

	Montana Mental Health Nursing Care Center Policy Manual	Policy Number	523
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	Assistive Restraints – Safety Device or Restraint		

Restraints: Physical, chemical, safety devices, assistive devices, orthotic devices, and postural support.

POLICY:

Montana Mental Health Nursing Care Center must demonstrate the presence of a specific medical symptom that would require the use of restraints, and how the use of restraints would treat the cause of the symptoms and assist the resident in reaching his or her highest level of physical and psychosocial well being

DEFINITION:

A restraint is a chemical or physical means of restricting a person’s freedom of movement that prevents them from independent and purposeful functioning.

Physical restraints are any manual method of physical or mechanical device, material, or equipment attached or adjacent to the resident’s body that the individual cannot remove easily and which restricts freedom of movement or normal access to one’s body.

Safety device is meant to maximize a resident’s independence and maintain their health and safety by reducing the risk of falls and injuries.

Assistive device is any device whose primary purpose is to maximize the independence and the maintenance of health an of a individual who is limited by physical injury or illness, psychosocial dysfunction, mental illness, developmental or learning disability, the aging process, cognitive impairment or an adverse environmental condition. If the device is primarily used to restrict an individual’s movement, it is considered a safety device or restraint other than an assistive device.

Postural support is an appliance or device used to achieve proper body position, and balance to improve a resident’s mobility and independent functioning, or to position rather than restrict movement and prevent a resident from falling out of a bed or chair.

Chemical restraint is a psychopharmacologic drug that is not required to treat medical symptoms.

PROCEDURE:

1. The use of a restraint, safety device or postural support is prohibited except to treat a resident's medical symptom or to reduce the risk of falls and injuries associated with a resident's medical symptom and may not be imposed for purposes of coercion, retaliation, discipline or staff convenience.
2. Restraints may be used for brief periods if a resident needs emergency care:
 - a) To permit medical treatment to proceed unless there is a previous valid refusal.
 - b) Violent or aggressive behavior that places the resident or others in imminent danger.
3. Residents must be assessed on an individual basis to determine if the benefits of a restraint outweigh the risks.
4. A licensed nurse shall contact the physician for restraint orders prior to the use of a restraint or within one hour of application of a restraint in an emergency situation. If the physician does not order the restraint device, it may not be used. The order must specify the medical symptom for the intended use. The nurse must document in the resident's clinical record the circumstances requiring the restraints and the duration the restraint is needed
5. A competent resident has a choice to use or not use a safety device or restraint. A family member may not agree with the resident's decision, but they cannot override the competent resident's request. In cases where a resident is not competent to make this decision, a guardian or DPOA can make the decision for the resident.
6. A licensed nurse will complete the restraint authorization (attachment #1) and place this in the appropriate social worker's mailbox to be sent to the resident's guardian or DPOA for signature. A written explanation describing why the device is used, the risks associated with its use, and any alternatives to its use should accompany the authorization (attachment #2). Verbal consent from the guardian should be obtained prior to using a restraint unless it is an emergency situation.
7. If a resident is his own guardian, review the written explanation and authorization form with them. Obtain their signature (attachment #1) if they are in agreement with the need for the restraint/safety device. In the case of a resident's unanticipated violence or aggressive behavior that places the resident or others in imminent danger, the resident does not have the right to refuse the use of restraints.

8. A restrained resident must be monitored and restraints removed as soon as their condition warrants.
9. While restrained, the resident must be given the opportunity to exercise and use the bathroom at least every two hours while awake (or more often upon request). The CNA should check and document every ½ hour to assure the resident's safety and comfort
10. Restraint devices can only be applied in accordance with manufacturer's instructions. Staff must be able to rapidly remove the device in case of an emergency.
11. The restraint cannot be applied until the Minimum Data Set (MDS) CAA #18 Physical Restraint assessment is utilized and all information is satisfactorily compiled and documented in the resident' medical record. (see attachment #3)
12. The facility will review the use of the restraint at least monthly or more often if the resident's condition changes. This evaluation should include any behaviors or incidents that have arisen as the result of using the device that could endanger the resident or others. The facility will work with family, resident and physician to find the least restrictive device, while meeting the concerns for physical safety.
13. Safety measures must be in place prior to discontinuing a restraint device. The physician and guardian are to be notified prior to discontinuing of the restraint.
14. Staff training by a licensed health care professional shall include the proper techniques for applying and monitoring restraints, prevention of harm to resident by use of positioning and ROM, adequate clothing and covering, and provision of additional attention to meet the physical, mental, emotional and social needs of the resident.