February 27, 2020

Donna Jerry
Senior Health Policy Analyst
Green Mountain Care Board
144 State St.
Montpelier, VT 05602

RE: Docket No. GMCB-003-19con, Emergency Department Modernization Project

Dear Donna:

Thank you for your January 3, 2020 questions regarding the above-referenced project. This set of questions has taken additional time to address given the in-depth nature, the need for statistics, and other pressing priorities here. Attached you will find our responses to your questions and the verification under oath form.

I hope you will find these clarifications complete and satisfactory. If you have any additional questions, please contact Jonathan Billings, NMC's Vice President of Community Relations, at jbillings@nmcinc.org or (802) 524-1044.

We have also reached out to invite those who have submitted public comment regarding the project to a meeting here at NMC in March (date currently being finalized). This will provide an opportunity for those individuals to appreciate NMC's current emergency department situation which is to be addressed by this project and to work toward a shared understanding of the best approaches to future operational circumstances, such as locking protocols, appropriate access to family space, etc.

NMC has worked hard to answer the many rounds of questions on this project from the Green Mountain Care Board and those raised in public comment. At this point, we respectfully ask that the project be ruled complete and the process move forward efficiently, as we do run the risk of having to rework the construction schedule which may adversely impact costs.

Sincerely,

Jill Berry Bowen, RN
Chief Executive Officer

CC: Jonathan Billings, NMC Vice President of Community Relations
Anne Cramer, Esq.

Verification Under Oath

STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re:	Northwestern Medical Center's Emergency Department Modernization Project Response to 07/03/19 Request	))))	Docket No. GMCB-003-19con

Verification Under Oath to file with Certificate of Need Application, correspondence and additional information subsequent to filing an Application.

Jill Berry Bowen, being duly sworn, states on oath as follows:

1. My name is Jill Berry Bowen. I am the Chief Executive Officer of Northwestern Medical Center. I have reviewed Northwestern Medical Center's response to the Green Mountain Care Board's questions dated 01/03/20 regarding NMC's Certificate of Need Application for our Emergency Department Modernization project (Docket No. GMCB-003-19con).

2. Based on my personal knowledge and after diligent inquiry, I attest that the information contained in Northwestern Medical Center's response to the Green Mountain Care Board's questions dated 01/03/20 regarding NMC's Certificate of Need Application for our Emergency Department Modernization project (Docket No. GMCB-003-19con) is true, accurate and complete, does not contain any untrue statement of a material fact, and does not omit to state a material fact.

3. My personal knowledge of the truth, accuracy and completeness of the information contained in the Northwestern Medical Center's response to the Green Mountain Care Board's questions dated 01/03/20 regarding NMC's Certificate of Need Application for our Emergency Department Modernization project (Docket No. GMCB-003-19con) is based upon either my actual knowledge of the subject information or upon information reasonably believed by me to be true and reliable and provided to me by the individuals identified below in paragraph 4. Each of these individuals has also certified that the information they have provided is true, accurate and complete, does not contain any untrue statement of a material fact and does not omit to state a material fact.

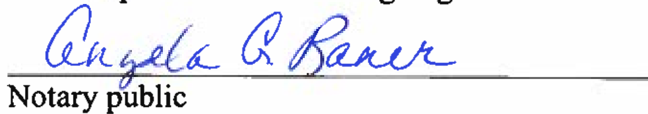
4. The following individuals have provided information or documents to me in connection with Northwestern Medical Center's response to the Green Mountain Care Board's questions dated 01/03/20 regarding NMC's Certificate of Need Application for our Emergency Department Modernization project (Docket No. GMCB-003-19con) and each individual has certified, based either upon his or her actual knowledge of the subject information or, where specifically identified in such certification, based on information reasonably believed by the individual to be reliable, that the information or documents provided are true, accurate and complete, do not contain any untrue statement of a material fact, and do not omit to state a material fact:

