PHYSICAL RESTRAINTS IN NURSING HOMES: AN ANALYSIS OF QUALITY OF CARE AND LEGAL LIABILITY

Evan M. Meyers

In this note, Mr. Meyers looks at the use of physical restraints in American nursing homes. For many decades, a variety of physical restraints have been used in nursing homes to reduce residents' movements and prevent falls from chairs and beds. However, in recent years the trend has been to move away from the use of restraints. In addition, many federal and state regulations have restricted the instances and manner in which restraints may be used. Mr. Meyers considers the problems that are created by the use of restraints and the legal issues that nursing homes face when they choose to employ them. The note also explores the effectiveness of federal regulations and proposes potential changes in federal regulations and common law. The author recommends strategies by which nursing homes may reduce their reliance upon physical restraints and limit their legal liability.

Evan M. Meyers, is an Associate Editor, 2001–2002, member 2000–2001, *The Elder Law Journal*; J.D. 2002, University of Illinois College of Law, Urbana-Champaign; B.A. 1999, University of Michigan, Ann Arbor.

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I. Introduction

The United States is an aging society, with the elderly representing the fastest growing segment within the United States' population.[1] Just one decade ago, persons over the age of sixty-five comprised 12.5% of the U.S. population.[2] "[B]y 2020, it is projected this group will be 17.7% and by 2050, 25% of the total population."[3] It is also noteworthy that the proportion of individuals over the age of eighty-five is growing at a faster rate than the number of elderly, in general.[4] As the baby boomers begin to retire, and as medical technology allows individuals to live longer, the United States will see an increased demand for medical and health services,[5] as well as a general increased demand for adequate nursing home care.[6] In fact, the number of individuals in nursing homes has increased over the past decade.[7] In the early 1990s, for example, there

1. Seymour Moskowitz, *Saving Granny from the Wolf: Elder Abuse and Neglect—The Legal Framework*, 31 CONN. L. REV. 77, 78 (1998).
2. *Id*.
3. *Id*.
4. *Id*. at 86.
5. *See id*.
6. This note will be primarily focused on physical-restraint use in nursing homes. There are other living options which are similar to nursing homes, such as retirement homes, hospices, and long-term care facilities. Long-term care facilities are actually facilities designed to provide prolonged health care and domestic services for individuals who can not fully function on their own. Although nursing homes and long-term care facilities may not always technically be the same, the term "nursing home" encompasses the type of service provided by long-term care facilities, and they are both generally governed by the same government regulations. In fact, federal regulations even use the term "skilled nursing facilities," and for the purposes of this note, that term will also have the same definition as nursing homes. *See* 42 U.S.C.A. § 1395i-3(a) (2000). In this note, the term "nursing home" is meant to apply generally to the various geriatric living options, including both actual nursing homes and long-term care facilities, and if the term "long-term care facility" is used, it is meant to apply interchangeably with "nursing home." *See* Gerard Mantese et al., *Issues Relating to the Care of the Elderly in Nursing Homes*, 73 MICH. B.J. 176, 176 (1994); *see also* 210 ILL. COMP. STAT. 45/1-113 (2000) (including nursing homes within the definition of long-term care facilities for purposes of the Illinois Nursing Home Care Act). Moreover, nursing homes may be operated by a private corporation, a government entity, or a charitable institution, and they may be for-profit or not-for-profit. This note will not make any distinction between nursing homes, as relating to their ownership or for-profit status. *See* David A. Bohm, *Striving for Quality of Care in America's Nursing Homes: Tracing the History of Nursing Homes and Noting the Effect of Recent Federal Government Initiatives to Ensure Quality of Care in the Nursing Home Setting*, DEPAUL J. HEALTH CARE L. 317, 366 n.1 (2001).
7. Although the percentage of elderly within the total population increased, the percentage of the elderly living in nursing homes has actually decreased during the mid-1980s through the mid-1990s. *See* Judith Feder et al., *Long-Term Care in the United States: An Overview*, HEALTH AFF., May-June 2000, at 4. However, be-

existed approximately 18,000 nursing homes with over 1.4 million total residents,[8] while today there are approximately 1.6 million nursing home residents.[9]

As the number of elderly Americans has increased, so too has the focus on the quality of care that the elderly receive.[10] Such a focus has spawned the creation of literature regarding the use of physical restraints in nursing homes.[11] Physical restraints have played a significant role in hospitals and nursing homes in the United States for hundreds of years.[12] In recent years, roughly 500,000 nursing home residents, at any point in time, are subject to physical restraints.[13] At the same time, however, there has been a heightened awareness of the problems associated with physical restraints, resulting from federal regulations.[14]

This note will examine the problems identified with physical restraint use, the impact of such problems on legal liability, and the regulations affecting physical restraint use in nursing homes. Moreover, this note will examine the effectiveness of federal regulations on physical restraint use, and articulate additional ideas and suggestions for the safety of nursing home residents, while considering the legal ramifications of such measures. Part II will provide background information on physical restraint use and regulation in the United States, discussing the disadvantages to physical restraint use, as well

cause of the increased percentage of the elderly population, the total number of nursing home residents has increased.

8. *See* Marshall B. Kapp, *Nursing Home Restraints and Legal Liability*, 13 J. LEGAL MED. 1, 5–6 (1992).

9. Julie A. Braun & Lawrence A. Frolik, *The Legal Aspects of Chemical Restraint Use in Nursing Homes*, 2 ELDER'S ADVISOR 21, 21 (2000). While the estimates of the total number of nursing homes and nursing home residents varies by a small margin within the literature, in general, between the late 1980s and today there has been an increase of approximately twenty percent in the total number of U.S. nursing homes and an increase of approximately fifteen percent in nursing home residents. Bohm, *supra* note 6, at 322.

10. Tom Barrett, *It's Time to Address the Long-Term Healthcare Crisis*, HUM. RTS., Spring 2001, at 13; *see also* Kapp, *supra* note 8, at 3–4.

11. Lois K. Evans & Neville E. Strumpf, *Tying Down the Elderly*, 37 J. AM. GERIATRICS SOC'Y 65, 66 (1989).

12. Kapp, *supra* note 8, at 2; Evans & Strumpf, *supra* note 11, at 65.

13. Kapp, *supra* note 8, at 2; Evans & Strumpf, *supra* note 11, at 65.

14. *See generally* Senator Charles Grassley, *The Resurrection of Nursing Home Reform: A Historical Account of the Recent Revival of the Quality of Care Standards for Long-Term Care Facilities Established in the Omnibus Reconciliation Act of 1987*, 7 ELDER L.J. 267, 268 (1999); Marshall B. Kapp, *Quality of Care and Quality of Life in Nursing Facilities: What's Regulation Got to Do with It?*, 31 MCGEORGE L. REV. 707, 724–25 (2000).

as the development of government regulations addressing physical restraint use and nursing home care, in general. Part II will also discuss the increased use of restraint alternatives and "non-restraints." Part III will more closely examine the legal implications of restraint use with an analysis of recent case law, articulating the truths and fallacies shared by nursing homes regarding liability. Part IV will examine techniques and approaches to nursing home care that have an effect on physical restraint use, and Part V will offer recommendations for decreasing legal liability and increasing resident safety and quality of life.

II. Background

A. Restraint Use

The use of physical restraints in the United States has generally decreased, but a problem still remains.[15] Approximately "[e]ighty-five percent of nursing home residents will be restrained in some manner at some time."[16] Physical restraints are typically 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.'"[17] There are a variety of different types of physical restraints used by nursing homes, including arm and leg restraints, hand mitts, vests, wheelchair lap cushions and trays, and soft belts and ties.[18] Nursing homes also utilize other products and techniques which are classified as restraints, including wheelchair safety bars, placing a resident's wheelchair close enough to a wall to prevent the resident from rising, and preventing movement from a bed by tucking in the sheets tightly.[19] The use of restraints has traditionally

15. Cory W. Brooks, Note, *Skilled Nursing Homes: Replacing Patient Restraints with Patient Rights*, 45 S.D. L. REV. 606, 613 (2000).

16. *Id*.; *see also* Julie A. Braun, *Legal Aspects of Physical Restraint Use in Nursing Homes*, HEALTH LAW., Jan. 1998, at 10 [hereinafter *Legal Aspects*].

17. Brooks, *supra* note 15, at 612 (quoting *Legal Aspects*, *supra* note 16, at 12–13); *see also* 38 C.F.R. § 51.90(a)(1)(ii) (2001) (describing a physical restraint as "any method of physically restricting a person's freedom of movement, physical activity or normal access to his or her body. Bed rails and vest restraints are examples of physical restraints.").

18. *Legal Aspects*, *supra* note 16, at 10.

19. *See id*.; Julie A. Braun & Elizabeth A. Capezuti, *The Legal and Medical Aspects of Physical Restraints and Bed Siderails and Their Relationship to Falls and Fall-Related Injuries in Nursing Homes*, 4 DEPAUL J. HEALTH CARE L. 1, 4 (2000). Al-

been considered an effective, and perhaps necessary, means by which a nursing home can prevent a resident from falling out of bed or out of a wheelchair.[20]

Caregivers have also used restraints to prevent a resident from interfering with treatment, including wounds and tubes, as well as when a resident manifests violent behavior and may be a threat to himself, to the caregiver, or to others.[21] At the same time, however, many studies have shown that physical restraints may actually *promote* fall-related injuries.[22] The rationale behind such findings is that residents can become agitated and attempt to escape from the restraint and/or from the chair or bed, resulting in falls, strangulation, or suffocation.[23] In fact, every year, "one to two residents per thousand die by strangulation after becoming entangled in their restraints."[24] A 1992 investigation revealed that over "'200 Americans die each year in restraints.'"[25]

Moreover, studies have shown that physical restraints can produce harmful physical side effects, including skin abrasions, decubitus ulcers (bedsores), nerve damage, and decreased muscle strength.[26] Perhaps even more important are the serious psychological side ef-

though the topic will be discussed more at length later in this note, it is worth noting that nursing homes also utilize a variety of products which effectively restrain the resident but are not necessarily classified as "restraints." For example, certain cushions are used to effectively prevent a resident from rising from a wheelchair, yet such cushions may not be classified restraints. Telephone Interview with Mark Grabel, an Illinois medical restraints and related products salesman, familiar with federal and state regulations regarding their use (Oct. 8, 2000) [hereinafter Grabel Interview]. Also certain belts used to restrain residents in wheelchairs are also not classified as restraints if the buckle is located on the front side of the resident, theoretically allowing removal by the resident. *Id*. Moreover, bed siderails are frequently used in nursing homes, but their classification as a restraint or a non-restraint depends on the specific use. Braun & Capezuti, *supra* note 19, at 4. Siderails used for the purpose of impeding the resident's ability to get out of bed are considered restraints. *Id*. However, side rails used on an immobile resident to prevent falling out of bed, or used to facilitate mobility in and out of bed, are not considered restraints. *Id*. at 4–5.

20. *See* Braun & Capezuti, *supra* note 19, at 7.

21. *Id*.; *see also* Terry Terpstra et al., *Reducing Restraints: Where to Start*, 29 J. CONTINUING EDUC. NURSING 10, 13 (1998).

22. Kapp, *supra* note 8, at 11–12; *see also* Brooks, *supra* note 15, at 613–14.

23. Kapp, *supra* note 8, at 11–12.

24. *Legal Aspects*, *supra* note 16, at 11.

25. Brooks, *supra* note 15, at 614 (citing *Skilled Nursing Homes: Care Without Dignity, 1991: Hearing Before Little Hoover Commission, Report No. 109*, at 16 (Apr. 1991), *available at* http://www.bsa.ca.gov/lhcdir/109rp.html).

26. Beth A. Buchanan Staudenmaier, *Use of Restraints in the Hospital Setting: Is the Law a Help or Hindrance to the Advancement of Changing Medical Ideology?*, 22 U. DAYTON L. REV. 149, 152 (1996).

fects associated with restraint use, including an increase in resident fear, anxiety, anger, depression, and humiliation due to the potentially dehumanizing situation created by the restraints.[27] As previously mentioned, caregivers tend to cite reducing the risk of falling as the primary reason for restraint use. However, studies have shown that the rate of serious injury does not increase "appreciably in situations where restraints have not been imposed."[28] In fact, most studies seem to indicate that the use of physical restraints does not reduce the risk or incidence of falls or other accidents.[29] A review of the literature seems to corroborate these findings, showing not only that restraints do not significantly reduce falls and injuries, but also that "serious injury rates increase when restraints are in place."[30]

B. Restraint Regulations

The emphasis on restraint reduction was caused by (and may have helped create) various new federal regulations for nursing homes.[31] The regulation of medical devices is not a particularly recent phenomenon in American history. The Food and Drug Administration (FDA) and its regulatory powers evolved throughout the twentieth century,[32] with the roots of medical device regulation dating back to the 1938 Food and Drug Cosmetic Act.[33] In 1976, the Medical Device Amendments to the Act[34] were passed, creating a new system for the classification of medical devices, the application of performance

27. *Id*.

28. Kapp, *supra* note 8, at 13. The author explains that more than two-thirds of falls do not result in serious injury. *See id*.

