SECTION .1300 - USE OF PHYSICAL RESTRAINTS AND ALTERNATIVES

10A NCAC 13G .1301 USE OF PHYSICAL RESTRAINTS AND ALTERNATIVES (EFFECTIVE UNTIL MARCH 31, 2024)

(a) A family care home shall assure that a physical restraint, any physical or mechanical device attached to or adjacent to the resident's body that the resident cannot remove easily and which restricts freedom of movement or normal access to one's body, shall be:

(1) used only in those circumstances in which the resident has medical symptoms that warrant the use of restraints and not for discipline or convenience purposes;
(2) used only with a written order from a physician except in emergencies, according to Paragraph (e) of this Rule;
(3) the least restrictive restraint that would provide safety;
(4) used only after alternatives that would provide safety to the resident and prevent a potential decline in the resident's functioning have been tried and documented in the resident's record.
(5) used only after an assessment and care planning process has been completed, except in emergencies, according to Paragraph (d) of this Rule;
(6) applied correctly according to the manufacturer's instructions and the physician's order; and
(7) used in conjunction with alternatives in an effort to reduce restraint use.

Note: Bed rails are restraints when used to keep a resident from voluntarily getting out of bed as opposed to enhancing mobility of the resident while in bed. Examples of restraint alternatives are: providing restorative care to enhance abilities to stand safely and walk, providing a device that monitors attempts to rise from chair or bed, placing the bed lower to the floor, providing frequent staff monitoring with periodic assistance in toileting and ambulation and offering fluids, providing activities, controlling pain, providing an environment with minimal noise and confusion, and providing supportive devices such as wedge cushions.

(b) The facility shall ask the resident or resident's legal representative if the resident may be restrained based on an order from the resident's physician. The facility shall inform the resident or legal representative of the reason for the request and the benefits of restraint use and the negative outcomes and alternatives to restraint use. The resident or the resident's legal representative may accept or refuse restraints based on the information provided. Documentation shall consist of a statement signed by the resident or the resident's legal representative indicating the signer has been informed, the signer's acceptance or refusal of restraint use and, if accepted, the type of restraint to be used and the medical indicators for restraint use.

Note: Potential negative outcomes of restraint use include incontinence, decreased range of motion, decreased ability to ambulate, increased risk of pressure ulcers, symptoms of withdrawal or depression and reduced social contact.

(c) In addition to the requirements in Rule 13F .0801, .0802 and .0903 of this Subchapter regarding assessments and care planning, the resident assessment and care planning prior to application of restraints as required in Subparagraph (a)(5) of this Rule shall meet the following requirements:

(1) The assessment and care planning shall be implemented through a team process with the team consisting of at least a staff supervisor or personal care aide, a registered nurse, the resident and the resident's responsible person or legal representative. If the resident or resident's responsible person or legal representative is unable to participate, there shall be documentation in the resident's record that they were notified and declined the invitation or were unable to attend.
(2) The assessment shall include consideration of the following:
    (A) medical symptoms that warrant the use of a restraint;
    (B) how the medical symptoms affect the resident;
    (C) when the medical symptoms were first observed;
    (D) how often the symptoms occur;
    (E) alternatives that have been provided and the resident's response; and
    (F) the least restrictive type of physical restraint that would provide safety.
(3) The care plan shall include the following:
    (A) alternatives and how the alternatives will be used prior to restraint use and in an effort to reduce restraint time once the resident is restrained;
    (B) the type of restraint to be used; and
    (C) care to be provided to the resident during the time the resident is restrained.

(d) The following applies to the restraint order as required in Subparagraph (a)(2) of this Rule:

(1) The order shall indicate:

(A) the medical need for the restraint;
(B) the type of restraint to be used;
(C) the period of time the restraint is to be used; and
(D) the time intervals the restraint is to be checked and released, but no longer than every 30 minutes for checks and two hours for releases.

(2) If the order is obtained from a physician other than the resident's physician, the facility shall notify the resident's physician of the order within seven days.

(3) The restraint order shall be updated by the resident's physician at least every three months following the initial order.

(4) If the resident's physician changes, the physician who is to attend the resident shall update and sign the existing order.

(5) In emergency situations, the administrator or administrator-in-charge shall make the determination relative to the need for a restraint and its type and duration of use until a physician is contacted. Contact with a physician shall be made within 24 hours and documented in the resident's record.

(6) The restraint order shall be kept in the resident’s record.

(e) All instances of the use of physical restraints and alternatives shall be documented by the facility in the resident's record and include the following:

(1) restraint alternatives that were provided and the resident's response;
(2) type of restraint that was used;
(3) medical symptoms warranting restraint use;
(4) the time the restraint was applied and the duration of restraint use;
(5) care that was provided to the resident during restraint use; and
(6) behavior of the resident during restraint use.

(f) Physical restraints shall be applied only by staff who have received training according to Rule .0506 of this Subchapter and been validated on restraint use according to Rule .0504 of this Subchapter.

History Note: *Authority G.S. 131D-2.16; 143B-165;*
Temporary Adoption Eff. July 1, 2004;
Temporary Adoption Expired March 12, 2005;
Eff. June 1, 2005.