- JoAnn Manahan, RN, NMC Emergency Department Nurse Manager
- Louis Danderand, MD, NMC Emergency Department Medical Director
- Tyson Moulton, Director of Facilities
- Jamie Pinkham, Manager of Regulatory Affairs
- Anneke Merritt, Director of Quality & Process Improvement
- Anthony Stevens, Northwestern Counseling & Support Services
- Jonathan Billings, Vice President of Community Relations

5. In the event that the information contained in the Northwestern Medical Center's response to the Green Mountain Care Board's questions dated 01/03/20 regarding NMC's Certificate of Need Application for our Emergency Department Modernization project (Docket No. GMCB-003-19con) becomes untrue, inaccurate or incomplete in any material respect, I acknowledge my obligation to notify the Green Mountain Care Board and to supplement the Northwestern Medical Center's response to the Green Mountain Care Board's questions dated 01/03/20 regarding NMC's Certificate of Need Application for our Emergency Department Modernization project (Docket No. GMCB-003-19con) as soon as I know, or reasonably should know, that the information or document has become untrue, inaccurate or incomplete in any material respect.

[signature]

On 2/28, 2020, Jill Berry Bowen appeared before me and swore to the truth, accuracy and completeness of the foregoing.



Notary public

My commission expires 1/31/2021
[seal]

Northwestern Medical Center Certificate of Need Response to 010320 Questions
Emergency Department Modernization: GMCB-003-19con

The following are Northwestern Medical Center's (NMC's) responses to the Green Mountain Care Board's (GMCB's) questions dated 01/03/20 regarding NMC's Certificate of Need application and request for expedited review relating to NMC's Emergency Department (ED) Modernization project – GMCB-003-19con.

1. **For 2016, 2017, 2018 and 2019 (to date), provide, in a table format: (a) NMC's total number of ED visits; (b) the total number and percentage of ED visits that were mental health visits; (c) the number and percentage of ED mental health visits where services were sought voluntarily; and (d) the total number and percentage of ED mental health visits where the patient was committed involuntarily. Explain how these volumes relate to the number of rooms that would be needed to treat persons with mental health conditions.**

	FY 2016	FY 2017	FY 2018	FY 2019
a) Total NMC ED Visits per fiscal year	27470	25932	24536	25681
b) # of ED visits that are mental health visits	217*	559	553	613
b) # of ED visits that are mental health visits	0.8%	2.2%	2.3%	2.4%
c) # of ED mental health visits: voluntarily sought	29	64	52	49
c) % of ED mental health visits: voluntarily sought	13%	11.4%	9.4%	8%
d) # of ED mental health visits: involuntary	9	19	19	17
d) % of ED mental health visits: involuntary	4.1%	3.4%	3.4%	2.6%

The numbers for the b) lines above represent totals from NMC's system for Emergency Department patients with a chief complaint of: anxiety; depression; psychiatric evaluation; suicide ideation; and overdose. *The 2016 number of 217 in line b is a partial year of data given the midyear start of the computer tracking system used to generate this data. The numbers in the c) and d) lines were provided by Anthony Stevens of Northwestern Counseling & Support Services (NCSS) and represent those patients for whom NCSS provided a crisis consult and the differentiation between voluntary and involuntary. You will note that not all mental health related visits to the Emergency Department require a crisis consultation, resulting in the percentages above.

An understanding of the daily implications of these numbers and percentages was part of the clinically guided decision making which led to the design of the modernized NMC ED. As previously explained in this process, the total number of patient rooms in the modernized NMC ED is informed by and benchmarked against national reference material as well as comparable Vermont hospitals. The determination of how many of the total count should be ligature-free patient treatment rooms and ligature-resistant convertible patient treatment rooms has some relation to, but is not driven by, the numbers requested above.

The numbers above are simple visit counts. They do not take into account the drastically different length of stay between various visit types. This timing disparity renders counts as detailed above and the resulting percentages impractical as a driving force within determining room use within a benchmarked number of total rooms. Rather, our ED design team (ED physicians, ED nurses, healthcare architects, facilities experts, etc. with review facilitated through our partners at NCSS that included individuals who identify as having lived experience relevant to mental health care) considered numbers such as these and the practical daily realities faced within the NMC ED given volumes and timing and room use.

