

# Legal Aspects of Chemical Restraint Use in Nursing Homes

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# The Legal Aspects of Chemical Restraint Use in Nursing Homes

*Chemical restraint, the excessive control of behavior by the use of medication, is just one of the many risks faced by the residents of nursing homes. This article explores the definition of chemical restraint, its adverse effect, relevant federal and state laws and regulation, customary industry practice, and practice tips for correcting discovered abuse.*

**By Julie A. Braun and  
Lawrence A. Frolik**

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The 1.6 million people who live in the nation's nursing homes are a highly vulnerable population. Among the risks faced by nursing home residents are excessive behavior control and restraint by the use of medication, commonly referred to as *chemical restraint*. "[M]edication, when used judiciously, can be a valuable adjunct in maximizing function and maintaining well-being in elderly nursing home residents. When used inappropriately, [it] can be an instrument of harm, abuse, negligence and malpractice."<sup>1</sup> Of course, drugs are used for a variety of purposes and may have a positive value as part of a well-planned therapeutic strategy. For example, absent treatment, severe depression can lead to suicide or indirect life-threatening behavior such as a failure to eat. Too often, however, drugs are used without adequate monitoring for harmful side effects, or even worse, are used to restrain rather than help the resident. Moreover, many, if not most, residents take multiple drugs, a practice known as polypharmacy.<sup>2</sup> How many is too many? While no precise guidelines exist, it is known that as the number of prescription drugs increases, the likelihood of drug interactions, toxicity, and side effects increases exponentially for the older adult.<sup>3</sup> Five drugs or more in a treatment regimen arouses concern; ten or more sharply increases the likelihood that the resident will experience deleterious side effects.<sup>4</sup>

## **What Are Chemical Restraints?**

Chemical restraints include "any drug that is used for discipline or convenience and not required to treat medical symptoms."<sup>5</sup> Interestingly, this definition no longer singles out psychopharmacological

drugs.<sup>6</sup> Removing the term psychopharmacological from the standard acknowledges that a wide range of drugs may be used as chemical restraints. Discipline means "any action taken by the facility for the purpose of punishing or penalizing residents."<sup>7</sup> Convenience involves actions taken by the facility to reduce its burdens rather than to promote the best interest of the resident.<sup>8</sup>

Older nursing home residents who suffer from mental disability are often prescribed psychotropic medications. Commonly prescribed psychotropic<sup>9</sup> medications appear in Table 1.<sup>10</sup> This list is not exhaustive; new drugs continue to be developed and employed.

### Adverse Effects of Chemical Restraint

When used properly, psychotropic drugs can be an important treatment therapy. Unfortunately, such drugs can also be used to control or chemically restrain residents who would otherwise pose behavioral problems. A growing awareness of the risk of chemical restraint has led to an examination and reevaluation of drug use in long-term care

facilities. (Even drugs prescribed for medically sound reasons may have harmful side effects particularly when they interact and when used with over-the-counter drugs.)

Aging affects how the body handles a drug (that is, movement into, around, and out of the body) as well as the specific action of the drug itself on the older person's body. A review of nineteen clinical studies concluded that a substantial number of nursing home residents who were taking psychotropic drugs on a regular, long-term basis suffered harmful side effects.<sup>11</sup> A 1997 report released by the Office of Inspector General Department of Health and Human Services arrived at a similar conclusion.<sup>12</sup> Numerous drugs and drug combinations place persons over the age of sixty-five at greater risk of adverse drug outcomes.<sup>13</sup>

Not surprisingly, overuse of drugs erodes the resident's autonomy. Overdrugged residents may not speak or think clearly and exhibit less interest in self-care. Other consequences of over-reliance on drugs or the resort to chemical restraint include the risks presented in Table 2.<sup>14</sup>

