

## 5122-14-01 Definitions.

(A) The purpose of this rule is to provide definitions for rules 5122-14-01 to [5122-14-14](#) of the Administrative Code.

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

(C) The following definitions shall apply:

(1) "Abuse" means any act or absence of action caused by an employee inconsistent with rights which results or could result in physical injury to a patient; any act which constitutes sexual activity, as defined under Chapter 2907. of the Revised Code, when such activity would constitute an offense against a patient under that Chapter; insulting or coarse language or gestures directed toward a patient which subjects the patient to humiliation or degradation; or depriving a patient of real or personal property by fraudulent or illegal means. For children, in addition to the above, the definition of abuse is the same as in section [2151.031](#) of the Revised Code.

(2) "Admission" means acceptance by the inpatient psychiatric service provider of a person with the intent of providing at least twenty-four hours continuous care and treatment to that person.

(3) "Advance directives" means a legal document an adult can use to direct in advance the decisions about his or her mental and/or physical health treatment, if in the future he/she lacks the capacity to make his/her own health care decisions.

(4) "Certified nurse practitioner" means a registered nurse who holds a current, valid certificate of authority issued by the Ohio board of nursing that authorizes the practice of nursing as a nurse practitioner in accordance with Chapter 4723. of the Revised Code.

(5) "Chemical restraint" means a drug or medication that is used as a restriction to manage the patient's behavior or restrict the individual's patient's freedom of movement; and is not a standard treatment or dosage for the patient's condition.

(6) "Child and adolescent psychiatrist" means a psychiatrist who is certified in child and adolescent psychiatry by the American board of psychiatry and neurology or has successfully completed training in a child and adolescent psychiatry program approved by the residency review committee of the accreditation council for graduate medical education of the American medical association. A child and adolescent psychiatrist is also a psychiatrist as defined in this rule.

(7) "Clear treatment reasons" means that a patient would present a substantial risk of physical harm to him/herself or others, or that effective treatment of the patient would be substantially precluded.

(8) "Clinical nurse specialist" means a registered nurse who holds a current, valid certificate of authority issued by the Ohio board of nursing that authorizes the practice of nursing as a clinical nurse specialist in accordance with Chapter 4723. of the Revised Code.

(9) "Clinical privileges" means authorization granted to a practitioner to provide specific health care services in the organization within well-defined limits, based on the following factors, as applicable: license, certification, registration, education, training, experience, competence, health status, and judgment.

(10) "CMS" means the centers for medicare and medicaid services, a federal agency within the U.S. department of health and human services.

(11) "Community mental health agency" means any agency, program, or facility with which a board of

alcohol, drug addiction, and mental health services contracts to provide the mental health services listed in section [340.09](#) of the Revised Code.

(12) "Counselor" means an individual who is licensed as a professional counselor or a professional clinical counselor according to Chapter 4757. of the Revised Code.

(13) "Cultural sensitivity" means an awareness, understanding, and responsiveness to the beliefs, values, customs, and institutions (family, religious, etc.) of a group of people, particularly those of a race or ethnic group different from one's own, or those identified cultures of persons with specific disabilities such as deafness.

(14) "Culturally relevant" means incorporating awareness, understanding, and responsiveness to the beliefs, values, customs, and institutions (family, religious, etc.) and ethnic heritage of individuals or those identified cultures of persons with specific disabilities such as deafness, into training, treatment, and services designed to impact upon, or meet the needs of individuals or groups.

(15) "Department" means the Ohio department of mental health.

(16) "Det norske veritas (DNV) healthcare, inc." means the organization, a division of det norske veritas, which operates the national integrated accreditation for healthcare organizations program.

(17) "Developmental disability" means physical, neurological, developmental, or accidental disabilities that seriously impair health, mobility, or functioning. The disability may be congenital or acquired. Included are persons with epilepsy, autism, narcolepsy, tourette's disorder, spina bifida, head injuries, learning disabilities, and others who have chronic or lifelong conditions and impairments and are at considerable risk for mental health problems.

(18) "Director" means the director of the Ohio department of mental health.

(19) "Dietitian" means an individual who is licensed as a dietitian according to Chapter 4759. of the Revised Code.

(20) "Emergency" means an impending or crisis situation that creates circumstances demanding immediate action.

(21) "Expressive therapist" means an individual who provides treatment intervention through the use of such activities as art, music, dance; who is certified or registered by the national expressive therapist association, certification board for music therapists, American arts therapy association, American dance therapy association, or is licensed, certified or registered by another recognized state or national body to practice expressive therapy.

(22) "Family members" means persons related by family to a patient.

(23) "Grievance" means a written record of a patient's, family member's, or significant other's dissatisfaction with mental health services, initiated by the patient, family member, significant other, patient rights advocate or other interested person or agency.

(24) "Guardian" means any person, association, or corporation appointed by the probate court to have responsibility for the care and management of a minor or a person declared incompetent in accordance with Chapter 2111. of the Revised Code.

(25) "HFAP" means the healthcare facilities accreditation program, a program of the American osteopathic association (AOA).

(26) "Hospital" means the same as inpatient psychiatric service provider.

- (27) "Incident" means any event that poses a danger to the health and safety of patients and/or staff and visitors of the hospital, and is not consistent with routine care of persons served or routine operation of the hospital.
- (28) "Informed consent" means the voluntary, knowing, reasoned choice of a person, or, as appropriate, the person's legal guardian to a proposed treatment and/or procedure.
- (29) "Inpatient psychiatric service provider" means a psychiatric hospital, or psychiatric inpatient unit(s) administered by a general hospital, or community mental health agency or other facility, that provides inpatient psychiatric services.
- (30) "Involuntary" means against an individual's will and/or without having been provided informed consent.
- (31) "Joint commission" (TJC) means the joint commission, formerly known as the joint commission on accreditation of healthcare organizations (JCAHO).
- (32) "License" means the department's written approval and authorization for an inpatient psychiatric service provider to receive persons with a mental disorder for care and treatment.
- (33) "Licensed practical nurse" means an individual who is licensed as a practical nurse according to Chapter 4723. of the Revised Code.
- (34) "Medical record" means the account of a patient's hospitalization, compiled by health care professionals, including but not limited to a patient's history, present illness, findings on examination, details of care, services and treatment, and progress notes.
- (35) "Medication" means therapeutic drugs (or agents or compounds) that require a prescription and/or order by an appropriately licensed independent practitioner.
- (36) "Mental retardation" now designated as developmental disability (DD), means having significantly sub-average general intellectual functioning existing concurrently with deficiencies in adaptive behavior. The assessed level of retardation is based on I.Q. scores moderated by adaptive behavior testing or an assessment of the individual's actual functioning in daily life activities.
- (37) "Neglect" means a purposeful or negligent disregard of duty imposed on an employee or staff member by statute, rule, or professional standard and owed to a patient by that employee or staff member.
- (38) "Nursing staff" means clinical nurse specialists, nurse practitioners, registered nurses, licensed practical nurses, nursing assistants, and other nursing personnel who perform patient care.
- (39) "Occupational therapist" means an individual who is licensed as an occupational therapist according to Chapter 4755. of the Revised Code.
- (40) "Occupational therapy assistant" means an individual who is licensed as an occupational therapy assistant according to Chapter 4755. of the Revised Code.
- (41) "Patient" means a person admitted to a hospital or inpatient unit(s) either voluntarily or involuntarily who is under observation or receiving treatment, or is receiving any other mental health services by the inpatient psychiatric service provider.
- (42) "Patient rights specialist" means that person(s), designated by each inpatient psychiatric service provider to safeguard patient rights and to assist patients in exercising their rights, including the rights in rules 5122-14-01 to [5122-14-14](#) of the Administrative Code and in Chapter 5122. of the Revised Code.
- (43) "Physician" means a person licensed by the state medical board according to Chapter 4731. of the

Revised Code to practice medicine, or a medical officer of the government of the United States while in this state in the performance of his/her official duties.

(44) "Prone Restraint" means all items or measures used to limit or control the movement or normal functioning of any portion or all of an individual's body while the individual is in a face-down positions. Prone restraint may include either physical (also known as manual), or mechanical restraint.

(45) "Psychiatric intensive care" means a program, within a defined secure physical space, normally including patient lounge and sleeping room space, utilized to provide a more intense form of care for those patients requiring closer observation, decreased environmental stimulation, or a more intensive staff to patient ratio.

(46) "Psychiatrist" means a licensed physician who has satisfactorily completed a residency training program in psychiatry as approved by the residency review committee of the accreditation council for graduate medical education of the American medical association; or the committee on postgraduate education of the American osteopathic board of neurology and psychiatry, or who has been recognized as of July 1, 1989, as a psychiatrist by the Ohio state medical association or the Ohio osteopathic association, on the basis of formal training and five or more years of medical practice limited to psychiatry.

(47) "Psychiatrist with clinical privileges in adolescent psychiatry" means a psychiatrist who is qualified through training and experience specific to the needs of adolescent age patients, and who has specific hospital clinical privileges to provide treatment to adolescent age patients.

(48) "Psychiatrist with clinical privileges in geriatric psychiatry" means a psychiatrist who is qualified through the American board of psychiatry and neurology or through other documented training or experience specific to the needs of geriatric age patients, and who has specific hospital clinical privileges to provide treatment to geriatric age patients.

(49) "Psychologist" means an individual who holds a current license under Chapter 4732. of the Revised Code which authorizes the practice of psychology.

(50) "Psychotropic medication" means that group of medications which has a specific and intended effect on central nervous system functions and which is ordinarily used to alter disorders of thought, perception, mood, or behavior.

(51) "Recovery" means a personal process of overcoming the negative impact of a psychiatric disability despite its continued presence.

(52) "Recreational therapist" means an individual who is registered by the Ohio recreational therapy registration board or certified by the national council for therapeutic recreation certification; or is licensed, certified or registered by another recognized state or national body to practice recreational therapy.

(53) "Registered nurse (R.N.);" means an individual who is licensed as a registered nurse according to Chapter 4723. of the Revised Code.

(54) "Rehabilitation therapist" means either an occupational therapist, an occupational therapy assistant, a recreational therapist, or an expressive therapist as defined in this rule. Such individuals shall comply with current, applicable scope of practice and supervisory requirements as identified by their appropriate licensing, certifying or registering bodies.

(55) "Rehabilitation therapy services" means structured activities designed to help a patient develop or maintain functional living skills including physical, social and creative skills through participation in activities of daily living, vocational, recreational, social, expressive, or other activities designed to promote patient recovery, resiliency and independence in both the hospital and community setting.

(56) "Reportable incident" means an incident that must be submitted to the department, including incidents that must then be forwarded by the department to the Ohio legal rights service pursuant to section [5123.604](#) of the Revised Code. As referenced in division (C) of section [5119.611](#) of the Revised Code, "major unusual incident" has the same meaning as "reportable incident".

(57) "Resiliency" means the personal and community qualities that enable individuals to rebound from adversity, trauma, tragedy, threats, or other stresses – and to go on with life with a sense of mastery, competence and hope.

