

## 5122-14-10 Patient safety and physical plant requirements.

(A) The purpose of this rule is to:

- (1) Require written policies and procedures for building and fire inspections, sanitation standards, patient safety;
- (2) State requirements concerning the patient living environment including designated smoking areas, patient sleeping rooms, and common patient areas;
- (3) Ensure inpatient services have appropriate space, equipment and facilities;
- (4) Ensure inpatient services are appropriately and sufficiently staffed; and
- (5) State required procedures for seclusion and restraint.

(B) The provisions of this rule are applicable to each inpatient psychiatric service provider licensed by the department.

(C) Definitions applying to this rule are those appearing in rule [5122-14-01](#) of the Administrative Code.

(D) Each inpatient psychiatric service provider shall comply with all applicable TJC, HFAP and/or DNV, and/or federal, state, and local laws and regulations regarding patient care, safety, sanitation, and fire protection.

(1) A building inspection shall be made upon application for an initial license, repeated whenever renovations or changes in the building are made that would affect either the maximum number of licensed patient beds or substantially change the services provided by the inpatient psychiatric service provider, or whenever the department deems necessary.

(2) If an inpatient psychiatric service provider occupies part of a building, the entire building shall be inspected except where there is a fire wall or other fire resistant separation between the part of the building to be licensed and the rest of the building. If this fire separation does not exist the total building shall be used to determine safety for inspection purposes only.

(3) A building inspection shall be performed by a local certified building inspector or, where none is available, by the chief of the division of factory and building inspection of the Ohio department of industrial relations.

(4) The inpatient psychiatric service provider shall be inspected annually by a certified fire authority or, where none is available, by the division of state fire marshal of the Ohio department of commerce. Copies of annual inspections shall be maintained by the inpatient psychiatric service provider for a period of at least three years or until the next on-site licensure survey.

(5) The inpatient psychiatric service provider's food service shall be inspected annually by the authorized local municipal county health department. Copies of annual inspections shall be maintained by the inpatient psychiatric service provider for a period of at least three years or until the next on-site licensure survey.

(6) If the inpatient psychiatric service provider's water supply and sewage disposal is not part of a municipal system, it shall comply with applicable state or local regulations, rules, codes, or ordinances.

(E) Each inpatient psychiatric service provider shall provide an environment that is clean, safe, aesthetic, and therapeutic. Appropriate space, equipment, and facilities shall be available to provide services.

(1) If smoking is permitted, separate enclosed area(s) shall be used for smoking;

(2) Each patient's sleeping room shall have a:

(a) Window, with an operable covering for privacy, that has a view to the outdoors;

(b) Minimum of one hundred net square feet of usable floor space per bed for single occupancy, and a minimum of eighty net square feet of usable floor space per bed for multi-occupancy;

(c) Minimum of a bed, chair, storage for personal belongings, and other therapeutic furnishings as appropriate; and

(d) Degree of privacy from other patients if there is more than one bed in the room.

(3) Child/adolescent patients shall not share the same sleeping room with adult patients.

(4) For all patients, a safe and secure storage area(s) for personal belongings accessible to the patient shall be provided. Personal belongings that may pose safety issues for patients may be placed in a safe and secure storage area accessible to patients through a request of staff.

(5) Each inpatient psychiatric service provider shall provide common patient areas that adequately meet patient needs and program requirements.

(a) There shall be a minimum of eighty total square feet of usable social space per licensed bed to include:

(i) Patient lounge area(s) totaling at least thirty square feet per licensed bed, including separate smoking and non-smoking areas if smoking is permitted in the lounge area;

(ii) Patient activity area(s) totaling at least thirty square feet per licensed bed which may include indoor recreation areas;

(iii) Dining room facilities to meet patient needs;

(iv) Patient kitchen area to include a sink, a refrigerator, and cooking facilities as appropriate to patient need; and

(v) Patient laundry area.