**Table 1. Psychotropic Medications (generic name followed by brand name in parentheses)**

<b>Antidepressant Medications</b>	<b>Anxiolytic Medications</b>
Imipramine (Tofranil)	(counteract or diminish anxiety)*
Desipramine (Norpramin)	Oxazepam (Serax)
Doxepin (Adapin, Sinequan)	Alprazolam (Xanax)
Nortriptyline (Aventyl, Pamelor)	Diazepam (Valium)
Fluoxetine (Prozac)	Lorazepam (Ativan)
Sertraline (Zoloft)	Diphenhydramine (Benadryl)
Trazodone (Desyrel)	Hydroxyzine (Atarax, Vistaril)
	Bupirone (BuSpar)
<b>Antipsychotic Medications</b>	<b>Sedative-Hypnotic Medications**</b>
Haloperidol (Haldol)	(sleep inducers)
Thioridazine (Mellaril)	Flurazepam (Dalmane)
Thiothixene (Navane)	Temazepam (Restoril)
Chlorpromazine (Thorazine)	Lorazepam (Ativan)
Risperidone (Risperdal)	Oxazepam (Serax)
Olanzapine (Zyprexa)	Diphenhydramine (Benadryl)
	Hydroxyzine (Atarax, Vistaril)
<b>Mood Stabilizers</b>	Chloral hydrate (several brands)
Lithium carbonate (several brands)	
Valproic acid (Depakene)	

\* TABER'S CYCLOPEDIA MEDICAL DICTIONARY, 129 (17th ed. 1993) (defining anxiolytic).

\*\* *Id.* at 944, 1773 (defining hypnotics and sedative, respectively).

**Table 2. Consequences of Chemical Restraint**

• Agitation	• Functional decline
• Gait disturbance	• Increased fall risk
• Memory impairment	• Movement disorders
• Sedation	• Orthostatic/Postural hypotension
• Withdrawal	

**Increased Fall Risk**

“An increase in body sway or unsteadiness has been demonstrated shortly after the administration of psychotropic medications” in the older adult.<sup>15</sup> Any drug that interferes with the resident’s postural control, cerebral perfusion, or cognitive function may potentially influence a resident’s gait and balance and induce a fall.<sup>16</sup> Injuries suffered as a result of the fall may lead to further decline.<sup>17</sup>

**Orthostatic/Postural Hypotension<sup>18</sup>**

Medications with anticholinergic<sup>19</sup> properties (for example, tricyclic antidepressant drug therapy) may cause a drop in blood pressure when the patient attempts to stand. This may result in dizziness, fainting, falls, and even heart attack or stroke.<sup>20</sup>

**Sedation**

Older residents are more vulnerable to the common side effects of psychotropic medication, such as sedation, and may experience drowsiness or decreased consciousness. Families who find a relative unresponsive or difficult to wake should investigate whether staff members are using drugs merely to make the resident more quiescent and easier to care for. If so, there may be grounds for a successful lawsuit.

**Movement Disorders**

Some psychotropic drugs cause a complete or partial loss of muscle movement that markedly decreases body activity (akinesia);<sup>21</sup> motor restlessness—an inability to sit still (akathisia);<sup>22</sup> muscle spasms of the eye, neck, and back (dystonias);<sup>23</sup> stiffness, rigidity, tremor, and drooling (symptoms resembling Parkinson’s disease);<sup>24</sup> and slow, rhythmic, involuntary, repetitive, purposeless movements involving the eyes, face, mouth, tongue, trunk, and limbs (tardive dyskinesia).<sup>25</sup>

**Memory Impairment**

Psychotropic medications may cause the patient to become confused, disoriented, or suffer amnesia.

**Functional Decline**

Many residents who receive psychotropic drugs suffer functional decline in activities of daily living such as eating, walking, dressing, using a wheelchair, or using the restroom. If the decline is not reversed, the resident is at risk of malnutrition, contractures, aspiration pneumonia, and pressure sores.<sup>26</sup>

**Agitation**

Sedative or hypnotic drugs may cause some patients to become agitated, experience insomnia, hallucinations, nightmares, and become hostile or even violent.

**Withdrawal**

Even taking the resident off the drugs can be problematic. Many residents suffer severe physical or psychological withdrawal symptoms. To avoid these and other harmful effects, drugs must be carefully prescribed and monitored. Any side effects must be documented, and the resident’s behavior monitored.