29. *See* Braun & Capezuti, *supra* note 19, at 12. The authors claim that a review of research studies demonstrates that restraint removal does not increase falls. *Id.* In particular, the authors cite a 9.5-month study of 332 residents in three Philadelphia-area nursing homes, demonstrating that "restraints were not associated with a significantly lower risk of falls or fall-related injuries." *Id*. at 13. In fact, the authors explain that a one-year study at twelve nursing homes in southern Connecticut associated restraint use with continued, and perhaps, increased occurrence of serious injurious falls. *Id*.

30. Terpstra, *supra* note 21, at 14.

31. *See* Bohm, *supra* note 6, at 331–32; *see also* Grassley, *supra* note 14, at 268; Kapp, *supra* note 14, at 725.

32. *See generally* Larry R. Pilot & Daniel R. Waldmann, *Food and Drug Administration Modernization Act of 1997: Medical Device Provisions*, 53 FOOD & DRUG L.J. 267, 267–72 (1998).

33. 21 U.S.C. § 301 (1988 & Supp. V 1993); *see also* Charles J. Walsh & Alissa Pyrich, *Rationalizing the Regulation of Prescription Drugs and Medical Devices: Perspectives on Private Certification and Tort Reform*, 48 RUTGERS L. REV. 883, 894–95 (1996).

34. 21 U.S.C. § 360 (1994).

standards, and the use of expert advisory committees.[35] The 1976 amendments also established good manufacturing practices (GMPs) and the regulation of restricted devices,[36] concepts which revolutionized the process by which medical devices are examined, classified, and utilized.[37] With the passage of the 1990 Safe Medical Device Act,[38] the FDA received greater enforcement powers over hospitals and nursing homes, requiring them to make reports about negative medical device experiences and accidents.[39] The FDA Modernization Act of 1997 had additional impact on the regulation of medical devices, as Congress attempted to "assure greater accountability through measurement of performance against the FDA plan for compliance."[40]

Overall, the evolution of the FDA and its regulation of medical devices has impacted the physical restraint market, mandating that manufacturers pay attention to the classification and labeling of their products.[41] Under FDA regulations, a manufacturer must state whether it intends its product to be used as a restraint.[42] If it does, the FDA more thoroughly scrutinizes it, and more heightened regulations apply.[43] The more elaborate classifications, combined with stricter accountability and increased regulations, have increased the focus on physical restraint use and the potential problems associated with it.[44]

While the legislation affecting the FDA has had a significant effect on physical restraint manufacturers, the legislation most directly affecting nursing homes has likely been the Omnibus Budget Recon-

35. *See* Pilot & Waldmann, *supra* note 32, at 268.

36. *Id.* at 269; *see also* Richard A. Merrill, *The Architecture of Government Regulation of Medical Products*, 82 VA. L. REV. 1753, 1808 (1996).

37. *See* Pilot & Waldmann, *supra* note 32, at 269.

38. 21 U.S.C. § 360.

39. Pilot & Waldmann, *supra* note 32, at 269; *see also* Julie A. Braun & Elizabeth Capezuti, *Siderail Use and Legal Liability in Illinois Nursing Homes*, 88 ILL. B.J. 324, 331 (2000) (citing 21 C.F.R. § 803.30 (1999)).

40. Pilot & Waldmann, *supra* note 32, at 267.

41. *See* Walsh & Pyrich, *supra* note 33, at 918–19.

42. Telephone Interview with Cindy Roberts, Manager of Regulatory Affairs, Hollister Incorporated, a Libertyville, Illinois, company that manufactures medical supplies and devices that are classified as restraints, as well as "non-restraints" (Mar. 27, 2001) [hereinafter Roberts Interview]

43. *Id.* If a manufacturer intends for its product to be used as a restraint, or if the FDA finds that the product acts as a restraint, the manufacturer must go through a 510K regulatory process, which includes proof of the product's purpose, effectiveness, and labeling. *Id.* If the product is not classified as a restraint, then the manufacturer is exempt from the 510K process and premarket notification. *Id.*

44. *See* Karen Dorman Marek et al., *OBRA '87: Has It Resulted in Better Quality of Care?*, 22 J. GERONTOLOGICAL NURSING 28, 31 (1996).

ciliation Act of 1987 (OBRA),[45] which was created after years of attempted remedies for the nursing home problems in America.[46] The concern over nursing home quality of care grew appreciably in the 1960s and 1970s, and President Nixon proposed an initiative in 1971 to improve conditions in nursing facilities throughout the country.[47] In 1978, the Older Americans Act[48] was amended to require each state to establish an ombudsman program that would investigate complaints at nursing homes and long-term care facilities.[49] OBRA was then passed after a 1986 Institute of Medicine report to Congress documented an investigation which had found "resident abuses occurring nationwide, many of which violated rights of privacy, informed consent, and access to legal advocacy services."[50] OBRA contained the Nursing Home Quality Reform Act,[51] which "mandated the most comprehensive legislative requirements ever to affect nursing homes."[52] This legislation

> revised the statutory authority applicable to nursing homes participating in the Medicare and Medicaid programs by establishing a detailed set of federal requirements for participation in the federal health programs, a survey and certification process to evaluate compliance with these requirements, and an enforcement structure to sanction those facilities that fail to comply.[53]

45. 42 U.S.C. §§ 1395i-3(a)-(i), 1396r(a)-(i) (1994) (commonly referred to as OBRA and pertaining only to nursing facilities).

46. *See* Kapp, *supra* note 14, at 711–12. ("Passage of [OBRA] demonstrated the impatience of Congress and the courts with what they and the public perceived as HCFA's ineffectual regulation of [nursing facilities].").

47. Elizabeth B. Harrington, Note, *Strengthening the Older Americans Act's Long-Term Care Protection Provisions: A Call for Further Improvement of Important State Ombudsman Programs*, 5 ELDER L.J. 321, 332 (1997). For a brief historical summary of nursing homes in America and their development relative to federal regulations, see Bohm, *supra* note 6, at 324–34.

48. *See* Older Americans Act of 1965, Pub. L. No. 89-73, 79 Stat. 218 (codified in various sections of 42 U.S.C.).

49. *See* Harrington, *supra* note 47, at 332. OBRA also had an effect on the ombudsmen programs throughout the nation, mandating that states guarantee ombudsmen access to facilities and patient records and giving ombudsmen the official authority to designate local programs to carry out ombudsmen functions. *See id.* at 333. State ombudsman statutes have been updated and revised and are still in effect and well-regulated. There are ombudsman programs in all fifty states, the District of Columbia, and Puerto Rico. *See id*. at 334. Some states have statutes that "supplement and enhance the federal mandate of OBRA." *Id*. The section of the Illinois Act on Aging, entitled Long Term Care Ombudsman Program, is a fine example of such a statute. *See* 20 ILL. COMP. STAT. 105/4.04 (2001).

50. Harrington, *supra* note 47, at 333; *see also* Grassley, *supra* note 14, at 2.

51. *See* Kapp, *supra* note 8, at 17. The Nursing Home Quality Reform Act is codified at 42 U.S.C. § 1396 (1994).

52. Marek, *supra* note 44, at 28.

53. Grassley, *supra* note 14, at 268.

OBRA was created with the intent to improve the quality of care in nursing homes throughout the nation, primarily via a single, well-defined certification process.[54] More specifically, OBRA established: (1) requirements for providers participating in Medicare and Medicaid; (2) survey and certification processes for the purpose of evaluating these requirements; and (3) sanctions and enforcement procedures to address noncompliance with the requirements.[55] OBRA had a broad impact in establishing regulations for the care of residents, particularly addressing residents' rights and quality of life, as well as requirements for institutional staffing, training, and evaluation.[56] OBRA has benefited nursing home residents, not only by mandating an increased focus on general resident quality of life concepts, such as resident dignity and resident rights,[57] but also by initiating the promulgation of specific regulations directly affecting nursing homes.[58] More specifically, the regulations were (and continue to be) promulgated by the Health Care Financing Administration (HCFA),[59] which is now known as the Centers for Medicare and Medicaid Services (CMS), and they establish "specific rights and services a nursing home must supply in order to be eligible to participate in Medicare and Medicaid programs."[60] The regulations explicitly address the use of physical and chemical restraints in nursing homes, providing that "[t]he resident has the right to be free from any physical restraints imposed[] or psychoactive drug administered[] for purposes of discipline or convenience, and not required to treat the resident's medical symptoms."[61] Moreover, CMS has established guidelines which expressly identify certain medical devices and products as physical restraints, including any device or equipment attached to or adjacent to the resident's body that cannot easily be moved by the resident and that restricts the free movement of the resident or typical access to his body.[62] OBRA further specifies that

54. *See* Marek, *supra* note 44, at 28.
55. Grassley, *supra* note 14, at 270.
56. *See* Marek, *supra* note 44, at 28.
57. *Id*. at 31.
58. Grassley, *supra* note 14, at 271.
59. *Id*.
60. *Id*.
61. 42 C.F.R. § 483.13(a) (1990).
62. *Id*. Some products identified by HCFA as being physical restraints include leg and arm restraints, soft ties and vests, wheelchair safety bars, and hand mitts. *Id*.

> [r]estraints may only be imposed to ensure the physical safety of the resident or other residents, and only upon the written order of a physician that specifies the duration and the circumstances under which the restraints are to be used (except in emergency circumstances which are to be specified by the secretary [of DHHS][63] until such an order could reasonably be obtained).[64]

Nursing homes are also regulated by the Joint Commission on the Accreditation of Health Organizations (JCAHO).[65] JCAHO is a nongovernmental organization that promulgates standards in health organizations, including nursing homes, and certifies those organizations that are compliant with its standards.[66] JCAHO promulgates its own standards for physical restraint use and restraint reduction, most recently updated as the 1997 JCAHO Physical Restraint Standards.[67]

63. DHHS stands for the Department of Health and Human Services.

64. Kapp, *supra* note 8, at 18 (citing Pub. L. No. 100-203, § 4201(c)(1)(A)(ii) (Medicare) (codified at 42 U.S.C. §§ 1395i-3(c)(1)(A)(ii) (Supp. 1991)) and Pub. L. No. 100-203 § 4211(c)(1)(A)(ii) (Medicaid) (codified at 42 U.S.C. § 1396r(c)(1)(A)(ii) (Supp. 1991))).

65. JCAHO, headquartered in Oak Park, Illinois, is not a government organization, but rather a governing body that promulgates its own regulations similar to the federal government's regulations. *See* Joint Commission on Accreditation of Healthcare Organizations Website, *at* http://www.jcaho.org/whatwedo_frm.html (last visited Oct. 15, 2001). "The Joint Commission evaluates and accredits nearly 19,000 health care organizations and programs in the United States. An independent, not-for-profit organization, the Joint Commission is the nation's predominant standards-setting and accrediting body in health care." *Id*. JCAHO also produces explanatory videos and literature that aid nursing homes and other health care organizations in understanding the scope of regulations and how to best care for a patient/resident under various circumstances. *See id*. To earn and maintain accreditation, nursing homes must undergo an on-site survey by a JCAHO survey team at least every three years. *See id*. The JCAHO will then choose whether to certify the nursing home, and this certification, although not required by law, is necessary for federal Medicaid funding and is important as a quality indicator for patients and families. *See* 42 C.F.R. § 488.5 (2001).

66. JCAHO develops standards for nursing homes and other health care facilities "in consultation with health care experts, providers, measurement experts, purchasers, and consumers." Joint Commission Standards, *available at* http://www.jcaho.org/standard/jcstandards.html (on file with The Elder Law Journal). JCAHO explains its standards, in part, as follows:

> Joint Commission standards address a health care organization's level of performance in specific areas—not just what the organization is capable of doing, but what it actually does. The standards set forth the maximum achievable performance expectations for activities that affect the quality of care. The standards detail important functions relating to care of individuals and the management of health care organizations, framed as performance objectives that are unlikely to change substantially over time. Because the standards aim to improve outcomes, they place little emphasis on how to achieve these objectives.

Id.

67. J.C.A.H.O. TX. 7.1.3.2.3 (on file with The Elder Law Journal).

C. Use of Restraint Alternatives

It is important to note that there exists a variety of products that are currently used by nursing homes that have characteristics very similar to physical restraints and may serve similar purposes, yet are not considered to be physical restraints.[68] The scholarly literature on the subject of restraints makes almost no reference to these devices, which are often referred to as "non-restraints."[69] What makes these products unique is that they are less restrictive on the resident, and in fact, the resident must have the ability to remove the device.[70] Federal regulations attempt to describe what qualifies as a restraint, and those products that do not fit that definition may be used by nursing homes without the significant restrictions that are placed on restraints.[71] For example, a belt that prevents a resident from falling out of a wheelchair is considered a restraint if the buckle or release mechanism is located in the back of the wheelchair, beyond access to the resident. However, if that same belt utilizes a buckle that is located in the front of the resident, and if the resident could reasonably remove the device, then the product may not be considered a restraint.[72] The rationale behind such a categorization is, no doubt, the fact that with the non-restraint belt, the resident could theoretically loosen the buckle and remove the belt.[73] A product which is not necessarily a restraint may be labeled as such if its use contravenes regulations, including not only devices but also the use of certain materials.[74] Such a concept

68. Grabel Interview, *supra* note 19.

69. *Id*. "Non-restraint" is an industry term. *Id*.

70. *Id*.; Telephone Interview with George Guidas, RN, Director of Nursing at a Champaign, Illinois, nursing home (Feb. 28, 2001).