Patients are not evenly spread across the hours of a day or the days of a year. While the percent figures above might inaccurately suggest that a single room would suffice, we know from a day-to-day basis that we can frequently have two patients, occasionally four, and even six individuals on rare occasions needing this type of resource at any given time.

A properly-designed ED must have the flexibility to address the various types of patients in various quantities, including surges, on an ongoing basis. The design of the modernized NMC ED provides that flexibility. Our experience shows us that for much of the time, two ligature-free rooms will meet the need. When there are even small surges of patients who would benefit from this type of environment, the flexibility of the two ligature-resistant rooms is critical. Similarly, in times of surge for patients with strictly medical needs, the flexibility of the convertible rooms will be greatly beneficial. We believe that having four rooms of this nature (two ligature-free and two ligature-resistant) within our appropriately benchmarked total bed count will prudently meet the needs of our community in the vast majority of instances.

2. **Confirm that the doors from the main hallway into the area where the two designated mental health rooms and the two convertible rooms are located do not automatically lock at all times and can remain unlocked. Also confirm that the doors to each of the four rooms and the door between the two sets of rooms do not automatically lock at all times and can remain unlocked. Describe the steps that are required to lock and unlock each of these doors.**

We can confirm this. The doors to the two ligature-free patient treatment rooms, the doors to the two ligature-resistant convertible patient treatment rooms, and the two hallway doors in this area of the Emergency Department will not automatically lock and can remain unlocked.

In terms of the mechanical steps to lock the doors, the specific door hardware mechanisms have not been finalized in this stage of project design. NMC will ensure that the hardware on these doors meets the applicable FGI guidelines whether the final model involves twisting dead-bolt, removeable key, or identification badge activation steps to lock and unlock.

In terms of process steps to lock the doors, that is covered by NMC's "Restraint Use" policy (updated 12/2018) which speaks to "seclusion" (defined to include use of a locked room) as a form of "physical restraint". The 10-page policy (attached) presents the steps needed to apply a restraint, such as seclusion by locking a room with a patient inside, and is discussed in greater detail in our response to question 4 below.

3. **It is represented that the two convertible rooms could be used to treat any population. Confirm whether these two "convertible" rooms are also ligature resistant and could be used for mental health visits to the ED.**

   The two "convertible" rooms are ligature-resistant patient treatment rooms. Their differentiating ligature-resistant features include hard ceilings and sliding panels to cover (when necessary) wall-mounted equipment. When needed, they can be used for mental health visits to the ED.

4. **On page 5 of responses to questions dated December 23, 2019, it is stated that guidance has not yet been formalized regarding when the doors into the area from the main hallway, the four rooms and door between the two sets of rooms and this area will be locked or unlocked to be compliant with CMS and state regulations and statutes. Please submit the policy NMC will follow regarding locked areas that is compliant with all CMS requirements and state statutes.**

   It is NMC's commitment to treat all patients and visitors with respect and compassion in a way that is consistent with CMS regulation and industry best practices.

   Having the capacity to lock a space in a busy Emergency Department is an important security measure for patient and staff safety. These rooms can be utilized for patients who pose any sort of a security risk in order to keep the entire department safe. They can also be used in the event of an active safety or security threat coming into the department.

   In the event a patient requires restraint in order to keep themselves and/or others safe, the use of locked doors is addressed within NMC's organizational "Restraint Use" policy (updated 12/2018). A copy of this policy is attached. This policy clearly specifies NMC's approach to "seclusion" which is defined in a manner that includes locked doors.

   As the policy indicates, NMC maintains a philosophy of using the least restrictive restraint that is appropriate. We believe the option of lockable patient treatment rooms provides an appropriate form of restraint in certain clinical circumstances that may actually be less intrusive and preserve more of an individual's civil liberties than other forms of restraint (such as chemical restraint).

