ADMINISTRATIVE STANDARD PRACTICE MANUAL (ASPM)

	POLICY NUMBER →	NUR-008-14, ASP
HUH HOWARD UNIVERSITY HOSPITAL	TITLE: Restraint, Seclusion and Reporting Requirements of Deaths Associated with Restraints- Date of Origin: June 2001 Date Last Revised: December 2015	
	Department of Nursing	

PURPOSE:

To identify the process for ensuring the use of restraints and seclusion are utilized when clinically justified or when warranted by patient behavior that threatens the physical safety of the patient, staff, or other.

- To ensure regulatory compliance with the Center for Medicare (CMS) Condition of Participation (COP), The Joint Commission, and the District of Columbia Department of Health.

SCOPE:

This policy applies to all clinical and non-clinical staff who applies, assist, monitor or order the application of restraints or seclusion.

Restraint is defined as any manual method, physical or mechanical device, material or equipment that immobilizes or reduces the ability of the patient to move their arms, legs, body or head freely. 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 the standard treatment or dosage for the patient's condition.

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 is the involuntary confinement of a patient 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.

POLICY:
General Principles

1. All patients have the right to be free from physical or mental abuse and corporal punishment.

2. All patients have the right to be free from restraints or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff.
3. 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, regardless of the scheduled expiration of the order.
4. Inappropriate use of restraints and seclusion is a violation of the patient's rights and is subject to disciplinary action.
5. Diagnosis cannot drive the decision to use restraints. A comprehensive individual assessment is required.
6. Restraint application is not based on previous restraint or seclusion history, or solely on history of dangerous behavior.
7. At the time of admission to the hospital staff should attempt to notify family/significant other of the need for restraint application.
8. Restraints or Seclusion are to manage violent or nonviolent behavior:

   Violent: self-destructive behavior that jeopardizes the immediate physical safety of the patient, staff, or others.

   Nonviolent: to ensure physical safety from attempting or removing airway devices, drains, intravenous lines, tubes or other medical devices.
9. Restraints or Seclusion is employed only after less restrictive interventions were considered, attempted and failed.
   a. Pain relief measures
   b. Move the patient closer to the nursing station
   c. Encourage family/friend to visit
   d. Diversion activities
10. Orders for the use of restraint and seclusion must never be written as a standing order or on as needed basis (PRN). The order must be written as an individual order.
11. Protocols cannot serve as substitute for obtaining a written order from a Physician/Resident/Licensed Independent Practitioner (LIP) prior to each application of restraint or seclusion, except during emergent situations.
12. The least restrictive form of restraint or seclusion is utilized in order to protect the physical safety of the patient, staff, or others
13. For all restraint applications the Director/Manager or House Supervisor on duty must be notified prior to initiation of restraints.
14. The use of handcuffs, manacles, shackles, other chain-type restraint devices, or other restrictive devices applied by non-hospital employed or contracted law enforcement officials for custody, detention, and public safety reasons are not governed by this rule. **The use of such devices are considered law enforcement restraint devices and would not be considered safe, appropriate health care restraint interventions for use by hospital staff to restrain patients.** The law enforcement officers who maintain custody and direct supervision of their prisoner (the hospital's patient) are responsible for the use, application, and monitoring

of these restrictive devices in accordance with Federal and State law. **However, the hospital is still responsible for an appropriate patient assessment and the provision of safe, appropriate care to its patient (the law enforcement officer's prisoner).**

15. Restraints or seclusion must include safe techniques identified by the hospital's policy and procedures in accordance with law and regulation.
16. The use of restraints and seclusion is in accordance with written modification to the patient's plan of care.
17. In an emergency, Registered Nurses may initiate the use of restraints prior to an order. In these situations the emergency must be documented and an order obtained either during the emergency application of the restraint or seclusion or, immediately (from the Physician/LIP within minutes).
18. If the attending did not order the restraint or seclusion, the attending physician is consulted as soon as possible.
19. The need for restrain or seclusion must be explained to the patient. Discussion must include the criteria for restraint removal.

Medication Used as Restraint Chemical 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.

<u>Exceptions to the Definition of Medication Used as Restraint (Chemical Restraint)</u>
Drugs or medications that are used as part of a patient's standard medical or psychiatric treatment, and are administered within the standard dosage for the patient's condition are not considered chemical restraint.