71. Physical restraints are defined as

> [a]ny manual method of physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot move easily which restricts free movement or normal access to one's body. Leg restraints, arm restraints, hand mitts, soft ties or vests, wheelchair safety bars, and Geri-chairs are physical restraints.

Kapp, *supra* note 8, at 18 (citation omitted).

72. *See* Kapp, *supra* note 8, at 18; Guidas Interview, *supra* note 70.

73. Guidas Interview, *supra* note 70.

74. *Id*. A prime example is the use of side rails (bedrails). "Whether a siderail is a restraint depends on how it functions for the particular individual for whom it is being used, not on what type of rail, size rail, or time of use." Braun & Capezuti, *supra* note 19, at 4 (referring to HEALTH CARE FIN. ADMIN., U.S. DEP'T OF HEALTH & HUM. SERVS., SIDERAILS INTERIM POL'Y (Feb. 4, 1997)). For example, if a side rail is used to prevent a resident from getting out of bed, it is considered a restraint. *Id*. However, if the side rails are used to prevent a comatose person from falling out of

has various implications. On one hand, it could be argued that nursing homes are simply taking advantage of "intentional weaknesses" in the HCFA guidelines and restraining the residents in a similar manner as they would with physical restraints. The strongest argument for this contention is that while a resident could theoretically release the belt himself, it is very unlikely that many residents could physically do so, much less even think to do so. A product classified as a restraint must be treated as a restraint by the nursing home, regardless of how the product is actually being used on the resident.[75] Once a product is classified as a non-restraint or is simply not classified as a restraint,[76] it may be applied to a resident who is reasonably capable of removing it without being subject to the same procedural regulations as with a restraint, such as procuring a doctor's order and limiting the time for which the device is used.[77] If the nursing home be-

bed, they are not considered restraints because the resident would not actually be trying to get out of bed. *Id*.

75. 21 C.F.R. § 880.6760 (referring to products considered protective restraints); Guidas Interview, *supra* note 70; Roberts Interview, *supra* note 43.

76. The FDA does not actually classify devices as "non-restraints." Roberts Interview, *supra* note 43. A manufacturer may classify a device as a wheelchair accessory, for example, and the FDA will typically defer to the manufacturer's classification. 21 C.F.R. § 890.3910 (indicating that a lap belt used to keep a resident's proper posture in a wheelchair is considered a wheelchair accessory). However, regardless of the specific classification given to the product, as long as it is not considered a restraint, per se, then the nursing home can use the product without prior receipt of a doctor's order, so long as the product does not improperly restrict the resident's movement. Roberts Interview, *supra* note 43.

77. *Legal Aspects*, *supra* note 16, at 12. An interesting case dealing with the very fine-line distinction of restraint classification is *Kujawski v. Arbor View Health Care Center*, 407 N.W.2d 249 (Wis. 1987). In this case, a nursing home resident fell out of her wheelchair when being pushed by an employee of the facility. *Id*. at 250. The resident was injured, and she filed suit alleging, inter alia, that the nursing home was negligent in not securely strapping her into the wheelchair. *Id*. In its defense, the nursing home alleged that the plaintiff did not adequately present expert testimony about the restraint use and that expert medical testimony was necessary because the wheelchair restraint belt that allegedly should have been used would have been classified as a restraint requiring a doctor's approval. *Id*. at 252–53. The Wisconsin Supreme Court rejected the nursing home's argument on the basis that Wisconsin law dictated that a device is only a restraint if it is used to modify resident behavior and if the resident is unable to easily remove it. *Id*. at 254. Moreover, Wisconsin regulations also dictated that a device used only to achieve proper position or balance would not be considered a restraint requiring a doctor's order. *Id*. The Wisconsin Supreme Court reasoned:

> If the restraint was applied to keep a patient from running around the nursing home, the restraint would in that situation be used to modify behavior, and it may then constitute a physical restraint. Because the type of restraint proposed by [plaintiff] was not to be used for behavior modification, we conclude that the proposed restraint is not a physical restraint, and its use would not require a physician's order.

lieves that the resident would not be able to easily remove the product, it must receive a doctor's order for the use of the device.[78] Although most nursing homes probably fear improper use of physical restraints—for reasons of legal liability and loss of accreditation[79]—it is likely that they could more easily hide a violation of non-restraint use. Theoretically, a nursing home would only need to argue that the device in use was reasonably removable by the resident. If the resident is injured or killed in a fall, it would be very difficult for a plaintiff to disprove the nursing home's findings.

On the other hand, it could be argued that even if the non-restraints serve the same purpose as actual restraints, the fact that they are usually either less physically restrictive, or at least provide an opportunity for release by the resident, allows the resident to maintain some dignity and autonomy that would have been lost had he been forced to remain tied down at the will of his caregiver. Both points of view may be correct, as perhaps CMS realizes that applying some restraining device to nursing home residents is often necessary, while applying overly restrictive devices that destroy one's dignity is simply unnecessary. The use of non-restraints, therefore, is a reasonable compromise.

It is unlikely that many scholars or practitioners would disagree with the value of non-restraints, yet the literature currently available does not adequately address the use of non-restraints. Rather, the literature rebukes the use of restraints, overall, and calls for nursing homes to become as "restraint free" as possible.[80] Scholars and practi-

Id. at 254.

78. Guidas Interview, *supra* note 70.

79. Kapp, *supra* note 8, at 4.

80. *See generally* Brooks, *supra* note 15. In this article, the author explains the harms associated with physical restraint use and claims that they are "too often used to meet the needs of the institution rather than to help elders live their lives in comfort and with dignity." *Id*. at 621. The author does not explain the non-restraint alternatives, and given that non-restraints often serve a very similar purpose as restraints, the failure to differentiate between the two appears to be an implicit rebuke of the use of non-restraints. Such a rebuke may have been an oversight, but if not, it deserves more attention and more explanation. *See also* Braun & Capezuti, *supra* note 19, (making a strong argument for the elimination of restraints). In fact, the authors of this article point out that in 1991, the American Geriatrics Society took the position that restraint-free environments should be encouraged in all health care settings. *Id*. at 61. But although it is likely that the American Geriatrics Society approves of the limited use of non-restraints and products that meet the requirement of being used for "postural support," the authors themselves mention restraint alternatives, but fail to explain their significance or practical implications. The authors are not necessarily to fault, as their

tioners must be willing to address current realities and not only acknowledge that nursing home residents are still placed in restraint-like devices, but also be willing to stop pretending that a facility is completely restraint-free when non-restraint devices could potentially be used in a restraining manner. Moreover, the lack of commentary on this issue does a disservice to the nursing home community, as non-restraints may be valuable as reasonable alternatives to restraints.

III. Analysis

A. Results: Have Federal Regulations Been Effective?

Between CMS, JCAHO, and individual state regulations and ombudsmen programs, it would seem that nursing home care, as a whole, would be much safer and of a higher quality than even a decade ago. Although safety and quality are very difficult to measure, the results appear to be mixed. CMS recently published a report on nursing facilities throughout the nation.[81] In this report, the authors evaluated data for 1993 through 1999 using 185 measures chosen by

antirestraint premise is informative and very valid, yet the current literature, perhaps, mischaracterizes the "restraint free" movement and the current use of restraint alternatives and non-restraints in nursing homes.

81. CHARLENE HARRINGTON ET AL., NURSING FACILITIES, STAFFING, RESIDENTS, AND FACILITY DEFICIENCIES, 1993 THROUGH 1999, *available at* http://www.ncfa.gov/medicaid/nursing fac/nursingfac99.pdf (Oct. 2000). This report was produced by members of the Department of Social and Behavioral Sciences at the University of California San Francisco, and the research was funded by CMS.

There are other ways to analyze the effectiveness of federal regulations on nursing homes, and Eric M. Carlson, who serves as the Director of Nursing Home Advocacy Project of Bet Tzedek Legal Services, claims that continuing problems in nursing homes can be attributed to poor enforcement systems in the federal regulations. Eric M. Carlson, *Siege Mentality: How the Defensive Attitude of the Long-Term Care Industry Is Perpetuating Poor Care and an Even Poorer Public Image*, 31 MCGEORGE L. REV. 749, 753–54 (2000). Mr. Carlson asserts that due to pressure from the nursing facility trade associations, CMS has inserted "significant loopholes in the enforcement procedures set forth in the Code of Federal Regulations and the HCFA State Operations Manual." *Id*. The example he provides is that a government survey agency typically will not assess a remedy for a violation until the facility has had an opportunity to correct the violation. *Id*. at 754. He argues that "remedies" are often not actually assessed because the violation may have been considered a "one-time occurrence," or a remedy is not assessed because the survey agency lacks the resources to determine if the violation has not been corrected. *Id*. "Because sanctions rarely [are] imposed, some facilities [go] through this 'yo-yo pattern of compliance and noncompliance' as many as six or seven times." *Id*. at 756. "For these reasons, the federal enforcement system has been unable to compel substandard facilities to make real improvements." *Id*.

HCFA.[82] The report shows that between 1993 and 1997, there was a decline in the average number of deficiencies issued per facility, but there was an average increase in deficiencies from 1997 through 1999.[83]

1. PHYSICAL RESTRAINT DEFICIENCIES

Deficiencies for physical restraint use generally decreased throughout the 1990s.[84] In 1993, 17.8% of nursing facilities surveyed had deficiencies in physical restraint use, but that number has steadily decreased and was at 11.2% in 1999.[85] The optimistic view of this data holds that physical restraint use is, on average, increasingly more in-line with federal regulations. However, it is important to realize that the data shows that more than one out of every ten nursing facilities is not following federal regulations, a number that some could still consider too high. Moreover, a review of the data reveals that eleven states showed an increase, or at least no decrease, in deficiencies from 1993 through 1999.[86] In South Dakota, for example, the percentage of facilities with restraint deficiencies has steadily increased from 13.9% in 1993 to its seven-year high of 24.7% in 1999.[87]

2. ACTIVITIES PROGRAM DEFICIENCIES

Another important measure analyzed by the report is a nursing home's activities program.[88] "Facilities must provide residents with

82. HARRINGTON ET AL., *supra* note 81, at 74. State surveyors assess the process and outcomes of nursing home care in fifteen major areas. *Id*. All fifteen areas have specific regulations relied upon by state surveyors to determine whether facilities have met the proper standards. *Id*. CMS has identified 185 measures of quality based on outcomes and processes. *Id*. This report shows data using these measures from 1993 through 1999. *Id*. The measures used by CMS include outcome measures and process indicators. *Id*. "An outcome is an evaluation of the impact of facility care on a resident, whereas a process indicator is services or activities which a facility does or does not provide." *Id*. Examples of outcomes include falls, weight loss, and decubitus ulcers. *Id*. The outcome measures include ensuring that certain negative problems, such as decubitus ulcers, weight loss, and falls do not occur. *Id*. Examples of processes include urinary training programs, psychotropic drug programs, and daily activities within the nursing home. *Id*. "The process measures include whether proper procedures are used in providing each of the major nursing home services." *Id*.

83. *Id*. at 75.

84. *See id*. at 87.

85. *Id*.

86. *Id*. at 88.

87. *Id*.

88. *Id*. at 91.

ongoing activities that meet the interests and the physical, mental, and psychosocial well-being needs of each resident."[89] In 1993, 12% of U.S. facilities were given deficiencies for their activities programs, while 8.6% received deficiencies in 1999.[90] Once again, the data seems to be positive, but one must wonder if 8.6% is acceptable. Moreover, in the seven-year time period, nineteen states either increased or did not decrease the percentage of deficiencies.[91] It is also important to note that while some states showed a significant decrease in their facilities' deficiencies, the 1999 numbers were still higher than many states' 1993 numbers.[92] For example, 19.2% of California facilities had deficiencies in 1999, and even though that represents a decrease from 28.1% in 1993, it still represents the highest percentage of any state in the nation.[93]

3. STAFFING DEFICIENCIES

Another factor important to nursing home quality is the nursing staff. In addition to the training of the staff, a feature of any nursing home is sufficiency of staff. "Facilities must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of residents."[94] The report shows that in 1993, 6.2% of facilities in the nation were given deficiencies for failing to meet the requirement of sufficient nursing staff, and that in 1999, deficiencies fell to 5.7%.[95] An analysis of the data shows that while twenty-one states showed a decrease in deficiencies, seventeen states showed an increase, and eleven states experienced a change of less than 1% in either direction.[96] When taken together, therefore, a majority of states did not show any significant decrease in deficiencies over the seven-year period. Unlike physical restraint use or activities programs, however, the percentage

89. *Id*.
90. *Id*.
91. *Id*. at 92. For purposes of analyzing the report's data in this article, a state is considered to not have decreased nor increased its deficiencies if the net change in percentage was less than one percent between 1993 and 1999.
92. *Id*.
93. *Id*. There are several states that have seen sizable decreases that have been maintained over several years. For example, Tennessee had 8% in 1993, dropped to 6.5% in 1996, and remained below 3% in 1997, 1998, and 1999. *Id*. Georgia represents a similar situation of consistently lower percentages. *Id*.
94. *Id*. at 107.
95. *Id*.
96. *Id*. at 108.

of deficiencies in nursing staff was relatively low. In fact, only six states had deficiencies of over 10% in 1999, down from ten states in 1993.[97]

Although these numbers appear relatively reasonable, there is reason to believe that insufficient staffing remains an important problem in nursing homes.[98] The report seems to show that, on paper, insufficient staffing is not as big a problem as deficiencies in activities programs, but not all deficiencies are made apparent to regulators,[99] and insufficient staffing continues to be a major issue of concern. In fact, one attorney who has handled nursing home litigation commented, "'Whether the case involves bedsores or falls or untreated bladder infections, the underlying problem is understaffing.'"[100]

B. Pain Management and Physical Restraints

1. PAIN IN NURSING HOMES

There is no doubt that many patients in hospitals experience pain related to sickness, surgery, or other procedures. A substantial number of these patients in pain are elderly individuals, as "[n]early four million Americans over sixty-five endured the pain of inpatient surgery in 1995."[101] Nursing home residents, many of whom are in poor health, are no strangers to pain. Indeed, "[m]any of the 1.4 million Medicaid recipients who live in nursing facilities are in pain."[102]

97. *Id*.