**Federal Law and Regulation**

For years nursing homes felt free to use drugs as a form of chemical restraint.<sup>27</sup> This pattern of practice changed dramatically with the passage of the landmark nursing home reforms contained within the Omnibus Budget Reconciliation Act of 1987 (OBRA ’87).<sup>28</sup> The OBRA ’87 contains the Nursing Home Bill of Rights<sup>29</sup> that applies to residents of facilities certified for participation in the Medicare and Medicaid programs, the primary funders of long-term care.<sup>30</sup> (Implementing regulations appear in Title 42 of the Code of Federal Regulations.<sup>31</sup>) The Health Care Financing Administration (HCFA), within the Department of Health and Human Services is responsible for ensuring the quality of nursing homes as part of its oversight of the Medicare and Medicaid programs. Government surveyors rely on HCFA guidelines, which are periodically updated, when they evaluate compliance with, among other things, the appropriateness of chemical restraint.

### **Freedom from Chemical Restraint**

The Nursing Home Bill of Rights specifically states that nursing home residents have “the right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident’s medical symptoms.”<sup>32</sup> The statute further states that “physical or chemical restraints may only be imposed...to ensure the physical safety of the resident or other residents.”<sup>33</sup>

### **Interdisciplinary Approach to Resident Care**

Under federal law each resident must receive the care needed to “attain or maintain the highest practicable physical, mental, and psychosocial well-being.”<sup>34</sup> A nursing home is required to create a comprehensive interdisciplinary clinical evaluation and care plan that demonstrates how it expects to assist the resident in reaching his or her highest level of well-being.<sup>35</sup> An interdisciplinary geriatric team may consist of a physician, nurse, pharmacist, activities therapist, occupational and physical therapists, speech and language pathologist, or a social worker.<sup>36</sup> The team creates a care plan, which might include the use of drugs. If, however, the plan does not, any use of drugs represents an unacceptable and illegal form of control or restraint.

### **The Need for Informed Consent**

Even if the care plan recommends the use of drugs, the resident must consent to such use. Residents, or their legal health care decision-makers, must give informed consent before they are given drugs for any purpose, including as a device to control behavior.<sup>37</sup> The risks, benefits, and alternatives to restraint must be explained in the context of the resident’s condition, circumstances, and environment. The resident has the right to refuse or accept chemical restraint<sup>38</sup> even if the resident’s physician recommends the medication, or the facility claims that without it the resident is too difficult to manage.<sup>39</sup> Significantly, a resident’s refusal does not absolve the facility from providing care that allows the resident to attain or maintain the highest practicable physical, mental, or psychosocial well-being.

When a resident is incapable of making an informed decision, the resident’s legal surrogate or representative may exercise the right based on the same information that would have been provided

to the resident.<sup>40</sup> However, the legal surrogate or representative cannot give permission to use chemical restraints for discipline or staff convenience or when the restraint is not necessary to treat the resident’s medical symptoms.<sup>41</sup> Residents can state in their advance health care directives their preferences concerning chemical restraint use.<sup>42</sup>

### **Physician Order Required**

Assuming that proper informed consent to the use of a drug has been obtained, it can be used “only upon the written order of a physician that specifies the duration and circumstances under which the restraints are to be used.”<sup>43</sup> The physician’s order will appear directly in the nursing home resident’s record or as a telephone order later signed by the physician. In an emergency, however, chemical restraints may be used without a physician’s order unless the nursing home has been previously notified that such treatment is not acceptable.<sup>44</sup>

### **Federal Law Prohibits Unnecessary Drugs**

Federal law requires that “[e]ach resident’s drug regimen must be free from unnecessary drugs.”<sup>45</sup> According to federal regulations, an unnecessary drug is any drug used:<sup>46</sup>

- in excessive dosage, including duplicate drug therapy;
- for excessive duration;
- without adequate monitoring;
- without adequate indications for its use;
- in the presence of adverse consequences which indicate that use of the drug should be reduced or discontinued; or
- any combination of the reasons above.<sup>47</sup>

