

**VETERANS HEALTH ADMINISTRATION**  
**Use of Physical Restraint for the Veteran at Risk of Falling/Fall-Related Injury**  
**Policy and Procedure Template**

**PURPOSE:**

The Veterans Health Administration (VHA) provides the necessary care and services to attain or maintain each veteran's highest practicable physical, mental, and psychosocial well being in accordance with their comprehensive assessment and plan of care. Such care minimizes the use of physical restraints in fall prevention. It is consistent with the VHA philosophy of individualized care that addresses each veteran's unique abilities, beliefs and values, health needs, and personal choices while promoting dignity, personal freedom, functional status, and safety. However, promotion of the highest level of physical functioning, including mobility, may possibly increase the likelihood of patient falls. The VHA recognizes that every fall cannot be prevented and, therefore, supports the use of fall risk interventions to reduce the feasible risk of falls and fall-related injury occurrence. Physical restraints inhibit an individual's voluntary movement and there are no studies supporting their efficacy in fall or injury prevention. The VHA policies and procedures supporting this standard of care are congruent with regulations and guidance promulgated by the Health Care Financing Administration (HCFA) and the Joint Commission for the Accreditation of Health Care Facilities (JCAHO). The VHA is working towards a restraint-free environment across the health care continuum.

**POLICY:**

The VHA strives toward restraint-free care through a process of planned change, Continuous Quality Improvement, evidence-based practice, an educated staff, and informed partners in care - veterans and their families. All health care team members, professional and non-professional, must work together to provide a safe environment designed to prevent falls and fall-related injury while reducing restraint use. The goal is to minimize the veteran's injury risk while promoting the VHA philosophy of individualized care. The Nursing and Patient Care Services of each VA facility is responsible for implementing this policy and procedure along with standardized fall risk assessment and standard and high-risk fall prevention intervention protocols. The Nursing Service is responsible to ensure the patient is informed of the patient safety plan that promotes restraint-free care and fall prevention.

**DEFINITION:**

Physical restraints are defined as “[a]ny manual method or physical or mechanical device, material, or equipment attached or adjacent to the [veteran/patient/resident’s] body that the individual cannot remove easily and which restricts freedom of movement or normal access to one’s body.” (USDHHS Surveyor Guidance, 2000; USDHHS Hospital Guidance, 2000) Examples include vest/chest restraints, wrist/arm or leg restraints, hand mitts, as well as waist belts/ties and lap trays or cushions that cannot be easily removed by the veteran. Under this functional definition, other devices or facility practices also may meet the definition of a restraint,

such as tucking in a bed sheet so tightly that a veteran's movement in or out of bed is restricted, or use of a specialty bed that limits a veteran from voluntarily exiting from bed. This definition considers siderails, regardless of size, as restraints if, on a case-by-case basis, they function to prevent a veteran from voluntarily transferring in or out of bed and cannot easily be lowered by the veteran.

**RESPONSIBILITY:**

*Institutional/Facility Wide Practices*

1. Use data collection practices that measure, evaluate, and reduce fall-related and restraint-related injuries as well as the overall use of restraints. Continuous Quality Improvement may be used to monitor non-injurious falls while Root Cause Analysis (RCAs) and Aggregate Review Teams (ARTs) are used to analyze etiologic factors contributing to falls resulting in serious injuries. These processes include an interdisciplinary team of clinical and administrative staff that result in recommendations for interventions.
2. Provide staff with continuing education on fall risk assessment, interventions (including alternatives to physical restraint and fall prevention equipment) to prevent falls, proper application of restraint, monitoring of the restrained veteran, methods to reduce restraint use, and documentation of these care practices.
3. Ensure availability and accessibility of resources and restraint-alternative interventions.
4. Implement communication systems to alert all appropriate staff of patient's fall risk status and fall history.

*Individualized Veteran Care*

1. All veterans entering VA facilities should be screened for fall and fall-related injury risk. A variety of validated tools are available. Each facility should select one tool to ensure a consistent measure of fall/injury risk. The Fall Risk Assessment Resource Guide is a recommended reference.
2. A thorough evaluation of specific fall/injury risk factors must be conducted and documented by the nursing staff, and, as needed, other members of the health care team if a veteran is assessed as at risk for falls/fall-related serious injury. If available, consultation with a fall prevention team or geriatric consultation team is encouraged. Every effort should be made to address risk factors responsive to treatment, such as underlying comorbidities and specific medications and/or the total number of drugs. Inform the patient/family of evaluation results. Ensure the patient and family are informed of the fall risk/prevention plan. Also, ascertain the meaning of the fall-related behaviors such as a need for control, independence or risk taking. Staff are referred to the Post Fall Assessment Protocol if this assessment is undertaken following a fall incident.