The purposes of this policy are stated as: "*To assure safe and effective care is provided when restraints are used for the support of medical healing or behavioral emergencies. To describe NMC's commitment to progressively minimizing the use of restraints by offering interventions and alternatives. To assure restraints are used only when medically necessary and are used for patient benefit and safety.*"

The policy statement provides that: "*Patients have the right to be free of restraint. Restraints are used only when clinically justified to prevent serious disruption of the therapeutic environment or when warranted by patient behavior that threatens the physical safety of the patient, staff, or others. Restraints may be used for non-violent/non-behavioral conditions or for violent/behavioral conditions – only after alternative, less restrictive interventions have failed – and by using the least restrictive form of restraint possible. An order is obtained for each restraint and cannot be a PRN (use if needed) order. Restrained patients are continually assessed, monitored, and re-evaluated with the goal to discontinue the restraint as soon as is clinically possible. All evaluations of the patient regarding need for restraint by the Licensed Independent Professional (LIP) are documented in the medical record.*"

The definition section of this policy specifies that: "*Seclusion: The involuntary confinement of a person in a room or an area where the person is physically prevented from leaving. Seclusion is a type of physical restraint.*"

"The involuntary confinement of a person in a room" – such as by locking the door to the room or hallway -- is formally and specifically defined as part of the "seclusion form" of a patient restraint. As such, the locking of the doorways within this modernization of the Emergency Department is governed by NMC's "Restraint Use" policy. This is the policy which NMC will use as we make appropriate clinical judgements regarding locking doors. We believe that this policy and the approach to seclusion communicated within this policy are compliant with CMS and state regulations and statutes and prioritize patient dignity and rights.

Restraint Use

Applicability: Organizational	Date Effective: 6/04
Department: Clinical Services	Date Last Reviewed: 12/18
Supersedes: Restraint	Or Date Last Revision: 12/18
Administration Approval: Maggie Conklin, RN, Interim Chief Nursing Officer	

Purpose:

To assure safe and effective care is provided when restraints are used for the support of medical healing or behavioral emergencies.

To describe NMC's commitment to progressively minimizing the use of restraints by offering interventions and alternatives.

To assure restraints are used only when medically necessary and are used for patient benefit and safety.

Policy Statement: Patients have the right to be free of restraint. Restraints are used only when clinically justified to prevent serious disruption of the therapeutic environment or when warranted by patient behavior that threatens the physical safety of the patient, staff, or others. Restraints may be used for non-violent/non-behavioral conditions or for violent/behavioral conditions – only after alternative, less restrictive interventions have failed – and by using the least restrictive form of restraint possible. An order is obtained for each restraint and **cannot** be a PRN (use if needed) order. Restrained patients are continually assessed, monitored, and re-evaluated with the goal to discontinue the restraint as soon as is clinically possible. All evaluations of the patient regarding need for restraint by the Licensed Independent Professional (LIP) are documented in the medical record.

This policy is not applicable to standard practices that include limitation of mobility or use of medically necessary positioning or securing device used to maintain the position, limit mobility, or temporarily immobilize the patient related to medical, dental, diagnostic, or surgical procedures and the related post-procedure care processes and forensic and correction restrictions used for security.

Northwestern Medical Center reports the death of any restrained or secluded patient.

Background: Non-Violent/Non-Behavioral Restraints are applied to prevent interferences with necessary care and to support medical healing. Violent/Behavioral Restraints are applied for the management of behavior that is violent or self-destructive and/or jeopardizes the immediate safety of

the patient, staff or others.

Definitions:

Physical Restraint: Any manual method, physical or mechanical device, material or equipment attached or adjacent to the patient's body that he/she cannot easily remove or that restricts freedom of movement or normal access to one's body. Types of physical restraint include: safety belt, soft limb restraint, neoprene limb restraint, and possibly geriatric/cardiac chair and bed rails.

