

RESTRAINTS

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REGULATORY FOCUS BULLETIN

FILE TOPIC: Restraints

A resident is weak, unsteady on her feet, and confused. The physician, family and care team have "weighed the risks and benefits" and decided it would be best to use physical restraints. When the resident begins to regain her strength, her confusion lessens, and the staff feels more comfortable with her ambulating independently, and the staff discontinues use of the restraint. If the resident then falls and breaks her hip, is the staff liable?

It is not within the parameters of the RFB Committee to address legal issues providers may encounter. Initiation and/or discontinuing a physical restraint must be based on the resident's medical needs and must be ordered by a physician. The answer to this question depends on many factors, such as whether the facility was acting in accordance with a physician's order in removing the restraint, whether the physician acted properly in issuing such an order, whether both the order and the resulting action were consistent with the standard of care, and so forth. Physicians and facilities both have a duty to residents to act with care and in accord with the standard of care. Whether that duty has been met depends on the unique facts of each case. It is impossible to predict accurately in any specific case whether a facility will incur civil liability for injuries to a resident.

An individual caregiver's liability is a legal matter determined in litigation on a case by case basis.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Restraints

A provider is trying to reduce restraints by means of lesser methods. What is the legal implication for the provider if the resident falls under lesser method when a physician's order on the chart calls for a more restrictive restraint? How should the provider handle this potential situation with a physician?

It is not within the parameters of the RFB Committee to address legal issues providers may encounter. However, the facility must assess and implement least restrictive measures, as appropriate. If the physician is insistent that a more restrictive restraint be used, documentation must support the medical necessity, as well as involvement of the resident, family member or legal representative. Where conflicts arise, involvement by the medical director may be necessary.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Restraints

What if an Alzheimer's resident constantly wanders to the point of exhaustion? Can the resident be restricted at times so he/she can get some rest?

There are times when restraints may be appropriate. The resident care planning process should provide for an assessment need under differing circumstances or resident behavior patterns and care plan accordingly. The care plan should be specific regarding times for restraint usage.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Restraints

Can a facility be cited for using a restraint that is made by a different manufacturer than one cited in the physician's order?

Restraint orders are to be specific as to type versus brand name of a restraint used. An order such as "Posey Restraint when OOB (out of bed) in chair" is not acceptable because it indicates the manufacturer, not the type of restraint.

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FILE TOPIC: Restraints

Regarding the statement in surveyor guidance regarding "did the resident or legal representative consent to use of restraints and is this documented" - what specific consent is the surveyor looking for?

Specific consent regarding restraint use must be obtained from the resident or legal representative at the time a decision to utilize a restraint is made by the interdisciplinary team. There is no requirement that this consent be documented in any specific format but there must be evidence that discussions have taken place.

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FILE TOPIC: Restraints

Can a resident be restrained in a non-mobile chair or is the facility required to use only chairs with wheels for restraining?

Regulations do not govern the type of chair selected by the care planning team.

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FILE TOPIC: Restraints

Is a geri-chair a restraint if you take the table/tray off? What if the resident can't move but wants the geri-chair table/tray to hold personal items (e.g., tissues)? Would the use of a geri-chair for meals and activities be considered a restraint or an enabler?

When geri-chairs are utilized with or without the table/tray to restrict freedom of movement or mobility, they are considered restraints. In the event that the geri-chair is used as a positioning device for an immobile resident (or the tray used at the resident's request per se), all measures to prevent functional decline must be implemented including, but not limited to, release and repositioning. In both circumstances, the use of the geri-chair must be incorporated into the care planning process.

When geri-chairs are utilized with or without the table/tray, the facility should apply the definition of a restraint. The definition for a physical restraint according to the Medicare State Operations Manual, Appendix PP and the Resident Assessment Instrument manual is, “Physical Restraints” are defined as 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 which restricts freedom of movement or normal access to one’s body”. So, if the geri chair meets the definition of a restraint, staff should code it as a restraint and the Resident Assessment Protocol will explain the use of the device. There are ways to hold personal items other than a table top on the geri chair. The care plan should also clearly define its use.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Restraints

What is acceptable evidence of consultation with appropriate health professionals (i.e., physical therapists, occupational therapists, etc.) in the use of less restrictive supportive devices prior to using physical restraints?

