Staff Education: Resident Rights and Prohibited Use of Restraints

Based on Rule 3701-16-09.1 (L), Ohio Administrative Code

+ Real-Life Case Example from April 2025

🛑 What's Prohibited in Our Facility?

Residents **must never** be restrained **physically**, **chemically**, or through **isolation**—especially for staff convenience or discipline.

📘 Key Definitions (Know the Terms!)

- **Physical Restraint**: Any device or setup that restricts movement and the resident can't remove on their own (e.g., locked door, geri-chair, or side rail).
- **Chemical Restraint**: Using medication to sedate or control behavior that's **not part of a medical treatment plan**.
- **Freedom of Movement**: The ability of a resident to move independently within the limits of their abilities.

✅ What *Is* Allowed (With Conditions)

- Devices that **help improve** a resident's physical or mental condition and **don't limit movement**.
- Medications that are part of a **documented medical or psychiatric treatment plan**.
- Secured units are OK **only if**:
  - Care is individualized and not for staff ease.
  - Resident assessments are regularly reviewed.
  - The area meets **fire/building codes**.
  - It's **not based only on diagnosis**.
- **Voluntary** residence in a secured unit is fine if the resident **can enter/exit freely** (e.g., to live with a spouse).

⚠️ Real-Life Story: What Can Happen When Standards Aren't Followed

Source: KARE 11 / Dana Thiede, April 2025

In December 2024, a resident at **Oak Park Senior Living** in Minnesota was found trapped between his **bed rail and bed frame**, with his **feet pinned under his motorized wheelchair**. He had allegedly been stuck for **two days**, during which time he **asked staff for help**.

Despite this, **required safety checks were missed**. One employee said she had seen him that morning, but the resident told EMS he'd been trapped for two days. He was found with pressure wounds, sepsis, and kidney failure—and **died four days later**.

📜 The Findings:

- The bed rail had **never been assessed for safety**.
- The facility was found to have **failed to act in the vulnerable adult's best interest**.
- The **claim of neglect was substantiated** by the Minnesota Department of Health.

🔍 What This Teaches Us:

- **Safety checks must be done and documented accurately.**
- **Bed rails and equipment must be assessed for safety risks.**
- **Every staff member must follow professional standards and exercise sound judgment.**

💡 Final Reminders for Staff

- Always ask yourself: "Is this in the resident's best interest?"
- If you're unsure whether a device or practice could be considered a restraint, **ask your supervisor or nursing leadership**.
- Document everything accurately.
- Follow up on resident concerns — **don't assume someone else will**.

📝 Staff Education Quiz: Resident Rights & Restraints

Name: _____ **Date:** _____
Position: _____

Instructions: Circle the correct answer or fill in the blank.

Multiple Choice (Circle the best answer):

1. Which of the following is considered a **physical restraint**?

   A. Walker used during ambulation
   B. Geri-chair that a resident cannot get out of independently
   C. Grabber tool used to open a door
   D. A pillow used for comfort

2. A **chemical restraint** is:

   A. Any over-the-counter medication
   B. A medication used to treat a diagnosed medical condition
   C. A medication given to make a resident easier to manage, not for medical treatment
   D. A vitamin supplement

3. Which of the following would NOT be considered restraint **if used appropriately**?

   A. A locked unit used only for residents with dementia
   B. A prescribed antipsychotic for a documented mental health condition
   C. Tying a resident to their wheelchair to prevent wandering
   D. Giving a sedative to keep a resident quiet during a shift

4. When can a resident voluntarily reside in a secured unit?

   A. When no other room is available
   B. When they want to live with their spouse
   C. When they can enter/exit independently
   D. All of the above

5. In the real-life case discussed, what key **safety failure** contributed to the resident's death?

   A. He was given the wrong medication
   B. He refused to follow safety instructions
   C. His bed rail was not assessed for safety, and safety checks were missed
   D. He was not wearing a call button

True or False (Circle T or F):

6. T / F – It's okay to use a bed rail without assessing it, as long as it helps the resident sit up.
7. T / F – A device that supports independence and does not restrict movement is not considered a restraint.
8. T / F – You can skip a safety check if you think the resident is fine.
9. T / F – Residents should always be able to move freely to the extent of their functional ability.
10. T / F – Documentation and communication are key to preventing resident harm.

Short Answer:

11. What should you do if you're unsure whether something could be a restraint?

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12. What was one change the facility in the real-life story made after the incident?

✅ Answer Key (For Administrator Use)

1. B
2. C
3. B
4. D
5. C
6. **False**
7. **True**
8. **False**
9. **True**
10. **True**
11. *Ask your supervisor or nursing leadership immediately.*
12. *They changed procedures for conducting safety checks and assessing equipment.*