
   a. During the survey, surveyors will be placing the standard, EP under which a finding is noted onto the SAFER matrix. This placement is determined by the likelihood the finding has to harm a patient, staff, or visitors and scope of the finding within the organization. This results in the actual findings driving the placement of the standard, EP on the SAFER matrix and not the pre-designation of A vs C or Indirect vs Direct EPs.

4. Will the Risk Designations (R) and Document Requirements (D) within ICM still exist?
   a. Yes, these two icons will still exist as they both serve a value-added purpose.

5. What will the follow up process look like?
   a. Instead of having two separate Evidence of Standards Compliance (ESC) forms, one due 45 days after survey and one due 60 days after survey, there will now only be one ESC form. This will result in all findings noted within the survey report having corrective actions be submitted within one ESC due 60 days after the final survey report is received.
   
   b. Also, for those findings of a higher risk level (those in the dark orange and red areas of the SAFER matrix), two additional fields will be required within the ESC to provide a more detailed description of the organization’s sustainment of compliance plan. These two areas will be surrounding Leadership Involvement and Preventive Analysis. These findings will also be provided to surveyors for possible review the following onsite surveys, up until the next full triennial survey occurs.
   
   c. On the following page is a grid illustrating which boxes will require which level of follow up.
6. Does the SAFER matrix tie to a decision?
   a. The SAFER matrix is meant to be utilized as a tool in the survey process to illustrate potential risk areas at the organization. It will not be used in isolation to drive or determine if certain decision rules will be applied.
   b. Also, the SAFER matrix will not impact the process utilized onsite to determine a Condition Level Deficiency or the declaration of an Immediate Threat to Health and Safety.

7. For deemed organizations, will the placement of a finding within the SAFER matrix influence if the finding will be scored as a Condition or a Standard Level Deficiency?
   a. No, the placement of a finding within the SAFER matrix will not determine if a Condition Level Deficiency is called. The determination of a Condition Level Deficiency will follow the current process established by CMS of looking at manner (occurrence/frequency of the issue) and degree (gravity of the issue) of the finding(s) being observed during the survey.

8. What is going away?
   a. 45-day ESC
   b. Measure of Success
   c. Opportunities for Improvement section of the report
   d. A vs C categories of EPs
   e. Direct vs Indirect EPs

9. What if my organization receives an onsite survey in 2016 and a Measure of Success (MOS) is required, but my MOS is due in 2017?
   a. The Measure of Success requirement will be eliminated for all accreditation and certification organizations effective January 1, 2017.
   b. Please note, for organizations that have an MOS due in 2016, they will still be required to submit the MOS.
   c. However, for organizations that have an MOS that is due on or after 1/1/17:
i. On 1/1/17 all open MOSs will be closed out in our system, resulting in organizations NOT being required to submit the MOS.

ii. The MOS tool will stay open on your Extranet site through the end of 2016 if you wish to enter and “save” data, print it off, etc. for your own internal improvement efforts. However, organizations will not be required to “submit” this data and the MOS will officially close on 1/1/17.

iii. The Joint Commission still encourages organizations to continue to monitor the effectiveness of their corrective actions through future measurement as it pertains to each organization.

10. Will ICM be updated to include the SAFER matrix?
   a. ICM will be updated to incorporate the SAFER matrix’s scoring methodology in January of 2017.
   b. AMP will also be updated with these changes as well.
   c. Please note, the ICM and AMP tools will be updated with the SAFER matrix to allow for organizations to identify SAFER designations of Likelihood to Harm and Scope throughout the self-assessment process. However, this designation will be optional and will not be required in order to submit the ICM. In addition, the Plan of Action section of the ICM will remain the same as it is today.

11. Who does this change apply to?
   a. Starting June 6, 2016, the process will be implemented for Deemed Psychiatric Hospitals (tailored and non-tailored) only.
   b. For all other programs (including both accreditation and certification), the SAFER matrix will be implemented January 1, 2017.