Evidence of consultation with appropriate health professionals includes interdisciplinary notes, assessments and care plans.

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FILE TOPIC: Restraints

A physician's order reads "may restrain with geri-chair with tray and/or vest restraint for resident's safety." Is it possible for the charge nurse to apply a lesser restraint (e.g., soft waist) without a new physician's order?

No. If, after evaluating the resident, the nurse determines that a less restrictive restraint is appropriate, the physician must be advised and a change in the restraint order obtained.

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FILE TOPIC: Restraints

Can surveyors "mark" restraints?

No. Surveyors should make continuous observations to determine if the physician's order or care plan approaches are being implemented.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Restraints

What do you do if a resident's family requests restraints even though they have not been ordered by the physician?

Restraints are applied after a thorough assessment of the need to treat a medical symptom, a trial of less restrictive measures, and only with a physician's order. Restraints are not to be applied solely at the request of a family member.

The facility should consult and educate the family about why a restraint is not used or a restraint is being reduced. The facility should have a systemic method for reducing or removing restraints with family participation. The facility should have clear policies and procedures concerning the use of restraints, reduction and removal. This should be shared with the resident/family/responsible party upon admission and periodically throughout the resident's stay.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Restraints

Can restraints be tied to the siderails of beds?

No. Restraints are not to be tied to siderails. Siderails can slip and fall, causing serious injury to the resident.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Restraints

If a resident is in a geri-chair and is wearing a vest restraint, is this a "double restraint" and therefore a violation of the resident's rights?

There is no regulatory terminology that refers to "double restraints." We would really discourage the use of vests in any situation. If it is determined to be medically necessary, it would be used as an exception. This issue would be surveyed from the perspective of compliance with restraint usage.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Restraints

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REGULATORY FOCUS BULLETIN

FILE TOPIC: Restraints

Can a resident who is alert and oriented be restrained because the family wants him/her restrained? Can the family refuse restraints on the behalf of an alert and oriented resident?

No. An alert, oriented resident who is his own legal representative has the right to make decisions regarding restraints regardless of family opinion.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Restraints

How do we address restraints on care plans?

Interpretive Guidelines for the restraint requirement §483.13(a) at tag numbers F221 describe in detail the factors which the facility should consider in determining when and how to utilize restraints as well as considerations for care planning.

An entire section of the interpretive guidelines for restraints is devoted to assessment and care planning for restraint use.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Restraints

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REGULATORY FOCUS BULLETIN

FILE TOPIC: Restraints

Is a reclining chair a restraint? Do you need to have a physician's order?

The federal regulations define a restraint as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body which the resident cannot easily remove, which restricts freedom of movement or access to his or her body. The Interpretive Guidelines at §483.13(a), F221 state, "When coupled with appropriate exercise, therapeutic interventions such as pillows, pads or removable lap trays, are often effective in achieving proper body position, balance and alignment, and preventing contractures without use of restraints." This language indicates that such pillows, pads, lap trays, etc. may not be considered restraints in some cases. Instead, they may be viewed as alternatives to restraints.

If a reclining chair restricts the resident's body so that he or she cannot easily move, and the resident cannot remove the restriction easily, then the reclining chair would be considered a restraint and would require a physician's order. Because of the manner in which the federal regulations define restraint, each resident must be assessed on an individual basis to determine if the device being used meets the federal definition of restraint.

When residents are physically incapable of initiating any voluntary movement and the reclining chair is an alternative to bedrest, the reclining chair is not considered a restraint.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Restraints

Are bed cover retainers restraints?