98. Telephone Interview with Catie Vosburgh, RN, In-service Director at two Illinois nursing homes (Feb. 10, 2001) [hereinafter Vosburgh Interview]. Ms. Vosburgh says that understaffing is one of the most important problems faced by nursing homes today. *Id*.; *see also* Barrett, *supra* note 10, at 14.

99. Donald C. Dilworth, *Negligent Nursing Home Care Triggers Juror Outrage*, 34-Aug. TRIAL 16, at 16 (1998), WL 34-AUG JTLATRIAL 16. One veteran litigator of nursing home cases explained, "'Perhaps because they have too much to do, regulatory agencies typically look to whether, on paper, there has been compliance. Trial lawyers, through the instruments of discovery and depositions and comprehensive investigations, can get beneath the surface to address the real lack of care.'" *Id*. (quoting Steve Levin, a Chicago attorney).

100. *Id*. (quoting Lesley Clement of Sacramento, California, an attorney with several years of experience in nursing home cases).

101. Timothy S. Jost, *Public Financing of Pain Management: Leaky Umbrellas and Ragged Safety Nets*, 26 J. L. MED. & ETHICS 290, 290 (1998).

102. *Id.* "In 1994, 376,200 Americans over age sixty-five died of cancer. Virtually all of these would have been Medicare recipients, and as many as seventy percent of them died in unrelieved pain." *Id*.

2. NEW PAIN MANAGEMENT STANDARDS

JCAHO has created new standards for staff treatment of patient pain. The new standards, which became effective January 1, 2001, require that health care organizations have an established pain management system in order to receive certification by JCAHO.[103] The new standards, which apply to nursing homes, as well as hospitals, home health agencies, outpatient clinics, and others,[104] establish that pain is to be treated as the fifth vital sign, in addition to pulse rate, breathing rate, temperature, and blood pressure.[105] By treating pain as a vital sign, health care providers must identify pain during the initial assessment of the patient,[106] record the pain rating of the patient, on a scale of one to ten, on a new chart,[107] and educate the patient and his family about pain management.[108] The most important change that the new standards may bring about will be the increased attention that the caregiver will give to the patient's pain and the more active communication that such attention will likely necessitate.[109]

3. EFFECT OF PHYSICAL RESTRAINT USE

Although JCAHO's new pain management standards were not necessarily designed to affect physical restraint use, it is likely that they will have an effect. Physical restraint use in nursing homes is, in part, based on the idea that an elderly individual is more likely to attempt to rise from his bed or chair or wander around the halls if he is agitated or anxious.[110] Caregivers need to realize that some of that anxiety may be caused by physical pain that the resident may be experiencing: "[n]ot only is pain, well, painful, it also can delay recu-

103. Robert Strauss, *Where It Hurts*, N.Y. TIMES, Jan. 14, 2001, at 7.

104. Therese Smith Cox, *Who Feels Your PAIN? New Standards Give Patients Input on Seeking Relief*, CHARLESTON DAILY MAIL, Jan. 23, 2001, at P1D.

105. *Id.*

106. *Medical Centers Required to Treat Pain or Lose Accreditation*, MEDICAL INDUS. TODAY, Jan. 2, 2001 [hereinafter MEDICAL INDUS. TODAY].

107. Cox, *supra* note 104.

108. MEDICAL INDUS. TODAY, *supra* note 106.

109. In fact, Ms. Vosburgh, RN, has stated that the new pain standards have, indeed, resulted in staff members paying more attention to residents' needs, and the new standards have increased the focus that staff have given to residents' pain and discomfort. Telephone Interview with Catie Vosburgh, RN, In-service Director at two Illinois nursing homes (Sept. 15, 2001).

110. Vosburgh Interview, *supra* note 98. Ms. Vosburgh explained that while confusion is, perhaps, the primary reason why a resident might attempt to get out of his bed or wheelchair, other important reasons for such behavior include anxiety, pain, discomfort, boredom, and the need to use the bathroom. *Id.*

peration and prompt anxiety and depression."[111] "Untreated pain may prevent patients from eating, sleeping, or walking."[112] The obvious ramifications of this are that a resident who is less willing to eat can become malnourished and dehydrated, and a resident who is unwilling to walk is more susceptible to decubitus ulcers. Equally important, however, is that a resident who is anxious or depressed may be less willing to listen to his caregiver's instructions and may be less likely to sit or lay comfortably in his chair or bed.[113] The effect of such behavior could lead to an increased need for physical restraint use, or if restraints are already being used, an increased likelihood that the resident will try to remove the restraint or get out of his restrained position.[114] As previously mentioned, it is thought that physical restraints can promote injuries through falls by making a resident agitated and anxious and causing him to attempt to get out of bed or get out of his chair.[115] By making a caregiver pay more attention to the resident's pain and discomfort, the new JCAHO standards should decrease the number of injuries associated with physical restraint use, particularly those accidents resulting from the agitation and anxiety created by the restraint use. A more comfortable resident is likely to be more cooperative and should feel less of a need to try to free herself from the restraint.

The increased comfort and decreased anxiety of the resident may also reduce the actual need for physical restraint use. While decreased pain may not lead to decreased resident confusion, it may allow the resident to rest more comfortably, reducing the need to restrain the resident at night.[116]

111. Cox, *supra* note 104 (paraphrasing a statement made by Dr. Timothy Deer, Director of Pain Medicine at Charleston Area Medical Center). For example, chronic or acute pain can affect eating habits and even longevity. *See id*. Also, a decrease in pain can allow the patient/resident to take deeper breaths and be more mobile, which can reduce the risk of blood clots or pneumonia. *See* Strauss, *supra* note 103 (paraphrasing a statement made by Dr. Jeffery Komins, Vice President of Clinical Outcomes for Virtual Health in Voorhees, Camden County).

112. Lydia Carrico, *U.S. Hospitals Are Urged to Treat Patients' Pain More Effectively*, MESSENGER-INQUIRER I (Ownesboro, Ken.), Jan. 6, 2001, ¶ 18.

113. *See* Buchanan, *supra* note 26, at 152.

114. *See* Kapp, *supra* note 8, at 11–12.

115. *Id.*

116. *Id.*

IV. Legal Liability Analysis

A. Background

1. REGULATORY PENALTIES

Legal liability is always something that nursing homes must consider when establishing programs for resident care.[117] A significant impediment to the goal of decreased physical restraint use "is a widespread anxiety among many long-term care providers about potential legal liability resulting from injuries associated with the non-restraint of a resident."[118] Such anxiety is not completely unjustified, as nursing homes face serious repercussions for inappropriate or indiscriminate use of restraints, particularly when alternatives are readily available.[119] For example, nursing homes face decertification from Medicare or Medicaid participation, as well as a restriction or moratorium on new Medicare or Medicaid admissions.[120] "Other penalties include temporary denial of Medicare/Medicaid payments for some or all federally-funded residents, civil monetary penalties, temporary management (receivership), and facility closure."[121] OBRA also authorizes states to impose sanctions or remedies.[122] States may take immediate action to correct any deficiencies through the appointment of temporary management, or they may even terminate the facility's participation in Medicaid.[123] Like the federal government, the states may also impose more specified remedies, "such as the denial of payment for new admissions, civil money penalties, or, in case of an emergency, closure of the facility or the transfer of residents, or both."[124]

2. HOW JURIES RESPOND TO NURSING HOME LITIGATION

An examination of legal precedent also reveals that, in addition to state and federal penalties, nursing homes may also face the wrath

117. *Id.* at 4.
118. *Id.*
119. *Legal Aspects*, *supra* note 16, at 14; *see, e.g.*, Smith-Gutter v. State of Washington, 2001 WL 877565 (Wash. Ct. App. July 30, 2001) (a case in which an RN who operated several adult homes was disciplined for various violations, including the inappropriate use of physical restraints).
120. *Legal Aspects*, *supra* note 16, at 14.
121. *Id.*; *see also* 42 U.S.C. § 1396r(g-h) (1994); 42 C.F.R. § 488 (1997).
122. 42 C.F.R. § 488.410(a).
123. Grassley, *supra* note 14, at 274.
124. *Id*.

of sympathetic juries. One author found that "[i]n forty-nine verdicts regarding restraint of hospital patients, only six involved injuries from restraints while the remaining forty-three involved either a failure to restrain or inadequate restraint of a patient."[125] Although this data reflects restraint use at hospitals rather than at nursing homes, it does still demonstrate that legal liability is something that should not be ignored. Juries are naturally difficult to predict, but the news for nursing home defendants may be particularly disheartening, as jurors at civil trials for nursing home negligence or abuse have at times been quite harsh on the defendants.[126] "Outraged by evidence that nursing home administrators and owners have ignored patients' basic needs, jurors are awarding significant compensatory and punitive damages to force the industry to change its ways."[127] In fact, a 1997 legal marketing firm study showed that "the two fact situations angering juries most involved negligence of nursing home residents and of small children."[128]

3. MISAPPLICATION OF RESTRAINTS

Although it has been argued that this apprehension of liability is actually pretext for actions based on a "professional bias toward paternalism on behalf of older disabled persons, staff convenience, and desire for resident behavior control[,]"[129] common sense, as well as an examination of legal precedent, demonstrate that such apprehension is certainly not without some justification. Nursing homes must consider their potential liability not only for the failure to restrain a resident, but also for the improper application of a physical restraint. In fact,

> in quantitative terms, cases holding providers liable in the absence of nursing home restraints are far eclipsed by legal judgments rendered and settlements made on the basis of inappropriate ordering of restraints, failure to monitor and correct their adverse effects on the resident, or errors in the mechanical application of the restraints.[130]

125. Buchanan, *supra* note 26, at 154.
126. *See* Dilworth, *supra* note 99, at 16.
127. *Id*.
128. Julie A. Braun & Cheryl C. Mitchell, *Recent Developments in Seniors' Law*, 34 TORT & INS. L.J. 669, 683 (1999).
129. Kapp, *supra* note 8, at 4.
130. *Id.* at 13.

Liability arising from the misapplication of restraints typically falls entirely upon the nursing home, as restraint manufacturers are usually absolved of liability so long as the instructions for proper use that accompany the restraint are in accordance with FDA standards.[131] In 1990, a jury held a nursing home liable for almost forty million dollars after an eighty-four-year-old resident was strangled by a misapplied vest restraint,[132] and there are other examples of nursing homes being held liable for the misapplication of restraints.[133]

B. Case Law

In addition to liability arising from the misapplication of restraints, nursing homes may also fear liability resulting from a failure to restrain the resident at all.[134] However, such a fear, although seemingly justified by a commonsense analysis, is not well justified when legal authority is examined. As of 1992, there had been no successful lawsuits against a long-term care facility "*solely* for failure to restrain a resident."[135] At the same time, however, there have been successful lawsuits against nursing homes for injuries incurred or inflicted by residents who were not restrained at the time of the incident.[136] A review of the case law on this subject reveals that court decisions have

131. *Id*. at 14. Of course, this is not to say that restraint manufacturers are not also named in lawsuits against nursing homes.

132. Wayne E. Green & Ellen Joan Pollock, *Nursing Home Is Liable in Restraint Case*, WALL ST. J., Mar. 26, 1990, at B5. The article is referring to the case *Baumann v. Seven Acres Jewish Geriatric Center*, No. 86-44019 (234th Judicial Dist. Ct., Tex. 1990). The judgment of $4.4 million in compensatory damages and $35 million in punitive damages was at the time the largest verdict ever rendered against a nursing home. Kapp, *supra* note 8, at 14 n.73. "The judgment was later set aside and a new trial was ordered for January of 1991 on the basis of misconduct by plaintiff's attorneys, and subsequently was settled under undisclosed terms." *Id.*

133. *See, e.g.*, Smith v. Gravois Rest Haven, Inc., 662 S.W.2d 880 (Mo. Ct. App. 1983). In this case, the defendant nursing home appealed from a $20,000 verdict rendered in favor of the plaintiff who had fallen as a result of a vest restraint being improperly applied. *Id.* at 882. The court ruled that improper application of a restraint can be equated with using no restraint at all. *Id*. at 883.

134. *See* Evans, *supra* note 11, at 68; Braun & Capezuti, *supra* note 19, at 7.