12. What are the published materials available regarding the SAFER matrix?
   a. *Perspectives* Article sent to all organizations – May Issue – Published April 19th (approximately)
   b. *JCO*Online sent to all organizations – May 4, 2016
   c. *Perspectives* article provided to all organizations – October Issue
Frequently Asked Questions, Definitions, and Additional Information from the Standards BoosterPak™ for Use of Restraint and Seclusion for Organizations Using Joint Commission Accreditation for Deemed Status

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

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

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

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

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

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

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

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

- The 42 CFR (Code of Federal Regulations) 482.13(e)(1) Definitions. (i) A restraint is—(A) Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely; or 42 CFR 482.13(e)(1)(i)(B) A drug or medication when it is used as a restriction to manage the patient’s behavior or restrict the patient’s freedom of movement and is not a standard treatment or dosage for the patient’s condition.
- 42 CFR 482.13(e)(1)(C) A restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort).
- 42 CFR 482.13(e)(1)(ii) Seclusion is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may only be used for the management of violent or self-destructive behavior.
Q Do the new standards require a debriefing process after an episode during which a patient has been placed in restraints for violent or self-destructive behavior?
A No, the Hospital Accreditation Program restraint/seclusion standards for deemed status purposes do not require a debriefing process to be completed. This does not prohibit the organization from requiring a debriefing process as it sees fit. The debriefing process is often used when the patient has a behavioral health issue and is part of the process.

Q Do orders for restraints still have definite time limits?
A A restraint order that is being used for violent or self-destructive behavior still has a definite time limit associated with it. Standard PC.03.05.05, EP 4, states: Unless state law is more restrictive, orders for the use of restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, staff, or others may be renewed within the following limits:
• 4 hours for adults 18 years of age or older
• 2 hours for children and adolescents, 9 to 17 years of age
• 1 hour for children under 9 years of age
Orders may be renewed according to the time limits for a maximum of 24 consecutive hours. Organizations must develop their own guidelines for the time limits on restraints for other than violent or self-destructive behavior. Patient safety, patient assessment, and the type of restraint used will determine the guideline for the time limit for a restraint that is used for nonviolent, non self-destructive behavior.

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

Q Is the use of a telemedicine link allowed for use by the licensed independent practitioner who conducts the in-person evaluations of the individual in restraint or seclusion?
A No. A telemedicine link does not fulfill the in-person requirement for the evaluation by a licensed independent practitioner of the individual in restraint or seclusion.

Section B2: Definitions of Key Terms

Criticality level: The Joint Commission defines criticality as the immediacy of risk to patient safety or quality of care as a result of noncompliance with a Joint Commission requirement (for example, an EP, National Patient Safety Goal, Universal Protocol). The four levels of criticality are as follows:
1. Immediate Threat to Health and Safety
2. Situational Decision Rules
3. Direct Impact Requirements
4. Indirect Impact Requirements

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

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

1. A doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he performs such function or action (including a physician within the meaning of section 1301(a)(7))

2. A doctor of dental surgery or of dental medicine who is legally authorized to practice dentistry by the State in which he performs such function and who is acting within the scope of his license when he performs such functions

3. A doctor of podiatric medicine for the purposes of subsections (k), (m), (p)(1), and (s) of this section and sections 1814(a), 1832(a)(2)(F)(ii), and 1835 but only with respect to functions which he is legally authorized to perform as such by the State in which he performs them

4. A doctor of optometry, but only for purposes of subsection (p)(1) with respect to the provision of items or services described in subsection (s) which he is legally authorized to perform as a doctor of optometry by the State in which he performs them

5. A chiropractor who is licensed as such by the State (or in a state which does not license chiropractors as such, is legally authorized to perform the services of chiropractor in the jurisdiction in which he performs such services), and who meets uniform minimum standards promulgated by the Secretary, but only for the purpose of sections 1861(s)(1) and 1861(s)(2)(A) and only with respect to treatment by means of manual manipulation of the spine (to correct a subluxation) which he is legally authorized to perform by the State or jurisdiction in which such treatment is provided.

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

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

- 42 CFR 482.13(e)(1) Definitions. (i) A restraint is—(A) Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely
- 42 CFR 482.13(e)(1)(i)(B) A restraint is—(A) A drug or medication when it is used as a restriction to manage the patient’s behavior or restrict the patient’s freedom of movement and is not a standard treatment or dosage for the patient’s condition.
- 42 CFR 482.13(e)(1)(i)(C) A restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort).

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

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

* See section B3 for additional information.
Scoring categories: The performance expectations for determining if a standard is in compliance are included in its EPs. EPs are divided into two scoring categories: Category A EPs and Category C EPs.

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

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

**Definitions from CMS Interpretive Guidelines:**

1. An arm board, if used to stabilize an IV line, is generally not considered a restraint. If the arm board is tied down or attached to the bed or the entire limb is immobilized, the use would be considered a restraint.