(58) "Restraint" means any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely.

(59) "Seclusion" means the involuntary confinement of a patient alone in a room where the patient is physically prevented from leaving.

(60) "Significant other" means individuals who are significant and important to the well-being of the patient, as identified by the patient.

(61) "Social worker," means an individual who is licensed as an independent social worker or as a social worker according to Chapter 4757. of the Revised Code.

(62) "Transitional hold" means a brief physical (also known as manual) restraint of an individual face-down for the purpose of effectively gaining physical control of an individual in order to prevent harm to self and others, or for the purpose of transport, i.e. carrying a individual to another location within the facility.

(63) "Treatment plan" means a written statement of goals and objectives for a patient with corresponding treatment interventions and services.

(64) "Variance" means permission granted by the director or designee in writing to an inpatient psychiatric service provider to change the conditions or specific requirements of a rule.

(65) "Waiver" means permission granted by the director or designee in writing to an inpatient psychiatric service provider to be exempted from the conditions of specific requirements of a rule.

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## 5122-14-02 Accreditation.

(A) The purpose of this rule is to state the accreditation requirements necessary for psychiatric hospitals and inpatient unit (s) licensed by the department.

(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 licensed by the department shall be accredited under a hospital accreditation program by either the joint commission (TJC) healthcare facilities accreditation program (HFAP) or DNV healthcare inc (DNV).

(E) Proof of such accreditation shall be submitted by the inpatient psychiatric service provider as indicated in rules [5122-14-03\(D\)\(1\)\(h\)](#) and [5122-14-03\(E\)\(7\)](#) of the Administrative Code.

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## 5122-14-03 Licensure procedure.

(A) The purpose of this rule is to state various licensure procedures including application, renewal, correction of deficiencies or non-compliance, and determination of the number of licensed beds.

(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) An inpatient psychiatric service provider wishing to establish inpatient services for the first time for persons with mental disorders shall, prior to occupancy and provision of services, make application for full licensure to the department.

(1) The application shall consist of, at minimum:

(a) Completed application form;

(b) Approved building inspection or certificate of occupancy report;

(c) Approved fire inspection report;

(d) Non-refundable annual licensure fee;

(e) Reduced line drawing showing location and function of all patient and staff areas including the floor and social space square footage;

(f) Comprehensive plan of service;

(g) Proof of psychiatric bed registration as reported annually to the Ohio department of health, as applicable;

(h) Verification of current TJC, HFAP, or DNV accreditation as demonstrated by the submission of a copy of the most recent letter of accreditation;

(i) Completed self-survey checklist; and

(j) Statement of the number of licensed beds designated for treatment of persons less than eighteen years of age, and the number of licensed beds designated for treatment of persons eighteen years of age and older. The sum of beds designated for treatment of persons less than eighteen years of age and beds designated for treatment of persons eighteen years and older shall equal the total number of licensed beds for the inpatient psychiatric service provider.

(2) The proposed inpatient psychiatric service provider shall be subject to an on-site inspection by a designee of the department prior to occupancy to determine if the inpatient psychiatric service provider is in compliance with rules [5122-14-01](#) to 5122-14-14 of the Administrative Code.

(3) An interim license not to exceed ninety days may be issued to the inpatient psychiatric service provider upon completion and departmental approval of the requirements stated in paragraphs (D)(1) to (D)(2) of this rule.

(4) Prior to expiration of the interim license, the department may issue a full license based on review and approval by the department of:

(a) Implementation of policies and procedures; and

(b) Documentation of being in compliance with licensure rules [5122-14-01](#) to 5122-14-14 of the Administrative Code.

(E) For inpatient psychiatric service provider(s) holding a current license, annual renewal of full licensure shall be based on receipt and approval by the department of:

(1) Completed application form which assures that the private inpatient psychiatric service provider remains in compliance with licensure rules [5122-14-01](#) to 5122-14-14 of the Administrative Code;

(2) All substantial changes in written policies and procedures specific to inpatient psychiatric service provider treatment and licensure rules [5122-14-01](#) to 5122-14-14 of the Administrative Code to be submitted to the department when the inpatient psychiatric service provider does not receive an on-site survey;

(3) Approved fire inspection report, dated within one year of licensure renewal date;

(4) Approved building inspection report, if renovations or major changes in the building have been made, or a major change has been made in the use of space;

(5) Non-refundable annual licensure fee;

(6) Statement of the number of licensed beds designated for treatment of persons less than eighteen years of age, and the number of licensed beds dedicated for treatment of persons eighteen years of age and older. The sum of beds designated for treatment of persons less than eighteen years of age and beds designated for treatment of persons eighteen years and older shall equal the total number of licensed beds for the inpatient psychiatric service provider;

(7) Verification of current TJC, HFAP, or DNV accreditation as demonstrated by the submission of a copy of the most recent letter of accreditation; and

(8) A thirty-day notice shall be given whenever possible by the department to the inpatient psychiatric service provider prior to the expiration of the annual license.

(F) Renewal of full licensure shall require an on-site survey of the inpatient psychiatric service provider every three years, or as determined by the department, to be conducted by a designee of the department to assure compliance with licensure rules [5122-14-01](#) to 5122-14-14 of the Administrative Code. A thirty-day notice shall be given whenever possible by the department to the inpatient psychiatric service provider prior to such a survey.

(G) The department shall provide to an inpatient psychiatric service provider a written communication identifying any deficiencies or non-compliance with licensure rules [5122-14-01](#) to 5122-14-14 of the Administrative Code subsequent to an on-site survey, or whenever the inpatient psychiatric service provider is found to be in non-compliance with such rules.

(1) If deficiencies or non-compliance with such rules are present, the inpatient psychiatric service provider shall submit documentation of its corrective actions as specified by the department in its written report.

(2) When the deficiencies have been corrected, or a plan to do so has been received and granted approval by the department, the department may then issue a full or probationary license. The existing license shall remain in effect until the department grants a full, probationary or interim license, or rescinds the license in accordance with provisions of Chapter 119. of the Revised Code.

(3) The inpatient psychiatric service provider shall fully implement its plan of correction within the timeframes specified by the department.

(H) A license shall be issued to a specific inpatient psychiatric service provider for a specified total maximum daily census expressed as licensed beds, and may not be transferred, modified, or changed without prior approval from the department.

(1) Licensed beds shall be registered annually with the Ohio department of health, pursuant to section [3701.07](#) of the Revised Code.

(2) Any change in the location or the total number of licensed beds shall require prior approval from the department.

(3) The number of licensed beds shall refer to the actual number of set up and staffed beds available for immediate patient occupancy, or which can be made available for patient occupancy within twenty-four hours.

(a) If an inpatient psychiatric service provider has temporarily designated patient bed space for other purposes to best meet space allocation needs, or if beds have been unavailable for occupancy due to renovation of the psychiatric hospital's or inpatient unit(s)' physical facilities, these beds once available for patient occupancy may be licensed upon application by the inpatient psychiatric service provider to the department.

(b) The total number of licensed beds shall not exceed the number of beds registered with the department of health pursuant to section [3701.07](#) of the Revised Code.

(4) If an inpatient psychiatric service provider wishes to cease provision of inpatient services, it shall notify the department in writing so that its license can be terminated. The inpatient psychiatric service provider shall also notify the department of health, as applicable.

(I) An inpatient psychiatric service provider may be visited at any time by a designee of the department to determine compliance with rules [5122-14-01](#) to 5122-14-14 of the Administrative Code.

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R.C. [119.032](#) review dates: 03/21/2011 and 07/01/2016

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Rule Amplifies: [5119.20](#)

Prior Effective Dates: 10-12-1978, 1-1-1991, 1-1-2000

## 5122-14-04 Classification of licenses.

(A) The purpose of this rule is to state the three classifications of licenses and the authorization to treat specific age categories of patients.

(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) Licenses shall be classified as follows:

(1) A probationary license, which shall expire within one hundred twenty days of the date of issuance, to be used when:

(a) Serious deficiencies are found during the department's on-site survey of an inpatient psychiatric service provider; or

(b) An inpatient psychiatric service provider's documented corrective action(s) is not approved by the department.

(2) An interim license, which shall expire within ninety days after the date of issuance, to be used for emergency licensure purposes or administrative reasons as determined by the department.

An inpatient psychiatric service provider applying for its first license, and who has preliminary, interim, or similar accreditation shall be issued an interim license until it obtains full accreditation from either TJC, HFAP, or DNV.

(3) A full license, which shall expire one year after the date of issuance.

(E) All licenses are renewable, except that an interim license may be renewed only twice.

(F) A license shall specify authorization to admit either one or both age categories of patients based upon the provision of age appropriate diagnostic and treatment services. The child/adolescent category shall apply to all persons less than eighteen years of age upon admission. The adult category shall apply to all persons eighteen years of age and older upon admission.

(1) Persons less than eighteen years of age shall be admitted only to authorized child/adolescent designated beds;

(2) Persons eighteen years of age and older shall be admitted only to authorized adult designated beds.

(3) The following will be the only exceptions permitted for not admitting a patient to an age appropriate bed. All exceptions shall be based on clinical needs specific to each patient, or the unavailability of age appropriate designated beds. For all exceptions there shall be documentation in the patient's medical record of the reasons for the exception, and ongoing concurrent utilization review. The inpatient service provider shall maintain a log which shall contain the reason for admission, length of stay, referral arrangements, and reason for the exception. The department shall review the log annually.

(a) For child/adolescent admissions to adult beds due to the unavailability of child/adolescent beds, the concurrent utilization review shall include documentation indicating all efforts made to seek appropriate resources and linkages with child/adolescent providers for consultation including treatment planning and after hospitalization care.

(b) The inpatient psychiatric service provider shall inform the parent or legal guardian of the reasons for the decision to admit a child/adolescent to an adult designated bed and also provide information about all available child/adolescent designated beds.

(c) When the admission is an emergency and all child/adolescent designated beds are unavailable, a person less than eighteen years of age upon admission may be admitted to an adult designated bed.

(i) A sixteen or seventeen-year-old patient may remain in an adult designated bed for up to seventy-two hours, and if all child/adolescent beds remain unavailable, the admission may be extended for an additional seventy-two hours. If the admission is extended beyond the first seventy-two hours, an assessment as required in accordance with paragraph (H)(2) (g) of rule [5122-14-13](#) of the Administrative Code shall be conducted, and rehabilitation therapy services and family therapy/interventions shall be available in accordance with paragraphs (N)(3) to (N)(4) of rule [5122-14-12](#) of the Administrative Code.

(ii) A fifteen-year-old or younger patient may remain in an adult designated bed for a maximum of forty-eight hours if all child/adolescent beds remain unavailable.

(d) A seventeen-year-old person may be electively admitted and treated in an adult designated bed if the person is functioning as an adult in such areas as employment (with limited or no school involvement), family, or marriage, or if the diagnosis or problem is such that treatment is warranted in an adult designated bed, providing that such treatment best meets the patient's needs.

(e) An eighteen through twenty-one year old patient may be admitted to a child/adolescent designated bed based on developmental or other clinical needs specific to the patient.