Whether or not an order for a drug or medication is PRN or a standing-order does not determine whether or not the use of that drug or medication is considered a restraint.
The use of PRN or standing-order drugs or medications is only prohibited if the drug or medication meets the definition of a drug or medication used as a restraint.

Criteria used to determine whether the use of a drug or medication, or combination of drugs or medications is a standard treatment or dosage for the patient's condition includes all of the following:

- The drug or medication is used within the pharmaceutical parameters approved by the Food and Drug Administration (FDA) and the manufacturer for the indications that it is manufactured and labeled to address, including listed dosage parameters;

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

associations or organizations; and,

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

Restraint Devices:

The following devices have been approved for use as a restraint:
Mittens pinned or attached to bedding or in conjunction with the hand mitts, or if applied tight that patients hand or fingers are immobilized, or bulky that patient's ability to use their hands is significantly reduced (482.13(e)(1)(i)(C)

- Soft limb holder
- T.A.T. (Twice as Tough Quick Release) limb holder
- Hard limb holder
- Side-rails that cannot be removed by the patient

Excluded/Non-restraint Devices & Seclusion:

- **Any devices** that can be easily removed by the patient.
- **IV Arm Board** to stabilize an IV line
- **Mechanical Support – e.g.** leg braces for walking, neck, head, or back braces for proper body position, balance, or alignment
- A medically necessary **positioning or securing device** used to maintain the position, limit mobility, or temporarily immobilize the patient during medical, dental, diagnostic, or surgical procedures not considered a restraint. i.e. (ED papoose boards for children))
- **Hand Mitts** not pinned or otherwise attached, or so tightly that the patient's hand or fingers are immobilized.[4]

Side rails are a form of restraints, unless:

- Used to prevent from sliding out of beds, or raised stretchers
- Used to position on the side for pressure relief
- Padded and raised for seizure precautions or with involuntary
- movements
- Used with those who are not physically capable of getting out Of bed.

- When a patient is in custody and law enforcement appliedrestraints are present, the nurse should perform the same assessment utilized for patients in restraints with a frequency of **every 4 hours.**

- Recovery from anesthesia that occurs when the patient is in a critical care or post anesthesia care unit is part of the surgical procedure; therefore medically necessary restraint use in this setting would not meet the definition of restraint or seclusion

- Physical escort that includes a light grasp to escort a patient to a desired location, if the patient can easily remove or escape the grasp.

Seclusion Exclusions:

- Confinement on a locked unit or other areas where the patient is with other patients. **Time Out**-An intervention in which the patient consents to being alone in a designated area for an agreed upon timeframe (up to 30 minutes) from which the patient is not physically prevented from leaving. During the time out the patient will remain under frequent observation.

I. RESTRAINT USE FOR NON-VIOLENT PATIENTS

A. Clinical Justification

- Attempts to remove medically needed equipment because of confusion and/or lack of ability to comprehend the reasons for the medical devices
- The degree that the patient is not responsible for safe decision making and may accidentally or purposefully harm him/herself.
- Less restrictive measures tried or considered have failed..
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B. Physician/LIP Notification

- The Physician or LIP must order restraint prior to restraining the patient. The physician or LIP has the discretion to write the order for a shorter length of time.

Physician/Resident/LIP orders must include:

- Clinical justification(reason for restraint),
- Type of restraint
- Number & type of extremities to be restrained
- Duration(time frame) for restraint application
- Criteria for release

C. Order Renewal

The order for continued use of restraint or seclusion **after the first 24 hours** is based upon the Physician or LIP's **d a i l y** examination of the patient (no less often than once every 24 hours by a Physician or LIP). However, restraints use must be ended at the earliest possible times.

Nursing Assessment

Must be assessed every 2 hours following the initiation of the intervention by a Registered Nurse.

II. RESTRAINT & SECLUSION FOR VIOLENT PATIENTS

A. Clinical Justification

- The patient's behavior jeopardizes the safety of self, others, or staff.

It is used against injury to self/others/staff, due to an emotional or behavioral disorder. Nonphysical techniques are the preferred intervention in behavior management. **Seclusion should not be used in combination with restraint.**

- Restraint or seclusion non-physical are not effective or viable (i.e., verbal interaction, time out, offering of ordered PRN medication, diversional activities).

B. Physician/LIP Notification

- Physician or LIP must order restraint prior to restraining
- During an emergency situation, if physician or LIP is not immediately available to give the order, the RN may initiate based on patient assessment results.
- A verbal or telephone order is obtained from the physician or LIP **during** the emergency restraint application **or immediately (within minutes)** after the restraint was applied.