The bed cover retainers are not considered a restraint when applied to assist the resident in maintaining privacy and dignity by insuring proper covering of the resident. However, when bed cover retainers are applied and limit the resident's freedom of movement or a resident's access to his or her body, then the bed cover retainer would be considered a restraint.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Restraints

Can a positioning pillow be used at the facility without being considered a restraint? The pillow slides under the arms of a wheelchair and fits snugly but can be pushed out of place with minimal effort. Does the facility need a physician's order to use this type of positioning device?

The federal regulations define a restraint as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body which the resident cannot easily remove, which restricts freedom of movement or access to his or her body. The accompanying Interpretive Guidelines at tag number F221 state, "When coupled with appropriate exercise, therapeutic interventions such as pillows, pads or removable lap trays, are often effective in achieving proper body position, balance and alignment, and preventing contractures without use of restraints."

This language indicates that such pillows, pads, lap trays, etc. may not be considered restraints in some cases. Instead, they may be viewed as alternatives to restraints. However, because of the manner in which the federal regulations define restraint, each resident must be assessed on an individual basis to determine if the device being used meets the federal definition of restraint. If the positioning pillow described in the question is easily removable by the resident, it would not meet the definition of restraint. As such, no physician's order is required for the use of the devices.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Restraints

What is to be done when a resident emergency occurs which calls for a physical restraint, but there are no physician's orders for a restraint?

When a resident emergency occurs for which a restraint is necessary to alleviate an immediate and serious danger to the resident or other persons in the facility, minimum effective restraint measures may be applied for brief periods in accordance with nursing judgment when it is not possible to contact the physician to report the significant change in the resident's condition and obtain instructions from the physician. Orders for emergency use must be obtained or confirmed in writing as soon as possible. Refer to federal interpretive guidelines for tag F221. The facility should have policies and procedures that address these situations.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Restraints

Are siderails considered a restraint? What if the facility has the half siderails like in hospitals and the resident can still get out of bed without putting them down? Do we need a release signed? Is a siderail considered a restraint or a safety device?

Interpretive Guidelines for the restraint requirement §483.13(a) at tag number F221 address side rail usage.

The Resident Assessment Instrument manual also addresses side rails on page 3-198-202.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Restraints

A resident's mental capacity is such that they are unable to understand, retain or utilize safety techniques and training so as to prevent self-injury such as falling. The person's gait is unsteady and she is in constant motion. Would the use of a restraint be appropriate under federal guidelines for this resident? The resident is diagnosed with Alzheimer's.

Restraints are only appropriate when required to treat medical symptoms and when less restrictive measures have been ruled out. Restraints can never be used for purposes of discipline or convenience. When determining medical necessity for restraints, causal factors must be considered.

Given the causal factors and the absence of a way to remove them, the risks and benefits of restraint usage must be determined and explained to the resident (surrogate when appropriate). If the risks are great for self inflicted injuries, pain and suffering, i.e., fractures, head and facial injuries, or surgery restraint use may be warranted.

The least restrictive intervention that will enable a resident to attain or maintain his/her highest practicable level of functioning should be employed. Restraints can have negative impacts. Restraints can be an accident hazard, a serious affront to the dignity of the resident, and they can lead to urinary and fecal incontinence, pressure sores, loss of muscle tone, loss of independent mobility, increased agitation, loss of balance, symptoms of withdrawal or depression, reduced social contact, and decreased appetite.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Restraints

When is the use of a mechanical or physical device attached or adjacent to the resident's body that restricts movement considered to be an enabler?

Restraining devices are considered to also be enablers when they enhance functional ability in the least restrictive manner.

Examples include but are not limited to:

1. A seated walker when, without its use, the resident's mobility would be further restricted or risk for injury increased.
2. A reclining chair when, without its use, the resident's condition would limit their positioning to a bed or wheelchair.
3. Devices that enable residents to maintain optimal anatomical position to prevent discomfort and/or deformities caused by immobility such as contractures, e.g., positioning is enhanced by supporting the pelvis or upper trunk or extremities.

