3. **Seclusion and Restraint**
   - Use of Seclusion and Restraint in Hospitals - 42 CFR Part 482
   - PA 531 of 2004 Seclusion & Restraint in CCI’s (amends 116 of 1973)
   - Use of Seclusion and Restraint – Under 21 - 42 CFR Part 483
Sec. 482.13  Condition of participation: Patient's rights.

A hospital must protect and promote each patient's rights.

(a) Standard: Notice of rights. (1) A hospital must inform each patient, or when appropriate, the patient's representative (as allowed under State law), of the patient's rights, in advance of furnishing or discontinuing patient care whenever possible.

(2) The hospital must establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance. The hospital's governing body must approve and be responsible for the effective operation of the grievance process and must review and resolve grievances, unless it delegates the responsibility in writing to a grievance committee. The grievance process must include a mechanism for timely referral of patient concerns regarding quality of care or premature discharge to the appropriate Utilization and Quality Control Quality Improvement Organization. At a minimum:

(i) The hospital must establish a clearly explained procedure for the submission of a patient's written or verbal grievance to the hospital.

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

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

(b) Standard: Exercise of rights. (1) The patient has the right to participate in the development and implementation of his or her plan of care.

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

(3) The patient has the right to formulate advance directives and to have hospital staff and practitioners who provide care in the hospital comply with these directives, in accordance with Sec. 489.100 of this part (Definition), Sec. 489.102 of this part (Requirements for providers), and Sec. 489.104 of this part (Effective dates).
(4) The patient has the right to have a family member or representative of his or her choice and his or her own physician notified promptly of his or her admission to the hospital.

(c) Standard: Privacy and safety. (1) The patient has the right to personal privacy.
(2) The patient has the right to receive care in a safe setting.
(3) The patient has the right to be free from all forms of abuse or harassment.
(d) Standard: Confidentiality of patient records. (1) The patient has the right to the confidentiality of his or her clinical records.
(2) The patient has the right to access information contained in his or her clinical records within a reasonable time frame. The hospital must not frustrate the legitimate efforts of individuals to gain access to their own medical records and must actively seek to meet these requests as quickly as its record keeping system permits.

(e) Standard: Restraint or seclusion. All patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time.

(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
(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.
(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).
(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.

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

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

(4) The use of restraint or seclusion must be--
(i) In accordance with a written modification to the patient's plan of care; and
(ii) Implemented in accordance with safe and appropriate restraint and seclusion techniques as determined by hospital policy in accordance with State law.

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

(6) Orders for the use of restraint or seclusion must never be written as a standing order or on an as needed basis (PRN).
(7) The attending physician must be consulted as soon as possible if the attending physician did not order the restraint or seclusion.

(8) Unless superseded by State law that is more restrictive--

(i) Each order for restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others may only be renewed in accordance with the following limits for up to a total of 24 hours:
   (A) 4 hours for adults 18 years of age or older;
   (B) 2 hours for children and adolescents 9 to 17 years of age; or
   (C) 1 hour for children under 9 years of age; and

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

(iii) Each order for restraint used to ensure the physical safety of the non-violent or non-self-destructive patient may be renewed as authorized by hospital policy.

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

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

(11) Physician and other licensed independent practitioner training requirements must be specified in hospital policy. At a minimum, physicians and other licensed independent practitioners authorized to order restraint or seclusion by hospital policy in accordance with State law must have a working knowledge of hospital policy regarding the use of restraint or seclusion.

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

(i) By a--
   (A) Physician or other licensed independent practitioner; or
   (B) Registered nurse or physician assistant who has been trained in accordance with the requirements specified in paragraph (f) of this section.

(ii) To evaluate--
   (A) The patient's immediate situation;
   (B) The patient's reaction to the intervention;
   (C) The patient's medical and behavioral condition; and
   (D) The need to continue or terminate the restraint or seclusion.

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

(14) If the face-to-face evaluation specified in paragraph (e)(12) of this section is conducted by a trained registered nurse or physician assistant, the trained registered nurse or physician assistant must consult the attending physician or other licensed independent practitioner who is responsible for the care of the patient as specified under Sec. 482.12(c) as soon as possible after the completion of the 1-hour face-to-face evaluation.
(15) All requirements specified under this paragraph are applicable to the simultaneous use of restraint and seclusion. Simultaneous restraint and seclusion use is only permitted if the patient is continually monitored--
   (i) Face-to-face by an assigned, trained staff member; or
   (ii) By trained staff using both video and audio equipment. This monitoring must be in close proximity to the patient.
(16) When restraint or seclusion is used, there must be documentation in the patient's medical record of the following:
   (i) The 1-hour face-to-face medical and behavioral evaluation if restraint or seclusion is used to manage violent or self-destructive behavior;
   (ii) A description of the patient's behavior and the intervention used;
   (iii) Alternatives or other less restrictive interventions attempted (as applicable);
   (iv) The patient's condition or symptom(s) that warranted the use of the restraint or seclusion; and
   (v) The patient's response to the intervention(s) used, including the rationale for continued use of the intervention.

(f) **Standard: Restraint or seclusion: Staff training requirements.**
The patient has the right to safe implementation of restraint or seclusion by trained staff.