C. Orders

Physician / LIP Orders include:

- Behavioral clinical justification
- Type of restraint (including limbs restrained) and/or seclusion
- *Number & type of extremities to restrained*
- *Duration (time frame) for restraint application based on time limits (see below)*
- Criteria for release of restraints

D. Order Renewal

- Must be renewed following limits:
- 4 hours for adults 18 years of age or older
- 2 hours for children and adolescents 9 to 17 years of age; or
- 1 hour for children under 9 years of age
- *May be renewed within the required time limits for up to a total of **24 consecutive** hours*

- At the end of the time frame, if continued use of restraint or seclusion to manage violent or self-destructive behavior is deemed necessary based on individualized patient assessment, another order is required.
- When the original order is about to expire, an RN must contact the physician or other LIP, report the results of his/her most recent assessment & recommendation that the original order be renewed not to exceed the time limits.

- Patients who remain in restraint or seclusion for a total of **24 consecutive** hours after the original order, the physician or LIP must conduct a **face to face re-evaluation** before writing a new order.
- Documentation is required describing the findings of the re-evaluation supporting continued use of restraint or seclusion

E. **Patient Assessment**

- Must be seen face-to-face within 1 hour of the initiation of the restraint or seclusion intervention by a trained Physician or LIP and also applies when a drug or medication is used as a restraint to manage violent self- destructive behavior.
- Documentation in the medical record must include:
- Face-to-face medical and behavioral evaluation (within one hour)
- An evaluation of the patient's immediate situation
- Patient's reaction to the intervention
- The patient's medical and behavioral condition
- Need to continue or terminate the restraint or seclusion
- If a patient's violent or self-destructive behavior resolves and the restraint or seclusion intervention **is discontinued** before the practitioner arrives to perform the one **(1) hour** face to face evaluation, the practitioner is **still required** to see the patient face to face and conduct the evaluation within the one (1) hour after the initiation of this intervention.

III. If the face to face evaluation is conducted by the resident/NP/PA, they must consult the attending physician or other LIP who is responsible for the care of the patient as soon as possible **(within 1 hour)** after completion of the one (1) hour face to face evaluation. The consultation should include, at a minimum, a discussion of the findings of the (1) hour face to face evaluation, the need for other interventions or treatments, and the need to continue or discontinue the use of restraints or seclusion.

IV. **DOCUMENTATION FOR NON- VIOLENT & VIOLENT RESTRAINT & SECLUSION**

Documentation in the patient's medical record, the restraint flowsheet and frequent monitoring tool must include the following;

- Use of less restrictive measures (Alternatives or other less restrictive interventions) tried or considered as applicable to the situation
- On- going assessments that support the need for use of restraint or seclusion
- If the restraint or seclusion is lengthy, evidence that symptoms necessitating use of restraint or seclusion have persisted
- Evaluation whether or not Restraint or Seclusion can be safely discontinued
- A description of the patient's behavior and response to intervention used;
- The patient's condition or symptom(s) that warranted the continued use of restraint; and, the patient's response to the intervention(s) used, including the rationale for continued use of the intervention or release from restraint

- Patient's or treatment plan1 hour face to face medical & behavioral evaluation for violent or self-destructive behavior
- Patients' behavior in descriptive terms, detailed description of the patient's physical & mental status assessments & any environmental factors that may have contributed to the situation at the time of intervention
- Renewal or new order authorizing continued use of Restraint or Seclusion, must document the findings of the re-evaluation supporting continued use

V. NURSING ASSESSMENT FOR VIOLENT & NONVIOLENT PATIENTS

1. The RN must assess the need for restraint usage during the treatment of certain specific conditions or meeting the criteria for clinical justification.
- **NON-VIOLENT** patient must assessed within 1 hour of initial application and every 2 hours thereafter.
- **VIOLENT** patients must be assessed every 15 minutes.
- **Violent and Non-Violent patient assessment shall include the following:**
- Determine if the behavior or activities that precipitated the use of
- restraint is still present
  - The readiness for discontinuation of restraints.
  - Circulatory assessment
  - Proper application of restraints and body alignment
  - Vital signs
  - Signs of physical injury and skin integrity
  - Signs of psychological discomfort
  - Address patient elimination, hygiene and nutritional needs,
- Need for PRN medications

VI. STAFF COMPETENCY AND TRAINING:

- All staff designated by the hospital as having direct patient care responsibilities including contract or agency personnel must demonstrate the competencies prior to participating in the application or restraints, implementation of seclusion, monitoring, assessment, or care of a patient in restraint or seclusion. This is to be accomplished before performing any of the actions specified above, as part of orientation, and subsequently annually and on as needed basis.