The application of physical force to administer a medication against the patient's wishes is considered a physical restraint.

Seclusion: The involuntary confinement of a person in a room or an area where the person is physically prevented from leaving. Seclusion is a type of physical restraint.

Chemical Restraint: See Addendum 1 (Chemical Restraint Decision Tree). Any medication used to control behavior to restrict the patient's freedom of movement and is not a standard treatment for the patient's medical or psychiatric condition.

The application of physical force to administer a medication acting as a chemical restraint (against the patient's wishes) is considered a physical restraint and requires an additional separate order.

Interruption: Brief removal of restraint to render care with no plan for discontinuation of restraint.

Break: Trial period of restraint removal to assess need for continued use.

Licensed Independent Practitioner (LIP): A Physician or a Nurse Practitioner

Non-Violent/ Non-Behavioral Standard: applies to the use of restraint to temporarily immobilize a patient due to a medical condition or to promote healing.

Violent/ Behavioral Management Standard: applies to the emergent use of a restraint to control violent, or potentially violent, behavior.

Procedure: See Addendum 2 (Regular Restraint Decision Tree)

I. **Procedure for Non-Violent/Non-Behavioral Restraint:**

A. Registered Nurse (RN) responsibilities for non-violent/non-behavioral restraints:
- Initially assesses patient, documents unsafe behavior warranting the use of restraint.
- Describes patient behaviors posing immediate threat to the safety of the patient.

- Documents all interventions attempted prior to implementing a restraint.
- After assessment of the patient, may make the decision to apply restraint prior to receiving an order but obtains a restraint order from an LIP as soon as possible.
- The type of restraint selected is the least restrictive intervention based on the initial and current patient assessment and addresses the risk associated with vulnerable patient populations, such as geriatric, pediatric, and cognitively or physically-limited patients.
- Frequently assesses the patient's need for continued restraint
- May make the decision to discontinue restraint early, based on patient assessment
- May make the decision to reapply restraint under the most recent order if still within the 24-hour time frame, if a patient's medical condition or reason for which the restraint was originally used continues or recurs after discontinuing the restraint early.

B. <u>LIP responsibilities for non-violent/non-behavioral restraints</u>:
- Views and assesses the patient for need for restraint
- Documents findings of their evaluation in the medical record.
- Signs the restraint order within 24 hours of the application of restraint.
- Each restraint order is documented utilizing <u>Restraint Orders</u>.
- An LIP may renew a restraint order ONCE PER CALENDAR DAY if continued restraint is clinically indicated based on the LIP's examination and evaluation of the patient.

LIP documentation for non-violent/non-behavioral restraints includes:
- Date & time of order
- Specific patient condition/behavior clinically justifying need for restraint
- Specific type of restraint and location(s)
- Specific start and stop times

C. <u>Nursing (RN, LPN, LNA or Tech under the direction of an RN) responsibilities for non-violent/non-behavioral restraints</u>:
- Nursing (or the LIP) explains the procedure and rationale for using restraint, including the condition/behavior required for release from restraint to the patient and family whenever possible.
- Nursing applies restraint in accordance with safe and appropriate restraining techniques following manufacturer's guidelines, including elevating head of bed for patient comfort, if indicated.
- Nursing monitors the patient in person, and provides care based on patient needs a minimum of every 2 hours.
- Nursing documents a minimum of every 2 hours.
- Restraint(s) order(s) written by a LIP in any department may be continued by

receiving unit upon patient transfer.