135. Kapp, *supra* note 8, at 8 (emphasis added).

136. *Id*.; *see also Legal Aspects*, *supra* note 16, at 14. Although a fear of liability from failure to restrain may not be appropriate, it may also not be without at least some justification. A review of forty-nine verdicts involving restraint use in hospitals between 1985 and 1995 reveals that "only six involved injuries from restraints while the remaining forty-three involved either a failure to restrain or inadequate restraint of a patient." Staudenmaier, *supra*, note 26, at 154. Therefore, although lawsuits against nursing homes for failure to restrain may be typically unsuccessful, that is not to say that lawsuits are still not a legitimate fear for nursing homes. *Id.*

produced mixed results for nursing homes. The prevailing view, however, seems to be that nursing homes will not likely be held liable for failure to restrain a resident if the nursing home can establish that it provided reasonable care.[137]

Of course, the term "reasonable care" is not always easily interpreted, but a 1986 Louisiana state court of appeals opinion summarized it well:

> There is no presumption of negligence on the part of the institution merely because of the injury to the patient. . . . [A]fter showing it has provided reasonable care for the safety and well being of its patient under the circumstances presented, a nursing home is not liable for injury caused by an untoward event unless it has breached a contractual agreement to furnish special care beyond that usually furnished which relates to the injury giving rise to the cause sued on.[138]

That same court also articulated that "the degree of supervision required by the reasonable standard of care to each patient varies with the known physical and mental condition and propensities of the patient."[139] A 1988 Georgia appellate court upheld a jury's finding that a nursing home was liable for failure to restrain a resident who later assaulted another resident, holding that the nursing home had a duty to not subject its residents to an unreasonable risk of harm and "to supervise or otherwise manage lawfully any known resident who was prone to use assaultive behavior."[140] Even more troubling for nursing homes are some more recent cases holding the facilities liable for damages. For example, a 1999 Illinois circuit court case resulted in a verdict against a nursing home for failing to restrain an eighty-seven-

137. *See* 35 AM. JUR. PROOF OF FACTS 2D *Negligent Hospital* § 10 (1983) [hereinafter *Negligent Hospital*]. "A hospital or nursing home will not be liable for failing to restrain a patient in the absence of evidence that the patient's known condition was such as to require the use of restraints to protect the patient from an unreasonable risk of harm." *Id*. § 10; *see also* Kapp, *supra* note 8, at 9. "Prevailing nursing home plaintiffs in non-restraint cases have had to prove by a preponderance of evidence the presence of one or more other elements of negligence or deviation from the professionally acceptable standard of care . . . ." Kapp, *supra* note 8, at 8.

138. McGillivray v. Rapides Iberia Mgmt. Enters., 493 So. 2d 819, 822 (La. Ct. App. 1986) (citing Murphy v. Allstate Ins. Co., 295 So. 2d 29, 34–35 (La. Ct. App. 1974)).

139. *Id*. at 823.

140. Associated Health Sys., Inc. v. Jones, 366 S.E.2d 147, 151 (Ga. Ct. App. 1988). In this case, the trial jury had returned a verdict of $782 in special damages, $50,000 in general damages, and $200,000 in punitive damages. *Id*. at 149. The appellate court upheld the ruling but struck the punitive damages. *Id*. at 152.

year-old resident who got out of bed and fell.[141] In that case, the plaintiff claimed that the nursing home ignored a doctor's order to keep the patient restrained, while the nursing home argued that the resident did not require restraint and that it had discretion as to whether to follow the doctor's order.[142] Although the medical expenses were only $64,771, the jury awarded the plaintiff a verdict of $216,771 plus attorney's fees.[143]

Although nursing homes have been held liable for substantial damages in certain cases, nursing homes must understand that they are generally only found liable if they breach a reasonable standard of care.[144] For example, a nursing home may be held liable for injuries resulting from a failure to restrain if the failure to restrain directly contravenes a doctor's order,[145] or if the nursing home was, or should have been, aware of the resident's propensity to leave his bed or chair.[146] Even in cases where a resident is known to leave his bed or chair, the nursing home may not be found to have a duty to restrain the resident unless the resident's unrestricted movement represented an unreasonable risk of harm to himself or to others.[147] A 1997 Washington case, in which a hospital was charged with the inappropriate failure to restrain, resulted in an "error-of-judgment" instruction by the trial court, which was upheld by the appellate court.[148] The court explained, "[t]he error-of-judgment instruction provides that a 'health care provider is not liable for an error of judgment if, in arriving at

141. 19 No. 7 VERDICTS, SETTLEMENTS & TACTICS 302 (1999) (discussing Wilks v. Avenue Care Ctr., Inc., No. 95 L 5369 (Cook Cty. Cir. Ct. Chicago, Ill. Feb. 23, 1999)).

142. *Id*.

143. *Id*. In this case the plaintiff was willing to settle for $75,000, but the nursing home was unwilling to make any monetary offer, demonstrating the risky nature of some nursing home litigation. *Id.*

144. Kapp, *supra* note 8, at 8–9; *see also Negligent Hospital*, *supra* note 137, at 24.

145. *See Negligent Hospital*, *supra* note 137, at 24; *see also* Loewer v. Cla-Cliff Nursing & Rehab. Ctr., 39 S.W.3d 771, 772 (Ark. 2001); Hoover v. Innovative Health of Kan., Inc., 988 P.2d 287, 293 (Kan. Ct. App. 1999).

146. *Negligent Hospital*, *supra* note 137, at 24; *see also* St. Elizabeth Hosp. v. Graham, 883 S.W.2d 433 (Tex. Ct. App. 1994). A major issue in the suit against the hospital was whether the nursing staff should have restrained the plaintiff-patient given his likelihood/propensity to fall from his chair. *Graham*, 883 S.W.2d at 435–36.

147. *See, e.g.*, Swann v. Len-Care Rest Home, Inc., 497 S.E.2d 282 (N.C. 1998). In this case, the North Carolina Supreme Court followed the dissent of the appellate court, 490 S.E.2d 572, 575–76 (N.C. Ct. App. 1997), and determined that the resident's history of two previous falls was not sufficient to indicate that she was at a risk of falling on that particular occasion. *Id.* at 282.

148. Gerard v. Sacred Heart Med. Ctr., 937 P.2d 1104 (Wash. Ct. App. 1997).

that judgment, the health care provider exercised reasonable care and skill, within the standard of care the health care provider was obliged to follow.'"[149] The court also explained that the decision whether to restrain a patient requires that deference be given to the health care provider, and the court affirmed the principle "that whether a patient is put under physical restraint is a matter of medical judgment with which it would not interfere."[150]

In *Dollins v. Hartford Accident & Indemnity Co.*,[151] a 1972 case before the Arkansas Supreme Court, the court explained that "conduct becomes negligent only as it gives rise to appreciable risk of injury to others, and there is no negligence in not guarding against a danger which there is no reason to anticipate."[152] This case involved a patient in a hospital who fell from her bed and sustained injuries.[153] The Arkansas Supreme Court upheld the ruling in favor of the hospital, explaining that although the restraint option was available, the use of restraints was properly left to the discretion of the hospital and that there was no foreseeable risk of the patient falling out of bed that would have made the decision to not restrain unreasonable.[154] In 1968, the court in *DeBand v. Southern Baptist Hospital*,[155] ruled that a hospital was not liable for a patient sustaining injuries from falling out of bed because there was no evidence that the hospital had any reason to believe that the patient represented a fall risk.[156] The court reasoned that because there was no foreseeable risk of injury, the hospital did not breach its duty of care by exercising its discretion to not utilize bedrails as a means of restraint.[157] Another encouraging case for nursing homes is *Nichols v. Green Acres Rest Home, Inc.*,[158] a 1971 case in which a nursing home resident was found dead outside after wandering from the nursing home in the middle of night.[159] The court explained that the individual characteristics of the resident showed that

149. *Id*. at 1104.
150. *Id*. at 1105 (citing, with approval, Adams v. State, 429 P.2d 109 (Wash. 1967)).
151. 477 S.W.2d 179 (Ark. 1972).
152. *Id*. at 183 (citing North Little Rock Transp. Co. v. Finkbeiner, 420 S.W.2d. 874 (Ark. 1967)).
153. *Id.*
154. *Id*.
155. 207 So. 2d 868 (La. Ct. App. 1968).
156. *Id*. at 871.
157. *Id*.
158. 245 So. 2d 544 (La. Ct. App. 1971).
159. *Id.*

he was capable of high function and that no physical restraints were needed.[160] The court reasoned,

> A nursing home is not the insurer of the safety of its patients. The nursing home does have a duty to provide a reasonable standard of care, taking into consideration the patient's mental and physical condition. This duty owed does not include having a nurse or attendant following the patient around at all times.[161]

In short, although liability for injuries associated with a failure to restrain is certainly something for nursing homes to consider and take quite seriously, the use of restraints is not necessarily the most appropriate means by which to reduce that liability.

C. Modern Realities

The trend in federal regulations has been to reduce restraint use, and such a trend makes it less likely that nursing homes will be held liable for reasonably using discretion in not applying physical restraints.[162] Federal regulations such as OBRA are causing nursing homes to become less reliant on restraints, and this decreased reliance has changed what is considered the "accepted practice" of nursing homes, thereby making the non-use of restraints easier to justify and the use of restraints more difficult to justify.[163] "Further, the legal standard of care in nursing homes incorporates a strengthened presumption against restraint use unless identifiable alternatives have been investigated and found impossible for a particular resident."[164] This trend derives not only from federal regulation, but also from state regulations. Almost every state has promulgated regulations making it a right for a nursing home resident to be free from excessive physical restraints.[165] Violations of these state regulations may result in loss of license or monetary fines.[166] But more importantly, a court may be willing to accept compliance with the regulations as proof of fulfilling a duty of care, while deviation from the regulations may be considered at least some evidence of negligence, if not negligence per

160. *Id*. at 546.
161. *Id*. at 545 (citing LeBlanc v. Midland Nat'l Ins. Co., 219 So. 2d 251 (La. Ct. App. 1969); Tait v. Western World Ins. Co., 220 So. 2d 226 (La. Ct. App. 1969)).
162. *See Legal Aspects*, *supra* note 16, at 14.
163. *See id*. at 12; *see also* Kapp, *supra* note 8, at 20.
164. *Legal Aspects*, *supra* note 16, at 14.
165. *See* Kapp, *supra* note 8, at 21. Most states have created a Resident Bill of Rights similar to the applicable federal regulations regarding restraint use. *See id*.; *see, e.g.*, FLA. STAT. ANN. § 400.628 (West 2000) (Florida's Residents' Bill of Rights).
166. Kapp, *supra* note 8, at 22.

se.[167] Although anxiety over potential liability is understandable, nursing homes should not use restraints as a means to avoid potential liability. As has been explained thus far, nursing homes potentially face more liability through the misuse or misapplication of restraints than they do through the decision to not restrain a resident who later injures himself or others. It seems that

> there is relatively limited realistic . . . exposure associated with resident injuries due to falls, wandering, or the aggressive behavior of other residents when the nursing home has withheld the use of physical restraints, so long as the facility has taken other reasonable measures to assess and meet the resident's needs regarding safety.[168]

Nursing homes should never consider the use of restraints to be a panacea, but rather should take the time to accurately assess the resident's physical and mental capacities and general needs.

D. Playing Defense: Some Things Nursing Homes Can Do

Nursing homes, like hospitals, may be able to effectively plead affirmative defenses, such as contributory negligence and assumption of the risk, in restraint-related litigation. Such defenses are difficult to plead in nursing home litigation, in part, because residents who require restraints are often not of completely sound mind at the time of an accident.[169] For example, an unrestrained resident may ignore the assistance call-button by his bed and attempt to climb out of bed on his own accord. It would probably be difficult to show that this resident assumed the risk of any fall, however, because it is very possible that the resident was not completely aware of his surroundings nor of his physical condition. Consider, however, *Lynch v. Huntington Memorial Hospital*,[170] a 1997 California Superior Court case in which a

167. *See id*.
168. *Id*. at 27.
169. Dilworth, *supra* note 99, at 16.
170. No. KCO26950, 1996 WL 526082 (Cal. County Super. Ct. June 25, 1996); *see also* Judge v. Covina Valley Cmty. Hosp., No. G15100, 1998 WL 1017021 (Cal. County Super. Ct. Dec. 28, 1998). In this case, the unrestrained and agitated elderly patient injured himself while getting out of bed. *Id.* at *1. The defendant hospital claimed that the patient had been improving and they saw no reason to continue restraining him. *Id.* The facts are similar to those in *Lynch v. Huntington Memorial Hospital*, and like that case, the jury in this case rendered a verdict in favor of the hospital with no money damages. *Id.* Both of these cases involved hospitals, rather than nursing homes. While fact patterns in nursing home litigation may not always be the same as those in hospital litigation, the premise of duty and foreseeable risk still apply.

hospital applied a nightly restraint to an eighty-four-year-old patient who had just undergone surgery.[171] The patient requested that the restraint be removed, the hospital obliged, and the patient was injured when he attempted to get out of bed.[172] The hospital contended that it was simply honoring the patient's request and that the patient was responsible for his own behavior thereafter.[173] The jury ruled in favor of the defendant, despite the plaintiff's claim that he was confused and disoriented at the time he requested the restraint removal.[174]

A nursing home might be able to argue that there was no foreseeable risk of harm and also contend that neither the resident nor his family members requested the use of restraints. As we have seen, courts are willing to give nursing homes some discretion in the nonuse of restraints if there is no foreseeable risk of danger to the resident.[175] In *Nichols v. Green Acres Rest Home, Inc.*,[176] a Louisiana court of appeals pointed out that the daughter of the deceased nursing home resident had never requested that the nursing home restrain her father's activities in any way.[177] It seems reasonable, therefore, to say that nursing homes should explain not only that there was no foreseeable risk of danger to the resident, but also that there had been no request that the resident be restrained in any way. At the same time, however, nursing homes must take requests for restraints very seriously, as the rationale behind the restraint request and the circumstances surrounding it may serve as evidence that the nursing home was made aware of the resident's personality and/or propensity to fall.[178]