(6) Patient lounge, activity, and dining area(s) may be shared space(s) as appropriate to patient need. Child/adolescent patients shall be provided the use of a patient lounge area(s) appropriate for their use separate from adult use of patient lounge areas.

(7) There shall be private areas to include:

(a) Private area(s) for visitation from family members, significant others, or other persons;

(b) Private area(s) for telephone use;

(c) Group therapy area(s) as appropriate to patient need; and

(d) Private areas to include places and times for personal privacy.

(8) Each inpatient psychiatric service provider shall provide an environment that is accessible to persons with disabilities and make reasonable accommodations in accordance with all applicable federal, state and local laws and regulations.

(9) Each inpatient psychiatric service provider shall develop policies and procedures regarding services designed to assist deaf/hard of hearing persons as well as persons for whom English is not the primary language.

(a) Services shall be provided at such a level so that the patient and patient's family or significant others are not denied the benefits of participation in the inpatient psychiatric service provider's treatment program. Services shall comply with all applicable state, federal and HIPAA guidelines regarding the maintenance of patient confidentiality. As applicable, such services shall consist of but may not be limited to availability of:

(i) Qualified interpreters with demonstrated ability and/or certification;

(ii) Telecommunication devices for the deaf/hard of hearing; and

(iii) Television closed caption capability.

(b) Such services shall be available to patients and their family members or significant others who are receiving services. Specifically for emergency services, the inpatient psychiatric service provider shall have policies and procedures that address the need for immediate accessibility to qualified interpreters, telecommunication devices for the deaf/hard of hearing, and/or other assistance with communication.

(c) Direct care staff and treatment team members shall be trained in issues relating to barriers to traditional verbal/English communication.

(d) Services to assist patients and families of patients or significant others shall be available at no charge to the patient, family or significant others.

(10) Each inpatient psychiatric service provider shall implement a falls prevention program that is monitored through its quality improvement process.

(F) Each inpatient psychiatric service provider shall have a sufficient number of professional, administrative, and support staff to meet both census needs and patient needs.

(1) Staffing for all services shall reflect the volume of patients, patient acuity, and the level of intensity of the services provided to ensure that desired outcomes of care are achieved and negative outcomes are avoided.

(2) Staffing of any organized patient activity (e.g., rehabilitation therapy services or nursing services provided to groups of patients), shall be sufficient to ensure safety and may be dependent on the type, duration and location of the activity and the immediate accessibility of other staff.

(3) For nursing services:

(a) A 1:4 minimum nursing staff-to-patient ratio shall be maintained as an overall average in any four week period with the exception of night hours when patients are sleeping.

(b) For reasons of safety at least two staff shall be present at all times.

(c) A registered nurse must be on site twenty-four hours each day, seven days a week.

(d) A registered nurse must be available for direct patient care when needed.

(G) Each inpatient psychiatric service provider shall meet all applicable medicare conditions of participation, TJC, HFAP and/or DNV standards for seclusion and restraint in addition to the following:

(1) The following shall not be used under any circumstances:

(a) Behavior management interventions that employ unpleasant or aversive stimuli such as: the contingent loss of the regular meal, the contingent loss of bed, and the contingent use of unpleasant substances or stimuli such as bitter tastes, bad smells, splashing with cold water, and loud, annoying noises;

(b) Any technique that obstructs the airway or impairs breathing;

(c) Any technique that obstructs vision;

(d) Any technique that restricts the individual's ability to communicate;

(e) Weapons and law enforcement restraint devices, as defined by CMS in appendix A of its interpretive guidelines to 42 C.F.R. 482.13(f) and found in manual publication No. 100-7, "Medicare State Operations", used by any hospital staff or hospital-employed security or law enforcement personnel, as a means of subduing a patient to place that patient in patient restraint/seclusion; and

(f) Chemical restraint. A drug or medication administered involuntarily to an individual in an emergency may be considered a chemical restraint if both conditions cited in paragraph (C)(6) of rule [5122-14-01](#) of the Administrative Code are met.

