Virginia Department of Health

Office of Licensure and Certification

August 2004

Consumer Guide to Restraint Usage in Nursing Facilities

State and federal law and regulation prohibit the use of restraints on nursing facility residents unless the resident's medical condition requires the use of restraints. Restraint usage by facility staff for the purposes of convenience or discipline is a violation of law and regulation.

Nationally, restraint usage has been recognized as significantly contributing to the deterioration of a resident's physical and mental status. Potential negative outcomes of restraint usage include, but are not limited to:

- Decline in the resident's physical functioning (e.g., ambulation) and muscle condition;
- Contractures;
- Increased incidence of infections
- Development of pressure ulcers, delirium, agitation; and
- Incontinence.

Residents who are restrained face loss of autonomy, dignity and self respect, and may show symptoms of withdrawal, depression, or reduced social contact. Restraint usage can reduce independence, functional capacity and quality of life. Restraint usage may constitute an accident hazard as residents have been injured, sometimes fatally, attempting to get out of a restraint.

Therefore, the decision to apply restraints must be made cautiously.

A chemical restraint is a psychopharmacologic drug (a drug prescribed to control mood, mental status, or behavior) that is used for discipline or convenience, and not required to treat medical symptoms or symptoms from mental illness or mental retardation, that prohibit an individual from reaching his highest level of functioning.

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 that restricts freedom of movement or normal access to one's own body. "Freedom of movement" is defined as any movement a resident is capable of and wishes to perform. Physical restraints include, but are not limited to: (i) leg restraints, (ii) arm restraints, (iii) hand mitts, (iv) soft ties or vests, (v) lap cushions, and (vi) lap trays the resident cannot remove easily. Also included as restraints are practices that meet the definition of a restraint, such as:

- Using side rails to keep a resident from voluntarily getting out of bed;

- Tucking in, or using hook and loop fasteners, e.g., Velcro®, to hold bedding or clothing tightly so that a resident's movements are restricted.

- Preventing a resident from rising from a chair by using trays, tables, bars or belts that the resident cannot easily remove;

- Using any chair that restricts a resident's movement or access to their body, and

- Preventing a resident from vacating a chair or rising from bed by placing the chair or bed too close to a wall.

A resident's medical symptoms should be viewed in the context of the resident's condition, circumstances, and environment, not viewed in isolation. The facility must determine the presence of a specific medical symptom that would require the use of restraints, and how the use of restraints would treat the medical symptom, protect the resident's safety, and assist the resident in attaining or maintaining his or her highest practicable level of physical and psychosocial well-being.

Facilities are required to *continually* explore and utilize least restrictive alternatives to restraints and plan how best to reduce the time that a resident is restrained. Interventions that a facility might incorporate in care planning include, but are not limited to:

- Providing restorative care to enhance abilities to stand, transfer, or walk safely;
- Providing a device, such as a trapeze, to increase a resident's mobility in bed;
- Lowering the bed and surrounding it with soft mats;
- Equipping the resident with a device that monitors his or her attempts to rise;
- Providing frequent monitoring by staff with periodic assisted toileting;
- Furnishing visual and verbal reminders to use the call bell;
- Providing exercise and therapeutic interventions, based on individual assessments and care planning that may assist the resident in achieving proper body position, balance and alignment, without the potential negative effects associated with restraint use; and
- Modifying the resident's environment or routine to allow for close observation by staff.

  Note: A device may have the effect of restraining one individual but not another, depending on the individual resident's condition and circumstances.

Facilities must fully inform a resident of the potential risks and benefits of all options under consideration, in the context of the resident's condition and circumstances, including the use of a restraint, not using a restraint, and alternatives to restraint use. The resident has the right to accept or refuse use of restraints. In the case of a resident who is incapable of making a decision, the legal representative may exercise the same right based on the information that would have been provided to the resident. However, a resident's legal representative cannot give permission to use restraints for the sake of discipline or staff convenience or when a restraint is not necessary to treat a resident's medical symptoms. In other words, a facility *cannot* use restraints in violation of the law and regulation based solely on a legal representative's request or approval.

If a resident is restrained, a nursing home must provide all the care that is necessary to prevent the decline that may occur with the use of physical restraints.

Side rails

All side rails are devices but only some devices are restraints. Residents who attempt to exit a bed through, between, over or around side rails are at risk of injury or death. The potential for serious injury is more likely from a bed with raised side rails than from a fall from a bed where side rails are not used. Side rails may also increase the likelihood that a resident will spend more time in bed and fall when attempting to transfer from the bed.

To determine whether a side rail is a restraint, a facility must conduct an individual resident assessment and, by using the care planning process, identify the safety issue and/or medical symptoms supporting its use as the least restrictive way to address the issue. Half rails are NOT restraints *if*:

1. They do not prevent the resident from moving in ways the resident would otherwise be able to move;
2. They are used by a resident for bed mobility, repositioning, transferring, etc;
3. They support or facilitate the resident's highest practicable level of physical functioning and may contribute to the resident's psychosocial well-being by enhancing independence and mobility.

A side rail may have the effect of restraining one individual but not another, depending on an individual resident's condition and circumstances. For example, partial rails may assist one resident to enter and exit the bed independently while acting as a restraint for another.