(4) Licensure authorization to admit persons less than eighteen years of age shall require diagnostic and treatment services to meet the needs of these patients in accordance with rules [5122-14-12](#) and 5122-14-14 of the Administrative Code.

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R.C. [119.032](#) review dates: 03/21/2011 and 07/01/2016

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Statutory Authority: [5119.20](#)

Rule Amplifies: [5119.20](#)

Prior Effective Dates: 10-12-1978, 1-1-1991, 1-1-2000

## 5122-14-05 Termination of license.

(A) The purpose of this rule is to state criteria and procedures for termination of an inpatient psychiatric service provider license.

(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) The inpatient psychiatric service provider's existing license shall remain in effect until the department grants a full, probationary, or interim license or rescinds the license in accordance with provisions of Chapter 119. of the Revised Code.

(E) The department may refuse to grant or renew, or revoke, a full, probationary, or interim license, in accordance with Chapter 119. of the Revised Code if:

(1) An inpatient psychiatric service provider is found to be in non-compliance with any or all of rules [5122-14-01](#) to 5122-14-14 of the Administrative Code and a plan of correction is requested of the inpatient psychiatric service provider by the department and is either not received within the time period specified by the department, is not granted approval by the department, or is not implemented by the inpatient psychiatric service provider; or

(2) An inpatient psychiatric service provider's submitted application materials are not approved by the department; or

(3) An inpatient psychiatric service provider ceases provision of inpatient services; or

(4) An inpatient psychiatric service provider does not apply for licensure renewal at least thirty days prior to the expiration date of the license.

(F) Notice of the department's intent to deny or revoke a license shall be provided to the inpatient psychiatric service provider in accordance with section [119.07](#) of the Revised Code. An opportunity for a hearing shall be afforded the inpatient psychiatric service provider in accordance with Chapter 119. of the Revised Code.

Effective: 07/01/2011

R.C. [119.032](#) review dates: 03/21/2011 and 07/01/2016

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Statutory Authority: [5119.20](#)

Rule Amplifies: [5119.20](#)

Prior Effective Dates: 10-12-1978, 1-1-1991, 1-1-2000, 11-1-2005

## 5122-14-06 Waivers and variances.

(A) The purpose of this rule is to describe how the department may permit waivers and variances.

(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) An inpatient psychiatric service provider may submit a dated, written request to the department for a waiver or variance. The written request must clearly state the licensure rule of the waiver/variance request, the rationale and need for the requested waiver or variance, and the consequence of not receiving approval of the request.

(E) Upon receipt of a written request for a waiver or variance that provides a clear and valid statement of need, the department in its discretion may grant a waiver or variance for a period of time determined by the department but that shall not exceed the expiration date of the current license.

(F) The department shall acknowledge and respond to the waiver/variance request within thirty days of receipt by the department.

Effective: 07/01/2011

R.C. [119.032](#) review dates: 03/21/2011 and 07/01/2016

Promulgated Under: [119.03](#)

Statutory Authority: [5119.20](#)

Rule Amplifies: [5119.20](#)

Prior Effective Dates: 10-12-1978, 1-1-1991, 1-1-2000

## 5122-14-07 Display of license.

(A) The purpose of this rule is to state criteria for how the inpatient psychiatric service provider shall display its license.

(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) The current license shall be displayed by the inpatient psychiatric service provider in a conspicuous place which is readily accessible to the patients and the public.

(E) The license shall remain the property of the department, and revoked or terminated licenses shall be returned to the department.

Effective: 07/01/2011

R.C. [119.032](#) review dates: 03/21/2011 and 07/01/2016

Promulgated Under: [119.03](#)

Statutory Authority: [5119.20](#)

Rule Amplifies: [5119.20](#)

Prior Effective Dates: 10-12-1978, 1-1-1991, 1-1-2000

- (A) The purpose of this rule is to state the fees for various classifications of license.
- (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) Inpatient psychiatric service provider(s) shall pay an annual fee with ~~the~~ each application for full licensure or full licensure renewal according to the following schedule:

Fee schedule

Psychiatric bed capacity	Fee
25 or less persons	\$750
26-50 persons	\$1350
51-75 persons	\$1650
76-100 persons	\$1950
Over 100 persons	\$2250

- (E) Fees for probationary and interim licenses or re-issuance of a license due to a change in the number of licensed beds may be assessed and shall be prorated based on the annual fee.

Effective: 11/10/2014

Five Year Review (FYR) Dates: 08/26/2014 and 11/10/2019

CERTIFIED ELECTRONICALLY

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Certification

10/31/2014

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Date

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Rule Amplifies: 5119.33  
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## 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

Replaces: 5122-14-10

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## 5122-14-11 Patient rights, participation and education.

(A) The purpose of this rule is to:

- (1) Require written policies and procedures for patient rights including a grievance procedure, and requirement of a patient rights advocate;
- (2) Require policies and procedures about family and patient communication, patient abuse or denial of patient rights; and
- (3) Require written policies and procedures regarding how patients are educated about and involved in their care or services and in care decisions.

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

(C) In addition to the definitions appearing in rule [5122-14-01](#) of the Administrative Code, the following definitions apply to this rule:

- (1) "Client rights specialist" means the individual designated by the inpatient psychiatric service provider with responsibility for assuring compliance with the patient rights and grievance procedure rule.
- (2) "Grievance" means a written complaint initiated either verbally or in writing by a patient or by any other person or agency on behalf of a patient regarding denial or abuse of any patient's rights.
- (3) "Reasonable" means a standard for what is fair and appropriate under usual and ordinary circumstances.
- (4) "Services" means the complete array of professional interventions designed to help a person achieve improvements in mental health such as counseling, individual or group therapy, education, community psychiatric supportive treatment, assessment, diagnosis, treatment planning and goal setting, clinical review, psychopharmacology, discharge planning, professionally-led support, etc.

(D) Each patient shall have the following twenty-two rights which are the same as or similar to those that are described in rule [5122-26-18](#) of the Administrative Code for an individual receiving mental health services from a community mental health center, as well as the additional rights listed in paragraph (E) of this rule:

(1) Each person who accesses mental health services is informed of these rights:

- (a) The right to be informed within twenty-four hours of admission of the rights described in this rule, and to request a written copy of these rights;
- (b) The right to receive information in language and terms appropriate for the patient's understanding; and
- (c) The right to request to speak to a financial counselor.

(2) Services are appropriate and respectful of personal liberty:

- (a) The right to be treated in a safe treatment environment, with respect for personal dignity, autonomy and privacy, in accordance with existing federal, state and local laws and regulations;
- (b) The right to receive humane services;
- (c) The right to participate in any appropriate and available service that is consistent with an individual service/treatment plan, regardless of the refusal of any other service, unless that service is a necessity for clear treatment reasons and requires the person's participation;

- (d) The right to reasonable assistance, in the least restrictive setting; and
- (e) The right to reasonable protection from physical or emotional abuse or harassment.

(3) Development of service/treatment plans:

(a) The right to a current individualized service/treatment plan (ISP/ITP) that addresses the needs and responsibilities of an individual that specifies the provision of appropriate and adequate services, as available, either directly or by referral; and

(b) The right to actively participate in periodic ISP/ITP reviews with the staff including services necessary upon discharge.

(4) Declining or consenting to services:

The right to give full informed consent to services prior to commencement and the right to decline services absent an emergency.

(5) Restraint or seclusion.

The right to be free from restraint or seclusion unless there is imminent risk of physical harm to self or others.

(6) Privacy:

(a) The right to reasonable privacy and freedom from excessive intrusion by visitors, guests and non-hospital surveyors, contractors, construction crews or others; and

(b) The right to be advised of a refuse observation by techniques such as one-way vision mirrors, tape recorders, televisions, movies, or photographs, or other audio and visual recording technology. This right does not prohibit a hospital from using closed-circuit monitoring to observe seclusion rooms or common areas, which does not include patient bedrooms and bathrooms.

(7) Confidentiality:

(a) The right to confidentiality unless a release or exchange of information is authorized and the right to request to restrict treatment information being shared; and

(b) The right to be informed of the circumstances under which the hospital is authorized or intends to release, or has released, confidential information without written consent for the purposes of continuity of care as permitted by division (A)(7) of section [5122.31](#) of the Revised Code.

(8) Grievances:

The right to have the grievance procedure explained orally and in writing; the right to file a grievance with assistance if requested; and the right to have a grievance reviewed through the grievance process, including the right to appeal a decision.

(9) Non-discrimination:

The right to receive services and participate in activities free of discrimination on the basis of race, ethnicity, age, color, religion, gender, national origin, sexual orientation, physical or mental handicap, developmental disability, genetic information, human immunodeficiency virus status, or in any manner prohibited by local, state or federal laws.

(10) No reprisal for exercising rights:

The right to exercise rights without reprisal in any form including the ability to continue services with uncompromised access. No right extends so far as to supersede health and safety considerations.

(11) Outside opinions:

The right to have the opportunity to consult with independent specialists or legal counsel, at one's own expense.

(12) No conflicts of interest:

No inpatient psychiatric service provider employee may be a person's guardian or representative if the person is currently receiving services from said provider.

(13) The right to have access to one's own psychiatric, medical or other treatment records, unless access to particular identified items of information is specifically restricted for that individual patient for clear treatment reasons in the patient's treatment plan. If access is restricted, the treatment plan shall also include a goal to remove the restriction.

(14) The right to be informed in advance of the reason (s) for discontinuance of service provision, and to be involved in planning for the consequences of that event.

(15) The right to receive an explanation of the reasons for denial of service.

(E) In addition to the rights listed in paragraph (D) of this rule, each consumer residing in an inpatient psychiatric hospital shall have the following sixteen rights:

(1) Each consumer of mental health services are informed of these rights:

(a) The right to receive humane services in a comfortable, welcoming, stable and supportive environment; and

(b) The right to retain personal property and possessions, including a reasonable sum of money, consistent with the person's health, safety, service/treatment plan and developmental age.

(2) Development of service/treatment plans:

The right to formulate advance directives, submit them to hospital staff, and rely on practitioners to follow them when within the parameters of the law.

(3) Labor of patients:

The right to not be compelled to perform labor which involves the operation, support, or maintenance of the hospital or for which the hospital is under contract with an outside organization. Privileges or release from the hospital shall not be conditional upon the performance of such labor.

(4) Declining or consenting to services:

(a) The right to consent to or refuse the provision of any individual personal care activity and/or mental health services/treatment interventions; and

(b) The right, when on voluntary admission status, to decline medication, unless there is imminent risk of physical harm to self or others; or

(c) The right when hospitalized by order of a probate or criminal court to decline medication unless there is imminent risk of harm to self or others, or through an order by the committing court, except that involuntary medication is not permitted, unless there is imminent risk of harm to self or others, for persons admitted for

a competency evaluation under division (G)(3) of section [2945.371](#) of the Revised Code or admitted for sanity evaluation under division (G)(4) of section [2945.371](#) of the Revised Code. The inpatient psychiatric service provider shall provide the opportunity for informed consent.

