

Restraint/Enabler Decision Flowchart

Initial Individualized Assessment

Determine the need for the device, identify the medical symptoms that warrant use, determine enabling qualities, and determine safety hazards

ASK ALL THREE QUESTIONS

1. Can the resident remove the device purposefully?

2. Does the device prevent or restrict movement the resident would otherwise be capable of doing?

3. Does the device restrict or prevent the resident access to his/her body he/she would otherwise have?

Does the device allow the resident to do something that would improve their quality of life?
Does the device allow the resident to participate in an activity otherwise incapable of?
Does the device improve the resident's physical or emotional status?

Is this device used to treat a medical symptom or does the device help the resident function?

YES

NO

YES

NO

The device is an enabler.

Question the intent of use.
Document the reason for use.
Track as a restraint.

The device is a restraint and an enabler.

Use not allowed.

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| <ol style="list-style-type: none"> 1. Document the reason for use. 2. Obtain physician order. 3. Create POC (plan of care) to include risk and benefits. | <ol style="list-style-type: none"> 4. Re-evaluate at least quarterly and with change of condition. 5. Track like a restraint. 6. Code P100 as 0, not used (source: MDS RAI User's Manual, version 3.0 Chapter 3: MDS Items [P], Pg P-4 Coding Instructions) |
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Follow the Restraint Process Indicator (See back)

MDS Section P: Physical Restraints

The intent is to record the frequency over the 7-day look-back period that the resident was restrained by any of the listed devices at any time during the day or night. Assessors will evaluate whether or not a device meets the definition of a physical restraint and code only the devices that meet the definition in the appropriate categories of Item P0100.

Definition: A physical restraint is any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body. Source: RAI User's Manual Version 3.0 Chapter 3: MDS Items [P], pg P-1

Restraint Process Indicator

The use of any device requires a care plan. The following information should be included in the resident's individual care plan.

STEP 1: Assessment and Problem Recognition

1. Identify and document a detailed history of the symptom for which you are using or proposing to use a restraint.
2. Identify any triggers for restraint use from the Minimum Data Set (MDS).
3. Identify whether the problem is chronic and irreversible or acute and reversible.
4. Attempt to find alternate ways to manage the problem. Explain to the resident and family the benefits and risks of restraints.
5. Notify a physician or advanced practice nurse/physician assistant about symptoms that could require restraint use.

STEP 2: Diagnosis and Identify Cause

1. Identify likely causes of falling, problematic behavior, or some other problem (for example, medication side effects or environmental factors) for which you propose to use a restraint or are already using one?
2. Did the practitioner help identify specific medical symptoms that led to the use or proposed use of the restraint?
3. If the resident was not evaluated for the medical symptom(s) causing a need for restraints, document why.
4. For any device that is a restraint, obtain a practitioner's order. Physician orders must reflect the presence of a medical symptom; however, the order alone is not sufficient to warrant use.

STEP 4: Monitoring

1. Monitor the impact of the restraint on the resident and the problems or risks for which it is used.
2. Monitor for complications related to the restraint and stop or adjust use accordingly.
3. If you continued to use a restraint despite complications, explain why continued use was needed.
4. Periodically (at least quarterly) reassess the resident for continued need for device and document in the care plan.

STEP 3: Care Plan – Treatment and Management

1. Document attempted alternatives before using a restraint.
2. Document rationale for use (be specific). Identify reasons for selecting a specific device and base the use on risks and benefits for the resident.
3. Document how facility manages identified or probable causes of falling, problematic behavior, or another condition for which a restraint is used OR explain why the causes could not or should not be managed. Care plan the device.
4. Determine if the device places the resident at risk for any of the following: depression, loss of dignity, agitation, UTIs, decreased mobility, loss of muscle tone, strangulation, incontinence, constipation, pressure ulcers, asphyxiation, entanglement, pain from lack of movement, skin tears/scrapes/bruises, decreased bone density/increased fractures, injury from devices not adapted or fitted to resident, injury from defective or improperly used devices and address these in the plan of care.
5. Use the device correctly: Apply it correctly; release it at the right time, provide for exercise.
6. Identify goals for restraint use, including least restrictive and reduction (i.e., correction of underlying causes).