- New employee will receive training during hospital orientation and complete a unit-based competency before participating in the restraint

or seclusion activities.

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

- Techniques to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of restraint or seclusion.
- Relationship of threatening behavior to medical conditions. The use of non-physical intervention skills or de-escalation techniques.
- Choosing the least restrictive intervention based on an individualized assessment of the patient's medical, or behavioral status, or condition.
- The safe application and use of all types of restraint or seclusion used in the hospital, including training in how to recognize and respond to signs of physical and psychological distress.
- Clinical identification of specific behavioral changes that indicate that the restraint or seclusion is no longer necessary.
- Monitoring the physical and psychological well-being of the restrained or secluded patient, including but not limited to, respiratory and circulatory status, skin integrity, vital signs, nutrition and hydration, elimination and hygiene, and any special requirements with the one hour face to face evaluation.
- Techniques and physical application of restraint or seclusion, including physical holding techniques and take-down procedures.
- Recognition of signs that the restrained or secluded patient is suffering physical or emotional distress that requires contacting the physician.

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

The hospital must document in the staff personnel record that the training and demonstration of competency was successfully completed.

RESTRAINT OR SECLUSION DEATH REPORTING:

In accordance with federal regulation 42 CPR 482.13(g) of the Patients' Rights Final Rule:

1. Hospitals must report the following information to CMS:
    - Each death that occurs while a patient is in restraint or seclusion (except when no seclusion has been used and the only restraint used was a soft cloth like two point wrist restraint.)
    - Deaths occurring during or within 24 hours of discontinuation of 2-

point soft cloth like non rigid wrist restraints used in combination with any other restraint devise or with seclusion or deaths associated with the use of other types of restraints, such as 2-point rigid or leather wrist restraints (482.13(g)(2), (3)(ii), & (4)

- Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion (except when no seclusion has been used and the only restraint used was a soft cloth like two point wrist restraint)
- Within one week after use of restraint or seclusion where death is known to the hospital **and** it is reasonable to assume that the use of restraint or seclusion contributed directly or indirectly to the patient's death, regardless of the type of restraints used on the patient during this time. "Reasonable to assume" applies only to those deaths that occur on days 2-7 after restraint or seclusion has been discontinued **and** it is reasonable to assume the use of restraint or seclusion contributed to the patient's death

2. Each death must be reported to CMS Regional Office by telephone, facsimile or electronically as determined by the Regional Office no later than the close of business the next CMS business day following the day in which the hospital knows of the patient's death.
3. The report must include the basic identifying information related to the hospital, patient's name, date of birth, date of death, name of attending physician/practitioner, primary diagnosis(es), cause of death (preliminary in case a final, official cause of death is not yet available), and type of restraints or seclusion used. Hospital staff must document in the patient's medical record the date and time each reportable death associated with restraint & seclusion is s reported to CMS Regional Office.
4. Use of log or tracking system is limited only to when **no seclusion** was used and when **only 2 point restraint** used on the patient are those applied exclusively to the **patient's wrist(s),** and which are composed solely of **soft, non-rigid cloth-like materials.** The hospital staff must record in an internal log or other system the following information:

(1) Any death that occurs while the patient is in only 2 point soft, cloth-like non-rigid wrist restraints and there is no use of seclusions
(2) Any death that occurs within 24 hours after the patient has been removed from such restraints.
The staff must document in the patient's medical record the date & time the death was recorded in the internal log or other systems.

Each entry must be made not later than 7 days after the date of death of the patient

The death report log entry must include the following:

- The patient's name,
- Date of birth,

- Date of death,
- Name of attending physician or other LIP who is responsible for the care of the patient,
- Medical record number, and
- Primary diagnosis(es)

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

PERFORMANCE IMPROVEMENT DATA COLLECTION AND ANALYSIS:

- Performance improvement data are collected following each use. Data analysis and aggregation are used to identify opportunities to incrementally improve the rate and safety of seclusion use, and to identify any need to redesign care processes.