3. After addressing modifiable risk factors, attempt and document other individualized fall prevention strategies. References specific to fall prevention include the Resource Guide: Technology to Prevent Patient Falls and the Program Guide: Evidence-Based Fall Prevention. Possible interventions include, but are not limited to, the following:

- a. Supplying rehabilitation or restorative therapy to enhance the veteran's mobility and transfer abilities.
- b. Addressing the veteran's customary routines (for example, time for bed).
- c. Offering meaningful activity based on previous lifetime interests.
- d. Providing environmental or equipment modifications specific to individual veteran needs (a nightlight, commode at the bedside, room near the nurses' station, adaptive seating devices, bed height that facilitates transfer, for instance).
- e. Providing protective accessories such as a helmet or padded clothing.
- f. Promoting use of appropriate, nonskid footwear.
- g. Encouraging involvement of family/friends or paid companion.
- h. Monitoring and observing the veteran for assistance by staff.
- i. Furnishing visual and verbal reminders that prompt the veteran to ask for assistance verbally or to use a call bell.
- j. Use of over bed signage as alert for fall risk.
- k. Use of technology to reduce patient handling and promote safe patient movement.

#### *Use of Physical Restraint*

1. *Assess the Veteran for Restraint Use.* Physical restraints may be used only if documentation reflects the presence of a specific medical symptom warranting their use, how such restraint is used to treat the symptom, and how the restraint assists the veteran in attaining or maintaining his or her highest level of physical, mental, and psychosocial well being. Physical restraints must never be used as a mode of discipline, for staff convenience, or as a substitute for adequate staffing to monitor patients. The potential psychological consequences of restraint use in former prisoners of war should also be carefully considered in the decision to restrain. The Resident Assessment Protocol (RAP) for physical restraints should be used as a guideline in evaluating potential restraint use in the nursing home.

2. *Use the Least Restrictive Device.* Staff may consider use of physical restraints only after individualized interventions have been implemented and judged ineffective in preventing falls. If a physical restraint is used, it should be the least restrictive device to treat the veteran's medical symptoms and it should be used for the shortest possible duration. Restrictiveness is determined by the degree of mobility impairment.

3. *Evaluate the Veteran for Risk of Restraint-Related Injury.*

Evaluate the veteran for risk of restraint-related injury including asphyxiation and siderail entrapment. If appropriate, implement measures to prevent such injuries (increased staff

monitoring or closure of the gap between a siderail and mattress, for example).

4. *Address Potential Negative Consequences of Restraint Use.* Address other potential negative consequences of restraint use such as the physical effects of immobility (such as deconditioning or pressure ulcers) and psychological/social outcomes (for instance, agitation, depression, loss of dignity, or reduced social contact).

5. *Secure Informed Consent.* The decision to restrain also requires the veteran's informed consent (emergency care exception). Decisionally capable veterans, as well as the guardians/legal representative and/or family members of decisional-incapable veterans, have the right to be informed of the risks and benefits of restraint use and, possess the right to refuse their use. Further, informed consent requires that restraint alternatives be fully explained. Consistent with HCFA regulations, a veteran cannot be restrained solely because of a request by a family member, guardian or legal representative. When the veteran lacks decision making capacity and there is no surrogate decision maker or family member available, the case will be referred to the facilities' ethics committee.

6. *Require Written Order.* Physical restraint use requires a written order that specifies the type of restraint, when it is to be used, and the rationale for use. This order must be written by a qualified practitioner eligible to write such orders pursuant to medical staff bylaws and state licensure requirements. Order for restraints via protocol or signed policy statements are limited to the acute care setting in cases where a physician is not on site. The order will be time limited to not more than 24 hours in the acute medical-surgical setting and thirty days in the nursing home.

7. *Staff Training and Education.* Staff applying the physical restraint should be appropriately trained in their use and application. The restraint must be properly applied according to the manufacturer's instructions that should be properly maintained and stored by the facility.

8. *Monitoring the Restrained Veteran.* When a veteran is restrained, attention to comfort and safety, including nutrition, hydration, elimination, exercise, and social interaction needs is required. The ongoing monitoring of the restrained veteran should include, among other areas, the veteran's behavioral/clinical condition (e.g., observation flow sheet to document the veteran's skin integrity and neurovascular status, for example). Document the care provided to reduce the negative effects of restraint at least every hour in the acute care setting and every two hours in the nursing home.

9. *Address Decline in Veteran's Physical/Mental Status.* If the veteran demonstrates a decline in physical or psychological health status, staff should investigate if the deterioration is due to restraint and/or disease progression. If the restraint is the cause or contributing factor, the plan of care should reflect specific interventions attempted to regain health status and minimize further risk of decline.

10. *Gradual Process Towards Restraint Reduction.* Frequent attempts to reduce the period of time the veteran is restrained or to eliminate the restraint should be conducted with specific criteria for removal of the restraint based on each veteran's individual condition. Restraint use should trigger ongoing evaluation and treatment aimed at understanding and treatment of the medical symptom(s) that precipitated its' use. The periods of non-restraint and the veteran's reactions should be documented.

