Ohio Administrative Code

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

Effective: April 24, 2024

(A) Each inpatient psychiatric service provider is to comply with all applicable TJC, ACHC, or DNV mandates and federal, state, and local laws and regulations regarding patient care, safety, sanitation, and fire protection.

(1) A building inspection is to be made upon application for an initial license and 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, as well as when the department deems a building inspection is necessary.

(2) If an inpatient psychiatric service provider occupies part of a building, the entire building is to 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 is to be used to determine safety for inspection purposes only.

(3) A building inspection is to be performed by a local certified building inspector or, where none is available, by the chief of the bureau of building code compliance in the Ohio department of commerce.

(4) The inpatient psychiatric service provider is to be inspected annually by a certified fire authority or, where none is available, by the division of state fire marshal in the Ohio department of commerce. Copies of annual inspections are to 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 is to be inspected annually by the authorized local municipal county health department. Copies of annual inspections are to 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 is to comply with applicable state or local regulations, rules, codes, or ordinances.

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

(1) If smoking is permitted, a separate, enclosed area is to be used for smoking;

(2) Each patient's sleeping room is to have all of the following:

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

(b) A 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) A minimum of a bed, chair, storage for personal belongings, and other therapeutic furnishings as appropriate; and

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

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

(4) For all patients, a safe and secure storage area for personal belongings accessible to the patient is to 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 is to provide common patient areas that adequately meet patient needs and program mandates.

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

(i) A patient lounge area 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) A patient activity area totaling at least thirty square feet per licensed bed which may include indoor recreation areas;

(iii) Dining room facilities to meet patient needs;

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

(v) A patient laundry area.

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

(7) There are to be private areas to include all of the following:

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

(b) A private area for telephone use;

(c) A group therapy area as appropriate to patient need; and

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

(8) Each inpatient psychiatric service provider is to 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 is to 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 are to 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 will comply with all applicable state and federal guidelines regarding the maintenance of patient confidentiality. As applicable, such services are to consist of but are not to be limited to availability of all of the following:

(i) Qualified interpreters with demonstrated ability or certification;

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

(iii) Television closed caption capability.

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

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

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

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

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

(1) Staffing for all services is to 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) is to 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 is to 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 members are to be present at all times.

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

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

(D) Each inpatient psychiatric service provider is to meet all applicable medicare conditions of participation (including 42 C.F.R. 482.13(e)), TJC, ACHC, or DNV standards for seclusion and restraint in addition to complying with all of the following provisions:

(1) The following are not to 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) Any technique that causes an individual to be retraumatized based on an individual's history of traumatic experiences;

(f) Weapons and law enforcement restraint devices, as defined by CMS in appendix A of its interpretive guidelines to 42 C.F.R. 482.13(e) and found in " CMS State Operations Manual, Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals,"July 21, 2023, revision, 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

(g) Chemical restraint; and

(h) Prone restraint.

(2) Position in physical or mechanical restraint.

An individual is to be placed in a position that allows airway access and does not compromise respiration. Hospital staff are not authorized to utilize prone restraint.

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

Staff are to have appropriate training prior to utilizing seclusion or restraint, and, at a minimum, annually thereafter. The exception to annual training is a first aid 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 are to be trained in and demonstrate competency in the safe application of all seclusion or restraint interventions he or she is authorized to perform;

(b) Staff are to 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 are to 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 are to be trained and certified in first aid and CPR;

(e) Staff are to 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 are to be trained in and demonstrate competency in taking them and understanding their relevance to physical safety and distress;

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

(h) Staff are to 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 is to be determined and considered, as well as documented in the medical record. If the inpatient psychiatric service provider will be unable to utilize seclusion or restraint in a manner in accordance with the patient's directives or preferences, the provider is to notify the patient, give 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 is to be documented. The specific contraindication is to be described and is to take into account the following which may place the patient at greater risk for such use:

(a) Gender;

(b) Chronological and developmental age;

(c) Physical body size;

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

(e) History of physical, 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;

(g) Physical disabilities; and

(h) Psychiatric condition.

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

(a) Psychiatrist or other physician; or

(b) Physician 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.

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

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

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

(b) The following are to 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.

(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 is to be performed.

(9) The inpatient psychiatric service provider is to maintain an ongoing log of its seclusion and restraint utilization for departmental review. A log is to 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 is to 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 restraint, mechanical restraint, or time-out. The log of physical and mechanical restraint is to 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; and

(c) The duration of the method or methods.

If restraint is necessary as a means of safely transporting an individual to seclusion, either a separate order for restraint and a separate order for seclusion is needed or, alternatively, one order may be

used that delineates a separate restraint and a separate seclusion.

If the restraint or seclusion episode is concluded, and the patient's behavior necessitates initiating another restraint or seclusion, then a new order needs to be obtained, even if the ending time of the original order has not passed.

(10) Plan to reduce seclusion and restraint.

(a) A inpatient psychiatric service provider that utilizes seclusion or restraint is to develop a plan designed to reduce its use. The plan is to 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 is to be prepared annually and reviewed by leadership.

(E) Pursuant to rule 5122-14-14 of the Administrative Code, the hospital is to notify the department of all of the following:

(1) Each 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) Each death that occurs while a person is restrained or in seclusion;

(3) Each death occurring within twenty four hours after the person has been removed from restraint or seclusion; and

(4) Each 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.

(F) 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 (D) of this rule.