

Resident Level Assessment of Essential Practices for Quality Care: Physical Restraints

Facility Name _____ Date _____

- Directions:
1. Enter the resident’s clinical record number or initials.
 2. Review the clinical record for evidence of each practice.
 3. Enter a “Y” if it is identified (found in the chart) and an “N” if it is not identified. (Some records may have “N/A”).
 4. Tally the number of “Y”s identified for each Best Practice, divide by the total number of records reviewed and multiply by 100 to determine the percent. Percentages below 90% should trigger plan of action intervention.

	Clinical Records										Tally		
	1	2	3	4	5	6	7	8	9	10	# Yes	Total Yes	%
Enter Resident’s Clinical Record ID # or Initials													
1. A comprehensive assessment is completed for restraint risks (i.e. fall risk, medical treatments that increase fall risk, cognitive status and behavioral symptoms) on admission, with a change in condition or medication, after a fall or behavior event, and with each MDS assessment. (See last page) <small>(If “N”, see # 3.1 & 4.1 on POA)</small>													%
2. If a restraint risk is identified, the care plan includes interventions appropriate for each identified restraint risk (i.e. restorative care, toileting schedule, etc.) <small>(If “N”, see # 4.4 on POA)</small>													%

	Clinical Records										Tally		
	1	2	3	4	5	6	7	8	9	10	# Yes	Total Yes	%
Enter Resident's Clinical Record ID # or Initials													
3. If the resident is restrained, the resident record contains a physician's order for the specific restraint including the medical symptom(s). (If "N", see #5.3 on POA)													%
4. If the resident is restrained, an explanation of how the restraint treats the medical symptom(s) and/or assists the resident in attaining or maintaining the highest practicable level of physical or psychological well-being is documented. (If "N", see 3 5.10 on POA)													%
5. If the resident is restrained, an assessment to determine if the physical restraint used is the least restrictive device to treat the resident's medical symptom(s) is documented. (If "N", see #5.10 on POA)													%
6. If the resident is restrained, a plan to regularly re-evaluate the resident for possible reduction or elimination of the physical restraint is documented. (If "N", see # 2.3 & 5.11 on POA)													%

	Clinical Records										Tally		
	1	2	3	4	5	6	7	8	9	10	# Yes	Total Yes	%
Enter Resident's Clinical Record ID # or Initials													
7. If the resident is restrained, the care plan includes a plan for implementation of alternatives to restraints. (If "N", see # 2.3 & 5.11 on POA)													%
8. If the resident is restrained, the care plan includes measures to minimize potential decline in level of functioning. (If "N", see #2.3 & 5.11 on POA)													%
9. If the resident is restrained an explanation to the resident/legal representative, prior to applying the restraint, regarding benefits, adverse effects and alternatives to restraint use is documented. (If "N", see # 6.1 on POA)													%
10. Does the effect of the device on the resident meet the RAI definition of a restraint and the MDS coding is consistent with that definition? (If "N", see # 2.8 on POA)													%

Comprehensive Assessment and Evaluation for Restraint Use

Examination and Evaluation

- Basic assessment to rule out acute illness:
- Physical examination and medical history
- Observation
- Interview resident and/or family

Assessment and Treatment

- Assessment log
- Activities of daily living (ADL) scales
- Functional capacity tests
- Functional simulations
- Fall scales
- Barriers check list

Explore underlying medical and environmental conditions

- **Unstable Gait** - Stability, strength, range of motion, balance, hearing/vision, assistive devices, fall risk, fractures/precautions, shoes/clothing
- **Cognition** - Delirium, confusion, depression, hallucinations, agitation, wandering, aggressive behaviors, psychoactive medications
- **Impaired Communication** - Difficulty making needs/wishes understood or understanding others
- **Environment** - Access to call light/television/telephone, lighting, access to bathroom, availability of nutrition/hydration, noise level, adaptive equipment
- **Medications** - Multiple medications/dosages, side effects, new medications
- **Cardiovascular Insufficiency** - Syncope, oxygen saturation, fluctuations in blood pressure, shortness of breath, TIA
- **Infections** - Urinary tract infection, upper respiratory infection, delirium, fever
- **Hyperglycemia/Hypoglycemia** - Blood sugar levels
- **Dehydration/Constipation** - Change in mental status, amount of fluid intake, bowel sounds, abdominal distension
- **Sleep Problems** - Sleep/wake patterns
- **Pain** - History of pain, location, intensity, onset, duration, ability to express pain, barriers to pain management, effectiveness of pain management
- **Wandering** - Cognition, medication, physical surroundings

Documentation

- Tests, performance, functional capacity
- Response to activity
- Safety awareness
- Education provided
- Family, caregiver involvement
- Plan of care
- Interventions, frequency, duration
- Referrals