2. A mechanical support used to achieve body position, balance, or alignment to allow greater freedom of mobility than would be possible without the use of such a mechanical support is not a restraint.

3. A positioning or securing device used to maintain the position or limit mobility during medical, dental, diagnostic, or surgical procedures is not a restraint.

4. Recovery from anesthesia. The use of a medically necessary restraint in this setting would not need to meet the requirements of a restraint. However, if the device continues to be used when the patient is transferred to another unit or recovers from the effects of the anesthesia, a restraint order would be necessary and the requirements would apply.

5. Many types of hand mitts would not be considered restraint. However, pinning or otherwise attaching those same mitts to bedding or using a wrist restraint in conjunction with the hand mitts would meet the definition of restraint and the requirements would apply. In addition, if the mitts are applied so tightly that the patient's hand or fingers are immobilized, this would be considered restraint and the requirements would apply. Likewise, if the mitts are so bulky that the patient's ability to use their hands is significantly reduced, this would be considered restraint and the requirements would apply.

**NOTE:** Because this definition of physical restraint does not name each device and situation that can be used to immobilize or reduce the ability of the patient to move his or her arms, legs, body or head freely, it promotes looking at each patient situation on a case-by-case basis. In addition, if a patient can easily remove a device, the device would not be considered a restraint. In this context, “easily remove” means that the manual method, device, material, or equipment can be removed intentionally by the patient in the same manner as it was applied by the staff (e.g., side rails are put down, not climbed over; buckles are intentionally unbuckled; ties or knots are intentionally untied; etc.) considering the patient’s physical condition and ability to accomplish the objective (e.g., transfer to a chair, get to the bathroom in time).

6. Physical hold of a patient for the purpose of conducting routine physical examinations or tests. Patients do have the right to refuse treatments. This includes the right to refuse physical examinations or tests. Holding a patient in a manner that restricts the patient’s movement against the patient’s will is considered restraint.

7. Physical hold in order to administer a medication against the patient’s wishes is considered restraint. A court order for medication treatment only removes the patient’s right to refuse the medication.
8. Physical hold when a patient consents to an injection or procedure but may not be able to hold still for the safe administration of the medication or procedure and requests the staff to “hold” is not considered restraint.

9. Side rails used as a measure to prevent the patient from exiting the bed would be considered a restraint and subject to the requirements.

10. When a patient is on a bed that constantly moves to improve circulation or prevent skin breakdown, raised side rails are a safe intervention and not viewed as a restraint.

11. When a patient is placed on seizure precautions and all side rails are raised, the use would not be considered restraint.

12. If a patient is on a stretcher, there is an increased risk of falling without raised side rails due to its narrow width. Therefore, the use of raised side rails on stretchers is not considered restraint.

13. Time-out is not considered seclusion. It is an intervention in which the patient consents to being alone in a designated area for an agreed-upon time frame, and the patient may leave the room if he or she chooses.

14. Tucking a patient’s sheets in so tightly that the patient cannot move is restraint.

15. Use of a “net bed” or an “enclosed bed” that prevents the patient from freely exiting the bed is restraint.

16. Use of “Freedom” splints that immobilize a patient’s limb is restraint.

17. A Geri chair or recliner is a restraint only if the patient cannot easily remove the restraint appliance and get out of the chair on his or her own.

18. Seat belts are a restraint only if the patient cannot easily remove the restraint appliance and remove the belt on his or her own.

19. The use of handcuffs, shackles, or other chain-type restraint devices applied by non-hospital employed or contracted law enforcement officials for custody, detention, and public safety reasons are not governed by the Conditions of Participation.

Section B3: Additional Information

Additional standards to consider regarding restraint/seclusion:

- **EC.01.01.01** The hospital plans activities to minimize risks in the environment of care.
- **HR.01.01.01** The hospital has the necessary staff to support the care, treatment, and services it provides.
- **HR.01.02.01** The hospital defines staff qualifications.
- **HR.01.02.07** The hospital determines how staff function within the organization.
- **HR.01.04.01** The hospital provides orientation to staff.
- **HR.01.05.03** Staff participate in ongoing education and training.
- **HR.01.06.01** Staff are competent to perform their responsibilities.
- **HR.01.07.01** The hospital evaluates staff performance.
- **LD.01.03.01** The governing body is ultimately accountable for the safety and quality of care, treatment, and services.
- **LD.02.01.01** The mission, vision, and goals of the hospital support the safety and quality of care, treatment, and services.
- **LD.02.03.01** The governing body, senior managers and leaders of the organized medical staff regularly communicate with each other on issues of safety and quality.
- **LD.03.01.01** Leaders create and maintain a culture of safety and quality throughout the hospital.
• **LD.03.02.01** The hospital uses data and information to guide decisions and to understand variation in the performance of processes supporting safety and quality.