- Restraint or Seclusion Log book is maintained on patient units (including Emergency Room) in which data on all restraints or seclusion episodes is collected and classified. The following parameters are used:
- Shift
- Staff initiating the process
- Length per episode
- Date/time each episode was initiated
- Day of the week each episode was initiated
- Type of restraint used
- Any injuries sustained (staff or patient)
- Patient's age
- Patient's gender

These data will be analyzed and aggregated on a quarterly basis. A monthly report is submitted to Nursing Directors and Managers.

DEFINITION(S):

Behavior Health Advance Directive:
A written document signed by a patient that indicates his/her preferences regarding medical treatment decisions, including mental health treatment.

Clinical leaders:
Attending Physician/Director of Nursing/Nurse Manager

Continuous Monitoring:
Uninterrupted face-to-face observation to manage patients with destructive or violent behavior.

Drug(s) Used as Restraints:
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 [7]

"Standard Treatment or dosage" for a drug or medication:

The use of drug or medication to treat the patient's condition enables the patient to more effectively or appropriately function in the world around them than would be possible without the use of drug or medication. If the overall effect of a drug or medication, or combination of drugs or medications, is to reduce the patient's ability to effectively or appropriately interact with the world around the patient, then the drug or medication is not being used as a standard treatment or dosage for the patient's condition. Drugs or medications that are used as part of a patient's standard medical or psychiatric treatment, and are administered within the standard dosage for the patient's condition would not be subject to this definition.

Family:

The person(s) who plays a significant role in the individual's life, which may include a person(s) not legally related to the individual receiving care. This person(s) is the surrogate decision maker, if authorized to make care decisions for the individual when he or she loses decision-making capacity.

Licensed Independent Practitioner (LIP)

Any practitioner permitted by State law and hospital policy as having the authority to independently order restraints or seclusion for patients. A resident who is authorized by State law and the hospital's residency program to practice is a physician can carry out functions reserved for a physician or LIP under the regulation. A medical school student holds no license, and his/her work is reviewed and must be countersigned by the attending physician; therefore, he or she is not licensed or independent. A medical school student is **not** an LIP [8].

Physical Holding:

Holding a patient in a manner that restricts the patient's movement against the patient's will is considered restraint. This includes holds that some members of the medical community may term **"therapeutic holds."** Many deaths have occurred while employing these practices. Physically holding a patient can be just as restrictive, and just as dangerous, as restraining methods that involve devices. Physically holding a patient during a forced psychotropic medication procedure is considered a restraint and is **not** included in this exception [4].

Physician:

A practitioner permitted by law and the Hospital as having the authority under his/her license to independently practice medicine.

Physician (Attending):

The physician who is responsible for the management and care of the patient.

Resident:

Resident (A physician-in-training) who meets the following requirements:

- State law permits residents to perform these two activities under the auspices of a graduate medical education program.
- The graduate medical education program has provided relevant education and training for the resident in performing these two activities.
- In the judgment of the graduate medical education program, the resident is able to competently perform these two activities.
- The health care organization in which the resident provides patient care permits residents to perform these two activities