The Centers for Medicare and Medicaid Services (CMS) considers ¾ side rails, or any combination of side rails that cover ¾ of a resident's bed, to be full bedrails. All side rails, whether restraints or enablers, should be considered accident hazards. Some residents (e.g., those who are frail, very thin, or have agitated behavior or uncontrolled movements) are at risk for injury using side rails. Facilities must take affirmative actions to eliminate the hazard or minimize the risk as much as possible. Each resident must be assessed individually to identify *all* safety problems and the *least* restrictive methods to solve them.

As with other physical restraints, for residents who are restrained by side rails, it is expected that the process facilities employ to reduce the use of side rails as restraints is systematic and gradual to ensure the resident's safety while treating the resident's medical symptom.

Resources

We want to emphasize that State and Federal laws prohibit the use of restraints except when necessary to treat medical symptoms. The following resources are available to assist you with state and federal requirements:

1. Section 32.1-138.A.8 of the Code of Virginia

2. Section 12 VAC 5-371-330 (Restraint Usage) of " The Rules and Regulations for the Licensure of Nursing Facilities"

3. Section 483.13 of Title 42 of the Code of Federal Regulations

4. "Restraint Usage in Nursing Facilities" guideline

This information provides an overview about state and federal laws and regulations regarding restraint usage. If you have any questions, please contact the Division of Long Term Care Services at (804) 367-2100.

1. Section 32.1-138 of the Code of Virginia

§ 32.1-138. Enumeration; posting of policies; staff training; responsibilities devolving on guardians, etc.; exceptions; certification of compliance. - A. The governing body of a nursing home facility required to be licensed under the provisions of Article 1 (§ 32.1-123 et seq.) of this chapter, through the administrator of such facility, shall cause to be promulgated policies and procedures to ensure that, at the minimum, each patient admitted to such facility: …;

8. Is free from mental and physical abuse and free from chemical and, except in emergencies, physical restraints except as authorized in writing by a physician for a specified and limited period of time or when necessary to protect the patient from injury to himself or to others;

2. Section 12 VAC 5-371-330, Restraint Usage "Rules and Regulations for the Licensure of Nursing Facilities"

A. A resident shall 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.

B. Restraints shall only be used:

1. In accordance with the comprehensive assessment and plan of care, which includes a schedule or plan of rehabilitation training enabling the progressive removal or the progressive use of less restrictive restraints when appropriate; and

2. As a last resort, after completing, implementing, and evaluating the resident's comprehensive assessment and plan of care, when the nursing facility has determined that less restrictive means have failed.

C. If a restraint is used in a nonemergency, the nursing facility shall:

1. Explain the use of the restraint, including potential negative outcomes of restraint use, to the resident or his legal representative, as appropriate;
2. Explain the resident's right to refuse the restraint;
3. Obtain written consent of the resident. If the resident has been legally declared incompetent, obtain written consent from the legal representative; and
4. Include the use of restraint in the plan of care.

D. Restraints shall not be ordered on a standing or PRN basis.

E. Restraints shall be applied only by staff trained in their use.

F. At a minimum, for a resident placed in a restraint, the nursing facility shall:

1. Check the resident at least every 30 minutes;
2. Provide an opportunity for motion, exercise and elimination for not less than 10 minutes each hour in which a restraint is administered; and
3. Document restraint usage, including outcomes, in accordance with facility policy.

G. Emergency orders for restraints shall not be in effect for longer than 24 hours and must be confirmed by a physician within one hour of administration. Each application of emergency restraint shall be considered a single event and shall require a separate physician's order.

H. Temporary restraints may be used for a brief period to allow a medical or surgical procedure, but shall not be used to impose a medical or surgical procedure which the resident has previously refused.

I. The nursing facility shall notify a resident's legal representative, if any, or designated family member as soon as practicable, but no later than 12 hours after administration of a restraint.

J. Chemical restraint shall only be ordered in an emergency situation when necessary to ensure the physical safety of the resident or other individuals.

K. Orders for chemical restraint shall be in writing, signed by a physician, specifying the dose, frequency, duration and circumstances under which the chemical restraint is to be used. Verbal orders for chemical restraints shall be implemented when an emergency necessitates parenteral administration of psychopharmacologic drugs, but only until a written order can reasonably be obtained.

L. Emergency orders for chemical restraints shall:

1. Not be in effect for more than 24 hours; and

2. Be administered only if the resident is monitored continually for the first 15 minutes after each parenteral administration (or 30 minutes for nonparenteral administration) and every 15 minutes thereafter, for the first hour, and hourly for the next eight hours to ensure that any adverse side effects will be noticed and appropriate action taken as soon as possible.

NOTE: A copy of the complete "Rules and Regulations for the Licensure of Nursing Facilities" is available on the OLC web site at: www.vdh.virginia.gov/olc or by calling the Division of Long Term Care at (804) 367-2100.

3. Section 483.13 of Title 42 of the Code of Federal Regulations

Sec. 483.13 Resident behavior and facility practices.

(a) Restraints. 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.

4. "Restraint Usage in Nursing Facilities" Guideline is available at: http://www.vdh.virginia.gov/OLC/Laws/index.htm, under nursing facilities