(1) Training intervals. Staff must be trained and able to demonstrate competency in the application of restraints, implementation of seclusion, monitoring, assessment, and providing care for a patient in restraint or seclusion--
   (i) Before performing any of the actions specified in this paragraph;
   (ii) As part of orientation; and
   (iii) Subsequently on a periodic basis consistent with hospital policy.
(2) Training content. The hospital must require appropriate staff to have education, training, and demonstrated knowledge based on the specific needs of the patient population in at least the following:
   (i) Techniques to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of a restraint or seclusion.
   (ii) The use of nonphysical intervention skills.
   (iii) Choosing the least restrictive intervention based on an individualized assessment of the patient's medical, or behavioral status or condition.
   (iv) The safe application and use of all types of restraint or seclusion used in the hospital, including training in how to recognize and respond to signs of physical and psychological distress (for example, positional asphyxia);
   (v) Clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary.
   (vi) Monitoring the physical and psychological well-being of the patient who is restrained or secluded, including but not limited to, respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by hospital policy associated with the 1-hour face-to-face evaluation.
   (vii) The use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic recertification.
(3) Trainer requirements. Individuals providing staff training must be qualified as evidenced by education, training, and experience in techniques used to address patients' behaviors.
(4) Training documentation. The hospital must document in the staff personnel records that the training and demonstration of competency were successfully completed.

(g) Standard: Death reporting requirements: Hospitals must report deaths associated with the use of seclusion or restraint.
   (1) The hospital must report the following information to CMS:
      (i) Each death that occurs while a patient is in restraint or seclusion.
      (ii) Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion.
      (iii) Each death known to the hospital that occurs within 1 week after restraint or seclusion where it is reasonable to assume that use of restraint or placement in seclusion contributed directly or indirectly to a patient's death. "Reasonable to assume" in this context includes, but is not limited to, deaths related to restrictions of movement for prolonged periods of time, or death related to chest compression, restriction of breathing or asphyxiation.
   (2) Each death referenced in this paragraph must be reported to CMS by telephone no later than the close of business the next business day following knowledge of the patient's death.
   (3) Staff must document in the patient's medical record the date and time the death was reported to CMS.

[71 FR 71426, Dec. 8, 2006]
CHILD CARE ORGANIZATIONS

Act 116 of 1973

AN ACT to provide for the protection of children through the licensing and regulation of child care organizations; to provide for the establishment of standards of care for child care organizations; to prescribe powers and duties of certain departments of this state and adoption facilitators; to provide penalties; and to repeal acts and parts of acts.


722.112b Definitions; scope.

(1) As used in this section and sections 2c, 2d, and 2e, unless the context requires otherwise:

(a) "Adaptive device" means a mechanical device incorporated in the individual plan of services that is intended to provide anatomical support or to assist the minor child with adaptive skills.

(b) "Chemical restraint" means a drug that meets all of the following criteria:

(i) Is administered to manage a minor child's behavior in a way that reduces the safety risk to the minor child or others.

(ii) Has the temporary effect of restricting the minor child's freedom of movement.

(iii) Is not a standard treatment for the minor child's medical or psychiatric condition.

(c) "Emergency safety intervention" means use of personal restraint or seclusion as an immediate response to an emergency safety situation.

(d) "Emergency safety situation" means the onset of an unanticipated, severely aggressive, or destructive behavior that places the minor child or others at serious threat of violence or injury if no intervention occurs and that calls for an emergency safety intervention.

(e) "Individual plan of services" means that term as defined in section 100b of the mental health code, 1974 PA 258, MCL 330.1100b.

(f) "Licensed practitioner" means an individual who has been trained in the use of personal restraint and seclusion, who is knowledgeable of the risks inherent in the implementation of personal restraint and seclusion, and who is 1 of the following:

(i) A physician licensed under article 15 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18838.

(ii) An individual who has been issued a specialty certification as a nurse practitioner under article 15 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18838.
(iii) A physician's assistant licensed under article 15 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18838.

(iv) A registered nurse licensed under article 15 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18838.

(v) A psychologist and a limited licensed psychologist licensed under article 15 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18838.

(vi) A counselor and a limited licensed counselor licensed under article 15 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18838.

(vii) Until July 1, 2005, a certified social worker registered under article 15 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18838. Beginning July 1, 2005, a licensed master's social worker licensed under article 15 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18838.

(g) "Mechanical restraint" means a device attached or adjacent to the minor child's body that he or she cannot easily remove and that restricts freedom of movement or normal access to his or her body. Mechanical restraint does not include the use of a protective or adaptive device or a device primarily intended to provide anatomical support. Mechanical restraint does not include use of a mechanical device to ensure security precautions appropriate to the condition and circumstances of a minor child placed in the child caring institution as a result of an order of the family division of circuit court under section 2(a) of chapter XIIA of the probate code of 1939, 1939 PA 288, MCL 712A.2.

(h) "Personal restraint" means the application of physical force without the use of a device, for the purpose of restraining the free movement of a minor child's body. Personal restraint does not include:

(i) The use of a protective or adaptive device.

(ii) Briefly holding a minor child without undue force in order to calm or comfort him or her.

(iii) Holding a minor child's hand, wrist, shoulder, or arm to safely escort him or her from 1 area to another.

(iv) The use of a protective or adaptive device or a device primarily intended to provide anatomical support.

