Restraints & Falls: Legal Perspective

Very few legal cases support action against nursing homes based solely on a failure to restrain or not restrain. Lawsuits are being won for harmful outcomes from using restraints; but fewer and fewer are won for harmful outcomes from non-use of restraints. Risk management strategies eliminating or reducing restraint use best serve the legal interests of nursing homes.

CMS has stated that the real liability is a lack of care regarding fall risk. Proper care revolves around individualized assessment of fall risk followed by appropriate intervention. Most negative outcomes resulted from substandard monitoring and supervision, lack of documentation to support the care plan, or failure to identify and/or use appropriate alternatives to restraints.

Before a restraining device can be used, the home must demonstrate that a medical reason exists that requires its use. Documentation must show how the restraint will be used to treat the cause of the medical reason and how the restraint would assist the resident to reach the highest level of physical and psychosocial well-being. A restraining device may only be used for the time needed to treat the symptom and care must meet regulatory standards.

Families may request a restraint be used, usually for safety. It is the home’s responsibility to assess whether that request is appropriate. Homes may rely on a consent form, falsely believing that the form relieves them of the responsibility for using a restraint. However, there is no legal directive for use of a consent form. Signed consent forms do not free the facility from meeting the requirements for restraint use.

Until the public understands the benefits of not using restraints, homes need to protect themselves. What can you do? Educate the resident and family before admission. Educate your staff. Follow accepted standards of practice.

Defense perspective:
The most common causes of nursing home litigation are falls with injury. Allegations usually involve

• Failure to assist and attend
• Failure to properly use a restraint
• Failure to properly use side rails
• The partial restraint was inadequate.

Allegations involving use or non-use of restraints most often include:

• Injuries due to use of restraints (most commonly strangulation or severe injury)
• Failure to properly apply the restraint or follow the physician’s order regarding the restraint.

The following are suggested defenses and preventive actions that should be in place. Of course, the best defense is good care processes and prevention:
## POTENTIAL DEFENSES | PREVENTIVE ACTIONS

### FALLS

**Federal and state regulations prohibit the use of restraints except as necessitated by the medical condition of the resident and as ordered by the physician.**

- Proper documentation of resident condition indicates the need for a restraint.
- Proper documentation of physician’s order with statement of medical necessity.

**The facility complied with federal and state regulations and the facility’s policies and procedures (P&P) manual.**

- Regular reviews and updates of policy and procedure (P&P) manuals are conducted and dated for compliance with regulations.
- A fall prevention/management program is in place and kept current to clinical practice guidelines. The guideline followed is identified in the P&P.
- Conduct regular reviews of P&P with all staff.
- Conduct, document regular spot-checks of staff for compliance with falls P&P.

**There was no order for a restraint by the physician, or, in the alternative, if there was an order, circumstances at the time of the occurrence did not permit the use of a restraint.**

- Base-line documentation of resident’s behaviors and daily activities in place and up-to-date.
- Incidence reports filled out completely. If these reports are internal only, be sure facility has policy for this.
- Quality assurance committee demonstrates timely follow-up for incidents, with failure mode and effects analyses, root cause analyses, and the relevant improvement measures in response to the incident.

**The family and/or resident did not give the appropriate permission for the use of restraints.** (Documents supporting this defense are usually found in the resident’s acknowledgment of receipt of the resident’s bill of rights, the contract, and the resident’s business file.)

- Thorough documentation of family/resident education with their responses. Obtain consent for either use or non-use if possible during the discussion.
- Dated documentation of attempts to communicate with family regarding medical needs and responses if received.

**The resident had a history and tendency of falling that was addressed in the resident’s care plan, which included an overview and assessment of the resident’s condition.**

- The care plan addresses all identified risk factors for falls with interventions.
- Documentation of attempted interventions for risk factors and if they worked or not (if an intervention is not appropriate for the resident, state why).
- Proper documentation (including incidence reports) of falls and outcomes.
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| Reasonable procedures were used to prevent the fall while still allowing the resident the least restricted environment. | • Interventions are addressed in the care plan, including the monitoring plan.  
• QA program to address non-clinical issues (environmental safety).  
• Regular assessment of staff performance is done (and documented) to demonstrate compliance with the care plan.  
• Document how the intervention is the least restrictive for that resident. What is the impact of more restrictive interventions? |
| The resident was receiving adequate assistance from the facility staff and transferring when the accident occurred. | • Competency checks of staff for proper transfer techniques done regularly.  
• Documentation and care plan reflects amount of assistance resident requires.  
• Staffing is appropriate for the resident’s identified level of care. |
| If the fall was caused by equipment malfunction, the equipment was properly maintained and had no prior history of a malfunction. | • Policy in place for, and records reflect, regularly scheduled safety checks of equipment, including bed systems.  
• Staff training for safe operation of devices is provided by manufacturer; i.e., lift, special chair, bath tubs… |