(2) Position in physical or mechanical restraint.

(a) An individual shall be placed in a position that allows airway access and does not compromise respiration.

(i) The use of prone restraint is prohibited.

(ii) A transitional hold shall be limited to the minimum amount of time necessary to safely bring the person under control, at which time staff shall either terminate the transitional hold, and begin the post-restraint process required by this rule, or, if the individual cannot safely be released from the transitional hold, re-position the individual into an alternate restraint position.

The use of transitional hold shall not be utilized with mechanical restraint.

(b) The use of transitional hold shall be subject to the following requirements:

(i) Applied only by staff who have current training on the safe use of transitional hold, including how to recognize and respond to signs of distress in the individual.

(ii) The weight of the staff shall be placed to the side, rather than on top of the individual. No transitional hold shall allow staff to straddle or bear weight on the individual's torso while applying the restraint, i.e. no downward pressure may be applied that may compromise the individual's ability to breathe.

(iii) No transitional hold shall allow the individual's hands or arms to be under or behind his/her head or body. The arms must be at the individual's side.

(iv) No soft device, such as a pillow, blanket or other item, shall be used to cushion the client's head, since such a device may restrict the individual's ability to breathe.

(v) All staff involved in the procedure must constantly observe the individual's respiration, coloring, and other signs of distress, listen for the individual's complaints of breathing problems, and immediately respond to assure safety.

(vi) After conclusion of the transitional hold, the hospital shall monitor and document the condition of the individual at least every fifteen minutes, for two hours. The inability to complete the fifteen minute monitoring and rational shall be documented.

(3) The agency shall identify, educate and approve staff members to use seclusion or restraint. Competency of staff in the use and documentation of seclusion or restraint methods shall be routinely evaluated. The results of evaluations shall be maintained by the agency for a minimum of three years for each staff member identified.

Staff shall have appropriate training prior to utilizing seclusion or restraint, and, at a minimum, annually thereafter. The exception to annual training is a first aid and/or CPR training/certification program of a

nationally recognized certifying body, e.g. the American Red Cross or American Heart Association, when that certifying body establishes a longer time frame for certification and renewal.

(a) Staff shall be trained in and demonstrate competency in the safe application of all seclusion or restraint interventions he or she is authorized to perform, including specific training in utilization of transitional holds, if applicable;

(b) Staff shall be trained in and demonstrate competency in choosing the least restrictive intervention based on an individualized assessment of the patient's behavioral and/or medical status or condition;

(c) Staff shall be trained in and demonstrate competency in recognizing and responding to signs of physical distress in clients who are being secluded or restrained;

(d) Staff shall be trained and certified in first aid and CPR;

(e) Staff shall be trained in and demonstrate competency in recognizing and responding to signs of physical distress in clients who are being secluded or restrained;

(f) Staff authorized to take vital signs and blood pressure shall be trained in and demonstrate competency in taking them and understanding their relevance to physical safety and distress;

(g) Staff shall be trained in and demonstrate competency in assessing circulation, range of motion, nutrition, hydration, hygiene, and toileting needs; and

(h) Staff shall be trained in and demonstrate competency in helping a client regain control to meet behavioral criteria to discontinue seclusion or restraint.

(4) The presence of advance directives or client preferences addressing the use of seclusion or restraint shall be determined and considered, and documented in the medical record. If the agency will be unable to utilize seclusion or restraint in a manner in accordance with the patient's directives or preferences, the agency shall notify the patient, including the rationale, and document such in the ICR

(5) In each patient's medical record, upon admission and upon any relevant changes in the patient's condition, any perceived medical or psychiatric contraindications for the possible use of seclusion or restraint shall be documented. The specific contra-indication shall be described and shall take into account the following which may place the patient at greater risk for such use:

(a) Gender;

(b) Age;

(c) Developmental issues;

(d) Culture, race, ethnicity, and primary language;

(e) History of physical and/or sexual abuse, or psychological trauma;

(f) Medical and other conditions that might compromise physical well-being, e.g., asthma, epilepsy, obesity, lung and heart conditions, an existing broken bone, pregnancy, and drug/alcohol use; and

(g) Physical disabilities.

