

# HCFA Regulations For Use Of Restraint And Seclusion In Psychiatric Residential Treatment Facilities Providing Inpatient Psychiatric Services To Individuals Under Age 21 – New, May 22, 2001.

Sec. 483.352 Definitions. 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.

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.

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(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

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***In the March 2001 issue we reported new regulations that were to take effect March 23, 2001.***

***We put the new regulations on our website.***

***In the May 2001 issue we reported that the date that the regulations were to take effect had changed to May 22, 2001.***

***On May 22, 2001 HCFA changed the new regulations just as they were taking effect.***

***We are reproducing here only HCFA's most recent changes to the regulations.***

***The full regulations are contained in Title 42 of the Code of Federal Regulations, Part 483.***

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Pages 28110 – 28117.

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period of the emergency safety intervention.

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(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--

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(1) The name of the ordering physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion;

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(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.

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(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.

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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.

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

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(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 in-

## HCFA Regs On Use Of Restraint And Seclusion – Inpatient Psych (Continued).

terventions, 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.

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(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. 483.374 Facility reporting.

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(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 Health Care Financing Administration (HCFA) regional office.

(1) Staff must report the death of any resident to the HCFA 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 HCFA regional office.

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## Needle Broken Off During Surgery: Court Faults Perioperative Nurses, But Finds No Fraudulent Concealment.

During a young child's tonsillectomy, as the surgeon was suturing a bleeding blood vessel the tip of the needle broke off inside the tonsil fossa. The bleeding only worsened when he tried to probe for the needle tip, so he decided not to retrieve it. He got an x-ray, determined the needle fragment was not a threat to the patient and finished the procedure.

### Perioperative Nursing Negligence

According to the Court of Appeals of Georgia, the root cause was the operating room nurses handing the surgeon a thinner needle than the size he called for.

The jury awarded \$22,500 as compensation for the child having to undergo a second procedure to remove the needle tip after complications arose.

The award went only against the hospital, the nurses' employer. The surgeon was ruled not negligent.

### No Fraudulent Concealment

#### No Punitive Damages

After the procedure, the surgeon and the hospital's director of perioperative services, a nurse, sat down with the parents. They admitted a small portion of a needle broke off and was left in the child's throat. They said this kind of thing happens all the time. They said it was not a problem and would never have to be removed. That turned out not to be true.

The surgeon estimated in his operative report the needle tip was .25 inch (0.635 cm). When removed it actually measured 1.6 cm, the court said.

The operating room nurses made no mention in their perioperative charting that a needle had broken off inside the patient's throat, that an x-ray was obtained, that the surgeon decided to leave it inside or that a different needle than the one requested had been handed to the surgeon.

The court stated in general terms that a patient can sue a nurse or a physician who fraudulently misinforms the patient or tries

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***Nurses and physicians have the legal duty not to injure their patients through negligence.***

***And if a patient is injured, the patient's nurses and doctors cannot try to deny, conceal or minimize that the injury occurred, its seriousness or the sequelae to be expected.***

***If nurses or doctors try to hide things from a patient it can be a separate and distinct basis for a lawsuit and it can lead to punitive damages being awarded.***

COURT OF APPEALS OF GEORGIA, 2001.

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to conceal the fact that a mistake has been made. Healthcare professionals have a legal duty not to deceive their patients by trying to cover up their mistakes. The special relationship of trust with their patients makes such conduct wholly inappropriate.

And the civil law, as a general rule, punishes intentional misconduct with punitive damages above and beyond the sum that is reasonable to compensate the patient for the patient's actual losses.

In this case, however, the court ruled there was no active misrepresentation or passive fraudulent concealment, even though what the family was told turned out not to be true exactly.

The court upheld the hospital's obligation to pay compensation for the nurses' negligence in selecting the wrong needle, but threw out the jury's award of punitive damages as contrary to the evidence. **Kodadek v. Lieberman, 545 S.E. 2d 25 (Ga. App., 2001).**