A-0166

§482.13(e)(4) - The use of restraint or seclusion must be --

(i) in accordance with a written modification to the patient's plan of care.

Interpretive Guidelines §482.13(e)(4)(i)

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

The regulation does not require that a modification to the patient's plan of care be made before initiating or obtaining an order for the use of restraint or seclusion. The use of a restraint or seclusion intervention should be reflected in the patient's plan of care or treatment plan based on an assessment and evaluation of the patient. The plan of care or treatment plan should be reviewed and updated in writing within a timeframe specified by hospital policy.

Survey Procedures §482.13(e)(4)(i)

- Determine whether the hospital's procedures are consistent with the requirements of this regulation. Does the plan of care or treatment reflect a process of assessment, intervention, and evaluation when restraint or seclusion is used?
- Is there evidence of assessment of the identified problem or of an individual patient assessment?
- Does the patient's plan of care reflect that assessment?
- What was the goal of the intervention?
- What was the described intervention?
- Who is responsible for implementation?
- Was the patient informed of the changes in his or her treatment plan or plan of care?
- Did the physician or other LIP write orders that included a time limit? Were these orders incorporated into the plan of care?
- After the discontinuation of the restraint or seclusion intervention, was this information documented in an update of the plan of care or treatment plan?