Nursing documentation for non-violent/non-behavioral restraints Includes:
- Initial assessment of patient for need for restraint
- Specific reason for the use of restraint
- All less-restrictive alternatives attempted prior to restraint
- Monitoring and care rendered every 2 hours based on patient need

II. Procedure for Violent/Behavioral Management Restraint:

A. <u>Registered Nurse (RN) responsibilities for violent/behavioral restraints</u>:
- Initially assesses patient, documents unsafe behavior warranting the use of restraint.
- Describes patient behaviors posing immediate threat to the safety of the patient, staff member, or others.
- Documents all interventions attempted prior to implementing a restraint.
- After assessment of the patient, may make the decision to apply restraint prior to receiving an order but obtains an order from an LIP for restraint as soon as possible and always within 1 hour of the application of restraint.
- The type of restraint selected is the least restrictive intervention based on the initial and current patient assessment and addresses the risk associated with vulnerable patient populations, such as geriatric, pediatric, and cognitively or physically-limited patients.
- Frequently assesses the patient's need for continued restraint
- May make the decision to discontinue restraint early, based on patient assessment
- Require a new order if need to reapply restraint

B. <u>LIP Responsibilities for violent/behavioral restraints</u>:
- Views and evaluates the patient for a <u>face-to-face</u> assessment within 1 hour of application of restraint or seclusion of the patient. This face-to-face must occur once every 24 hours.
- The LIP documents findings of their evaluation in the medical record.
- Views and assesses the patient for need for on-going restraint
- Documents findings of their evaluation in the medical record.
- Signs the restraint order within 24 hours of the application of restraint.
- Each restraint order is documented, utilizing <u>Restraint Orders</u>.

LIP documentation for violent/behavioral restraints includes:
- Date & time of order
- Specific patient condition/behavior clinically justifying need for restraint

- Specific type of restraint and location(s)
- Specific start and stop times (see following time frames)
- Each written order for physical restraint is limited to the following time frames:
  - Orders for adults (age 18 or older) are valid for 4 hours.
  - Orders for adults (age 18 or older) in involuntary hold (Emergency Evaluation – EE) status are valid for 2 hours.
  - Orders for children/adolescents (ages 9 - 17) are valid for 2 hours.
  - Orders for patients under 9 years of age are valid for 1 hour.

C. Nursing (RN, LPN, LNA or Tech under the direction of an RN) responsibilities for violent/behavioral restraints:

- Nursing (or the LIP) explains the procedure and rationale for using restraint, including the condition/behavior required for release from restraint to the patient and family whenever possible
- Nursing applies restraint in accordance with safe and appropriate restraining techniques following manufacturer's guidelines, including elevating head of bed for patient comfort if indicated.
- If physical restraint is required to administer a chemical restraint, the nurse obtains an additional, separate order for physical restraint.
- Nursing monitors the patient in person, and provides care based on patient needs a minimum of every 2 hours.
- Nursing documents a minimum of every 15 minutes.
- A patient who is both restrained and secluded requires 1:1 observation. A patient requiring 1:1 observation is continuously monitored face-to-face or by use of simultaneous video and audio equipment.
- An RN frequently assesses the patient 's need for continued restraint.
- An RN may obtain a renewal of a restraint order if continued restraint is clinically indicated, based on assessment of patient condition using the time frames below:
  - Orders for adults (age 18 or older) can be renewed via telephone order for an additional 4 hours.
  - Orders for children/adolescents (ages 9 - 17) can be renewed via telephone order for an additional 2 hours.
  - Orders for patients under 9 years of age can be renewed via telephone order for an additional 1 hour.
- New orders may be entered according to the time limits for a maximum of 24 consecutive hours. If a patient remains in restraint or seclusion 24 hours after the original order, an LIP must see the patient and conduct a face-to-face re-evaluation before issuing a new order for the continued use of restraint or seclusion.
- An RN may make the decision to discontinue restraint prior to expiration of the order, based on patient assessment; however, if restraint or seclusion is

discontinued early, a new order must be obtained before restraint is reinitiated.

- If the decision is made to discontinue restraints, RN should begin removing restraints as soon as decision is made, and removal of ALL restraints should be completed in the earliest time frame possible.
  - For Example: If patient is sleeping at a 15-minute check, all restraints should be removed during this check as long as each one is removed safely and sleeping and or calm demeanor continues.
- Restraint order written by a LIP in any department may be continued by the receiving unit upon patient transfer.