11. *Post-Restraint Care.* To minimize psychological effects, the veteran should be debriefed, that is, provided with an opportunity to discuss the experience of being restrained.

12. *Documentation.* Documentation of the comprehensive assessment, least restrictive alternatives attempted, the specific medical symptom(s), the rationale for physical restraint use, a signed consent form, the written order for restraint use, and the plan for gradually reducing or eliminating restraint use should be recorded in the medical record. The veteran's record also should reflect the use of restraints (type, size, and period of time), care of the veteran while restrained, and the veteran's response to restraint application, reduction, or elimination.

13. *Restraint-Related Injury/Death.* In a circumstance when a restraint/siderail is implicated in an injury or death of a veteran, there are specific reporting requirements, which include immediate notification of the attending physician, nursing supervisor, and the facility risk manager. The latter will be responsible to report the case to the FDA and the manufacturer. In cases of death, the attending physician will notify the medical examiner.

#### **REFERENCES :**

Braun, J.A. & Capezuti, E. (2000). The legal and medical aspects of physical restraints and bed siderails and their relationship to falls and fall-related injuries in nursing homes. DePaul Journal of Healthcare Law, 4 (1) 1-72.

Capezuti, E., Evans, L., Strumpf, N., & Maislin, G. (1996). Physical restraint use and falls in nursing home residents. Journal of the American Geriatrics Society, 44, 627-633.

Capezuti, E., Strumpf, N., Evans, L., Grisso, J.A., & Maislin, G. (1998). The relationship between physical restraint removal and falls and injuries among nursing home residents. Journal of Gerontology: Medical Sciences, 53A, M47-M53.

Capezuti, E., Talerico, K.A., Strumpf, N., & Evans, L. (1998). Individualized assessment and intervention in bilateral siderail use. Geriatric Nursing, 19 (6), 322-330.

Castle, N. G., & Mor, V. (1998). Physical restraints in nursing homes: A review of the literature since the nursing home reform act of 1987. Medical Care Research and Reviews, 55(2), 139-170.

Evans, L.K., Strumpf, N.E., Allen-Taylor, S.L., Capezuti, E., Maislin, G., & Jacobsen, B. (1997). A clinical trial to reduce restraints in nursing homes. Journal of the American Geriatrics Society, *45*, 675-681.

Frengley, J.D. & Mion, L.C. (1998). Physical restraints in the acute care setting: Issues and future directions. Clinics in Geriatric Medicine, *14*, 727-743.

Hanger, H.C., Ball, M.C., & Wood, L.A. (1999). An analysis of falls in the hospital: Can we do without bedrails? Journal of the American Geriatrics Society, *47*, 529-531.

Miles, S. H., & Irvine, P. (1992). Deaths caused by physical restraint. The Gerontologist, *32*(6), 762-766.

Minnick, A.F., Mion, L.C., Leipzig, R., Lamb, K., & Palmer, R.M. (1998). Prevalence and patterns of physical restraint use in the acute care setting. Journal of Nursing Administration, *28*, 19-24.

Mion, L.C (1996). Establishing alternative to physical restraint in the acute care setting: A conceptual framework to assist nurses' decision making. AACN Clinical Issues, *7*, 592-602.

Parker, K., & Miles, S.H. (1997). Deaths caused by bedrails. Journal of the American Geriatrics Society, *45*, 797-802.

Rader, J., Jones, D., & Miller, L. L. (1999). Individualized wheelchair seating: Reducing restraints and improving function. Topics in Geriatric Rehabilitation, *15*(2), 34-47.

Strumpf, N. E., Robinson, J. P., Wagner, J. S., & Evans, L. K. (1998). Restraint-free care: Individualized approaches for frail elders. New York, NY: Springer Publishing Company, Inc.

Todd, J.F., Ruhl, C.E., & Gross, T.P. (1997). Injury and death associated with hospital bed side-rails: Reports to the US Food and Drug Administration form 1985-1995. American Journal of Public, *87*, 1675-1677.

U.S. Dep't of Health & Human Servs., Health Care Fin. Admin., *Medicare and Medicaid Programs; Hospital Conditions of Participation: Patients' Rights; Interim Final Rule*, 42 C.F.R. Pt. 482 (July 2, 1999).

U.S. Dep't of Health & Human Servs., Health Care Fin. Admin., *Hospital Interpretive Guidelines—Patients' Rights* (June 2000).

U.S. Dep't of Health & Human Servs., Health Care Fin. Admin., *Guidance to Surveyors—*

*Long-Term Care Facilities* (revisions eff. Oct. 10, 2000).

U.S. Dep't of Health & Human Servs., Health Care Fin. Admin., Siderail Interim Policy (Feb. 4, 1997).

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