6.3 Nursing Administration

6.3.8 The resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.

6.3.8.1 The resident's comprehensive assessment shall document the medical symptom(s) potentially requiring the use of restraints.

6.3.8.2 The facility shall follow a comprehensive, systematic process of evaluation and care planning to ameliorate medical and psychosocial indicators prior to restraint use.

6.3.8.3 The resident's care plan shall document the facility's use of interventions, such as modifying the resident's environment to increase safety, and use of assistive devices to enhance monitoring in order to avoid the use of restraints.

6.3.8.4 Should such interventions and assistive devices fail to provide for the resident's safety, a physician's written order permitting the use of restraints shall be required and shall specify the type of restraint ordered.

6.3.8.5 The facility shall be accountable for the safe and effective implementation of the physician's order permitting the use of restraints.

6.3.8.6 When the use of restraints has been implemented, the facility shall initiate a systematic process, on an ongoing basis, documented in the care plan, in an effort to employ the least restrictive restraint.

6.3.8.7 In an emergency, when the resident’s unanticipated violent or aggressive behavior places him/her or others in imminent danger, restraints may be used as a last resort to protect the safety of the resident or others, and such use shall not extend beyond the immediate episode.

9.0 Records and Reports

9.5 Incident reports, with adequate documentation, shall be completed for each incident. Adequate documentation shall consist of the name of the resident(s) involved; the date, time and place of the incident; a description of the incident; a list of other parties involved, including witnesses; the nature of any injuries; resident outcome; and follow-up action, including notification of the resident’s representative or family, attending physician and licensing or law enforcement authorities, when appropriate.

9.6 All incident reports whether or not required to be reported shall be retained in facility files for three years. Reportable incidents shall be communicated immediately, which shall
be within eight hours of the occurrence of the incident, to the Division of Long Term Care Residents Protection. The method of reporting shall be as directed by the Division.

9.7 Incident reports which shall be retained in facility files are as follows:

9.7.1 All reportable incidents as detailed below.

9.7.2 Falls without injury and falls with minor injuries that do not require transfer to an acute care facility or neurological reassessment of the resident.

9.7.3 Errors or omissions in treatment or medication.

9.7.4 Injuries of unknown source.

9.7.5 Lost items which are not subject to financial exploitation.

9.7.6 Skin tears.

9.7.7 Bruises of unknown origin.

9.8 Reportable incidents are as follows:

9.8.1 Abuse as defined in 16 Delaware Code, §1131.

9.8.1.1 Physical abuse with injury if resident to resident and physical abuse with or without injury if staff to resident or any other person to resident.

9.8.1.2 Any sexual act between staff and a resident and any non-consensual sexual act between residents or between a resident and any other person such as a visitor.

9.8.1.3 Emotional abuse whether staff to resident, resident to resident or any other person to resident.

9.8.2 Neglect, mistreatment or financial exploitation as defined in 16 Delaware Code, §1131.

9.8.3 Resident elopement under the following circumstances:

9.8.3.1 A resident’s whereabouts on or off the premises are unknown to staff and the resident suffers harm.

9.8.3.2 A cognitively impaired resident’s whereabouts are unknown to staff and the resident leaves the facility premises.

9.8.3.3 A resident cannot be found inside or outside a facility and the police are summoned.

9.8.4 Significant injuries.

9.8.4.1 Injury from an incident of unknown source in which the initial investigation or evaluation supports the conclusion that the injury is suspicious. Circumstances which may cause an injury to be suspicious are: the extent of the injury, the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma), the number of injuries observed at one particular point in time, or the incidence of injuries over time.
9.8.4.2 Injury which results in transfer to an acute care facility for treatment or evaluation or which requires periodic neurological reassessment of the resident’s clinical status by professional staff for up to 24 hours.

9.8.4.3 Areas of contusions or bruises caused by staff to a dependent resident during ambulation, transport, transfer or bathing.

9.8.4.4 Significant error or omission in medication/treatment, including drug diversion, which causes the resident discomfort, jeopardizes the resident's health and safety or requires periodic monitoring for up to 48 hours.

9.8.4.5 A burn greater than first degree.

9.8.4.6 Any serious unusual and/or life-threatening injury.

9.8.5 Entrapment which causes the resident injury or immobility of body or limb or which requires assistance from another person for the resident to secure release.

9.8.6 Suicide or attempted suicide.

9.8.7 Poisoning.

9.8.8 Fire within a facility.

9.8.9 Utility interruption lasting more than eight hours in one or more major service including electricity, water supply, plumbing, heating or air conditioning, fire alarm, sprinkler system or telephones.

9.8.10 Structural damage or unsafe structural conditions.

9.8.11 Water damage which impacts resident health, safety or comfort.