(i) "Protective device" means an individually fabricated mechanical device or physical barrier, the use of which is incorporated in the individualized written plan of service. The use of a protective device is intended to prevent the minor child from causing serious self-injury associated with documented, frequent, and unavoidable hazardous events.
(j) "Seclusion" means the involuntary placement of a minor child in a room alone, where the minor child is prevented from exiting by any means, including the physical presence of a staff person if the sole purpose of that staff person's presence is to prevent the minor child from exiting the room. Seclusion does not include the use of a sleeping room during regular sleeping hours to ensure security precautions appropriate to the condition and circumstances of a minor child placed in the child caring institution as a result of an order of the family division of circuit court under section 2(a) and (b) of chapter XIIA of the probate code of 1939, 1939 PA 288, MCL 712A.2, if the minor child's individual case treatment plan indicates that the security precautions would be in the minor child's best interest.

(k) "Serious injury" means any significant impairment of the physical condition of the minor child as determined by qualified medical personnel that results from an emergency safety intervention. This includes, but is not limited to, burns, lacerations, bone fractures, substantial hematoma, and injuries to internal organs, whether self-inflicted or inflicted by someone else.

(2) The provisions of this section and sections 2c, 2d, and 2e only apply to a child caring institution that contracts with or receives payment from a community mental health services program or prepaid inpatient health plan for the care, treatment, maintenance, and supervision of a minor child in that child caring institution.


722.112c Personal restraint and seclusion; use in child caring institution contracting with community mental health services program or prepaid inpatient health plan; education, training, and knowledge.

(1) If a child caring institution contracts with and receives payment from a community mental health services program or prepaid inpatient health plan for the care, treatment, maintenance, and supervision of a minor child in a child caring institution, the child caring institution may place a minor child in personal restraint or seclusion only as provided in this section and sections 2d and 2e but shall not use mechanical restraint or chemical restraint.

(2) Not later than 180 days after the effective date of the amendatory act that added this section, a child caring institution shall require its staff to have ongoing education, training, and demonstrated knowledge of all of the following:

(a) Techniques to identify minor children's behaviors, events, and environmental factors that may trigger emergency safety situations.

(b) The use of nonphysical intervention skills, such as de-escalation, mediation conflict resolution, active listening, and verbal and observational methods to prevent emergency safety situations.

(c) The safe use of personal restraint or seclusion, including the ability to recognize and respond to signs of physical distress in minor children who are in personal restraint or seclusion or who are being placed in personal restraint or seclusion.
(3) A child caring institution's staff shall be trained in the use of personal restraint and seclusion, shall be knowledgeable of the risks inherent in the implementation of personal restraint and seclusion, and shall demonstrate competency regarding personal restraint or seclusion before participating in the implementation of personal restraint or seclusion. A child caring institution's staff shall demonstrate their competencies in these areas on a semiannual basis. The state agency licensing child caring institutions shall review and determine the acceptability of the child caring institutions' staff education, training, knowledge, and competency requirements required by this subsection and the training and knowledge required of a licensed practitioner in the use of personal restraint and seclusion.


722.112d Personal restraint or seclusion; use; limitations; requirements.

(1) Personal restraint or seclusion shall not be imposed as a means of coercion, discipline, convenience, or retaliation by a child caring institution's staff.

(2) An order for personal restraint or seclusion shall not be written as a standing order or on an as-needed basis.

(3) Personal restraint or seclusion must not result in harm or injury to the minor child and shall be used only to ensure the minor child's safety or the safety of others during an emergency safety situation. Personal restraint or seclusion shall only be used until the emergency safety situation has ceased and the minor child's safety and the safety of others can be ensured even if the order for personal restraint or seclusion has not expired. Personal restraint and seclusion of a minor child shall not be used simultaneously.

(4) Personal restraint or seclusion shall be performed in a manner that is safe, appropriate, and proportionate to the severity of the minor child's behavior, chronological and developmental age, size, gender, physical condition, medical condition, psychiatric condition, and personal history, including any history of physical or sexual abuse.

(5) Except as provided in subsection (6), at the time a minor child is admitted to a child caring institution, the child caring institution shall do all of the following:

(a) Inform the minor child and his or her parent or legal guardian of the provider's policy regarding the use of personal restraint or seclusion during an emergency safety situation that may occur while the minor child is under the care of the child caring institution.

(b) Communicate the provider's personal restraint and seclusion policy in a language that the minor child or his or her parent or legal guardian will understand, including American sign language, if appropriate. The provider shall procure an interpreter or translator, if necessary to fulfill the requirement of this subdivision.

(c) Obtain a written acknowledgment from the minor child's parent or legal guardian that he or she has been informed of the provider's policy on the use of personal restraint and seclusion.
during an emergency safety situation. The child caring institution's staff shall file the acknowledgment in the minor child's records.

(d) Provide a copy of the policy to the minor child's parent or legal guardian.

(6) The child caring institution is not required to inform, communicate, and obtain the written acknowledgment from a minor child's parent or legal guardian as specified in subsection (5) if the minor child is within the care and supervision of the child caring institution as a result of an order of commitment of the family division of circuit court to a state institution, state agency, or otherwise, and has been adjudicated to be a dependent, neglected, or delinquent under chapter XIIA of the probate code of 1939, 1939 PA 288, MCL 712A.1 to 712A.32, if the minor child's individual case treatment plan indicates that notice would not be in the minor child's best interest.

(7) An order for personal restraint or seclusion shall only be written by a licensed practitioner.