Not all cases reach trial, and those that do may never appear before a jury. Some courts have directed verdicts for the defendant and have been willing to hold plaintiffs to their burden of establishing prima facie cases of negligence, regardless of the sympathy evoked by

171. *Lynch*, 1996 WL 526082, at *1.
172. *Id*.
173. *Id*. at *2.
174. *Id*.
175. *See, e.g.*, Dollins v. Hartford Accident & Indem. Co. v. Finkbeiner, 420 S.W.2d 874 (discussed *supra* notes 151–54 and accompanying text); *see also* DeBlanc v. S. Baptist Hosp., 207 So. 2d 868 (La. Ct. App. 1968) (discussed *supra* notes 155–57 and accompanying text).
176. 245 So. 2d 544 (La. Ct. App. 1971).
177. *Id*. at 546.
178. Nursing homes cannot, nor will not, necessarily restrain a resident simply because his family requests restraints. *See* Vosburgh Interview, *supra* note 98.

the plaintiffs. For example, in *Swann v. Len-Care Rest Home, Inc.*,[179] the North Carolina Supreme Court affirmed the trial court's directed verdict for the nursing home.[180] The initial case involved a ninety-four-year-old woman who was a resident of Len-Care Rest Home.[181] Len-Care was not actually a nursing home, but rather served as a retirement home, and the plaintiff lived there for several years.[182] As the plaintiff's medical condition worsened over the several years in which she lived in the home, she became more confused, and she had the tendency to try to stand up from her wheelchair when unattended.[183] The plaintiff's granddaughter had requested that the plaintiff be restrained, and in 1994 (her fourth year at the facility), a doctor signed an order providing that the plaintiff be restrained as needed.[184] Later that year, the plaintiff fell out of her wheelchair, sustained injuries to her head, and died in the hospital shortly thereafter.[185] The trial court directed a verdict for the defendant on the plaintiff's negligence claim, but the court of appeals reversed on the grounds that the granddaughter's requests for restraint use and the doctor's orders provided ample evidence for the jury to determine if the defendant was negligent.[186] The North Carolina Supreme Court followed the court of appeals' dissenting opinion and upheld the directed verdict.[187] The logic that triumphed was that the plaintiff had not produced any actual evidence demonstrating any breach in the facility's duty of care.[188]

Although merely a state court decision, the ruling in this case is important nonetheless because it establishes a higher burden for plaintiffs. In effect, the North Carolina Supreme Court ruled that important evidence, such as the fact that the plaintiff had fallen twice in the preceding year, the fact that the plaintiff's family had asked that she be restrained, and the fact that the plaintiff's physician had authorized her restraint, were not sufficient to allow the case to be pre-

179. 497 S.E.2d 282 (N.C. 1998).
180. *Id.* at 282.
181. Swann v. Len-Care Rest Home, Inc., 490 S.E.2d 572, 573 (N.C. Ct. App. 1997).
182. *Id*.
183. *Id*.
184. *Id*.
185. *Id*.
186. *Id*. at 574.
187. Swann v. Len-Care Rest Home, Inc., 497 S.E.2d 282 (N.C. 1998).
188. Swann v. Len-Care Rest Home, Inc., 490 S.E.2d 572, 575 (N.C. Ct. App. 1997) (Martin, J., dissenting).

sented to a jury.[189] The court concluded that the burden was on the plaintiff to establish that on the date of the injury the defendant had "reason to know that [the plaintiff] required restraint for her own safety and, with such knowledge, failed to restrain her."[190]

As in any negligence claim, the plaintiff must establish that there was a duty and that such duty was breached.[191] In *Swann*, the dissenting opinion of the appellate court, on which the Supreme Court relied, argued that a duty of care cannot be established simply by showing that, in general, the plaintiff was susceptible to falling.[192] In fact, the ultimately persuasive dissenting opinion states, "[f]ollowing the majority's logic, defendants would have been negligent if they had not restrained [plaintiff] at all times, which would have been contrary to her physician's orders and to his wishes as expressed during his testimony."[193] When examined, such reasoning seems to have its merits, but also its problems. For example, it does appear unfair to hold a nursing home liable for any fall or injury sustained by a resident. It is likely that no court exists that would find a duty created simply because an injury happens inside the nursing home. It would be unfair to allow a plaintiff to establish a duty of care simply by showing that the resident had fallen in the distant past or had become confused on isolated occasions in the past. However, the unacceptable result of the *Swann* court's reasoning, when taken to the extreme, is that the nursing home would only be liable if it knew that the resident was likely to fall or injure himself on that particular day or on that particular occasion. Such reasoning is unacceptable because it allows nursing homes to ignore the past tendencies of the resident, particularly when the confused behavior and reactions of the resident may be difficult to predict. One reason for the higher burden on the plaintiff, as that advocated by the *Swann* court, could be that courts know very well that juries may not be sympathetic to the nursing home and may not strictly evaluate the duty of care, particularly when the plaintiff has been injured or is deceased.

189. *Id*.
190. *Id*. The court noted that there was evidence showing that plaintiff's restraint was found approximately two feet from her, inferring that she had actually been restrained but had managed to free herself. *Id*.
191. Kapp, *supra* note 8, at 8–9.
192. *Swann*, 490 S.E.2d at 575.
193. *Id*.

Although a nursing home is not an insurer of the safety of its residents, it does have a duty to provide a standard of care that is reasonable under the circumstances, taking into consideration the patient's mental and physical condition.[194] It seems that the very nature of a nursing home's duty of care is fact-specific and relies heavily on the resident's condition, the staff's knowledge of the condition, and the circumstances surrounding the accident/injury at issue.[195]

Although it seems that the *Swann* court's rationale for its directed verdict lacked thorough analysis of the facts, the decision was not unreasonable. Of course, it is impossible to analyze the court's decision without knowledge of all of the facts presented, but the plaintiff cannot be allowed to circumvent his burden of actually establishing the defendant's duty. Unfortunately for the plaintiff, this is a difficult burden because it relies entirely on the facts unique to the case. If the duty of the nursing home is essentially grounded in fact, rather than solely in law, such facts should ideally be analyzed by the jury. Absent any more solidified legal guidelines for the establishment of the nursing home's duty, the courts should not be in the business of bypassing the trial-by-jury unless there is simply no evidence that the nursing home could have or should have known that such an accident/injury might occur. Perhaps the most appropriate position for the courts to take is that of a middle ground, without forcing a herculean burden upon plaintiffs, while not easing the burden below that which would normally accompany a fact-specific negligence claim.

The primary ramification of a *Swann*-like decision for the nursing home-defendant is that, on a purely legal basis, it is crucial to establish that it was unreasonable for the nursing staff to think that the resident-plaintiff represented an accident risk on the actual day of the accident. And on a broader note, the nursing home should make sure to properly monitor, evaluate, and document instances of resident confusion, including episodes in which the resident might have attempted to stand up or get out of bed. Liability may attach when the nursing home knew the resident might present a risk of falling but did nothing to prevent it. At the same time, a "reasonableness" analysis

194. *Negligent Hospital*, *supra* note 137, § 10; *see, e.g.*, Associated Health Sys., Inc., v. Jones, 366 S.E.2d 147, 150 (Ga. Ct. App. 1988); DeBlanc v. S. Baptist Hosp., 207 So. 2d 868, 871 (La. Ct. App. 1968).

195. *Negligent Hospital*, *supra* note 137, § 10.

might also attach liability when the nursing home acted negligently in failing to record, document, or communicate the potential risk in the first place.

V. Recommendations

A. Education

There are a variety of reasons why restraints are still used in some capacity. They are still used in the medical healing process[196] and to prevent dangerous activity and violent behavior.[197] While nursing homes are not supposed to use restraints simply to prevent falls, it can be argued that some nurses do, indeed, continue to use restraints to prevent falls, but do so under the guise of the medical healing process or the prevention of violent activity.[198] Most hospitals and nursing homes continually educate and train their nursing staffs in proper restraint use.[199] It must be remembered, however, that some nurses began their careers during a time when restraint use was accepted protocol.[200] There has been a paradigm shift regarding restraint use, and modern nurses are being trained in a different culture than older nurses who may have begun their training fifteen or twenty years ago.[201] It is, therefore, important that a nursing home educate its staff not only about the proper way to assess when a restraint is needed, and the proper manner by which to administer re-

196. For example, hand mitts are restraints that prevent a patient or resident from pulling out IV or feeding tubes.

197. A resident that becomes violent to the nursing staff or other residents may have to be restrained for the protection of third parties and himself. Telephone Interview with Juanita Gryfinski, Nurse Specialist, RN, MS (Oct. 18, 2000) [hereinafter Gryfinski Interview]. Ms. Gryfinski is a nurse at an acute care facility in Illinois. Her insight on physical restraints was through the eyes of an acute care nurse, but she believes her analysis relates to most nursing homes as well.

198. *Id*. This is not to say that nurses are at all dishonest. However, as long as caregivers must split their time among several residents and tasks, the fear that residents will fall will always remain real. Restraints, therefore, may be thought to be used as a tool for maintaining resident physical health, although caregiver efficiency and piece-of-mind are, perhaps, more likely the dispositive factors at times. *Id*.

199. Vosburgh Interview, *supra* note 98 (as In-service Director, Ms. Vosburgh's duties include educating the nursing staff); *see also* RESURRECTION HEALTH CARE RESTRAINT POL'Y (on file with The Elder Law Journal).

200. The average age of employed registered nurses within the entire health-care field is forty-five, and forty percent of the RN workforce will be over the age of fifty by the year 2010. *See* Barrett, *supra* note 10, at 14.

201. Gryfinski Interview, *supra* note 197.

straints, but also about restraint alternatives. The JCAHO has promulgated a list of restraint alternatives and less restrictive measures that a nurse can utilize prior to applying a restraint,[202] and facilities have their own policies.[203] However, it is important that nurses remain well-informed about not only the variety of restraint alternative options available to them, but also about the reasons why those options are attractive. Needless to say, education and training must be an ongoing process for the entire staff.

B. Behavioral-Based Treatment

The primary value of the new JCAHO pain-management standards is that they will increase the attention that caregivers pay to a resident's comfort, and the new standards may further facilitate communication between the resident and caregiver. There exist a variety of mechanisms by which caregivers can relieve the pain of a resident. The mechanism often employed, and probably most often requested is the use of pain medication. Although prescription medication has, indeed, proven effective,[204] there do exist a variety of other techniques available for pain management: "[i]n addition to some 400 types of pain medications, most nonnarcotics, there are other treatments such as massage, visualization, relaxation, meditation, ice packs, sitz baths, physical therapy, guided imagery, and deep breathing."[205] It seems reasonable that techniques used to relax a patient or resident and make him feel more at ease would also be effective as alternatives to restraint use. For example, residents could participate in activities requiring simple, repetitive motion, including folding laundry, puzzles, and arts and crafts. "Any repetitive, commonplace activity can poten-

202. J.C.A.H.O. TX. 7.1.3.2.3, *supra* note 67, at 3–5. The JCAHO lists several options, including specific de-escalation strategies (verbal communication), changing bothersome treatments, providing additional companionship, modifying the environment, offering diversionary activities, etc. *Id*.

203. *See, e.g*., RESURRECTION HEALTH CARE RESTRAINT POL'Y, *supra* note 199, at 10.

204. *See generally* Ben A. Rich, *A Prescription for the Pain: The Emerging Standard of Care for Pain Management*, 26 WM. MITCHELL L. REV. 1 (2000). The author notes that there is a strong consensus that ninety percent of all pain experienced by patients can be relieved. *Id*. at 8. The author also notes that an important reason for the under-effectiveness of pain medication is that caregivers are unaware of the addictive effects of the drugs and fear that the patient may become addicted; such a fear is irrational, he claims, and the victim of such fear is the patient in pain. *Id*. at 55–61.

205. Cox, *supra* note 104, at 2.

tially function as a distractive device."[206] Distractive devices may be useful for preventing the resident from becoming confused, or from becoming restless when he does become confused,[207] thereby decreasing the need for physical restraint use. Two nurses at an acute care facility also found that rocking chairs can be "particularly successful with confused, restless patients[,]"[208] and that other items, "such as spools to thread, stuffed animals, music, and purses or wallets containing various items"[209] could also be used. As previously mentioned, HCFA has determined that almost nine percent of facilities have inadequate activities programs.[210] Although activities and programs may be valuable for general resident comfort, individual attention paid to the resident may be quite important in reducing the need for physical restraints.[211] Nurses and nursing assistants need to be able to understand that music, rocking chairs, hands-on activities,[212] and family visitation[213] are not simply tools to "distract" the resident, but that they are tools that serve to alleviate discomfort and agitation. A strong commitment to education and training of proper restraint

206. Kathy Missildine & Sherrie Harvey, *Restraints Rock*, NURSING MGMT., June 2000, at 44, 46.

207. *Id.* The authors of this article are nurses, and the patients they are referring to are older, acute care patients. *Id.* The authors note that, in their own experience, with increased use of distractive devices, following a staff education plan, restraint use decreased significantly, and caregiver confidence and knowledge increased significantly. *Id*. at 46–47. Additionally, Catie Vosburgh, RN, has noted that at the two nursing homes at which she works, distractive devices, such as folding laundry, are utilized and are greatly effective. Vosburgh Interview, *supra* note 98. Ms. Vosburgh finds that female residents, in particular, seem to think that they are helping the staff by folding laundry and that this increased feeling of "usefulness" results in a decrease in the manifestation of resident agitation. *Id*.