If these enabling devices are used when residents cannot remove or release themselves, the same assessment and planning process must be used to determine that their use is least restrictive and medically justified as with a device that is used solely to restrict movement. Documentation must support the assessment, planning and evaluation. The facility should code the device as a restraint under Section P4 of the MDS. The resident assessment protocol should then explain the use of the device as an enabler.

For bedrails, it is also helpful to refer to the definition found in the Long Term Care Facility Resident Assessment Instrument (RAI) User's Manual, Chapter 3, Item G-6, Modes of Transfer. "Bed rail(s) used for bed mobility or transfer -- refers to any type of side rail(s) attached to the bed USED by the resident as a means of support to facilitate turning and repositioning in bed, as well as for getting in and out of bed. **Do not check this item if resident did not use rails for this purpose.**

REGULATORY FOCUS BULLETIN

FILE TOPIC: Restraints

DATE: January 1996

What are some examples of restraint reduction?

Restraint reduction must be a result of assessment and planning for each individual resident. If discontinuance of a restraining device is ruled out based on the resident's medical condition, the speed and degree of reduction that is implemented is driven by the individual resident's need.

Examples include but are not limited to:

1. Reducing gradually the amount of time the resident is restrained and increasing the unrestrained periods based on the observations made during the time the restraint is off. Restraints are logically removed during periods of increased observation.
2. Trying an alternative device that is less restrictive such as orthotic devices or a different type of chair in the place of a vest restraint.

Documentation must support the assessment and determination of the resident's medical indication or need for restraints and the rationale for the reduction process chosen. A thorough review of the Resident Assessment Protocol (RAP) for restraints as well as a thorough review of the interpretive guidelines for §483.13(a) Tags F221 and F222 are essential to an appropriate assessment process.

The Carolinas Center for Medical Excellence has resources on line.

<http://www2.thecarolinascenter.org/ccme/>

The regional ombudsman may also provide restraint reduction resources.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Restraints

Please define assistance devices and supervision in relation to Tag F323.

The interpretive guidance at §483.25(h)(1) and (2) for accidents and supervision define these terms.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Restraints

If a resident has had a physical therapy evaluation for restraints prior to the time of discharge and is readmitted a month later - does the resident need a new physical therapy evaluation or is it permissible to pull the old physical therapy evaluation from medical records and update it?

There is no requirement for a physical therapy evaluation per se. The determination as to the need for a new resident assessment must be based on the guidelines for significant change and facility policy. The need for repeating the restraint evaluation would be based solely on the interdisciplinary team's findings. This team should include the physician and the resident (and/or family representative). The team will determine whether the previous P.T. evaluation continues to meet the needs of the resident.

If the previous P.T. evaluation is utilized by the team, it may be copied from the old record to be signed and dated as an entry into the new record. It should be reviewed to determine if it is still current to meet the resident's needs.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Restraints

If a physician orders a restraint (chemical or physical), can the provider then use the restraint or does the facility have to prove that they have tried less restrictive measures? What if the physician is insistent on the restraint only? What about potential conflict of facility staff practicing medicine?

State law and federal regulation prohibits the use of restraints for purposes of discipline or convenience, and allows restraints to be used only to treat a medical need. State law also requires that the facility conduct an evaluation to ensure that the least restrictive means of restraint are used on those residents who require restraints.

Therefore, before using a particular restraint ordered by the resident's physician, the facility must evaluate the resident to determine whether the resident requires a restraint and, if so, whether there is a less restrictive restraint than the particular restraint ordered by the physician. If the resident's evaluation shows that a restraint is needed, but that there is a less restrictive restraint than the restraint ordered by the physician, the physician should be advised accordingly. If the physician insists that an inappropriate restraint be used, it may be necessary to involve the medical director or others to convince the resident's physician to change his/her order. If the physician still insists on an inappropriate restraint, the facility has the right, after informing the resident or responsible party, to seek an alternative physician. The licensure rules require physicians to follow state and federal requirements for physician's services to insure that the resident receives appropriate care and treatment.