(5) Privacy, dignity, free exercise of worship and social interaction:

The right to enjoy freedom of thought, conscience, and religion; including religious worship within the hospital, and services or sacred texts that are within the reasonable capacity of the hospital to supply, provided that no patient shall be coerced into engaging in any religious activities.

(6) Private conversation, and access to phone, mail and visitors:

(a) The right to communicate freely with and be visited at reasonable times by private counsel or personnel of the legal rights service and, unless prior court restriction has been obtained, to communicate freely with and be visited at reasonable times by a personal physician or psychologist;

(b) The right to communicate freely with others, unless specifically restricted in the patient's service/treatment plan for reasons that advance the person's goals, including, without limitation, the following:

(i) The right of an adult to reasonable privacy and freedom to meet with visitors, guests, or surveyors, and make and/or receive phone calls; or the right of a minor to meet with inspectors, and the right to communicate with family, guardian, custodian, friends and significant others outside the hospital in accordance with the minor's individualized service/treatment plan;

(ii) The right to have reasonable access to telephones to make and receive confidential calls, including a reasonable number of free calls if unable to pay for them and assistance in calling if requested and needed. The right of a minor to make phone calls shall be in accordance with the minor's individualized service/treatment plan; and

(c) The right to have ready access to letter-writing materials, including a reasonable number of stamps without cost if unable to pay for them, and to mail and receive unopened correspondence and assistance in writing if requested and needed subject to the hospital's rules regarding contraband. The right of a minor to send or receive mail shall also be subject to directives from the parent or legal custodian when such directives do not conflict with federal postal regulations.

(7) Notification to family or physician:

The right to have a physician, family member or representative of the person's choice notified promptly upon admission to a hospital.

(F) Each inpatient psychiatric service provider shall provide a patient right advocate(s) to safeguard patient rights. The client rights specialist or a designee(s) shall:

(1) Be appropriately trained and knowledgeable in the fundamental human, civil, constitutional and statutory rights of psychiatric patients including the role of the Ohio legal rights service;

(2) Ensure that the patient, and as appropriate, the patient's family members, significant others, and the patient's legal guardian, are informed about patient rights, in understandable terms, upon admission, and throughout the hospital stay. Treatment staff shall also work with patient to assist them in understanding and exercising patient rights. For any person who is involuntarily detained, the inpatient psychiatric service provider shall, immediately upon being taken into custody, inform the person orally and in writing of his/her rights described in division (C) of section [5122.05](#) of the Revised Code;

(3) Be accessible in person during normal business hours, and during evenings, weekends, and holidays as

needed for advocacy issues. The name, title, location, hours of availability, and telephone number shall be available to the patient, the patient's legal guardian if any, and the patient's family and significant others, at all times;

(4) Assist and support patients, their family members, and significant others in exercising their legal rights and representing themselves in resolving complaints. This shall include providing copies of the inpatient psychiatric service provider's policies and procedures relevant to patient rights and grievances upon request, and assistance with the grievance procedure. This shall also include assistance in obtaining services of the Ohio legal rights service in accordance with sections [5123.60](#) to [5123.604](#) of the Revised Code, and assistance in obtaining access to or services of outside agencies or resources upon request;

(5) Not be a member of the patient's treatment team and not have clinical management or care responsibility for the patient for whom he or she is acting as the patient rights advocate; and

(6) Maintain a log available for department review of patient grievances, including all allegations of denial of patient rights as identified by patients, family members of patients, significant others or other persons.

(G) Each inpatient psychiatric service provider shall ensure that its staff members are knowledgeable about patient rights and referral of patients to the patient rights advocate.

(H) Each inpatient psychiatric service provider shall ensure that patients and families of patients participate in an advisory capacity related to programming and relevant policies and procedures.

(I) Each inpatient psychiatric service provider shall ensure that patient and family education is an interdisciplinary and coordinated process, as appropriate to the patient's treatment plan, consistent with patient confidentiality and documented in the medical record. Education shall incorporate appropriate members of the treatment team, types of materials, methods of teaching, community educational resources, and special devices, interpreters, or other aids to meet specialized needs.

(J) Each inpatient psychiatric service provider shall obtain the informed consent of a patient and/or when appropriate, a guardian, for all prescribed medications that have been ordered, except in an emergency, and for those medical interventions as referenced in and in accordance with division (A) of section [5122.271](#) of the Revised Code.

(1) Each inpatient psychiatric service provider shall ensure that the patient and legal guardian, when legally appropriate, receives written and/or oral information in a language and format that may be standardized and that is understandable to the person receiving it.

(a) Information shall include the anticipated benefits and side effects of the intervention, including the anticipated results of not receiving the intervention, and of alternatives to the intervention.

(b) Persons served shall be given the opportunity to ask questions, seek additional information and provide input before the intervention or medication is administered/dispensed.

(c) Documentation shall be kept in the patient's medical record regarding the patient's participation in this process, including the patient's response, objections, and decisions regarding the medication or medical intervention. Such documentation may be accomplished through a notation from an appropriate professional staff person, signature of the patient and/or guardian, or other mechanism.

(2) For purposes of informed consent specific to medication, each psychiatric inpatient service provider shall ensure that the patient and parent or legal guardian when legally appropriate receives written and/or oral information from a physician, registered nurse and/or registered pharmacist.

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## 5122-14-12 Program, specialty services and discharge planning requirements.

(A) The purpose of this rule is to:

- (1) State necessary components of a comprehensive plan of service, recovery and admission and discharge criteria;
- (2) Require treatment services that are culturally relevant and sensitive, and that are considerate of any relevant patient history of trauma and/or abuse;
- (3) List required treatment services;
- (4) Require special programs for specific groups of persons including children/adolescents, older adults, and patients with a secondary diagnosis of substance abuse or developmental disability; and
- (5) Identify both private and public community resources for adults, children/adolescents and other identified populations, including local mental health services when appropriate, and their participation in planning for treatment including admission and discharge, involvement of case managers, and providing or arranging for services post discharge.

(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 have a written comprehensive plan of service which shall be reviewed annually and revised if necessary.

(E) The comprehensive plan of service shall include:

- (1) Description of services provided;
- (2) Description of any affiliation or agreements with other agencies or entities;
- (3) Description of the population served including age groups and other relevant characteristics of the patient populations;
- (4) Criteria for admission, continued stay, and discharge; and
- (5) Description of how patients and family members of patients shall participate in an advisory role to the inpatient service.

(F) Criteria for admission shall:

(1) Limit admissions to those persons whose principal diagnosis and focus of treatment upon admission is a mental disorder according to the latest edition of the American psychiatric association's diagnostic and statistical manual of mental disorders (DSM), but excluding admissions to those persons whose principal diagnosis and focus of treatment is a substance abuse disorder, detoxification for substance abuse, a chronic dementing organic mental disorder, or mental retardation. This does not preclude admissions for which the above named excluded diagnoses may be a secondary diagnosis;

(a) To support best clinical practice of concurrent integrated treatment for persons with co-occurring of mental illness and substance abuse, an inpatient psychiatric service provider may co-locate both psychiatric and substance abuse and/or detox registered beds in the same physical area, and may use staff who are cross-trained in both treatment disciplines to provide integrated services.

(b) The total number of psychiatric beds and the total number of detox (med/surg) beds and/or substance abuse beds must

remain as registered with the Ohio department of health.

(c) Patients shall be admitted to the appropriate registered bed based upon their principal diagnosis and focus of treatment. However, this would not preclude integrated concurrent treatment for a co-occurring disorder.

(2) Include any applicable age limits, diagnostic categories, and other criteria necessary to ensure that each admission is the least restrictive alternative available and consistent with each patient's treatment needs;

(3) Specify procedures and timelines for responding to an application for voluntary admission; and

(4) Assure that the inpatient psychiatric service provider will accept patients on a civil commitment and that it has the clinical competence to treat these patients:

(a) Utilizing the same criteria applied to voluntary patients, and

(b) According to admission criteria applied to voluntary patients.

The inpatient psychiatric service provider shall assure that it will provide such patients access to its full range of available services.

(G) Discharge criteria shall include but not be limited to achievement of treatment goals, or that the patient must be transferred to a more appropriate treatment facility. A civilly committed patient shall be discharged when the patient no longer meets the criteria for civil commitment, however such patients shall have the right to apply for voluntary admission status at any time pursuant to division (G) of section [5122.15](#) of the Revised Code.

(H) The primary function of each inpatient psychiatric service provider shall be to provide diagnostic and treatment services for persons with a primary diagnosis of mental illness. Such services shall be culturally relevant and sensitive and shall take into consideration any relevant patient history of trauma and/or abuse.

(I) Clinical services shall be provided by an interdisciplinary treatment team working together.

(1) All members of the treatment team who have specific treatment responsibilities shall have either appropriate clinical privileges and be qualified by training or experience and demonstrated competence, or shall be supervised by a clinically privileged practitioner.

(2) Each inpatient psychiatric service provider shall specify in policy and procedures the roles and responsibilities of team members in identifying and meeting the clinical needs of patients in relationship to its goals and programs.

(3) Each inpatient psychiatric service provider shall assure and provide for the staffing of team members to meet the clinical needs of each patient as identified in the patient's treatment plan.

(J) Each professional discipline shall:

(1) Identify special skills required to render specific patient care and treatment services.

(2) Participate in the development of criteria for qualifications of its staff members, which shall include education, experience, and licensure or certification requirements.

(K) Each inpatient psychiatric service provider shall provide or make provision for the following services in order to promote recovery and meet the comprehensive needs of each patient. Such services may be provided by any qualified individual, unless otherwise specified in these rules and/or regulated by professional licensure and scope of practice:

(1) Medical services, including dental, to meet the comprehensive physical and psychiatric treatment needs of each patient as identified in the patient's treatment plan;

(2) Dietetic services shall include availability of a licensed dietitian;

(3) Emergency services shall be available and accessible through a written plan for psychiatric emergencies for both persons receiving inpatient treatment from the inpatient psychiatric service provider and for any persons presenting themselves as in need of and requesting emergency treatment;

(a) If the inpatient psychiatric service provider maintains an emergency room or emergency service, it will not refuse emergency care to individuals presenting with potentially life or health-threatening psychiatric situations.

(b) If the inpatient psychiatric service provider does not maintain an emergency room or emergency service, it shall provide emergency care on site until an individual presenting with a potentially life or health-threatening psychiatric situation is transferred to a more appropriate provider.

(4) Medical services shall;

(a) Be under the direction of a psychiatrist.

(b) Include availability of twenty-four hour, seven day a week consultation of a psychiatrist, either in person or by telephone;

(5) Nursing services shall be under the direction or supervision of a full time registered nurse who has a bachelor's or master's degree in nursing and four years psychiatric nursing experience. It is preferred, but not required, that the individual holds voluntary certification in psychiatric and mental health nursing by the American nurses credentialing association. This requirement shall apply to those individuals hired into this position after January 1, 2000;

(6) Pastoral services shall be offered by inpatient psychiatric service provider clergy and/or the provider shall arrange for pastoral services from family or community clergy;

(7) Patient education services shall be readily accessible at all reasonable hours and include current reading and resource materials for education and leisure to meet the needs of the patients;

(8) Pharmaceutical services shall:

(a) Be under the direction of a qualified registered pharmacist with a current license.