• **LD.03.05.01** Leaders implement changes in existing processes to improve the performance of the hospital.

• **LD.03.06.01** Those who work in the hospital are focused on improving safety and quality.

• **LD.04.01.01** The hospital complies with law and regulation.

• **LD.04.01.05** The hospital effectively manages its programs, services, sites, or departments.

• **LD.04.01.07** The hospital has policies and procedures that guide and support patient care, treatment, and services.

• **LD.04.03.09** Care, treatment, and services provided through contractual agreement are provided safely and effectively.

• **LD.04.04.01** Leaders establish priorities for performance improvement.

• **LD.04.04.05** The hospital has an organizationwide, integrated patient safety program within its performance improvement activities.

• **PL.01.01.01** The hospital collects data to monitor its performance.

• **RI.01.01.01** The hospital respects, protects, and promotes patient rights.

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

Updated July 2014
Appendix A: Resources

Print Resources

*JCR* periodical articles can be purchased on PubMed via Ingenta (http://www.ingentaconnect.com/).

Electronic Resources

The Joint Commission: http://www.jointcommission.org
Joint Commission Resources: http://www.jcrinc.co

NOTE: The Internet is an ever-evolving environment and links are subject to change without notice.
Appendix B: Faculty Biography

NOTE: This presenter does not have any financial arrangements or affiliations with corporate organizations that either provide educational grants to this program or may be referenced in this activity. This presenter has also attested that his discussions will not include any unapproved or off-label use of products.

Burton L. Thelander, RN, MS, NE-BC  
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Performance Improvement Specialist, NYU-Langone Medical Center

Burton Thelander currently is a resident of New York State. He surveys the standards in the Comprehensive Accreditation Manual for Hospitals and Behavioral Health Care and presently is a surveyor in the Hospital and Behavioral Health Accreditation Program.

Mr. Thelander is employed part time at NYU Langone Medical Center in New York, New York as a Performance Improvement Specialist. Prior to joining The Joint Commission, Mr. Thelander was a Director of Nursing and Director of Advanced Practice within the New York State Office of Mental Health inpatient and outpatient behavioral health service.

Mr. Thelander is certified as a Nurse Executive by the American Nurse Credentialing Center and currently is licensed in New York State as a Professional Registered Nurse.
Appendix C: Continuing Education (CE) Accrediting Bodies

To be eligible for CE credit from any of the following accrediting bodies, you MUST view the video presentation and read the Resource Guide first. Then, complete the post test at http://twnlms.com/ by the due date listed online. See Appendix E.

The Joint Commission is accredited by the Accreditation Council for Continuing Medical Education (ACCME-AMA PRA Category 1™), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC) to provide continuing education for the healthcare team.

NOTE: No ACPE credit was provided for this program.

The Joint Commission is provider approved by the California Board of Registered Nursing, provider number CEP 6381, for 1 contact hour.

The Joint Commission is authorized to award 1.0 contact hour of pre-approved ACHE Qualified Education credit for this program toward advancement or recertification in the American College of Healthcare Executives. Participants in this program wishing to have the continuing education hours applied toward ACHE Qualified Education credit should indicate their attendance when submitting application to the American College of Healthcare Executives for advancement or recertification.

This activity has been approved by the National Association for Healthcare Quality (NAHQ) for 1.0 Certified Professional Healthcare Quality (CPHQ) credit.

The Joint Commission Enterprise has been accredited as an Authorized Provider by the International Association for Continuing Education and Training (IACET).

This education offering qualifies for 1.0 Certified Joint Commission Professional (CJCP) credit hours towards CJCP recertification. In order to obtain CJCP credit hours, an individual must first be certified before they start acquiring CJCP credit hours. CJCP credit hours will not be retroactive.

Full attendance at every session is a prerequisite for receiving full continuing education credits. If a participant needs to leave early, his or her continuing education credits will be reduced.

Successful completion of this CE activity includes the following:

• View the presentation and read the accompanying Resource Guide.

• Complete the online Evaluation Form and Post Test.