(8) A licensed practitioner shall order the least restrictive emergency safety intervention measure that is most likely to be effective in resolving the emergency safety situation based on consultation with staff. Consideration of less restrictive emergency safety intervention measures shall be documented in the minor child's record.

(9) If the order for personal restraint or seclusion is verbal, it must be received by a child caring institution staff member who is 1 of the following:

(a) A licensed practitioner.

(b) A social services supervisor as described in R 400.4118 of the Michigan administrative code.

(c) A supervisor of direct care workers as described in R 400.4120 of the Michigan administrative code.

(d) A practical nurse licensed under article 15 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18838.

(10) A verbal order must be received while personal restraint or seclusion is being initiated by child caring institution staff or immediately after the emergency safety situation begins. The licensed practitioner shall be available to staff for consultation, at least by telephone, throughout the period of personal restraint or seclusion. The licensed practitioner shall verify the verbal order in signed written form in the minor child's record.

(11) An order for personal restraint or seclusion shall meet both of the following criteria:

(a) Be limited to no longer than the duration of the emergency safety situation.

(b) Not exceed 4 hours for a minor child 18 years of age or older; 2 hours for a minor child 9 to 17 years of age; or 1 hour for a minor child under 9 years of age.
(12) If more than 2 orders for personal restraint or seclusion are ordered for a minor child within a 24-hour period, the director of the child caring institution or his or her designated management staff shall be notified to determine whether additional measures should be taken to facilitate discontinuation of personal restraint or seclusion.

(13) If personal restraint continues for less than 15 minutes or seclusion continues for less than 30 minutes from the onset of the emergency safety intervention, the child caring institution staff qualified to receive a verbal order for personal restraint or seclusion, in consultation with the licensed practitioner, shall evaluate the minor child's psychological well-being immediately after the minor child is removed from seclusion or personal restraint. Staff shall also evaluate the minor child's physical well-being or determine if an evaluation is needed by a licensed practitioner authorized to conduct a face-to-face assessment under subsection (14).

(14) A face-to-face assessment shall be conducted if the personal restraint continues for 15 minutes or more from the onset of the emergency safety intervention or if seclusion continues for 30 minutes or more from the onset of the emergency safety intervention. This face-to-face assessment shall be conducted by a licensed practitioner who is 1 of the following:

(a) A physician licensed under article 15 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18838.

(b) An individual who has been issued a speciality certification as a nurse practitioner under article 15 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18838.

(c) A physician's assistant licensed under article 15 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18838.

(d) A registered nurse licensed under article 15 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18838.

(15) The face-to-face assessment shall be conducted within 1 hour of the onset of the emergency safety intervention and immediately after the minor child is removed from personal restraint or seclusion. The face-to-face assessment of the physical and psychological well-being of the minor child shall include, but is not limited to, all of the following:

(a) The minor child's physical and psychological status.

(b) The minor child's behavior.

(c) The appropriateness of the intervention measures.

(d) Any complications resulting from the intervention.

722.112e Personal restraint or seclusion; release; documentation; record; notification; debriefing; report of serious occurrence; annual report.

(1) A minor child shall be released from personal restraint or seclusion whenever the circumstance that justified the use of personal restraint or seclusion no longer exists.

(2) Each instance of personal restraint or seclusion requires full justification for its use, and the results of the evaluation immediately following the use of personal restraint or seclusion shall be placed in the minor child's record.

(3) Each order for personal restraint or seclusion shall include all of the following:

(a) The name of the licensed practitioner ordering personal restraint or seclusion.

(b) The date and time the order was obtained.

(c) The personal restraint or seclusion ordered, including the length of time for which the licensed practitioner ordered its use.

(4) The child caring institution staff shall document the use of the personal restraint or seclusion in the minor child's record. That documentation shall be completed by the end of the shift in which the personal restraint or seclusion occurred. If the personal restraint or seclusion does not end during the shift in which it began, documentation shall be completed during the shift in which the personal restraint or seclusion ends. Documentation shall include all of the following:

(a) Each order for personal restraint or seclusion.

(b) The time the personal restraint or seclusion actually began and ended.

(c) The time and results of the 1-hour assessment.

(d) The emergency safety situation that required the resident to be personally restrained or secluded.

(e) The name of the staff involved in the personal restraint or seclusion.

(5) The child caring institution staff trained in the use of personal restraint shall continually assess and monitor the physical and psychological well-being of the minor child and the safe use of personal restraint throughout the duration of its implementation.

(6) The child caring institution staff trained in the use of seclusion shall be physically present in or immediately outside the seclusion room, continually assessing, monitoring, and evaluating the physical and psychological well-being of the minor. Video monitoring shall not be exclusively used to meet this requirement.
(7) The child caring institution staff shall ensure that documentation of staff monitoring and observation is entered into the minor child's record.

(8) If the emergency safety intervention continues beyond the time limit of the order for use of personal restraint or seclusion, child caring institution staff authorized to receive verbal orders for personal restraint or seclusion shall immediately contact the licensed practitioner to receive further instructions.