Nursing documentation for violent/behavioral restraints includes:

- Initial assessment of patient for need for restraint
- Specific reason for the use of restraint
- All less-restrictive alternatives attempted prior to restraint
- Requires 1:1 or frequent monitoring and documentation **every** 15 minutes
- Any changes in behavior
- Behavior observed that supports the continued use of restraint or the discontinuation of restraint

Training requirements:
All staff designated as having direct patient care responsibilities, including contract or agency personnel, must demonstrate the competencies specified prior to participating in the application of restraints, monitoring, assessment, or care of a patient in restraint or seclusion. These competencies are demonstrated initially as part of orientation and subsequently on a periodic basis consistent with the hospital education plan.

NMC does not use law enforcement to assist in the restraint of patients. Hospital security officers may assist the direct care staff by holding the patient, when requested, in the application of restraints and therefore are expected to be trained and able to demonstrate competency in their role in safe application of physical hold for restraint application.

Hospital has documented evidence that all the required levels of staff have been trained and are able to demonstrate competency in the safe use of seclusion and the safe application and use of restraints.

Staff education programs include:

- techniques related to the specific patient populations being served
- techniques to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of restraint and seclusion.
- more in-depth training in the areas included in the regulation for staff members who routinely provide care to patients who exhibit violent or self-destructive behavior.

- address the use of nonphysical intervention skills
- choosing the least restrictive intervention based on an individualized assessment of the patient's medical or behavioral status or condition
- training in how to recognize and respond to signs of physical and psychological distress
- clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary.
- Monitoring the physical and psychological well-being of the patient who is restrained or secluded, including but not limited to, respiratory and circulatory status, skin integrity, vital signs, and and special requirements
- The use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic recertification.

Physicians and other LIPs authorized to order restraint or seclusion by hospital policy in accordance with State law must have a working knowledge of hospital policy regarding the use of restraint and seclusion.

Reporting of Deaths:

1. Death of any restrained or secluded patient, or patient restrained or secluded within past 7 days, is reported to NMC's Risk Management immediately. (See Sentinel Events Policy.)
2. NMC's Risk Management reports applicable deaths to the Center for Medicare and Medicaid Services within close of business the next business day following knowledge of the patient's death. Deaths reported include:
    - Deaths that occur while a patient is restrained or secluded.
    - Deaths that occur within 24 hours after a patient has been removed from restraint or seclusion.
    - Deaths known to the hospital that occur within one week after restraint or seclusion where it is reasonable to assume that the use of restraint or seclusion contributed directly or indirectly to the patient's death.
3. NMC Risk Management verifies that the date and time the death was reported to CMS is documented in the patient's medical record.

Note Well: Law Enforcement or Corrections 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 (handcuffs, manacles, shackles) in accordance with Federal and State law.
The use of such devices is considered law enforcement restraint devices and would not be considered safe, appropriate health care restraint interventions for use by hospital staff to restrain patients.

Related Policies:

Suicide/Violent Admitted Observation Patient Precautions
Fall Risk Assessment

Correctional Center Patient Guidelines
Sentinel Events Policy
Security Event – Code Green
Law Enforcement Involvement in the Healthcare Setting
Use of Force

References:
CMS Conditions of Participation and Regulations and Interpretive Guidelines for Hospitals Appendix A (Rev. 176, 12-29-17).

Joint Commission Comprehensive Accreditation Manual for Hospitals

Regulation Establishing Standards for Emergency Involuntary Procedures

Reviewers

A. **Key Stakeholders:**
   - John Minadeo, MD - Medical Director, Emergency Department & Hospitalists
   - Jodi Frei - Director of Quality
   - Chris Giroux - Manager, Informatics, Data Management and Integration Services
   - Chris Reinfurt – Coordinator, Emergency Management and Safety
   - Abbie Neville, RN - Clinical Informaticist
   - Jane Suder, RN – Manger, Care Management
   - Kelly Campbell, RN – Manager, Clinical Education
   - Deb Durant, RN – Director, Inpatient Services
   - Tara Sibley, RN - Clinical Informaticist
   - Maggie Conklin, RN - Interim Chief Nursing Officer
   - Jamie Pinkham – Manager, Regulatory Affairs & Health Information Integrity
   - Nilda Gonnella-French - Risk & Accreditation Coordinator