208. Missildine & Harvey, *supra* note 206, at 46.

209. *Id.*

210. HARRINGTON ET AL., *supra* note 81, at 91.

211. Guidas Interview, *supra* note 70; *see also* Missildine & Harvey, *supra* note 206, at 46.

212. *See* Missildine & Harvey, *supra* note 206, at 46; *see also* J.C.A.H.O. TX. 7.1.3.2.3.1, *supra* note 67, at 3–5.

213. Vosburgh Interview, *supra* note 98. Ms. Vosburgh explained that one of the nursing homes in which she works will even call a family member of a resident and request his presence in order to decrease the resident's agitation. *Id*. Ms. Vosburgh insists that sometimes resident agitation stems from a feeling of abandonment caused by no family visitation. *Id*. It should also be noted, however, that George Guidas, RN, believes that while family visitation can often alleviate agitation and loneliness, such a result depends heavily on the relationship between the resident and his family. Guidas Interview, *supra* note 70. Because residents and their families are all engaged in "human interaction," it is possible that visits from family members could actually lead to an increase in agitation. *Id*.

use, restraint alternatives, and the physical and psychological reasons for restraint alternatives must be maintained as a high priority.

C. Staffing

1. STAFF VIGILANCE

One remedy to the problem of understaffing is simply for nursing homes to hire more staff employees. While this solution offers many advantages, it is complicated and beyond the scope of this note.[214] Understaffing is a problem that can be readily identified, measured, and regulated, however, a lack of staff vigilance is more difficult to recognize. Common sense would seem to dictate that having one-on-one staff attention would be ideal for resident comfort and for reducing the risk of falls and fall-related injuries. Although such a solution is obviously not feasible,[215] staffing ratios can be scrutinized and regulated.[216] Staff vigilance, on the other hand, is difficult to measure because, as with any employee, a caregiver may act in accordance with all regulations yet still not pay as much attention to a particular resident as appropriate. Although nursing homes have procedural guidelines for checking on residents, the fine line between a safe resident and one who falls is often the fine line between a caregiver who makes frequent checks on the resident and one who does not.[217]

214. Practical limitations to the concept of simply hiring more staff might include budget restraints, lack of trained supply, and the problem of diminishing rate of return. For example, who pays for more staff? There are obvious problems with placing more costs upon residents' families. As for a diminishing rate of return, there are limits that must be placed upon the number of staff members in any single facility, as sheer numbers could overwhelm the effectiveness of programs and daily tasks. Guidas Interview, *supra* note 70.

215. In fact, George Guidas, Director of Nursing at a Champaign, Illinois nursing home indicated that while increased staff presence might be helpful, too much of an increase would be disruptive to the general daily routine. He explained that, as with any workforce, too many employees could increase confusion and decrease efficiency. Mr. Guidas explained that his nursing home, with ninety-nine beds, employs three nurses and nine CNAs (Certified Nursing Assistants) during the day shift, and two nurses and four to five CNAs during the night shift. He suggested that, if financial concerns were of no issue and the supply were plentiful, he would want roughly four nurses and eleven CNAs per 100 residents during the day shift. Guidas Interview, *supra* note 70.

216. *See, e.g.*, HARRINGTON ET AL., *supra* note 81, at 61–62. States may have their own minimum staffing ratios. *See, e.g.*, 210 ILL. COMP. STAT. ANN. 45/3-202(2) (West 2001).

217. George Guidas, RN, explained that nursing homes do have established procedures outlining the responsibilities of staff members. Guidas Interview, *supra* note 70. At the same time, however, there is a distinction between merely checking to see that a resident is still in his wheelchair and actually inquiring into

Specific recommendations for enhancing staff vigilance are beyond the scope of this note, but it should be noted that although sufficient staff numbers are important for preventing fall-related injuries and for general resident safety, staff sufficiency needs to be considered in qualitative terms, in addition to quantitative terms.[218] A helpful product for "keeping an eye" on residents is a chair alarm, a device that signals to the staff when a resident has risen from her chair or bed.[219] Unfortunately, these products are expensive, and some nursing homes cannot afford them.[220] Perhaps the government will one day assist in the funding of these products. Regardless, chair alarms should never be a substitute for adequate staffing numbers or for staff vigilance.

The JCAHO will be developing a new process by which to assess the staff effectiveness in health care organizations.[221] The new process will not likely create predetermined staff ratios, but it should highlight the need for adequate staffing numbers and vigilance.[222] The JCAHO believes that the summer 2001 trial of its new staffing process was greatly successful, and that it will soon apply to hospitals and may apply to nursing homes within a few years.[223]

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his comfort and needs, and determining whether he appears content or appears to be agitated or confused. *Id*.

218. Arguably, staffing vigilance may be even more important to resident safety than staffing numbers. Guidas Interview, *supra* note 70.

219. Vosburgh Interview, *supra* note 98. In fact, one of Ms. Vosburgh's nursing homes utilizes an alarm that indicates if the resident has "hunched over" and is at risk of falling out of his wheelchair. *Id*.

220. *Id*.

221. *See Joint Commission to Develop a New Approach to Assessing the Effectiveness of Staffing in Health Care Organizations*, *at* http://www.jcaho.org/news/nb301.html (last visited on Dec. 20, 2001) (on file with The Elder Law Journal).

222. Telephone Interview with Janet McAntyre, JCAHO spokeswoman (Feb. 8, 2001). The new approach was introduced into hospitals on a trial-basis during the summer of 2001. Telephone Interview with Janet McAntyre (Sept. 25, 2001). The new process to assess staff effectiveness utilizes a matrix of different outcome measures. *Id.*; *see also supra* note 81 and accompanying text. For example, the matrix could isolate decubitus ulcers and then look at the incidence of ulcers vis-à-vis staff numbers, staff ratios, frequency of resident examinations, etc. *Id.* The purpose of the new process is to allow facilities to identify areas that may need attention and to then make the necessary adjustments. *Id*. The new process does not mandate staff ratios, nor does it mandate that facilities do anything in particular; it merely serves as a way for facilities to examine their staffing concerns in a "new light." *Id*.

223. Telephone Interview with Janet McAntyre, *supra* note 222.

2. THE USE OF SITTERS

a. Background An additional problem related to staffing concerns Medicaid reimbursement for "sitters," or individuals hired to assist and watch over a particular resident. Although Medicaid will reimburse for private duty nurses when medically necessary,[224] it is obvious that most residents do not necessarily require a private nurse. As it stands, a resident's family can always hire an individual to personally assist the resident, but the family must absorb the cost. Although the use of sitters in a nonmedical capacity may not be necessary, the sitter might have several functions that can be of significant aid to the resident. In addition to assisting the resident in the performance of menial tasks, such as eating and getting dressed, the mere presence of the sitter may serve as a source of companionship and comfort for the resident.[225] The overall effect on the resident, therefore, may be on an emotional and psychological level, but there is also the possibility that there can be a correlation between sitters and physical restraint use. For example, if reasons for restraint use include a resident's confusion, discomfort, or desire to do something for which there is no available assistance,[226] it seems reasonable that the presence of a sitter could reduce the need for restraint use. The increased presence of a companion could serve as a way for the resident to communicate his discomfort or desires. And even if the resident could not effectively communicate his discomfort, the sitter is more likely to become cognizant of the discomfort by her own consistent observations than would a nurse assistant who may see the resident much less frequently. As

224. *See* E-mail from Janice Earle, HCFA, to the author, Evan Meyers (Mar. 15, 2001) (copy on file with the Elder Law Journal). Medicaid will cover the cost of a private duty nurse if having the nurse is "medically necessary for a nursing facility resident and it is written in the resident's plan of care." *Id.* Such a service would be covered under the Medicaid nursing facility benefit. *Id.*

225. Experienced sitters likely have assisted the resident as a home health assistant prior to serving as a companion in the nursing home setting. Telephone Interview with George Guidas, RN, Director of Nursing, at a Champaign, Illinois, nursing home (Mar. 23, 2001) [hereinafter Guidas Telephone Interview II]. Mr. Guidas notes that at his ninety-nine-bed facility, there are no medically necessary private-duty nurses, but there are usually about two sitters at any given time. *Id.*

226. Restraints can only legally be used if any of these situations/conditions creates an emergency in which the resident or those around him are in danger. *See* 42 C.F.R. § 483.13 (1997); *see also* 210 ILL. COMP. STAT. 45/2-106(c) (West 2001); RESURRECTION HEALTH CARE RESTRAINT POL'Y, *supra* note 199, at 2 ("Restraints are limited to emergencies in which there is an imminent risk of harm to self or others. Restraints should only be used when other less restrictive interventions . . . have been considered.").

for injuries resulting from an unrestrained resident attempting to get out of her wheelchair, the presence of a sitter would be more likely to reduce the likelihood of such an occurrence.[227]

b. Potential Problems Of course, because the effectiveness of sitters depends, in part, on the relationship developed between the sitter and the resident, the benefit of a sitter's presence will not apply to every situation. For example, as with any two individuals in a close environment, there is always a risk that the sitter will not be appreciated by the resident, either because there is a clash of personality or because the resident simply may not want a "stranger" at his side. Moreover, there is a risk that the resident can become too dependent on the sitter, refusing to cooperate with the nursing home staff, or even refusing to partake in any recreational programs outside the sitter's presence.[228] Additionally, the resident may become too reliant on the sitter, refusing to engage in even the most basic tasks on his own.[229]

An additional problem with Medicaid reimbursement for sitters is, of course, the cost. Although the financial burden to Medicaid is beyond the scope of this note, few could possibly argue that every resident should have free access to a sitter.[230] Moreover, the presence of too many sitters in a nursing home could become counterproductive, as it would create confusion and an overcrowded environment.[231]

227. Vosburgh Interview, *supra* note 98. Ms. Vosburgh indicated that falls occur relatively frequently and are often the result of a resident attempting to get out of her wheelchair. *Id*. Ms. Vosburgh further explained that the nursing staff is sometimes powerless to prevent these occurrences and that the best defense against injuries is sometimes a wheelchair alarm or any device which can simply notify the staff of the resident's attempt to leave his wheelchair. *Id*. If the risk of fall-related injuries is the price to be paid for not restraining a resident, it would seem reasonable to suggest that additional observation by a sitter would continue to allow residents to avoid restraints while decreasing the risk of wandering and falling.

228. *Id*.

229. *Id.*

230. It could be argued that even if Medicaid did partially reimburse for sitters, many, if not most, families would still not hire a sitter, either because of a lack of interest or the prohibitive nature of even a partially reduced price tag.

231. Guidas Interview, *supra* note 70. Mr. Guidas explained that while understaffing, in general, may be a problem, too many staff members could also be a problem. *Id*. The facility could become "oversaturated," resulting, in effect, in nurses tripping over one another. *Id*.

c. The Sitter Solution: A Compromise In accordance with the desire to increase general levels of staffing, as well as levels of staff vigilance, it seems reasonable to suggest that the addition of sitters would have some benefits. Because the government would never be able to fund, even in part, an extensive amount of sitters, and because too many sitters would become burdensome on the other staff members, a reasonable solution is that the government could partially reimburse individual families desiring to hire personal sitters. Perhaps an even more attractive plan would be for the government to help fund the hiring of sitters hired by the nursing home itself. In addition to an increase in nursing aides, the presence of a few sitters around the nursing facility would allow residents to get more individual attention while not creating too much confusion. Instead of a sitter providing "around the clock" attention to a single resident, sitters could be assigned a group of several residents and then be responsible for providing companionship to those residents. Such a situation would still allow the sitter to respond to the residents' needs and prevent or remedy attempts by the residents to get out of their wheelchairs and beds. Residents or families desiring not to take part in such an arrangement could opt out, and those residents and families that would like to take advantage of the extra companionship and vigilance could, perhaps, pay a reasonable additional fee. The government could eliminate or help reduce the cost of such a program either by reimbursing the families who opt into the arrangement or by increasing funding to the nursing homes to hire the sitters. And even if the government remained unwilling to fund such a program, the fee paid by the family would be much more reasonable than with a private sitter because it would be shared with several other families.[232]

The increased use of sitters is not a panacea, nor is it necessarily a solution for increased staffing needs, but it could have a positive impact on resident behavior, comfort, and physical restraint use. The need for restraint use would likely decrease with any increase in vigilance or individual attention to the residents. Moreover, families

232. In August 2001, The Medicaid Community-Based Attendant Services and Supports Act of 2001 was introduced into the Senate. *See* S. 1298, 107th Cong. § 1 (2001) The Bill is meant to increase federal funding for "sitter-like" services provided to the elderly. *Id.* However, the Bill explicitly states that it has a purpose of evening out the distribution of funding for community-based services and institutions. *Id.* Thus, nursing homes are expressly not included within the scope of this Bill. This would be a needed law, but because it does not include nursing homes, it is insufficient.

could feel more at ease knowing that someone whose salary they help pay is watching over their loved ones on a more personal level. And most important, residents may benefit emotionally from the increased companionship and the increased ability to more effectively communicate their needs. Such a plan could also decrease the need for restraints while at the same time decrease the risk of fall-related injuries which result from lack of restraint use.