Attachment A

	Non-Violent Restraint	Violent Restraint /
ıysician/AHP OTIFICATION	The Physician or LIP must order restraint prior to restraining the patient	• The Physician or LIP must order restraint prior to restraining the patient • During an emergency situation, if the physician or LIP is not
RDERS	Physician/AHP orders must include: • Clinical justification(reason for restraint), • Type of restraint • Number & type of extremities to be restrained • Duration(time frame) for restraint application • Criteria for release	Physician / AHP orders must include: • Behavioral clinical justification • Type of restraint (including limbs restrained) and/or seclusion • Number & type of extremities to be restrained • Duration (time frame) for restraint application based on time limits (see below) • Criteria for release
	The need for restraint or seclusion is explained to the patient and behavior needed to prevent and or release from restraint is discussed The Attending Physician must be consulted as soon as possible **if he/she did not order** the restraint or seclusion. It does not specify a face to face consultation; can occur via telephone 482.13(e)(7)	
RDER :NEWAL	The order for continued use of restraint or seclusion **after the first 24 hours** is based upon the Physician or LIP's daily examination of the patient (no less often than once every 24 hours by a Physician or LIP)	Must be renewed in accordance with 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; or • 1 hour for children under 9 years of age May be renewed within the required time limits for up to a total of 24 consecutive hours At the end of the time frame, if continued use of restraint or seclusion to manage violent or self-destructive behavior is deemed necessary based on individualized patient assessment, another order is required. When the original order is about to expire, an RN must contact the physician or other LIP, report the results of his/her most recent assessment & recommendation that the original order be renewed not to exceed the time limits.
ATIENT SSESSMENT	Must be assessed every one (1) hour (HUH policy) following the initiation of the intervention by a Registered Nurse.	Must be seen face-to-face within 1 hour of the initiation of the restraint or seclusion intervention by a trained Physician or LIP and also applies when a drug or medication is used as a restraint to manage violent self- destructive behavior. . Documentation in the medical record must include: • Face-to-face medical and behavioral evaluation (within one hour) • 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
ıcumentation	Documentation in the patient's medical record must include the following; • Description of steps or interventions used prior to use of restraints or seclusion • Use of less restrictive measures (Alternatives or other less restrictive interventions) tried or considered as applicable to the situation • On- going assessments that support the need for use of restraint or seclusion • If the restraint or seclusion is lengthy, evidence that symptoms necessitating use of restraint or seclusion have persisted • Evaluation whether or not Restraint or Seclusion can be safely discontinued • A description of the patient's behavior and response to intervention used; • The patient's condition or symptom(s) that warranted the continued use of restraint; and, • The patient's response to the intervention(s) used, including the rationale for continued use of the intervention or release from restraint • Patient's plan of care or treatment plan • 1 hour face to face medical & behavioral evaluation for violent or self-destructive behavior • Patients' behavior in descriptive terms, detailed description of the patient's physical & mental status assessments & any	

environmental factors that may have contributed to the situation at the time of intervention

- Renewal or new order authorizing continued use of Restraint or Seclusion, must document the findings of the re-evaluation supporting continued use

CITATION(S):

1. Joint Commission on Accreditation of Healthcare Organizations Hospital Accreditation Standards, 2014.
2. U.S. Department of Health and Human Services, Code of Federal Regulations, Title 42, Volume 4 (Revised as of October 1, 2007), Part 482.13(e) Condition of Participation: Patient's Rights.
3. State Operations Manual (Rev. 149 10-09-15) – Appendix A- Survey Protocol, Regulations and Interpretative Guidelines for Hospitals. 482.13 (e) Standards: Restraints or Seclusions, p109.
4. U.S. Department of Health and Human Services, Code of Federal Regulations, Title 42, Volume 4 (Revised as of October 1, 2007), Part 482.13(e)(1)(i)(C) Condition of Participation: Patient's Rights.
5. U.S. Department of Health and Human Services, Code of Federal Regulations, Title 42, Volume 4 (Revised as of October 1, 2007), Part 482.13(e)(9) Condition of Participation: Patient's Rights.
6. U.S. Department of Health and Human Services, Code of Federal Regulations, Title 42, Volume 4 (Revised as of October 1, 2007), Part 482.13(f)(1) Condition of Participation: Patient's Rights.
7. U.S. Department of Health and Human Services, Code of Federal Regulations, Title 42, Volume 4 (Revised as of October 1, 2007), Part 482.13(e)(1)(i)(B) Condition of Participation: Patient's Rights.
8. U.S. Department of Health and Human Services, Code of Federal Regulations, Title 42, Volume 4 (Revised as of October 1, 2007), Part 482.13(e)(5) Condition of Participation: Patient's Rights.
9. U.S. Department of Health and Human Services, Code of Federal Regulations, Title 42, Volume 4 (Revised as of October 1, 2007), Part 482.13(e)(1)(i)(A) Condition of Participation: Patient's Rights.
10. U.S. Department of Health and Human Services, Code of Federal Regulations, Title 42, Volume 4 (Revised as of October 1, 2007), Part 482.13(e)(1)(ii) Condition of Participation: Patient's Rights.
11. District of Columbia Law 14-56; D.C. Official Code Title 7, Human Health Care and Safety; Subtitle C, Mental Health; Chapter 12A, Mental Health Consumers' Rights Protection §7-1231.09, Freedom from Seclusion and restraint.
12. District of Columbia Mental Health Service Delivery Reform Act of 2001: Chapter 1, of Title 22A, Consent to Treatment. (D.C. Law 14-56; D.C. Official Code §7-1231.06).
13. District of Columbia Law 14-56; D.C. Official Title 7, Human Health Care and Safety; Subtitle C, Mental Health; Chapter 12A, Mental Health Consumers' Rights Protection §7-1231.09).