SECTION .1300 - USE OF PHYSICAL RESTRAINTS AND ALTERNATIVES

10A NCAC 13G .1301 USE OF PHYSICAL RESTRAINTS AND ALTERNATIVES (EFFECTIVE APRIL 1, 2024)

(a) A family care home shall assure that a physical restraint, any physical or mechanical device attached to or adjacent to the resident's body that the resident cannot remove easily and that restricts freedom of movement or normal access to one's body, shall be:

(1) used only in those circumstances in which the resident has medical symptoms for which the resident's physician or physician extender has determined warrant the use of restraints and not for , discipline or convenience purposes;

(2) used only with a written order from a physician or physician extender except in emergencies where the health or safety of the resident is threatened, according to Paragraph (d) of this Rule;

(3) the least restrictive restraint that would provide a safe environment for the resident and prevent physical injury;

(4) used only after alternatives that would provide a safe environment for the resident to prevent physical injury and prevent a potential decline in the resident's functioning have been tried and documented by the administrator or their designee in the resident's record as being unsuccessful.

(5) used only after an assessment and care planning process has been completed, except in emergencies where the health or safety of the resident is threatened, according to Paragraph (c) of this Rule;

(6) applied correctly according to the manufacturer's instructions and the physician's or physician extenders' order; and

(7) used in conjunction with alternatives in an effort to reduce restraint use. For the purpose of this Rule, "physician extender" means a licensed physician assistant or licensed nurse practitioner.

Note: Bed rails are restraints when used to keep a resident from voluntarily getting out of bed as opposed to enhancing mobility of the resident while in bed. Examples of restraint alternatives are: providing restorative care to enhance abilities to stand safely and walk, providing a device that monitors attempts to rise from chair or bed, placing the bed lower to the floor, providing frequent staff monitoring with periodic assistance in toileting and ambulation and offering fluids, providing activities, controlling pain, providing an environment with minimal noise and confusion, and providing supportive devices such as wedge cushions.

(b) The facility shall obtain written consent from the resident, the resident's responsible person, or legal representative for the resident to be restrained based on an order from the resident's physician or physician extender. The facility shall inform the resident, the resident's responsible person or legal representative of the reason for the request, the benefits of restraint use, and the negative outcomes and alternatives to restraint use. The resident or the resident's legal representative may accept or refuse restraints based on the information provided. Documentation shall consist of a statement signed by the resident or the resident's legal representative indicating the signer has been informed, the signer's acceptance or refusal of restraint use and, if accepted, the type of restraint to be used and the medical indicators for restraint use.

Note: Potential negative outcomes of restraint use include incontinence, decreased range of motion, decreased ability to ambulate, increased risk of pressure ulcers, symptoms of withdrawal or depression, and reduced social contact.

(c) In addition to the requirements in Rule .0801, .0802 and .0903 of this Subchapter regarding assessments and care planning, the resident assessment and care planning prior to application of restraints as required in Subparagraph (a)(5) of this Rule shall meet the following requirements:

(1) The assessment and care planning shall be implemented through a team process with the team consisting of at least a supervisor or personal care aide, a registered nurse, the resident and the resident's responsible person or legal representative. If the resident or resident's responsible person or legal representative is unable to participate, there shall be documentation in the resident's record that they were notified and declined the invitation or were unable to attend.

(2) The assessment shall include consideration of the following:
- (A) medical symptoms that warrant the use of a restraint;
- (B) how the medical symptoms affect the resident;
- (C) when the medical symptoms were first observed;
- (D) how often the symptoms occur;
- (E) alternatives that have been provided and the resident's response; and
- (F) the least restrictive type of physical restraint that would provide safety.

(3) The care plan shall include the following:
- (A) alternatives and how the alternatives will be used prior to restraint use and in an effort to reduce restraint time once the resident is restrained;
- (B) the type of restraint to be used; and
- (C) care to be provided to the resident during the time the resident is restrained.

(d) The following applies to the restraint order as required in Subparagraph (a)(2) of this Rule:

(1) The order shall indicate:
- (A) the medical need for the restraint based on the assessment and care plan;
- (B) the type of restraint to be used;
- (C) the period of time the restraint is to be used; and
- (D) the time intervals the restraint is to be checked and released, but no longer than every 30 minutes for checks and no longer than two hours for releases.

(2) If the order is obtained from a physician other than the resident's physician, the facility shall notify the resident's physician or physician extender of the order within seven days.

(3) The restraint order shall be updated by the resident's physician or physician extender at least every three months following the initial order.

(4) If the resident's physician changes, the physician or physician extender who is to attend the resident shall update and sign the existing order.

(5) In an emergency, where the health or safety of the resident is threatened, the administrator or their designee shall make the determination relative to the need for a restraint and its type and duration of use until a physician or physician extender is contacted. Contact with a physician or physician extender shall be made within 24 hours and documented in the resident's record. For the purpose of this Rule, an "emergency" means a situation where there is a certain risk of physical injury or death to a resident.

(6) The restraint order shall be kept in the resident's record.

(e) All instances of the use of physical restraints and alternatives shall be documented by the facility in the resident's record and include the following:

(1) restraint alternatives that were provided and the resident's response;
(2) type of restraint that was used;
(3) medical symptoms warranting restraint use;
(4) the time the restraint was applied and the duration of restraint use;
(5) care that was provided to the resident during restraint use; and
(6) behavior of the resident during restraint use.

(f) Physical restraints shall be applied only by staff who have received training on the use of alternatives to physical restraint use and on the care of residents who are physically restrained according to Rule .0506 of this Subchapter and have been validated on the care of residents who are physically restrained and the use of care practices as alternatives to restraints according to Rule .0504 of this Subchapter.

History Note: *Authority G.S. 131D-2.16; 143B-165;*
Temporary Adoption Eff. July 1, 2004;
Temporary Adoption Expired March 12, 2005;
Eff. June 1, 2005;
Readopted Eff. April 1, 2024.