(9) The child caring institution staff shall notify the minor child's parent or legal guardian and the appropriate state or local government agency that has responsibility for the minor child if the minor child is under the supervision of the child caring institution as a result of an order of commitment by the family division of circuit court to a state institution or otherwise as soon as possible after the initiation of personal restraint or seclusion. This notification shall be documented in the minor child's record, including the date and time of the notification, the name of the staff person providing the notification, and the name of the person to whom notification of the incident was reported. The child caring institution is not required to notify the parent or legal guardian as provided in this subsection if the minor child is within the care and supervision of the child caring institution as a result of an order of commitment of the family division of circuit court to a state institution, state agency, or otherwise, and has been adjudged to be dependent, neglected, or delinquent under chapter X11A of the probate code of 1939, 1939 PA 288, MCL 712A.1 to 712A.32, if the minor child's individual case treatment plan indicates that the notice would not be in the minor child's best interest.

(10) Within 24 hours after the use of personal restraint or seclusion, child caring institution staff involved in the emergency safety intervention and the minor child shall have a face-to-face debriefing session. The debriefing shall include all staff involved in the seclusion or personal restraint except if the presence of a particular staff person may jeopardize the well-being of the minor child. Other staff members and the minor child's parent or legal guardian may participate in the debriefing if it is considered appropriate by the child caring institution.

(11) The child caring institution shall conduct a debriefing in a language that is understood by the minor child. The debriefing shall provide both the minor child and the staff opportunity to discuss the circumstances resulting in the use of personal restraint or seclusion and strategies to be used by staff, the minor child, or others that could prevent the future use of personal restraint or seclusion.

(12) Within 24 hours after the use of personal restraint or seclusion, all child caring institution staff involved in the emergency safety intervention, and appropriate supervisory and administrative staff, shall conduct a debriefing session that includes, at a minimum, all of the following:

(a) Discussion of the emergency safety situation that required personal restraint or seclusion, including a discussion of precipitating factors that led up to the situation.

(b) Alternative techniques that might have prevented the use of personal restraint or seclusion.
(c) The procedures, if any, that child caring institution staff are to implement to prevent a recurrence of the use of personal restraint or seclusion.

(d) The outcome of the emergency safety intervention, including any injury that may have resulted from the use of personal restraint or seclusion.

(13) The child caring institution staff shall document in the minor child's record that both debriefing sessions took place and shall include the names of staff who were present for the debriefings, names of staff that were excused from the debriefings, and changes to the minor child's treatment plan that result from the debriefings.

(14) Each child caring institution subject to this section and sections 2c and 2d shall report each serious occurrence to the state agency licensing the child caring institution. The state agency licensing the child caring institution shall make the reports available to the designated state protection and advocacy system upon request of the designated state protection and advocacy system. Serious occurrences to be reported include a minor child's death, a serious injury to a minor child, and a minor child's suicide attempt. Staff shall report any serious occurrence involving a minor child by no later than close of business of the next business day after a serious occurrence. The report shall include the name of the minor child involved in the serious occurrence, a description of the occurrence, and the name, street address, and telephone number of the child caring institution. The child caring institution shall notify the minor child's parent or legal guardian and the appropriate state or local government agency that has responsibility for the minor child if the minor child is under the supervision of the child caring institution as a result of an order of commitment by the family division of circuit court to a state institution or otherwise as soon as possible and not later than 24 hours after the serious occurrence. Staff shall document in the minor child's record that the serious occurrence was reported to both the state agency licensing the child caring institution and the state-designated protection and advocacy system, including the name of the person to whom notification of the incident was reported. A copy of the report shall be maintained in the minor child's record, as well as in the incident and accident report logs kept by the child caring institution.

(15) Each child caring institution subject to this section and sections 2c and 2d shall maintain a record of the incidences in which personal restraint or seclusion was used for all minor children. The record shall include all of the following information:

(a) Whether personal restraint or seclusion was used.

(b) The setting, unit, or location in which personal restraint or seclusion was used.

(c) Staff who initiated the process.

(d) The duration of each use of personal restraint or seclusion.

(e) The date, time, and day of the week restraint or seclusion was initiated.

(f) Whether injuries were sustained by the minor child or staff.
(g) The age and gender of the minor child.

(16) Each child caring institution subject to this section and sections 2c and 2d shall submit a report annually to the state agency that licenses the child caring institution containing the aggregate data from the record of incidences for each 12-month period as directed by the state licensing agency. The state licensing agency shall prepare reporting forms to be used by the child caring institution, shall aggregate the data collected from each child caring institution, and shall annually report the data to each child caring institution and the state-designated protection and advocacy system.

Sec. 483.350  Basis and scope.

(a) Statutory basis. Sections 1905(a)(16) and (h) of the Act provide that inpatient psychiatric services for individuals under age 21 include only inpatient services that are provided in an institution (or distinct part thereof) that is a psychiatric hospital as defined in section 1861(f) of the Act or in another inpatient setting that the Secretary has specified in regulations. Additionally, the Children's Health Act of 2000 (Pub. L. 106-310) imposes procedural reporting and training requirements regarding the use of restraints and involuntary seclusion in facilities, specifically including facilities that provide inpatient psychiatric services for children under the age of 21 as defined by sections 1905(a)(16) and (h) of the Act.

(b) Scope. This subpart imposes requirements regarding the use of restraint or seclusion in psychiatric residential treatment facilities, that are not hospitals, providing inpatient psychiatric services to individuals under age 21.

Sec. 483.352  Definitions.

