LIABILITY
landscape

BY LINDA WILLIAMS, RN

Do you have the 'right' to use a chemical restraint?

The medical necessity for the use of any form of restraint must be clear and documented in writing before it is used. Therefore, no physical or chemical restraint should ever be utilized for any resident until:

- a thorough assessment of all the factors that may be the cause of behaviors (necessitating the restraint) have been completed;
- alternatives have been tried and documented, and have failed;
- informed consent from the resident and/or responsible party has been obtained; and
- the physician has given the appropriate orders.

If a physical restraint is utilized in an emergency situation, the facility must obtain orders and a written consent within 12 or 24 hours, depending on state regulations.

The term "informed consent" means the decision maker, usually the durable power of attorney (DPOA) for healthcare decisions, must be given information about the risks, benefits, and adverse effects of the use of the proposed restraint. Once consent is obtained, the facility is responsible for an ongoing assessment of the need for the restraint and assurance that the resident is not declining as a result. The DPOA should be kept informed of this process and can withdraw his or her consent for the restraint at any time. However, discontinuation of restraint usage should be done only after weighing the facts and conferring with facility staff and the attending physician.

By missing any of these details, a nursing facility can find itself in regulatory and/or legal hot water. The following case study is an example of how the staff at one facility thought they had done everything right, but wound up paying a price for missing some important follow-up interventions. Please be aware of the circumstances surrounding this case, and make changes as appropriate at your facility.

The Situation

A resident with a history of dementia and long-standing alcohol abuse was admitted to a residential care facility. Soon after, she began to exhibit psychotic behavior in which her ability to think, respond emotionally, remember, communicate, interpret reality, and behave appropriately was significantly impaired, affecting her daily functions. The woman was seen by her physician and a prescription for risperidone (Risperdal, Janssen Phameceutica Products, LP), an antipsychotic medication, was ordered at 0.5 mg twice a day.

Within two months of starting the risperidone therapy, the woman became lethargic, had involuntary facial and arm movements, and difficulty ambulating. The staff at the residential care facility notified her physician, who then decreased the risperidone dosage by half. Although the lower dosage seemed to help the woman, her daughter requested the medication be discontinued anyway because of the possibility of more adverse effects. The woman had taken risperidone for only six months.

The woman stayed at the residential care facility for another year and then was transferred to the skilled nursing unit within the same complex so she could receive more assistance with her daily cares. Another year passed, and the woman's behaviors began to escalate again, to the extent that she now would hit, kick, pinch, and make verbal threats to staff when they tried to assist her. For several months, staff members attempted various interventions to redirect her behavior but were unsuccessful. Finally during a care conference, the woman's physician again ordered risperidone 0.5 mg be given to her daily. The staff notified the resident's daughter via a phone message but did not obtain her written consent for the risperidone therapy.

Within a week of beginning the medication again, the resident became lethargic to the point that her physician again decreased her dosage by half. By the sixth day of lethargy, the resident began to lose weight from not eating, so a supplement was ordered to sustain her nutritional status. Despite these interventions, the resident continued to be lethargic and refused to eat adequately. The nurses notified the physician several times about the situation until a physician assistant (PA) visited her, almost two weeks after the risperidone therapy began. The PA discontinued the risperidone and noted the woman's increased lethargy. However, the PA neglected to address her nutrition or hydration status. The resident's health continued to decline for the next two days until a nurse notified the physician, who contacted the resident's daughter, and both agreed to send the resident to the hospital.

At the hospital, the resident was diagnosed with severe hypernatremic dehydration and acute renal failure. The resident was given intravenous fluids and slowly improved; however, her renal failure continued. After a month, the resident's hydration status became stable enough for her to be transferred from the hospital to a different skilled nursing facility, per her daughter's request. Unfortunately, the resident remained lethargic and resisted attempts by staff to feed and assist her. She died a month later of renal failure.

The resident's daughter believed that her mother's death was a direct result of the risperidone therapy. The daughter denied

giving the staff permission for the drug to be given to her mother at the first skilled nursing facility because of the ill experience she had while at the residential care facility. In fact, she insisted that she clearly told the staff *not* to give the medication. The daughter hired an attorney to file a wrongful death suit against the first skilled nursing facility.

The daughter's attorney deposed an expert MD, who testified that the risperidone contributed to the woman's hypernatremic dehydration, which caused such damage to her system that she was not able to return to her prior functional level, which ultimately led to her death. The expert MD further stated that the failure of the staff to inform the physician of the changes in the woman's condition after the PA visited her resulted in the prolonged hypernatremic state. In addition to the expert MD testimony, a state survey team investigated the woman's death and cited the facility for not notifying the physician in a timely manner during those two days.

The facility's defense attorney deposed another expert MD, who felt the woman's death was unrelated to the risperidone therapy. Both expert witnesses seemed to contradict each other. Just before the trial date, a mediation was held between the concerned parties and an agreement to settle the case for $75,000 was reached.

Risk Management Practices

In this case, the staff at the facility did many things right. They had an effective system to assess and monitor resident behaviors. The resident was clearly a candidate for the medication, as she was a danger to herself and others, as well as noncompliant with medically necessary cares. The staff had unsuccessfully tried other interventions, and they met as a team to discuss the situation prior to contacting the physician. The dose that the physician ordered was minimal—well below the *Physicians' Desk Reference* recommendations—and risperidone had potentially fewer adverse affects than similar medication options. So, what went wrong?

While the staff did perform most of their responsibilities correctly, they neglected two important areas that led to undesired consequences.

1. They did not obtain a written informed consent from the DPOA. Staff should never depend solely on a message through an answering machine or fax to relay important information that requires a response. If the resident is unable to make an informed decision and his or her DPOA cannot come to the facility and sign a consent form, the nurse should discuss the proposed therapy with the DPOA over the phone and obtain a verbal consent. Two nurses should witness this verbal consent and document in the resident's chart how the information was presented. If an informed consent cannot be obtained in a timely manner, the nurse should advise the resident's physician to see if the medication should be discontinued.

Also, note that the signature on an informed consent form is the final step of a process that should begin with educating the DPOA. The fact that the daughter in the above case insisted on discontinuing the initial risperidone therapy (given at the residential care facility), despite her mother's improvement, may indicate that the daughter did not fully understand the benefits of the medication. Perhaps if the medical staff had spent more time educating the daughter about the risks and benefits of risperidone in a comprehensive and candid fashion, she would have understood the use of the medication better.

2. They did not inform the physician of her declining state in a timely manner during the two-day delay. Perhaps the reason for this was because neither the physician nor PA took aggressive actions when the nurses previously reported her declines, so why would this episode be any different? Unfortunately, this is a dangerous mind-set that staff members can sometimes have. It is important to remember that every significant resident decline should be treated as unique and reporting policies should be followed closely. It is always better to err on the side of caution and report inconsequential information than to jeopardize the resident's health and face citations or lawsuits for not reporting.

Proactive risk management in a long-term care setting is an ongoing challenge, but the time and trouble is definitely worthwhile if incidents such as this can be avoided. ■

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