(b) Operate in accordance with Chapters 3715., 3719., and 4729. of the Revised Code regarding operation of pharmacies, storage, and dispensing of drugs;

(9) Physical rehabilitation services shall be under the direction of qualified staff;

(10) Psychological services shall be under the direction of a licensed psychologist;

(11) Psycho-social services shall be:

(a) Provided by qualified staff;

(b) Staffed by at least one person who is licensed either as a professional counselor, professional clinical counselor, independent social worker, or a social worker ; and

(c) Provided during the day, and available evenings, weekends, and holidays as needed.

(12) Rehabilitation therapy services shall be:

(a) Provided by qualified staff;

(b) Staffed by at least one rehabilitation therapist as defined in rule [5122-14-01](#) of the Administrative Code;

(c) Provided during the day, and available evenings, weekends, and holidays as needed;

(d) Provided by rehabilitation therapy staff with diverse skills to meet the needs of all patients; and

(13) Substance abuse diagnostic and treatment services for all patients who have a secondary problem of substance abuse shall be provided by a certified chemical dependency counselor in accordance with Chapter 3793. of the Revised Code, or by other individuals licensed to provide diagnostic and/or substance abuse treatment services.

(L) Each inpatient psychiatric service provider shall develop special programs to include but not be limited to the following groups whenever the annual average daily census for that group is six or more patients:

(1) Adults age sixty-five and older; ;

(2) Patients with a secondary diagnosis of substance use disorder; and

(3) Patients with a secondary diagnosis of developmental disability or pervasive developmental disorder.

(M) Written policies and procedures, and program descriptions shall document that patient needs, based on at least age and diagnosis, will be met for all patient groups in paragraphs (L)(1) to (L)(3) of this rule.

(1) Inpatient psychiatric service providers that provide services for adults sixty-five years of age and older shall develop written policies and procedures regarding services to meet the special needs of such patients. These needs shall include vision, hearing, dietary, physical, cognitive, functional living skills and psychiatric needs, and the needs of the patients' family members. Special attention shall be given to problems associated with utilization of medication including polypharmacy. Diagnostic and treatment services shall be provided by a psychiatrist with clinical privileges in geriatric psychiatry. Consultation with an occupational therapist or an occupational therapy assistant in collaboration with an occupational therapist shall be available as appropriate to each patient's needs.

(2) Services for patients who have a secondary problem of substance abuse shall include specialized diagnostic assessments, group and/or individual therapy, education, linkage to self help groups and referrals for post discharge substance abuse treatment if appropriate.

(3) Inpatient psychiatric service providers that provide services for patients with a secondary diagnosis of mental retardation or developmental disability shall adhere to treatment standards in accordance with Chapters 5122. and 5123. of the Revised Code or equivalent standards and as appropriate to the psychiatric services provided.

(N) Inpatient psychiatric service providers authorized to serve children and adolescents shall provide for the educational, recreational, developmental, social and functional needs of these patients and for the treatment needs of these patients' families.

(1) For all children twelve years of age and less, diagnostic and treatment services shall be provided by a child and adolescent psychiatrist, or by a psychiatrist in consultation with a child and adolescent psychiatrist within seventy-two hours of admission.

(2) For all children thirteen through seventeen years of age, diagnostic and treatment services shall be provided by a child and adolescent psychiatrist, a psychiatrist with clinical privileges in adolescent psychiatry, or by a psychiatrist in consultation with a child and adolescent psychiatrist within seventy-two hours of admission.

(3) Each inpatient psychiatric service provider shall provide rehabilitation therapy services including at least five hours per week per patient of active physical activities, as appropriate to patient need and indicated on the patient's treatment plan.

(4) Each inpatient psychiatric service provider shall provide a minimum of two hours per week per patient of family therapy

or other family interventions as appropriate to patient need and indicated on the patient's treatment plan.

(5) Each inpatient psychiatric service provider shall provide services to assist the patient in maintaining his/her educational and intellectual development at least five hours per week, consistent with the patient's treatment plan.

(a) If the admission is longer than ten days, the inpatient psychiatric service provider shall, with the consent of the parent/adult student, notify the school district where the provider is located, of the need for services, and shall provide appropriate physical space so that the patient can access or continue individualized education plan IEP services provided by the school district.

(b) If educational needs and/or eligibility for special education services under Chapter 3323. of the Revised Code are identified during the admission, the inpatient psychiatric service provider shall communicate this to the patient's home school, upon parent or guardian request with appropriate consent.

(O) If a psychiatric intensive care unit is provided the following additional standards shall be met:

(1) The psychiatric intensive care unit shall be directed and staffed according to the special needs of its patients;

(2) Written policies and procedures shall describe criteria for the use of psychiatric intensive care, and any special procedures used; and

(3) Psychiatric intensive care units shall be designed and equipped to facilitate safe and effective care of patients.

(P) Inpatient psychiatric service providers that accept individuals into an observation and/or treatment status for periods of less than twenty-four hours shall develop policies and procedures regarding the following:

(1) Conditions under which individuals are accepted and released;

(2) Provision of patient rights information; and

(3) Provision for after hospitalization care.

(Q) Prior to or within twenty-four hours of admission of each patient, appropriate community resources and needs relative to the patient's treatment shall be identified, which may include professionals who have rendered prior treatment, referral sources, court, school, employer, religious affiliation, community psychiatric supportive treatment services, and discharge planning.

(R) All identified community resources shall, when appropriate to patient need and with permission of the patient, be contacted to participate in treatment planning for discharge. Such efforts and involvement shall be documented in the medical record.

(S) If a patient is likely to be referred to a community mental health agency upon discharge, the inpatient psychiatric service provider with permission from the patient shall invite participation by the community psychiatric supportive treatment providers from the local community mental health agencies in team meetings and planning for discharge.

(T) The inpatient psychiatric service provider shall make arrangements for each patient for post discharge services as specified in the patient's treatment plan.

(1) Each inpatient psychiatric service provider shall provide an appropriate discharge plan for patients, or the inpatient psychiatric service provider shall arrange for each of these patients, as necessary, to receive mental health services from other mental health providers, consistent with patient choice and acceptance.

(a) The inpatient psychiatric service provider shall provide interim post discharge services for up to two weeks post discharge, unless the post discharge provider assumes responsibility for the provision of mental health services prior to the

end of the interim two-week period. This shall include an appointment for medication management as needed. Such interim post discharge services shall include a crisis management plan, which may include a mechanism to contact a physician, interim medication management, referral to or provision of a support group or individual supportive services, or a mechanism to contact an emergency services provider.

(b) The inpatient psychiatric service provider shall determine, in collaboration with the patient and post discharge provider, that the post discharge provider has the appropriate services the patient has been identified as needing, to include the provision of in-depth patient education regarding the nature and management of the patient's illness/disorder.

(2) As part of discharge planning, the inpatient psychiatric service provider shall make all reasonable efforts prior to discharge to ensure that the patient has a specified appointment, as appropriate, with a mental health service provider(s), upon discharge whenever possible and no later than two weeks post discharge if it has been concluded that these services are required within two weeks.

(3) For children/adolescents, each inpatient psychiatric service provider shall make provision for coordination of psycho-educational treatment and recommended aftercare with the patient's local school and any existing individualized education plan from the patient's local school.

(4) The clinical treatment team shall develop a discharge plan with active participation by the patient. The parent, guardian, or family shall also participate, where appropriate, according to the treatment plan and with permission of the patient as needed. If the patient is a minor in the custody of an agency, that agency shall participate in the development of the discharge plan.

(5) A copy of the relevant portions of the post discharge plan shall be given to the patient, or as appropriate, the patient's guardian, and shall be made available, with the patient's permission, to the person or agency that will assume primary responsibility for implementation of the discharge plan.

(U) When utilization patterns indicate problems or opportunities for improvement in the larger community system in which the inpatient psychiatric service provider is located, the inpatient psychiatric service provider shall discuss these issues with the relevant community mental health board(s), and such discussions shall be documented.

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## 5122-14-13 Medical records, documentation and confidentiality.

(A) The purpose of this rule is to require a complete medical record for each patient, state the necessary components of the medical record and require written policies and procedures regarding release of information.

(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 maintain a complete medical record for each individual patient.

(E) Necessary components of the medical record shall include to the extent possible, but not be limited to, the following:

(1) Patient demographic information, including indication of legal status as a voluntary or involuntary patient;

(2) All legal documents, including, as appropriate, an application for voluntary admission signed and dated by the patient, written requests for release pursuant to section [5122.03](#) of the Revised Code, and all legal documents pertaining to civil commitment and guardianship.

For patients with a guardian, the inpatient psychiatric service provider shall make effort to obtain all needed consent forms signed and dated by the guardian. If the guardian is unable to provide written consent, the provider may obtain and document verbal consent of the guardian as long as two individuals document, in writing, that each witnessed the guardian provide the verbal consent.

(3) The reason for admission including presenting problem(s), precipitating factors, and initial diagnosis;

(4) Previous hospitalizations;

(5) Reports of all patient assessments and examinations;

(6) An individualized treatment plan which shall include criteria for discharge and which shall meet requirements of section [5122.27](#) of the Revised Code;

(7) All medical orders;

(8) Documentation of the patient's progress, and other significant patient events which could impact on treatment;

(9) Appropriate, complete, signed and dated consents for treatment, and for release of confidential information;

(10) A discharge summary completed within thirty days after discharge and signed by the attending or treating physician; and

(11) A post discharge plan.

(F) All entries in the medical record shall be dated, signed, and legible.

(G) Each inpatient psychiatric service provider shall be responsible for conducting a complete assessment of each patient including a consideration of the patient's strengths and patient's needs, and types of services to meet those needs in the least restrictive environment consistent with treatment needs.

(1) The assessments shall include as appropriate to patient need: physical, laboratory, emotional, behavioral, social, recreational, cognitive, functional living skills, educational, legal, vocational, nutritional, cultural, religious, income support, housing needs, and other community support and discharge planning needs.

(2) Each inpatient psychiatric service provider shall define in writing the scope of assessments to be performed by each clinical discipline not otherwise specified in these rules, consistent with the discipline's scope of practice, state licensure laws, applicable regulations, certification, or registration.

(H) Written assessments of each patient shall be provided and dated by the respective interdisciplinary team members as soon as possible after admission and prior to the development of the treatment plan which is required within twenty-four hours of admission unless otherwise specified in this rule.

(1) For new admissions if assessments are available from prior evaluations and/or admissions within the past six months, each assessment shall be reviewed, revised as necessary, dated, and signed by a member of the respective discipline as soon as possible after admission and prior to the development of the treatment plan.