For purposes of this subpart, the following definitions apply:

Drug used as a restraint means any drug that—

1. Is administered to manage a resident's behavior in a way that reduces the safety risk to the resident or others;
2. Has the temporary effect of restricting the resident's freedom of movement; and
3. Is not a standard treatment for the resident's medical or psychiatric condition.

Emergency safety intervention means the use of restraint or seclusion as an immediate response to an emergency safety situation.

Emergency safety situation means unanticipated resident behavior that places the resident or others at serious threat of violence or injury if no intervention occurs and that calls for an emergency safety intervention as defined in this section.

Mechanical restraint means any device attached or adjacent to the resident's body that he or she cannot easily remove that restricts freedom of movement or normal access to his or her body.

Minor means a minor as defined under State law and, for the purpose of this subpart, includes a resident who has been declared legally incompetent by the applicable State court.
Personal restraint means the application of physical force without the use of any device, for the purposes of restraining the free movement of a resident's body. The term personal restraint does not include briefly holding without undue force a resident in order to calm or comfort him or her, or holding a resident's hand to safely escort a resident from one area to another.

Psychiatric Residential Treatment Facility means a facility other than a hospital, that provides psychiatric services, as described in subpart D of part 441 of this chapter, to individuals under age 21, in an inpatient setting.

Restraint means a “personal restraint”, “mechanical restraint”, or “drug used as a restraint” as defined in this section.

Seclusion means the involuntary confinement of a resident alone in a room or an area from which the resident is physically prevented from leaving.

Serious injury means any significant impairment of the physical condition of the resident as determined by qualified medical personnel. This includes, but is not limited to, burns, lacerations, bone fractures, substantial hematoma, and injuries to internal organs, whether self-inflicted or inflicted by someone else.

Staff means those individuals with responsibility for managing a resident's health or participating in an emergency safety intervention and who are employed by the facility on a full-time, part-time, or contract basis.

Time out means the restriction of a resident for a period of time to a designated area from which the resident is not physically prevented from leaving, for the purpose of providing the resident an opportunity to regain self-control.


Sec. 483.354 General requirements for psychiatric residential treatment facilities.

A psychiatric residential treatment facility must meet the requirements in Sec. 441.151 through Sec. 441.182 of this chapter.

Sec. 483.356 Protection of residents.

(a) Restraint and seclusion policy for the protection of residents.

(1) Each resident has the right to be free from restraint or seclusion, of any form, used as a means of coercion, discipline, convenience, or retaliation.

(2) An order for restraint or seclusion must not be written as a standing order or on an as-needed basis.

(3) Restraint or seclusion must not result in harm or injury to the resident and must be used only--

(i) To ensure the safety of the resident or others during an emergency safety situation; and
(ii) Until the emergency safety situation has ceased and the resident's safety and the safety of others can be ensured, even if the restraint or seclusion order has not expired.

(4) Restraint and seclusion must not be used simultaneously.

(b) Emergency safety intervention. An emergency safety intervention must be performed in a manner that is safe, proportionate, and appropriate to the severity of the behavior, and the resident's chronological and developmental age; size; gender; physical, medical, and psychiatric condition; and personal history (including any history of physical or sexual abuse).
(c) Notification of facility policy. At admission, the facility must--

(1) Inform both the incoming resident and, in the case of a minor, the resident's parent(s) or legal guardian(s) of the facility's policy regarding the use of restraint or **seclusion** during an emergency safety situation that may occur while the resident is in the program;

(2) Communicate its restraint and **seclusion** policy in a language that the resident, or his or her parent(s) or legal guardian(s) understands (including American Sign Language, if appropriate) and when necessary, the facility must provide interpreters or translators;

(3) Obtain an acknowledgment, in writing, from the resident, or in the case of a minor, from the parent(s) or legal guardian(s) that he or she has been informed of the facility's policy on the use of restraint or **seclusion** during an emergency safety situation. Staff must file this acknowledgment in the resident's record; and

(4) Provide a copy of the facility policy to the resident and in the case of a minor, to the resident's parent(s) or legal guardian(s).

(d) Contact information. The facility's policy must provide contact information, including the phone number and mailing address, for the appropriate State Protection and Advocacy organization.

Sec. 483.358  Orders for the use of restraint or **seclusion**.

(a) Orders for restraint or **seclusion** must be by a physician, or other licensed practitioner permitted by the State and the facility to order restraint or **seclusion** and trained in the use of emergency safety interventions. Federal regulations at 42 CFR 441.151 require that inpatient psychiatric services for recipients under age 21 be provided under the direction of a physician.

(b) If the resident's treatment team physician is available, only he or she can order restraint or **seclusion**.

(c) A physician or other licensed practitioner permitted by the state and the facility to order restraint or **seclusion** must order the least restrictive emergency safety intervention that is most likely to be effective in resolving the emergency safety situation based on consultation with staff.

(d) If the order for restraint or **seclusion** is verbal, the verbal order must be received by a registered nurse or other licensed staff such as a licensed practical nurse, while the emergency safety intervention is being initiated by staff or immediately after the emergency safety situation ends. The physician or other licensed practitioner permitted by the state and the facility to order restraint or **seclusion** must verify the verbal order in a signed written form in the resident's record. The physician or other licensed practitioner permitted by the state and the facility to order restraint or **seclusion** must be available to staff for consultation, at least by telephone, throughout the period of the emergency safety intervention.