D. Legal Recommendations

1. ASSUMPTION OF RISK

a. Background Nursing homes may consider pleading assumption of the risk as a defense to a negligence or wrongful death suit. Professor Marshall Kapp[233] has noted that "the risk of an adverse medical incident and its legal consequences may be shifted properly to the mentally competent resident, or if the resident is decisionally incapacitated, to the resident's authorized surrogate decision maker."[234] Professor Kapp notes:

> In other health care contexts, the courts consistently have recognized the doctrine of assumption of risk as a complete defense to a negligence action, where the patient voluntarily and knowingly (after being adequately informed by the provider) declined a particular intervention and agreed to accept responsibility for the reasonably foreseeable potential adverse results of that decision.[235]

b. Potential Benefits By applying an assumption of risk doctrine to injuries resulting from restraint use or non-use, nursing homes could seemingly be able to place the initial decision of whether to restrain on the resident himself. Besides potentially being dangerous, it has been previously noted that restraints can damper a resident's comfort and dignity.[236] "There is no reason to restrict the choice of nursing home residents or those acting in their best interest from knowingly and voluntarily accepting specific, limited risks of injury in exchange for

233. As of 1992, Mr. Kapp, J.D., M.P.H., was affiliated with Wright State University School of Medicine in Dayton, Ohio, where he served as a professor in the Department of Community Health and as Director of the Office of Geriatric Medicine & Gerontology. Kapp, *supra* note 8, at n.1.

234. *Id.* at 27.

235. *Id*.

236. *See supra* notes 26–27 and accompanying text.

retaining a modicum of freedom and dignity . . . ."[237] Currently, residents of sound mind[238] are allowed to provide voluntary consent to restraint use.[239] If a resident is allowed to provide consent for restraint use, and if the law has recognized assumption of risk in a variety of fields involving personal choice, then it seems to make sense that a nursing home should be allowed to offer the resident's consent or nonconsent as the basis of an assumption of risk defense. It is likewise reasonable to allow nursing homes to utilize as a legal defense the resident's documented desires to not be restrained. This desire of the resident should also be allowed to help insulate the nursing home from liability.

Such a rule would allow residents to have a more direct voice in their own care, and it would allow nursing homes to respect the wishes and desires of the resident without fearing litigation. The nursing home would then be able to provide care, vis-à-vis restraint use, based entirely on need, rather than on efficiency or fear of litigation. Likewise, such a rule would possibly decrease the chance that the resident (or his family) would pursue litigation, as there would be documented consent that the court would be likely to accept.

c. Potential Problems Although a resident should be allowed to consent to restraint use, how likely is it that a resident would ever provide such consent? It is certainly more likely that a resident would give the nursing home consent to not being restrained. Documentation of the resident's desire not to be restrained is likely to be easier for the nursing home to obtain.[240] However, it seems reasonable to suggest that most residents of sound mind would be willing to consent to not being restrained, and such a willingness could allow nursing homes to essentially obtain the consent of virtually all their residents. On its face, that seems like a reasonable idea, but the problem

237. Kapp, *supra* note 8, at 28.

238. Sound mind, in this situation, means a resident who is "cognitively intact." RESURRECTION HEALTH CARE RESTRAINT POL'Y, *supra* note 199, at 3.

239. Federal law only prohibits the *imposition* of restraints except under certain circumstances. The law, therefore, does not prohibit voluntary restraint use. *See* 42 U.S.C.A § 1395i-3(7)(c)(1)(A)(ii); *see also* RESURRECTION HEALTH CARE RESTRAINT POL'Y, *supra* note 199, at 2 (excluding from its definition of restraints any devices used voluntarily).

240. Such a thought is mere speculation, but the idea that a resident would rather be restrained than not be restrained seems to defy common sense at any level.

could be in its application. Obtaining the consent of residents to not use restraints would lead to less restraint use, but it could prevent nursing homes from using restraints when they are truly needed. If the assumption of risk defense becomes an absolute per se defense for nursing homes, then there would be decreased incentive for staff to remain diligent regarding restraint needs. The resident may consent to restraints not being used, but the resident may not be able to consider scenarios that might occur down the road. For example, if the resident's condition changed so that restraints would be needed for the resident's safety, would the nursing home have incentive to restrain the resident? A court should not completely accept a nursing home's assumption of risk defense without determining whether the resident's condition changed in a manner making his initial consent suspect.

2. FAMILY CONSENT FOR ASSUMPTION OF RISK

a. Rationale Professor Kapp also proposes, in addition to residents being able to provide consent necessary for an assumption of risk defense, that authorized surrogate decision makers should also be allowed to give consent. He states, "Unless a substitute is acting in clear disregard of a resident's best interests or personal values and preferences, the substitute should be able to choose non-restraint on the resident's behalf, accept the accompanying risks, and thereby relieve the nursing home of potential liability."[241] Currently, the resident's significant others may not be able to give consent to restraint use, and they may not be able to give consent for the non-use of restraints.[242]

b. Potential Benefits The idea that a family can speak on behalf of an elderly patient or resident is not a new concept. Family members are often responsible for choosing the resident's nursing home in the first place, and they may also pay the bills as well. If a family member

241. Kapp, *supra* note 8, at 28.

242. *See, e.g.*, RESURRECTION HEALTH CARE RESTRAINT POL'Y, *supra* note 199, at 2. The policy does not expressly address consent to not using restraints. *But see* 210 ILL. COMP. STAT. 45/2-106 (West 2001) (stating that a restraint may be used with the informed consent of the resident, the resident's guardian, or other authorized representative). *Id*. The Illinois statute does not refer to familial consent for the non-use of restraints. *See id*.

can make the decision whether to sustain a resident's life should that decision need to be made, then it simply defies common sense to not allow family members to provide consent for restraint use or non-use. Allowing the resident's significant others to provide consent would extend the benefits of having an assumption of risk defense for nursing homes—resident dignity and decreased fear of litigation—to those residents who are not of sound mind or are not mentally competent.

An additional benefit to allowing familial consent is that it would lead to an increase in communication between the facility and the family. As it stands, nursing homes will typically inform the resident's family if the resident is under restraint.[243] However, communication between the facility and the resident's family is important for several reasons. Communication can allow the family to gain a better understanding of the daily routine of the resident and the type of care that she receives; interested family members are likely to want to know who is taking care of their loved one. Nursing homes should also make sure that they properly communicate to family members the value of visitation. Family visitation can help a resident maintain a sense of "normalcy," as well as decrease agitation and loneliness.[244] Proper communication may also be able to help foster a greater understanding and appreciation for the work of the nursing home staff, which could lead to decreased litigation. The resident's family may become less upset when the resident falls if the family knows why she may have fallen and why he was not restrained.[245] If a family member is going to be authorized to provide consent for not restraining a resident, then it is imperative that the family member be fully informed of restraint options, the rationale behind restraint use and non-use, and the implications and ramifications of restraint use and non-use. Fami-

243. Guidas Telephone Interview II, *supra* note 225; *see also* RESURRECTION HEALTH CARE RESTRAINT POL'Y, *supra* note 199, at 3 ("The family is to be notified of the initiation of restraint/seclusion while considering patient confidentiality. The reason for restraint and circumstances for removal are to be explained to the patient and/or family as appropriate.")

244. Vosburgh Interview, *supra* note 98.

245. George Guidas, RN, explained that family members can become quite upset if the resident is injured, and proper communication and explanations prior to any incident, as well as immediately following same could help prevent the family from becoming upset. Guidas Interview, *supra* note 70.

lies may be tempted to request restraint use, as they may be unaware of the problems associated with restraints.[246]

c. Potential Problems Although some families may be very hesitant to provide consent for the non-use of restraints, others may be tempted to defer to the expert advice of the nursing home staff, and such advice, when combined with the desire for their loved one to not have to be stripped of freedom and dignity, may lead some families to easily provide consent to the non-use of restraints. It is incumbent upon the nursing home to provide the family with comprehensive and *objective* information. In any later court proceeding, the nursing home will not only have to provide documentation that it communicated with the family and obtained consent, but it should also have to establish that the consent was given voluntarily and with the family's full knowledge of the ramifications of such a decision. After all, nursing homes would benefit from an assumption of risk defense, so nursing homes would have incentive to attempt to convince the family that restraints are dangerous and oppressive and that consent to prevent their use should be quickly granted. For this reason, if assumption of risk becomes a valid defense for nursing homes in restraint cases, then the nursing home, prior to receiving consent, should have to communicate to the family the legal ramifications of such consent.

d. Recommendation: A Compromise Providing an assumption of risk defense for nursing homes is generally a good idea, not only as a way to decrease restraint use, but also as a way to be fair to nursing homes. Likewise, it would be wise to allow competent residents or incompetent residents' families to provide consent for the non-use of restraints. However, in order to guarantee that the nursing home adequately communicates with the family and explains the ramifications of providing consent, the nursing home should have to present evidence of what it communicated to the resident or family. Not only should the actual consent be well documented, but the general content of the communication should also be documented.[247] The nursing

246. *See, e.g.*, Swann v. Len-Care Rest Home, Inc., 490 S.E.2d 572, 573 (N.C. App. 1997). In that case, the resident's granddaughter requested that the resident be restrained after it was found that the resident was susceptible to falling. *Id*.

247. Professor Kapp recommends that the resident's chart "should note the process of communication and negotiation and the decisions ultimately made."

home should document what was said to the family, including the ramifications of restraint use and non-use, as well as the legal implications of the consent, including an acknowledgment that the consent may be revoked by the family at any time.

Assumption of risk in restraint-related cases should not be a complete per se defense for nursing homes. Just as the plaintiff has to demonstrate evidence that the nursing home actually breached its duty of care in that particular situation,[248] so too should the defendant have to provide evidence that any consent was made voluntarily and knowingly, meaning with full reasonable knowledge of the physical, psychological, and legal ramifications of restraint non-use. Professor Kapp recommends that nursing homes should not be held liable for injuries resulting from a failure to restrain a resident "unless that failure represents gross negligence."[249] However, such a standard would be an unfair burden on the plaintiff. Although reducing restraint use and providing the best standard of care possible for nursing home residents are both important objectives, they should not be achieved at the sacrifice of justice.

If the resident or family provides adequate consent, then the burden should shift to the nursing home to establish that the consent was voluntary and knowing (e.g., the resident or family was fully informed). Assuming that burden is met, the burden should then shift back to the plaintiff to prove gross negligence. If, however, no consent was given by the resident or family, then the burden should be on the nursing home to prove that the care it provided was reasonable under the circumstances and that no duty was breached. To properly defend itself, the nursing home would have to establish more than simply that it was not grossly negligent, yet less than a mere negligence standard. The standard should be one of professional reasonableness under the circumstances.[250]

The problem with such a burden-shifting scheme is that it could lead to more litigation against nursing homes than if the gross negligence standard was applied. However, by shifting the burden to the

Kapp, *supra* note 8, at 29. Kapp also writes, "Importantly, the chart should indicate which alternative methodologies were implemented to satisfy the facility's duty to protect the resident's safety or the safety of other residents." *Id*.

248. *See Swann*, 490 S.E.2d at 575 (Martin, J., dissenting).

249. Kapp, *supra* note 8, at 32. Kapp admits that the gross negligence standard would be a very difficult standard of proof for plaintiffs to meet. *Id*.

250. *See, e.g.*, Gerard v. Sacred Heart Med. Ctr., 937 P.2d 1104 (Wash. Ct. App. 1997).

nursing home if there was no consent given, there would be incentive for nursing homes to openly communicate with the resident or family, knowing that obtaining consent could create a potentially strong defense. It would also increase the incentive for the nursing home to document the consent process, as well as all actions taken regarding restraint use and the resident's risk of fall. By combining the availability of an assumption of risk defense with the above burden-shifting scheme, a diligent and responsible nursing home would be able to decrease its restraint use without fear of legal liability. And, if the nursing home was unable to secure consent for the non-use of restraints, then it would still be no worse off than if the assumption of risk defense did not exist, only it would have to document its activities and communications and prove that it acted reasonably. The assumption of risk defense should help reduce restraint use and increase the quality of care in nursing homes, but it should not serve as a panacea for ridding the nursing home of restraint use. There are other means available by which to reduce restraint use and increase the quality of care, and those means should supplement the availability of the assumption of risk defense.

VI. Conclusion

It was once thought that physical restraints played an important role in the care of nursing home residents. Restraints still have their role, only such a role has been reduced to emergency-like situations. There are a variety of techniques currently utilized by nursing homes in lieu of restraint use, and if caregivers are continually educated about restraint alternatives, non-restraints, and the physical and psychological problems with restraints, then restraint use in nursing homes should continue to decrease. As the population ages, it is imperative that nursing homes understand the realities of restraint-related legal liability. Through decreased restraint use and increased staff numbers and vigilance, the quality of care in U.S. nursing homes can continue to improve. And with a commonsense legal approach, including the establishment of an assumption of risk defense and a burden-shifting doctrine, nursing homes will be able to focus on quality of care rather than on legal liability. There is no doubt that nursing home residents and their families deserve that.