(2) The following required patient assessments shall be completed within twenty-four hours of a patient's admission:

(a) A physician shall be responsible for a medical history and physical examination. If the patient's condition does not permit completion of the examination each part of the examination shall be completed as soon as the patient's condition permits it. If a physician was responsible for the completion of a medical history and physical examination within thirty days of the current course of treatment and the patient's condition remains consistent with the results of that examination, a signed copy of this history and examination may suffice.

(i) The history and physical examination shall include a basic neurological examination that includes an examination of the cranial nerves, sensory and motor functions, coordination, and deep tendon reflexes.

(ii) If the patient is a child, adolescent, or person with mental retardation/developmental disabilities, the history and physical examination shall include evaluations of motor development and functioning, sensorimotor functioning, speech, hearing and language functioning, visual functioning, immunization status, and oral health and oral hygiene;

(b) A psychiatrist, or a physician with specific clinical privileges to conduct such an examination shall be responsible for a psychiatric examination including a mental status examination;

(c) A registered nurse shall be responsible for completing an assessment of each patient's nursing care needs. As part of the nursing assessment, the R.N. shall conduct a screening of each patient's nutritional status unless otherwise assessed by a registered dietitian;

(d) An assessment for functional and rehabilitation needs which may include activities of daily living; community living skills; social, leisure and vocational skills; self care and self control abilities; physical/sensori-motor capabilities, speech, language, oral, and pharyngeal sensor-motor competencies and auditory and vestibular competencies;

(e) An emotional and behavioral assessment which includes at least a history of emotional, behavioral, substance-abuse problems or treatment and physical or sexual abuse history;

(f) A psycho-social assessment which shall include the following information about the patient, as appropriate:

(i) Environment and home;

(ii) Leisure and recreation;

(iii) Work history;

(iv) Spirituality;

(v) Childhood history;

(vi) Military service history;

(vii) Financial status;

(viii) Usual social, peer-group, and environmental setting;

(ix) Sexual orientation; and

(x) Family circumstances, including the constellation of the family group, the current living situation, and social, ethnic, cultural, emotional, and health factors. The psychosocial assessment includes determining the need and extent for family participation;

(g) In programs serving children and adolescents, an assessment shall be performed which includes the following:

(i) The impact of the child's/adolescent's condition on the family and the family's impact on the child/adolescent;

(ii) The child/adolescent's legal custody status, when applicable;

(iii) The child/adolescent's growth and development, including physical, emotional, cognitive, educational, nutritional, and social development;

(iv) The child/individual's play and daily activities needs; and

(v) The family's or guardian's expectations for and involvement in the child/adolescent's assessment, initial treatment, and continuing care.

(I) Each patient shall have a written individualized treatment plan that is responsive and timely to the treatment needs of the patient based on information provided by the patient and the patient's family and assessments by the clinical treatment team. The initial treatment plan and subsequent revisions shall be developed with the active participation of the patient, and through collaborative efforts of the clinical team. As appropriate and with patient consent, family members and significant others shall also participate. Such patient, family, and clinical treatment team collaboration shall be documented on the treatment plan. A patient's inability or refusal to participate in treatment planning and the patient's reasons for such shall also be documented on the treatment plan. The patient, and as appropriate parent or guardian, shall have the right to be informed of changes on the treatment plan including a change in assignment of the primary therapist or attending physician.

(1) The initial treatment plan shall be developed with the active participation of the patient and implemented within twenty-four hours of admission through collaborative efforts by the interdisciplinary clinical treatment team.

(2) The initial treatment plan and any subsequent revisions to the plan shall:

(a) Reflect the patient's clinical needs, condition, functional strengths, and limitations.

(i) The patient's perceptions of his/her needs are documented, as are the families' perceptions when appropriate and available.

(ii) Justification is documented when identified needs are not addressed;

(b) Specify goals for achieving emotional and/or physical health as well as maximum growth and adaptive capabilities.

(i) Treatment plan goals are based on assessments of the patient and, as appropriate, the family.

(ii) Treatment plan goals are linked to living, learning, and work activities.

(iii) Treatment goals identified by the patient and actions the patient agrees to or requests to take, and the patient's involvement in and expressed concerns about the treatment plan are documented;

(c) Specify intermediate steps toward those goals in measurable terms;

(d) Specify target dates or time-frames for completion of goals and steps;

(e) Specify services and interventions to be provided to achieve patient goals, and to indicate the staff person(s) and/or discipline responsible for provision of service(s);

(f) Specify frequency of services; and

(g) Specify criteria for discharge.

(3) The initial treatment plan shall be reviewed, updated and/or revised within seventy-two hours of a patient's admission. All subsequent updates to the plan shall occur at least every seven days for the first month of hospitalization, at least monthly thereafter, and as appropriate to patient needs.

(J) The discharge summary completed within thirty days after discharge shall include:

(1) Assessment of the patient's condition on admission;

(2) Assessment of the patient's condition upon discharge and reason for discharge;

(3) Description of diagnostic and treatment services received by the patient, with reference to interventions identified on the treatment plan, and the patient's response;

(4) All recommendations made to the patient;

(5) Medications prescribed upon discharge; and

(6) Initial and final diagnosis, both physical and psychiatric, according to the American psychiatric association's latest edition of the diagnostic and statistical manual of mental disorders (DSM), which shall be recorded in full without the use of either symbols or abbreviations.

(K) A discharge plan shall be developed with each patient and shall:

(1) State all appropriate recommendations and specific plans to include but not be limited to psychiatric, medical, case management, housing, vocational, financial, educational needs, other community support needs, and community resources available to meet these needs;

(2) Identify specific resources and state recommendations for continued, ongoing patient and family education regarding the nature and management of the patient's illness/disorder;

(3) Specify persons or agencies responsible for each recommended intervention or service;

(4) Specify the time-frame for initiation of each recommended intervention or service;

(5) Specify a crisis management plan as described in paragraph (T)(1)(a) of rule [5122-14-12](#) of the Administrative Code; and

(6) Be signed and dated by the patient, or as appropriate parent or guardian, and by each member(s) of the clinical treatment team responsible for reviewing the plan with the patient. A patient's inability or refusal to sign or participate in discharge planning and the patient's reasons for such shall be documented on the plan.

(L) The patient's treatment plan and medical record shall be available to the patient and family members according to section [5122.31](#) of the Revised Code.

(M) The inpatient psychiatric service provider shall have written policies and procedures regarding the release of information and confidentiality of oral or written patient information, in compliance with section [5122.31](#) of the Revised Code.

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## 5122-14-14 Incident notification and risk management.

(A) This rule establishes standards to ensure the prompt and accurate notification of certain prescribed incidents. It also requires the agency to review and analyze all incidents so that it might identify and implement corrective measures designed to prevent recurrence and manage risk.

(B) Definitions

(1) "Incident" means an event that poses a danger to the health and safety of patients and/or staff and visitors of the hospital, and is not consistent with routine care of persons served or routine operation of the hospital.

(2) "Reportable incident" means an incident that must be submitted to the department, including incidents that must then be forwarded by the department to the Ohio legal rights service pursuant to section [5123.604](#) of the Revised Code. As referenced in division (C) of section [5119.611](#) of the Revised Code, "major unusual incident" has the same meaning as "reportable incident."

(3) "Six month reportable incident" means an incident type of which limited information must be reported to the department. A six month reportable incident is not the same as a reportable incident.

(4) "Six month incident data report" means a data report which must be submitted to the department.

(C) The inpatient psychiatric service provider shall develop an incident reporting system to include a mechanism for the review and analysis of all reportable incidents such that clinical and administrative activities are undertaken to identify, evaluate, and reduce risk to patients, staff, and visitors. The inpatient psychiatric service provider shall identify in policy other incidents to be reviewed and analyzed.

(1) An incident report shall be submitted in written form to the inpatient psychiatric service provider's chief executive officer or designee within twenty-four hours of discovery of the incident.

(2) As part of the inpatient psychiatric service provider's performance improvement process, a periodic review and analysis of reportable incidents, and other incidents as defined in policy, shall be performed.

(3) The inpatient psychiatric service provider shall maintain an ongoing log of its reportable incidents for departmental review.

(D) Any person who has knowledge of any instance of abuse or neglect, or alleged or suspected abuse or neglect, or of an alleged crime which would constitute a felony, of:

(1) Any child or adolescent, shall immediately notify any alleged or suspected abuse or neglect to the county children's services board, the designated child protective agency, or law enforcement authorities, in accordance with section [2151.421](#) of the Revised Code, or of an alleged crime against a child or adolescent which would constitute a felony, including a crime allegedly committed by another child or adolescent which would constitute a felony if committed by an adult, shall immediately notify law enforcement authorities.

(2) An elderly person, shall immediately notify the appropriate law enforcement and county department of jobs and family services authorities in accordance with section [5101.61](#) of the Revised Code.

(E) Each inpatient psychiatric service provider shall submit reportable incidents and six month reportable incidents as defined by and according to the schedule included in appendix A to the rule.

(F) Each reportable incident shall be documented on form "DMH-LIC-013" as required by the department, and shall be forwarded to the department within twenty-four hours of its discovery, exclusive of weekends and holidays. Form "DMH-LIC-013" shall include identifying information about the inpatient psychiatric service

provider, date, time and type of incident, and client information that has been de-identified pursuant to the HIPAA privacy regulations, [ 45 C.F.R.164.514(b)(2) ].

(1) The inpatient psychiatric service provider shall file only one incident form per event occurrence and identify each incident report category, if more than one, and include information regarding all involved patients, staff, and visitors.

(2) The inpatient psychiatric service provider shall notify the patient's parent, guardian or custodian, if applicable, within twenty-four hours of discovery of a reportable incident, and document such notification.

(a) Notification may be made by phone, mailing, faxing or e-mailing a copy of the incident form, or other means according to inpatient psychiatric service provider policy and procedures.

(b) When notification does not include sending a copy of the incident form, the inpatient psychiatric service provider must inform the parent, guardian or custodian, of his/her right to receive a copy, and forward a copy within twenty-four hours of receiving a request for a copy. The inpatient psychiatric service provider shall document compliance with the provisions of this paragraph.

(G) Each inpatient psychiatric service provider shall submit a six month incident data report to the department utilizing the form that is in appendix B to this rule.

The six month data report must be submitted according to the following schedule:

(1) The six month data report for the period of January first to June thirtieth of each year shall be submitted no later than July thirty-first of the same year; and

(2) The six month data report for the period of July first to December thirty-first of each year shall be submitted no later than January thirty-first of the following year.

(H) The department may initiate follow-up and further investigation of a reportable incident and six month reportable incidents, as deemed necessary and appropriate, or may request such follow-up and investigation by the inpatient psychiatric service provider, and/or regulatory or enforcement authority.