(e) Each order for restraint or **seclusion** must:

(1) Be limited to no longer than the duration of the emergency safety situation; and

(2) Under no circumstances exceed 4 hours for residents ages 18 to 21; 2 hours for residents ages 9 to 17; or 1 hour for residents under age 9.

(f) Within 1 hour of the initiation of the emergency safety intervention a physician, or other licensed practitioner trained in the use of emergency safety interventions and permitted by the state and the facility to assess the physical and psychological well being of residents, must conduct a face-to-face assessment of the physical and psychological well being of the resident, including but not limited to--
(1) The resident's physical and psychological status;
(2) The resident's behavior;
(3) The appropriateness of the intervention measures; and
(4) Any complications resulting from the intervention.

(g) Each order for restraint or seclusion must include--
(1) The name of the ordering physician or other licensed practitioner permitted by the state
and the facility to order restraint or seclusion;
(2) The date and time the order was obtained; and
(3) The emergency safety intervention ordered, including the length of time for which the
physician or other licensed practitioner permitted by the state and the facility to order restraint or
seclusion authorized its use.

(h) Staff must document the intervention in the resident's record. That documentation must
be completed by the end of the shift in which the intervention occurs. If the intervention does not
end during the shift in which it began, documentation must be completed during the shift in
which it ends. Documentation must include all of the following:
(1) Each order for restraint or seclusion as required in paragraph (g) of this section.
(2) The time the emergency safety intervention actually began and ended.
(3) The time and results of the 1-hour assessment required in paragraph (f) of this section.
(4) The emergency safety situation that required the resident to be restrained or put in
seclusion.
(5) The name of staff involved in the emergency safety intervention.
(i) The facility must maintain a record of each emergency safety situation, the interventions
used, and their outcomes.

(j) The physician or other licensed practitioner permitted by the state and the facility to order
restraint or seclusion must sign the restraint or seclusion order in the resident's record as soon as
possible.


Sec. 483.360 Consultation with treatment team physician.

If a physician or other licensed practitioner permitted by the state and the facility to order
restraint or seclusion orders the use of restraint or seclusion, that person must contact the
resident's
treatment team physician, unless the ordering physician is in fact the resident's treatment team
physician. The person ordering the use of restraint or seclusion must--
(a) Consult with the resident's treatment team physician as soon as possible and inform the
team physician of the emergency safety situation that required the resident to be restrained or
placed in seclusion; and
(b) Document in the resident's record the date and time the team physician was consulted.


Sec. 483.362 Monitoring of the resident in and immediately after restraint.

(a) Clinical staff trained in the use of emergency safety interventions must be physically
present, continually assessing and monitoring the physical and psychological well-being of the
resident and the safe use of restraint throughout the duration of the emergency safety intervention.

(b) If the emergency safety situation continues beyond the time limit of the order for the use of restraint, a registered nurse or other licensed staff, such as a licensed practical nurse, must immediately contact the ordering physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion to receive further instructions.

(c) A physician, or other licensed practitioner permitted by the state and the facility to evaluate the resident's well-being and trained in the use of emergency safety interventions, must evaluate the resident's well-being immediately after the restraint is removed.


Sec. 483.364 Monitoring of the resident in and immediately after seclusion.

(a) Clinical staff, trained in the use of emergency safety interventions, must be physically present in or immediately outside the seclusion room, continually assessing, monitoring, and evaluating the physical and psychological well-being of the resident in seclusion. Video monitoring does not meet this requirement.

(b) A room used for seclusion must—

(1) Allow staff full view of the resident in all areas of the room; and

(2) Be free of potentially hazardous conditions such as unprotected light fixtures and electrical outlets.

(c) If the emergency safety situation continues beyond the time limit of the order for the use of seclusion, a registered nurse or other licensed staff, such as a licensed practical nurse, must immediately contact the ordering physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion to receive further instructions.

(d) A physician, or other licensed practitioner permitted by the state and the facility to evaluate the resident's well-being and trained in the use of emergency safety interventions, must evaluate the resident's well-being immediately after the resident is removed from seclusion.


Sec. 483.366 Notification of parent(s) or legal guardian(s).

If the resident is a minor as defined in this subpart:

(a) The facility must notify the parent(s) or legal guardian(s) of the resident who has been restrained or placed in seclusion as soon as possible after the initiation of each emergency safety intervention.

(b) The facility must document in the resident's record that the parent(s) or legal guardian(s) has been notified of the emergency safety intervention, including the date and time of notification and the name of the staff person providing the notification.
Sec. 483.368  Application of time out.

(a) A resident in time out must never be physically prevented from leaving the time out area.
(b) Time out may take place away from the area of activity or from other residents, such as in
the resident's room (exclusionary), or in the area of activity or other residents (inclusionary).
(c) Staff must monitor the resident while he or she is in time out.

Sec. 483.370  Postintervention debriefings.