B. **Committees:**
   Patient Care Committee – 12/11/18
   Medical Staff Committee

C. **Key Process Owner (KPO):** JoAnn Manahan, RN - Nurse Manager, Emergency Department

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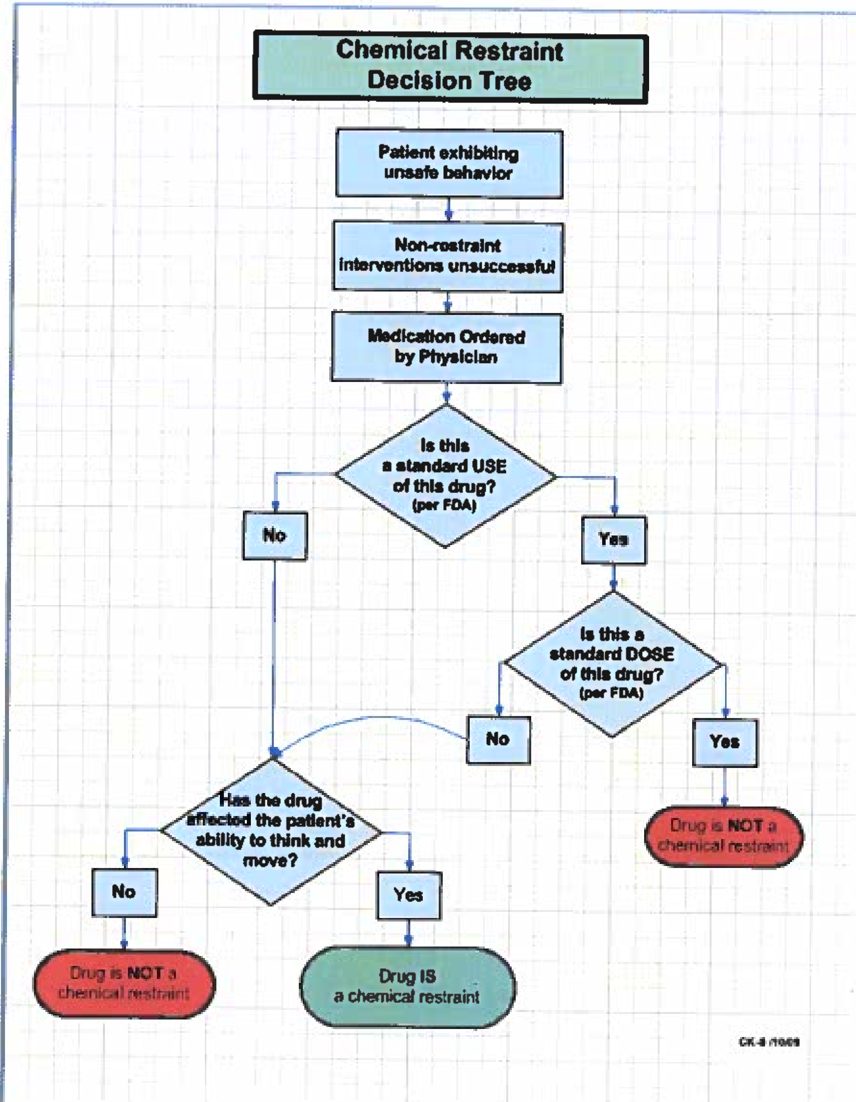
Keywords - Not part of policy: **Restraint, Chemical Restraint, Non-Violent, Non-Behavioral, Violent, Behavioral Management, emergency involuntary**

Addendum 1



NMC

NORTHWESTERN MEDICAL CENTER

Addendum 2