Replaces: Part of 5122-14-10

[Click to view Appendix](#)

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**Inpatient Psychiatric Service Provider  
Reportable and Six Month Reportable Incidents**

In addition to the definitions in rule 5122-14-01 and of the Administrative Code, the following definitions are applicable to Ohio Administrative Code (OAC) rule 5122-14-14 "Incident Notification and Risk Management":

- (1) "Emergency/Unplanned Medical Intervention" means treatment required to be performed by a licensed medical doctor, osteopath, podiatrist, dentist, physician's assistant, or certified nurse practitioner, but the treatment required is not serious enough to warrant or require hospitalization. It includes sutures, staples, immobilization devices and other treatments not listed under "First Aid", regardless of whether the treatment is provided in the hospital, or at a doctor's office/clinic/hospital ER, etc. This does not include routine medical care or shots/immunizations, as well as diagnostic tests, such as laboratory work, x-rays, scans, etc., if no medical treatment is provided.
- (2) "First Aid" means treatment for an injury such as cleaning of an abrasion/wound with or without the application of a Band-aid, application of a butterfly bandages/Steri-Strips™, application of an ice/heat pack for a bruise, application of a finger guard, non-rigid support such as a soft wrap or elastic bandage, drilling a nail or draining a blister, removal of a splinter, removal of a foreign body from the eye using only irrigation or swab, massage, drinking fluids for relief of heat stress, eye patch, and use of over-the-counter medications such as antibiotic creams, aspirin and acetaminophen. These treatments are considered first aid, even if applied by a physician. These treatments are not considered first aid if provided at the request of the patient and/or to provide comfort without a corresponding injury.
- (3) "Hospitalization" means inpatient treatment provided at a medical acute care hospital, regardless of the length of stay. Hospitalization does not include treatment when the individual is treated in and triaged through the emergency room with a discharge disposition to return to the community, or admission to a psychiatric unit.
- (4) "Injury" means an event requiring medical treatment that is not caused by a physical illness or medical emergency. It does not include scrapes, cuts or bruises which do not require medical treatment.
- (5) "Sexual Conduct" means as defined by Section 2907.01 of the Ohio Revised Code, vaginal intercourse between a male and female; anal intercourse, fellatio, and cunnilingus between persons regardless of sex; and, without privilege to do so, the insertion, however slight, of any part of the body or any instrument, apparatus, or other object into the vaginal or anal opening of another. Penetration, however slight, is sufficient to complete vaginal or anal intercourse.
- (6) "Sexual Contact" means as defined by Section 2907.01 of the Ohio Revised Code, any touching of an erogenous zone of another, including without limitation the thigh, genitals, buttock, pubic region, or, if the person is a female, a breast, for the purpose of sexually arousing or gratifying either person.

## Reportable Incidents

The following lists and defines each event category which must be reported per incident in accordance with paragraph (F) of rule 5122-14-14 of the Administrative Code.

<b>Category</b>	<b>Reportable Incident Definition</b>
<b>Suicide</b>	The intentional taking of one's own life by a patient.
<b>Suicide Attempt</b>	Intentional action by a patient with the intent of taking one's own life, and is either a stated suicide attempt or clinically determined to be so, regardless of whether it results in medical treatment.
<b>Self-Injurious Behavior</b>	Intentional injury caused by a patient to oneself that is neither a stated suicide attempt, or clinically determined to be so, which requires emergency/unplanned medical intervention or hospitalization, and which happens on the grounds of the hospital or during the provisions of care or treatment, including during hospital off-grounds events.
<b>Homicide by Patient</b>	The alleged unlawful killing of a human being by a patient.
<b>Homicide of Patient</b>	The alleged unlawful killing of a patient by another person.
<b>Natural Death</b>	Death of a patient without the aid of inducement of any intervening instrumentality, i.e. homicide, suicide or accident
<b>Accidental Death</b>	Death of a patient resulting from an unusual and unexpected event that is not suicide, homicide or natural, and which happens on the grounds of the hospital or during the provisions of care or treatment, including during hospital off-grounds events.
<b>Verbal Abuse</b>	Allegation of staff action directed toward a patient that includes humiliation, harassment, and threats of punishment or deprivation.
<b>Physical Abuse</b>	Allegation of staff action directed toward a patient of hitting, slapping, pinching, kicking, or controlling behavior through corporal punishment or any other form of physical abuse as defined by applicable sections of the Revised or Administrative Code.
<b>Sexual Abuse</b>	Allegation of staff action directed toward a patient where there is sexual contact or sexual conduct with the patient, any act where staff cause one or more other persons to have sexual contact or sexual conduct with the patient, or sexual comments directed toward a patient. Sexual conduct and sexual contact have the same meanings as in Section 2907.01 or the Revised Code.
<b>Neglect</b>	Allegation of a purposeful or negligent disregard of duty imposed on an employee by statute, rule, organizational policy, or professional standard and owed to a patient by that staff member.
<b>Defraud</b>	Allegation of staff action directed toward a patient to knowingly obtain by deception or exploitation some benefit for oneself or another or to knowing cause, by deception or exploitation, some detriment to another.

## Reportable Incidents

The following lists and defines each event category which must be reported per incident in accordance with paragraph (F) of rule 5122-14-14 of the Administrative Code (continued).

Category	Reportable Incident Definition
<b>Involuntary Termination Without Appropriate Patient Involvement</b>	Discontinuing services to a patient without informing the patient in advance of the termination, providing a reason for the termination, and offering a referral to the patient. This does not include situations when a patient discontinues services without notification, and the hospital documents it was unable to notify the patient due to lack of address, returned mail, lack of or non-working phone number, etc.
<b>Sexual Assault by Non-staff, Including a Visitor, Patient or Other</b>	Any allegation of one or more of the following sexual offenses as defined by Chapter 2907 of the Revised Code committed by a non-staff against another individual, including staff, and which happens on the grounds of the hospital or during the provisions of care or treatment, including during hospital off-grounds events: Rape, sexual battery, unlawful sexual conduct with a minor, gross sexual imposition, or sexual imposition.
<b>Physical Assault by Non-staff, Including Visitor, Patient or Other</b>	Knowingly causing physical harm or recklessly causing serious physical harm to another individual, including staff, by physical contact with that person, which results in an injury requiring emergency/unplanned medical intervention or hospitalization, and which happens on the grounds of the hospital or during the provision of care or treatment, including during hospital off-grounds events.
<b>Medication Error</b>	Any preventable event while the medication was in the control of the health care professional or patient, and which resulted in permanent patient harm, transfer to a hospital medical unit, or death. Such events may be related to professional practice, health care products, procedures, and systems, including prescribing; order communication, product labeling, packaging, and nomenclature; compounding; dispensing; distribution; administration; education; monitoring; and use.
<b>Adverse Drug Reaction</b>	Unintended, undesirable or unexpected effect of a prescribed medication(s) that resulted in permanent patient harm, transfer to a hospital medical unit, or death.
<b>Patient Fall</b>	Loss of upright position that results in landing on the floor, ground or an object or furniture, or a sudden, uncontrolled, unintentional, non-purposeful, downward displacement of the body to the floor/ground or hitting another object like a chair or stair, resulting in:
Subcategory (check one)	<ol style="list-style-type: none"><li>1. No injury</li><li>2. Injury requiring first aid</li><li>3. Injury requiring emergency/unplanned medical intervention</li><li>4. Injury requiring hospitalization</li></ol>

## Reportable Incidents

The following lists and defines each event category which must be reported per incident in accordance with paragraph (F) of rule 5122-14-14 of the Administrative Code (continued).

Category	Reportable Incident Definition
<b>Medical Events Impacting Hospital Operations</b>	The presence or exposure of a contagious or infectious medical illness within an hospital, whether brought by staff, patient, visitor or unknown origin, that poses a significant health risk to other staff or patients in the hospital, and that requires special precautions impacting operations. Special precautions impacting operations include medical testing of all individuals who may have been present in the hospital, when isolation or quarantine is recommended or ordered by the health department, police or other government entity with authority to do so, and/or notification to individuals of potential exposure. Special precautions impacting operations does not include general isolation precautions, i.e. suggesting staff and/or patients avoid a sick individual or vice versa, or when a disease may have been transmitted via consensual sexual contact or sexual conduct.
<b>Away Without Leave (AWOL)</b>	A patient in an acute inpatient setting has been absent from a location defined by the patient's status regardless of leave or legal status. A patient is considered to be AWOL if the patient (1) has not been accounted for when expected to be present, or (2) has left the grounds of the hospital without permission. Implicit in this definition is that the patient has been informed of the limits placed on his/her location prior to the elopement incident.
<b>Discharge to Homeless Shelter</b>	Discharge or relocation of a patient from an acute, inpatient setting to a homeless shelter, unless it is the expressed wish of the patient, the responsible Board or contract agency has been involved in the decision-making process, and other placement options have been offered to the individual patient and have been refused.
<b>Discharge to Homeless - Street</b>	Discharge or relocation of a patient from an acute, inpatient setting who refuses all aftercare placement options, including homeless shelters, offered by the hospital, board and agency.
<b>Temporary Relocation of Patients</b> Subcategory (check one)	Some or all of the patients must be moved to another unit or hospital for a minimum period of at least one night due to: <ol style="list-style-type: none"><li>1. Fire</li><li>2. Disaster (flood, tornado, explosion, excluding snow/ice)</li><li>3. Failure/Malfunction (gas leak, power outage, equipment failure)</li><li>4. Other (name)</li></ol>

**Continued On Page 5 & 6 for Seclusion and Restraint & Use of Force Related Incidents**

**Continued On Page 7 for Six Month Reportable Incidents**

## Reportable Incidents

The following lists and defines each event category which must be reported per incident in accordance with paragraph (F) of rule 5122-14-14 of the Administrative Code (continued).

Category	Reportable Incident Definition
<b>Inappropriate Use of Seclusion or Restraint</b>	Seclusion or restraint utilization that is not clinically justified or employed without the authorization of staff permitted to initiate/order mechanical seclusion or restraint
Subcategory (check all that apply)	<ol style="list-style-type: none"><li>1. Seclusion</li><li>2. Mechanical restraint</li><li>3. Physical restraint</li><li>4. Transitional hold</li></ol>
Total Minutes	The total number of minutes of the seclusion or restraint.
<b>Inappropriate Restraint Techniques and other Use of Force</b>	Staff utilize one or more of the following methods/interventions prohibited by paragraph (D)(2) of rule 5122-26-16 of the Administrative Code:
Subcategory (check all that apply)	<ol style="list-style-type: none"><li>1. 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</li><li>2. Any technique that restricts the patient's ability to communicate</li><li>3. Any technique that obstructs vision</li><li>4. Any technique that obstructs the airways or impairs breathing</li><li>5. 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; or</li><li>6. 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.</li></ol>
<b>Seclusion/Restraint Related Injury to Patient</b>	Injury to a patient caused, or it is reasonable to believe the injury was caused by being placed in seclusion/restraint or while in seclusion/restraint, and first aid or emergency/unplanned medical intervention was provided or should have been provided to treat the injury, or medical hospitalization was required. It does not include injuries which are self-inflicted, e.g. a patient banging his/her head, unless the hospital determines that the seclusion/restraint was not properly performed by staff, or injuries caused by another patient, e.g. a patient hitting another patient.
Subcategory (check one)	<ol style="list-style-type: none"><li>1. Injury requiring first aid</li><li>2. Injury requiring unplanned/emergency medical intervention</li><li>3. Injury requiring hospitalization</li></ol>

## Reportable Incidents

The following lists and defines each event category which must be reported per incident in accordance with paragraph (F) of rule 5122-14-14 of the Administrative Code (continued).

