

RESIDENT CONSENT TO THE USE OF PHYSICAL RESTRAINT

NAME OF RESIDENT: _____

Pursuant to F.S. 429.02(19)

“Physical restraint” means a device that physically limits, restricts, or deprives an individual of movement or mobility, including any device that is not specifically manufactured as a restraint but is altered, arranged, or otherwise used for that purpose. The term does not include any device that the resident chooses to use and is able to remove or avoid independently or any bandage material used for the purpose of binding a wound or injury.

Pursuant to F.S. 429.41(i)

The use of physical or chemical restraints. The use of Posey restraints is prohibited. Other restraints may be used in accordance with agency rules when ordered by the resident’s physician and consented to by the resident or, if applicable, the resident’s representative or designee or the resident’s surrogate, guardian, or attorney in fact. Such rules must specify requirements for care planning, staff monitoring, and periodic review by a physician. The use of chemical restraints is limited to prescribed dosages of medications authorized by the resident’s physician and must be consistent with the resident’s diagnosis. Residents who are receiving medications that can serve as chemical restraints must be evaluated by their physician at least annually to assess:

1. The continued need for the medication.
2. The level of the medication in the resident’s blood.
3. The need for adjustments in the prescription.

Pursuant to F.A.C. 59A-36.007(8)

Residents for whom a physician has prescribed a physical restraint must have a written care plan for the use of the physical restraint. The care plan must be developed within 14 days of the device being prescribed, and prior to use on the resident.

- a. The care plan must specify:
 - The device prescribed for use,
 - The maximum amount of time the resident is to have the restraint applied each day; and
 - In what manner and frequency staff will monitor, observe, and report to the physician any injuries, increase in agitation, signs, and symptoms of depression, or decline in mobility or function related to the use of the prescribed restraint.

Facility staff must ensure that the device is applied appropriately and safely.

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CONTINUED**

The resident's physician must review the appropriateness of continued use of the physical restraint annually, and documentation of this review must be maintained in the resident's record. If the resident's ability to independently remove or avoid the device fluctuates, the device must be considered a physical restraint and all requirements of this subsection apply.

I consent to the following as prescribed for my use by my physician. I am unable to remove or avoid it independently.

- HALF-BED RAILS** **FULL-BED RAILS**
 RECLINER CHAIR **RECLINER CHAIR WITH TRAY**
 WHEELCHAIR WITH SEAT BELT
 FULL-SIDE RAIL BUMPERS
 OTHER: _____

Resident/Legal Guardian/ Responsible Party

Date

Assisted Living Facility Administrator/Owner

Date