### RESTRAINTS

| Restraint was ordered by a physician. Order and physician’s notes document the justification for the restraint order. | • Proper documentation of physician order for use of the device including the purpose and frequency of use.  
• Identify how the device benefits the resident in physician’s notes |
| --- | --- |
| Restraint ordered was appropriate for the resident’s condition and/or personal safety. | • Conduct individualized and ongoing resident assessment by an interdisciplinary team, resident and family.  
• Identify the resident at risk for injury/entrapment and falls and indicate if the resident could benefit from restraint use.  
• Identify medical symptoms for which the restraint is to be used. Symptoms can be temporary or long-term resulting from conditions that require the use of particular devices for safety or treatment. (Symptom: Any subjective evidence of disease that is experienced by an individual. Anxiety, lower back pain, and fatigue are all symptoms) |
### POTENTIAL DEFENSES

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| Type of restraint used was in compliance with the physician's order for the restraint. | - Documentation should reflect the name of the device and manufacturer.  
- If device is called by different names (commercial/manufacture/medical name), have backup documentation to justify the name used for the device. |
| Restraint was properly applied and in compliance with the physician's order.  | - Check the proper application that is addressed in the care plan regularly.  
- Documentation reflects that this is carried out as care planned.                                                                                       |
| Restraints were checked and released on a regularly scheduled basis in compliance with physician's order. | - Address restraint reassessment in the care plan.  
- Screen and release the devices per physician order and nurse judgment.  
- Check the following upon screening and releasing: skin condition, posture and position for comfort; alignment, proper application and position of the device. |
| All federal/state regulations relative to restraint use were complied with   | Assessment should include:  
- Reason for use. What are the medical symptoms?  
- What are the benefits? (benefits can include physical and psychosocial aspects)  
- Is it temporary to treat the medical conditions?  
- How often should the facility evaluate the effectiveness of the devices?  
- Before using the devices, are there referrals to other care providers (PT/OT/ST/) to assess for least restrictive devices?  
- Does facility provide other special services (restoratives, activities) to reduce period of use?  
- What interventions will be put into place to compensate for activity prohibited by the restraint (e.g. additional assisted ambulation, ROM, socialization, etc) |
| - Regulations prohibit using restraints for convenience.  
- Restraints may be used only to treat medical symptoms.  
- Regulations require that if a restraint is needed, the facility must use the least restrictive restraint. |                                                                                                                                                         |
| The staff was educated in the proper application of restraint use and monitoring. | - Evidence of staff in-services/training for the device application. This can be done by vendor representatives, nurses, therapist, depending on the devices.  
- Evidence of competency checks to be sure staff has an understanding of the proper restraint application.                                                   |
| The need for the restraint and the risks for using the restrictive device were addressed in the care plan and authorized by the resident and/or family. | - Obtain consent for use (however, facility is still responsible for restraint, assessment and care).  
- Provide the clinical/medical information for the resident and/or family including benefits and risks.  
- Document that the information was provided.                                                                                                               |
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<td>Even if the restraint was properly applied, injury could occur if the resident</td>
<td>• Monitor and identify risks involved during the use of the device.</td>
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<td>loosened portions of the restraint (this can be established by expert testimony).</td>
<td>• Underlying conditions that might place the resident at risk for injury/entrapment, include: cognitive/mental status changes, incontinence, pain level and extent of pain control, lack of muscle control, physical deformities, inability to communicate needs or problems, alteration of sleeping habits and bedtime routines/customs, unfamiliar sleeping environment or change in accessibility of surroundings, distance from bed to toilet, level of resident independence (ability to safely toilet, get in and out of bed), residents who meet fall risk criteria, appropriateness of bed for resident needs, level of caregiver support resident requires, presence of medications, sedation, or prepping agents that increase risk.</td>
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<td>• Regular and ongoing equipment assessment (i.e., of the bed system entrapment zones) provides a foundation upon which to reduce the risk of entrapment.</td>
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References


Other Resources


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