Category	Reportable Incident Definition
<b>Seclusion/Restraint Related Injury to Staff</b>	Injury to staff caused, or it is reasonable to believe the injury was caused as a result of placing an individual in seclusion/restraint, and first aid or emergency/unplanned medical intervention was provided or should have been provided to treat the injury, or medical hospitalization was required. It does not include injuries which occur prior to, or are the rationale for, placing an individual in seclusion or restraint.
Subcategory (check one)	<ol style="list-style-type: none"><li>1. Injury requiring first aid</li><li>2. Injury requiring emergency/unplanned medical intervention</li><li>3. Injury requiring hospitalization</li></ol>
<b>Seclusion/Restraint Related Death</b>	Death of a patient which occurs while a patient is restrained or in seclusion, within twenty-four hours after the patient is removed from seclusion or restraint, or it is reasonable to assume the patient's death may be related to or is a result of seclusion or restraint
Subcategory (check one)	<ol style="list-style-type: none"><li>1. Death during seclusion or restraint</li><li>2. Death within twenty-four hours of seclusion or restraint</li><li>3. Death related to or result of seclusion or restraint</li></ol>

**Continued On Page 7 for Six Month Reportable Incidents**

## Six Month Reportable Incidents

The following lists and defines the incident data which must be reported every six months in accordance with paragraph (G) of rule 5122-14-14 of the Administrative Code.

Category	Six Month Reportable Incident Definition
<b>Injury Requiring Emergency/Unplanned Medical Intervention or Hospitalization</b>	An injury to a patient requiring emergency/unplanned medical intervention or transfer to a hospital medical unit and which happens on the grounds of the hospital or during the provision of care or treatment, including during hospital off-grounds events.
<b>Illness/Medical Emergency</b>	A sudden, serious and/or abnormal medical condition of the body experienced by a patient that requires immediate and/or unplanned transfer to a hospital medical unit for treatment, and which happens on the grounds of the hospital or during the provision of care or treatment, including during hospital off-grounds events. A medical illness/emergency does not include injury.
<b>Seclusion</b>	A staff intervention that involves the involuntary confinement of a patient alone in a room where the patient is physically prevented from leaving.
Age 17 and Under	The aggregate total number of all episodes of seclusion and aggregate total minutes of all seclusion episodes.
Age 18 and Over	The aggregate total number of all episodes of seclusion and aggregate total minutes of all seclusion episodes.
<b>Mechanical Restraint</b>	A staff intervention that involves any method of restricting a patient's freedom of movement, physical activity, or normal use of his or her body, using an appliance or device manufactured for this purpose.
Age 17 and Under	The aggregate total number of all episodes of seclusion and aggregate total minutes of all seclusion episodes.
Age 18 and Over	The aggregate total number of all episodes of mechanical restraint and aggregate total minutes of all mechanical restraint episodes.
<b>Physical Restraint excluding Transitional Hold</b>	A staff intervention that involves any method of physically (also known as manually) restricting a patient's freedom of movement, physical activity, or normal use of his or her body without the use of mechanical restraint devices
Age 17 and Under	The aggregate total number of all episodes of physical restraint and aggregate total minutes of all physical restraint episodes, excluding transitional hold.
Age 18 and Over	The aggregate total number of all episodes of physical restraint and aggregate total minutes of all physical restraint episodes, excluding transitional hold.
<b>Transitional Hold</b>	A staff intervention that involves a brief physical (also known as manual) restraint of a patient face-down for the purpose of quickly and effectively gaining physical control of that patient, or prior to transport to enable the patient to be transported safely.
Age 17 and Under	The aggregate total number of all episodes of transitional hold and aggregate total minutes of all transitional hold episodes.
Age 18 and Over	The aggregate total number of all episodes of transitional hold and aggregate total minutes of all transitional hold episodes.

**Inpatient Psychiatric Service Provider  
Six Month Reportable Incident Data Report Form****Instructions:**

Please complete the Inpatient Psychiatric Service Provider Information on this page. Please complete Parts A and B, beginning on Page 3. If the hospital did not utilize seclusion and restraint during the reporting period, please complete Part C on Page 3. If the hospital did utilize seclusion and restraint please skip Part C and complete Part D on Page 4. Definitions are found on Page 2.

You may submit this form by fax, e-mail or mail. Address and fax number information is available on the Ohio Department of Mental Health website.

**Please submit this report by the following deadline:**

- For the incident reporting period of January 1 through June 30, by July 31 of the same year
- For the incident reporting period of July 1 through December 31, by January 31 of the following year

**Inpatient Psychiatric Service Provider Information**

Hospital Name: \_\_\_\_\_ ODMH License Number: \_\_\_\_\_

Person Completing Report: \_\_\_\_\_ Title: \_\_\_\_\_

Phone \_\_\_\_\_ E-mail: \_\_\_\_\_

Reporting Period (please include year):  January 1 – June 30, 2\_\_\_\_ Report is due by July 31 of this year

July 1 – December 31, 20\_\_\_\_ Report is due by January 31 of the following year

Definitions. Please utilize the following definitions for completing this report:

"Emergency/Unplanned Medical Intervention" means treatment required to be performed by a licensed medical doctor, osteopath, podiatrist, dentist, physician's assistant, or certified nurse practitioner, but the treatment required is not serious enough to warrant or require transfer to a hospital medical unit. It includes sutures, staples, immobilization devices and other treatments not listed under "First Aid", regardless of whether the treatment is provided in the hospital, or at a doctor's office/clinic/hospital ER, etc. This does not include routine medical care or shots/immunizations, as well as diagnostic tests, such as laboratory work, x-rays, scans, etc., if no medical treatment is provided.

"First Aid" means treatment for an injury such as cleaning of an abrasion/wound with or without the application of a Band-aid, application of a butterfly bandages/Steri-Strips™, application of an ice/heat pack for a bruise, application of a finger guard, non-rigid support such as a soft wrap or elastic bandage, drilling a nail or draining a blister, removal of a splinter, removal of a foreign body from the eye using only irrigation or swab, massage, drinking fluids for relief of heat stress, eye patch, and use of over-the-counter medications such as antibiotic creams, aspirin and acetaminophen. These treatments are considered first aid, even if applied by a physician. These treatments are not considered first aid if provided at the request of the patient and/or to provide comfort without a corresponding injury.

"Hospitalization" means inpatient treatment provided at a medical acute care hospital, regardless of the length of stay. Hospitalization does not include treatment when the individual is treated in and triaged through the emergency room with a discharge disposition to return to the community or psychiatric inpatient unit.

"Illness/Medical Emergency" means a sudden, serious and/or abnormal medical condition of the body experienced by a patient that requires immediate and/or unplanned admission to a hospital medical unit for treatment, and which happens on the grounds of the hospital or during the provision of care or treatment, including during hospital off-grounds events. A medical illness/emergency does not include injury.

"Injury" means an event requiring medical treatment that is not caused by a physical illness or medical emergency. It does not include scrapes, cuts or bruises which do not require medical treatment.

"Mechanical Restraint" means a staff intervention that involves any method of restricting a patient's freedom of movement, physical activity, or normal use of his or her body, using an appliance or device manufactured for this purpose.

"Physical Restraint", also known as "manual restraint", means a staff intervention that involves any method of physically (also known as manually) restricting a patient's freedom of movement, physical activity, or normal use of his or her body without the use of mechanical restraint devices.

"Seclusion" means a staff intervention that involves the involuntary confinement of a patient alone in a room where the patient is physically prevented from leaving.

"Transitional Hold" means staff intervention that involves a brief physical (also known as manual) restraint of a patient face-down for the purpose of quickly and effectively gaining physical control of that patient, or prior to transport to enable the patient to be transported safely.

**Part A. Service Utilization (Please continue to Part B when finished)**

**Definition:**

“Patient Days” means the sum of all census days less the sum of all leave days (authorized or unauthorized absences when patient is not under direct supervision of psychiatric care setting staff).

	<b>January/ July</b>	<b>February/ August</b>	<b>March/ September</b>	<b>April/ October</b>	<b>May/ November</b>	<b>June/ December</b>
Total Number of Patient Days per Month						

**Part B: Incidents, Excluding Seclusion and Restraint (Please continue to Part C when finished)**

Hospital has no Table B1 incidents during the reporting period. Please continue to Part C.

**Table B1**

<b>Incident Category</b>	<b>January/ July</b>	<b>February/ August</b>	<b>March/ September</b>	<b>April/ October</b>	<b>May/ November</b>	<b>June/ December</b>
<b>Injuries Requiring Emergency/Unplanned Medical Treatment or Hospitalization</b>						
Number of injuries, excluding patient falls, requiring emergency/unplanned medical treatment or hospitalization.						
<b>Illness / Medical Emergency</b>						
Number of illnesses/medical emergencies, requiring immediate and/or unplanned admission to a hospital medical unit						

**Part C: Seclusion / Restraint Episodes**

Hospital did not utilize seclusion or restraint during the reporting period.

**If Box in Part C is checked, you are finished. Please return report.  
If not, please complete Part D**

**Part D: Seclusion / Restraint Episodes**

	January/ July	February/ August	March/ September	April/ October	May/ November	June/ December
<b>Seclusion for Ages ≤17 <input type="checkbox"/> None</b>						
Number of episodes of seclusion for ages ≤17						
Total minutes of all seclusion episodes for ages ≤17						
<b>Seclusion for Ages ≥18 <input type="checkbox"/> None</b>						
Number of episodes of seclusion for ages ≥18						
Total minutes of all seclusion episodes for ages ≥18						
<b>Mechanical Restraint for Ages ≤17 <input type="checkbox"/> None</b>						
Number of episodes of mechanical restraint for ages ≤17						
Total minutes of all mechanical restraint episodes s ≤17						
<b>Mechanical Restraint for Ages ≥18 <input type="checkbox"/> None</b>						
Number of episodes of mechanical restraint for ages ≥18						
Total minutes of all mechanical restraint episodes for ages ≥18						
<b>Physical Restraint for Ages ≤17 <input type="checkbox"/> None</b>						
Number of episodes of physical restraint, excluding transitional hold, for ages ≤17						
Total minutes of all physical restraints episodes, excluding transitional hold, for ages ≤17						
<b>Physical Restraint for Ages ≥18 <input type="checkbox"/> None</b>						
Number of episodes of physical restraint, excluding transitional hold, for ages ≥18						
Total minutes of all physical restraints episodes, excluding transitional hold, for ages ≥18						
<b>Transitional Hold for Ages ≤17 <input type="checkbox"/> None</b>						
Number of episodes of transitional hold for ages ≤17						
Total minutes of all transitional hold episodes for ages ≤17						
<b>Transitional Hold for Ages ≥18 <input type="checkbox"/> None</b>						
Number of episodes of transitional holds for ages ≥18						
Total minutes of all transitional hold episodes for ages ≥18						

**You are finished. Please return report. Thank you.**