(6) Orders shall be written only by an individual with specific clinical privileges/authorization granted by the agency to order seclusion and restraint, and who is a:

(a) Psychiatrist or other physician; or

(b) Physician's assistant, certified nurse practitioner or clinical nurse specialist authorized in accordance with his or her scope of practice and as permitted by applicable law or regulation.

(c) Countersignatures to telephone orders for seclusion and/or restraint shall be signed within twenty four hours by an individual with specific clinical privileges/authorization granted by the hospital to order seclusion and restraint, and who is a psychiatrist or other physician, physician's assistant, certified nurse practitioner, or clinical nurse specialist

(7) Following the conclusion of each incident of seclusion or restraint, the patient and staff shall participate in a debriefing(s).

(a) The debriefing shall occur within twenty-four hours of the incident unless the client refuses, is unavailable, or there is a documented clinical contraindication.

(b) The following shall be invited to participate unless such participation is clinically contraindicated and the rationale is documented in the clinical record:

(i) For a child/adolescent client, the family, or custodian or guardian, or

(ii) For an adult client, the client's family or significant other when the client has given consent, or an adult client's guardian, if applicable.

(8) As part of the inpatient psychiatric service provider's performance improvement process, a periodic review and analysis of the use of seclusion and restraint shall be performed.

(9) The inpatient psychiatric service provider shall maintain an ongoing log of its seclusion and restraint utilization for departmental review. A log shall be maintained for department review of each incident of mechanical restraint, seclusion, and physical restraint, and for time-out exceeding sixty minutes per episode. The log shall include, at minimum, the following information.

(a) The person's name or other identifier;

(b) The date, time and type of method utilized, i.e., seclusion, physical or mechanical restraint, or time-out. The log of physical and mechanical restraint shall also describe the type of intervention as follows:

(i) For mechanical restraint, the type of mechanical restraint device used;

(ii) For physical restraint, the type of hold or holds as follows:

(a) Transitional hold, and/or

(b) Physical restraint; and

(c) The duration of the method or methods.

If both transitional hold and physical restraint are utilized during a single episode of restraint, the duration in each shall be included on the log. For example, a physical restraint that begins with a one minute transitional hold, followed by a three minute physical restraint shall be logged as one restraint, indicating the length of time in each restraint type.

(10) Plan to reduce seclusion and/or restraint.

(a) An agency which utilizes seclusion or restraint shall develop a plan designed to reduce its use. The plan shall include attention to the following strategies:

(i) Identification of the role of leadership;

- (ii) Use of data to inform practice;
- (iii) Workforce development;
- (iv) Identification and implementation of prevention strategies;
- (v) Identification of the role of clients (including children), families, and external advocates; and
- (vi) Utilization of the post seclusion or restraint debriefing process.

(b) A written status report shall be prepared annually, and reviewed by leadership.

(H) Pursuant to rule [5122-14-14](#) of the Administrative Code, the hospital shall notify ODMH of each:

(1) Instance of physical injury to a patient that is restraint-related, e.g., injuries incurred when being placed in seclusion and/or restraint or while in seclusion or restraint, with the exception of injury that is self-inflicted, i.e. a patient banging his/her own head;

(2) Death that occurs while a person is restrained or in seclusion;

(3) Death occurring within twenty four hours after the person has been removed from restraint or seclusion, and

(4) Death where it is reasonable to assume that a person's death may be related to or is a result of such seclusion or restraint.

(I) Staff actions commonly known as therapeutic, supportive or directional touch, utilized to direct an individual to another area without the use of force and which do not restrict an individual's freedom of movement, are not considered restraint and are not subject to the provisions of paragraph (G) of this rule

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