• A CE certificate/statement of credit can be printed online following successful completion of the Post Test and the Evaluation Form

NOTE: This information applies to The Joint Commission Resources Quality & Safety Network program titled, *Be Prepared: Maximizing Behavioral Healthcare-Related Tracer Activities*, originally presented on Thursday, April 27, 2017 from 2:00 – 3:00 p.m. ET. There is no individual participant fee for this educational activity.
Appendix D: Discipline Codes Instructions

Some of our programs are accredited for more than one discipline. To ensure that we issue each participant a certificate by the appropriate accrediting body, we ask that you supply us with the following information: 1) two-digit discipline code. 2) followed by the position code (example: for a medical doctor, use 10 MD).

<table>
<thead>
<tr>
<th>Discipline</th>
<th>Discipline Code</th>
<th>Position Code</th>
<th>Position</th>
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<td>MD-Area Clinical Needs</td>
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<td>MSP</td>
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Appendix E: Post-Test

To be eligible for CE credit, you MUST view the video presentation and read the Resource Guide first. Then complete the post-test at http://jcrqsn.twnlms.com/ by the due date listed online.

1. Standard EC.02.06.01, EP 1 requires interior spaces_____.
   a. meet the needs of the patient population
   b. be safe
   c. be suitable to the care, treatment, and services provided
   d. All of the above.

2. National Patient Safety Goal (NPSG) 15.01.01 requires organizations_____.
   a. to conduct a risk assessment that identifies specific patient characteristics and environmental features that may increase or decrease the risk for suicide
   b. address the patient's immediate safety needs and most appropriate setting for treatment
   c. provide suicide prevention information (such as a crisis hotline) to the patient and his or her family when a patient at risk for suicide leaves the care of the hospital
   d. All of the above.

3. Standard PC.03.05.01 requires the hospital to use_____.
   a. restraint or seclusion only when it can be clinically justified or when warranted by patient behavior that threatens the physical safety of the patient, staff, or others
   b. restraint when a patient in uncooperative
   c. a and b
   d. None of the above.

4. Standard PC.01.03.01 requires that the_____.
   a. hospital plans the patient's care, treatment, and services based on needs identified by the patient's assessment, reassessment, and results of diagnostic testing
   b. written plan of care is based on the patient's goals and the time frames, settings, and services required to meet those goals
   c. a and b
   d. None of the above.

5. Standard PC.03.05.03 requires that the_____.
   a. hospital implements restraint or seclusion using safe techniques identified by the hospital's policies and procedures in accordance with laws and regulations
   b. use of restraint and seclusion is in accordance with a written modification to the patient's plan of care
   c. a and b
   d. None of the above.

6. Standard PC.01.03.01, EP 5 requires the written plan of care be based on the patient's goals and the time frames, settings, and services required to meet those goals.
   a. True
   b. False
7. Standard PC.03.05.01, EP 5 requires that the hospital _____.
   a. waits to evaluate discontinuing restraint or seclusion until the scheduled expiration of the order
   b. discontinues restraint or seclusion at the earliest possible time, regardless of the scheduled expiration of the order
   c. a and b
   d. None of the above.

8. Among other EPs, Standard PC.01.03.01 requires that the_____.
   a. staff evaluates the patient's progress, based on the goals established in the patient's plan of care
   b. hospital revises plans and goals for care, treatment, and services based on the patient's needs
   c. plan of care includes the responsibilities of each member of the treatment team for psychiatric hospitals that use Joint Commission accreditation for deemed status purposes
   d. All of the above.

9. Standard PC.03.05.11, EP 3 requires an in-person evaluation be conducted within _____ minutes of the initiation of restraint or seclusion.
   a. 15
   b. 30
   c. 60
   d. 90

10. The in-person evaluation conducted on a patient who is restrained or secluded includes ______.
    a. an evaluation of the patient's immediate situation
    b. the need to continue or terminate the restraint or seclusion
    c. the patient's medical and behavioral condition
    d. the patient's reaction to the intervention
    e. All of the above.
Appendix F: JCRQSN Contact Information

General information, customer service issues, or program reception issues
JCRQSN Customer Service Team
support@jcrqsn.com
toll-free 1-888-219-4678

Questions or comments about JCRQSN educational programming
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Executive Producer, Video and Audio Programs
Lean Six Sigma Certified Yellow Belt
Publications and Education Department
griccio@jcrinc.com
1-630-792-5428

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JCRQSN Continuing Education Support Team
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Questions about standards
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1-630-792-5900

Questions about JCR education or other resources
JCR Customer Service Center
1-877-223-6866