(a) Within 24 hours after the use of restraint or seclusion, staff involved in an emergency
safety intervention and the resident must have a face-to-face discussion. This discussion must
include all staff involved in the intervention except when the presence of a particular staff person
may jeopardize the well-being of the resident. Other staff and the resident's parent(s) or legal
guardian(s) may participate in the discussion when it is deemed appropriate by the facility. The
facility must conduct such discussion in a language that is understood by the resident's parent(s)
or legal guardian(s). The discussion must provide both the resident and staff the opportunity to
discuss the circumstances resulting in the use of restraint or seclusion and strategies to be used
by the staff, the resident, or others that could prevent the future use of restraint or seclusion.
(b) Within 24 hours after the use of restraint or seclusion, all staff involved in the emergency
safety intervention, and appropriate supervisory and administrative staff, must conduct a
debriefing session that includes, at a minimum, a review and discussion of--
(1) The emergency safety situation that required the intervention, including a discussion of the
precipitating factors that led up to the intervention;
(2) Alternative techniques that might have prevented the use of the restraint or seclusion;
(3) The procedures, if any, that staff are to implement to prevent any recurrence of the use of
restraint or seclusion; and
(4) The outcome of the intervention, including any injuries that may have resulted from the
use of restraint or seclusion.
(c) Staff must document in the resident's record that both debriefing sessions took place and
must include in that documentation the names of staff who were present for the debriefing,
names of staff that were excused from the debriefing, and any changes to the resident's treatment
plan that result from the debriefings.

Sec. 483.372  Medical treatment for injuries resulting from an emergency safety
intervention.

(a) Staff must immediately obtain medical treatment from qualified medical personnel for a
resident injured as a result of an emergency safety intervention.
(b) The psychiatric residential treatment facility must have affiliations or written transfer
agreements in effect with one or more hospitals approved for participation under the Medicaid
program that reasonably ensure that--
(1) A resident will be transferred from the facility to a hospital and admitted in a timely
manner when a transfer is medically necessary for medical care or acute psychiatric care;
(2) Medical and other information needed for care of the resident in light of such a transfer,
will be exchanged between the institutions in accordance with State medical privacy law,
including any information needed to determine whether the appropriate care can be provided in a less restrictive setting; and

(3) Services are available to each resident 24 hours a day, 7 days a week.

(c) Staff must document in the resident's record, all injuries that occur as a result of an emergency safety intervention, including injuries to staff resulting from that intervention.

(d) Staff involved in an emergency safety intervention that results in an injury to a resident or staff must meet with supervisory staff and evaluate the circumstances that caused the injury and develop a plan to prevent future injuries.

Sec. 483.374 Facility reporting.

(a) Attestation of facility compliance. Each psychiatric residential treatment facility that provides inpatient psychiatric services to individuals under age 21 must attest, in writing, that the facility is in compliance with CMS's standards governing the use of restraint and seclusion. This attestation must be signed by the facility director.

(1) A facility with a current provider agreement with the Medicaid agency must provide its attestation to the State Medicaid agency by July 21, 2001.

(2) A facility enrolling as a Medicaid provider must meet this requirement at the time it executes a provider agreement with the Medicaid agency.

(b) Reporting of serious occurrences. The facility must report each serious occurrence to both the State Medicaid agency and, unless prohibited by State law, the State-designated Protection and Advocacy system. Serious occurrences that must be reported include a resident's death, a serious injury to a resident as defined in Sec. 483.352 of this part, and a resident's suicide attempt.

(1) Staff must report any serious occurrence involving a resident to both the State Medicaid agency and the State-designated Protection and Advocacy system by no later than close of business the next business day after a serious occurrence. The report must include the name of the resident involved in the serious occurrence, a description of the occurrence, and the name, street address, and telephone number of the facility.

(2) In the case of a minor, the facility must notify the resident's parent(s) or legal guardian(s) as soon as possible, and in no case later than 24 hours after the serious occurrence.

(3) Staff must document in the resident's record that the serious occurrence was reported to both the State Medicaid agency and the State-designated Protection and Advocacy system, including the name of the person to whom the incident was reported. A copy of the report must be maintained in the resident's record, as well as in the incident and accident report logs kept by the facility.

(c) Reporting of deaths. In addition to the reporting requirements contained in paragraph (b) of this section, facilities must report the death of any resident to the Centers for Medicare & Medicaid Services (CMS) regional office.

(1) Staff must report the death of any resident to the CMS regional office by no later than close of business the next business day after the resident's death.

(2) Staff must document in the resident's record that the death was reported to the CMS regional office.

Sec. 483.376  Education and training.

(a) The facility must require staff to have ongoing education, training, and demonstrated knowledge of--
   (1) Techniques to identify staff and resident behaviors, events, and environmental factors that may trigger emergency safety situations;
   (2) The use of nonphysical intervention skills, such as de-escalation, mediation conflict resolution, active listening, and verbal and observational methods, to prevent emergency safety situations; and
   (3) The safe use of restraint and the safe use of seclusion, including the ability to recognize and respond to signs of physical distress in residents who are restrained or in seclusion.

(b) Certification in the use of cardiopulmonary resuscitation, including periodic recertification, is required.

(c) Individuals who are qualified by education, training, and experience must provide staff training.

(d) Staff training must include training exercises in which staff members successfully demonstrate in practice the techniques they have learned for managing emergency safety situations.

(e) Staff must be trained and demonstrate competency before participating in an emergency safety intervention.

(f) Staff must demonstrate their competencies as specified in paragraph (a) of this section on a semiannual basis and their competencies as specified in paragraph (b) of this section on an annual basis.

(g) The facility must document in the staff personnel records that the training and demonstration of competency were successfully completed. Documentation must include the date training was completed and the name of persons certifying the completion of training.

(h) All training programs and materials used by the facility must be available for review by CMS, the State Medicaid agency, and the State survey agency.