USING AND EVALUATING PHYSICAL RESTRAINTS POLICY - OH

POLICY:
This facility supports the belief that long-term care facility residents should live in the least restrictive setting possible. This is to preserve the dignity and autonomy of its residents and to provide quality of life. This facility does not use physical restraints except when other alternatives are not appropriate/effective in treating the medical symptom.

Medical Symptom – an indication or characteristic of a physical or psychological condition.

Before a resident is restrained, the facility must determine the presence of a specific medical symptom that would require the use of a restraint and how their use would treat the medical symptom, protect the resident's safety, and assist the resident in attaining or maintaining his or her highest practicable level of physical and psychosocial well-being.

- Restraints are used as a last resort (after less restrictive interventions have been proven ineffective).
- Restraints are applied only by staff who have been trained on their use.
- Residents, family, or resident representative will be informed of the risks and benefits of restraint use.

PROCEDURE:
1. Any staff may identify a need for interventions for a resident exhibiting medical symptoms.

2. A licensed nurse will assess the resident when a need for intervention is identified. The nurse will assess for contributing factors and reversible causes. Example: Environmental factors (noise, cold/heat, other environmental stimuli), pain, hunger or in the case of new or worsening medical symptoms, assess for possible physical illness (assess vital signs, blood sugar, oxygen sat as indicated). The licensed nurse will then implement nursing interventions to address the medical symptom based on the assessment and will document the interventions and effectiveness in the medical record. The licensed nurse, or social service staff member may call resident's family, resident representative, or care givers to determine past interventions that may have been effective in treating a resident's medical symptoms.

3. If after interventions are attempted and found to be ineffective, the licensed nurse determines there is a need for a device that may be a restraint the licensed nurse will look at the least restrictive device.

4. The resident's physician will be notified of the resident's change in condition and assessment findings. If a need for a restraint device is identified the order will reflect the type of restraint, the purpose of the restraint (medical symptoms) and when the restraint can be applied. The device will be used for the shortest period of time to address the immediate need/episode. Restraints will be released during supervised conditions such as activities, meals, 1:1 hands on care and at least every 2 hours unless otherwise specified by physician order and/or plan of care.

5. Family/resident representative will be notified of the change in resident's condition and initiation of a restraint, review of benefits and risks of the restraint use including loss of autonomy, dignity, and self-respect and may show symptoms of withdrawal, depression, or reduced social contact. The resident, resident representative will be given information to make an informed choice about the use of the restraint and this will be documented on the Restraint Decision Form (Form R-12).

6. The use of the restraint will be documented on the resident's care plan and care kardex. The plan of care will document how the restraint treats the medical symptom, protects the resident's safety or assists the resident in attaining or maintaining his or her highest practicable level of physical and psychosocial well-being. The facility interdisciplinary team will develop a plan towards a reduction and/or elimination of the restraint for the resident based on assessment of the resident.

   The care plan will identify the resident's medical symptom as well as resident strengths.

   The use of the device as an intervention will include:
   - Type of device ordered and under what circumstances the device will used.
   - Under what circumstances the device/restraint is released.
   - Monitoring the resident and what effect the device has on the resident.
   - Interventions to minimize functional decline due to the use of the device/restraint.

7. The Interdisciplinary Team or the Restraint Team, the QAPI committee, and the physician will review the resident's need for the restraint every month and as needed. This review will include any resulting isolation and any incidents that has resulted from their use.

8. In an emergency situation where there is immediate danger to the resident or others, apply the physical restraint and notify the physician immediately. Documentation will be made in the interdisciplinary notes.

NOTE: The facility will not and may not use restraints in violation of the regulation solely based on a legal surrogate or representative request or approval.

Intervention options to address resident's medical symptoms based on the assessment may include but are not limited to:
- Blanket or sweater (warmer or cooler clothing).
- Toileting or changing the resident.
- Offer food and/or fluids.
- Tylenol or pain medication (oral or topical pain treatments).
- Walk with the resident.
- Diversional activities (folding clothes, sorting objects, coloring/drawing, photo albums).
- Music or television.
- 1:1 with resident (talking or activity).
- Assisting resident to bed to rest.
- Other interventions as outlined in physician's orders or on the plan of care.