Check the surveyor’s guidelines interpreting the federal regulations for acceptable dosages for specific medications. For example, daily use is equal to or less than 7.5 mg by mouth for temazepam (Restoril), a drug for sleep induction, unless higher doses (as evidenced by the resident’s response and/or clinical record) are necessary for maintenance or improvement in the resident’s functional status.<sup>48</sup>

Although the federal guidelines do not create a private right of action, there have been successful civil suits for damages caused by excessive drug use. For example, a \$908,800 settlement was reached in a case involving a sixty-one-year-old

nursing home resident who was given too much Lithium, a drug with a narrow safety margin.<sup>49</sup> The plaintiff claimed that excessive doses of Lithium were given over a three-week period, resulting in acute Lithium toxicity and cognitive brain damage.<sup>50</sup>

### **Gradual Dose Reduction**

If the resident is a victim of chemical restraint, the reduction of drug dosages must be carefully monitored. There should be a systematic and gradual process of reducing or discontinuing the drugs that follow a physician-approved care plan.<sup>51</sup> "Gradual dosage reductions consist of tapering the resident's daily dosage to determine whether the resident's symptoms can be controlled by a lower dose or if the drug can be eliminated altogether."<sup>52</sup> Federal regulatory guidelines identify time periods within which gradual dose reduction should be attempted. For example, a gradual dose reduction should be attempted at least twice within one year for benzodiazepines.<sup>53</sup> For drugs in the sedative-hypnotic class, a gradual dose reduction is recommended at least three times within six months before concluding that a gradual dose reduction is clinically contraindicated.<sup>54</sup> Antipsychotic and antidepressant medications require gradual dose reduction, but no time period is suggested.<sup>55</sup>

### **Response to Federal Law and Regulation**

Thanks to federal and state regulations, there appears to be a reduction in the use of chemical restraints in nursing homes.<sup>56</sup> Clinicians report that OBRA '87 mandates regarding drug usage have increased awareness of chemical restraint<sup>57</sup> and have significantly reduced the excessive use of drugs in nursing homes.<sup>58</sup> Still, resident advocacy groups, such as the National Citizens' Coalition for Nursing Home Reform, claim that the use of psychotropic medication remains unnecessarily high.<sup>59</sup>

### **State Law and Regulation**

Virtually every state regulates restraint use in nursing homes. For example, Arkansas law prohibits chemical restraint unless authorized by a physician for a specified time period or needed for an emergency.<sup>60</sup> Residents injured by a facility's violation of this law may sue to recover actual and punitive damages, but the court cannot award attorneys' fees.<sup>61</sup> Colorado law limits chemical restraint to

instances when there is an emergency and no less restrictive alternatives are available or appropriate.<sup>62</sup> New York law requires the following controls:

- psychotropic drugs must not be used for discipline or convenience;
- psychotropic drugs must be ordered only by a physician who specifies the problem for which the drug is prescribed;
- psychotropic drugs may be used only as an integral part of the resident's comprehensive care plan and only after alternative methods of treating the resident's condition or symptoms have been tried and have failed;
- efforts must be made to discontinue psychotropic drug use through gradual dose reductions and behavioral interventions; and
- psychotropic drug use must be discontinued if the harmful effects outweigh the benefits of the drug.<sup>63</sup>

### **Customary Industry Practice**

Nursing home risk managers and attorneys handling or defending chemical restraint cases may find it useful to compare the frequency of chemical restraint use in the facility in question with that of other nursing homes. The customary industry practice, in part, establishes the legal standard of care.

### **Major Organizational Positions on Chemical Restraints**

When determining what constitutes unnecessary use of drugs, courts naturally rely on relevant government statutes and regulations as well as customary industry practice. They also look to major organizational policy statements regarding chemical restraint use as evidence of what is the appropriate standard of care. The American Association for Geriatric Psychiatry and the American Geriatrics Society have issued statements on the use of psychotherapeutic medications in nursing homes.<sup>64</sup> Both organizations "emphasize the importance of distinguishing between the appropriate use of psychoactive medications and their misuse."<sup>65</sup> In addition, the American Health Care Association, representing more than 10,500 nursing homes, has adopted a set of practice guidelines to reduce antipsychotic medication use in long-term care facilities.<sup>66</sup>

### **Voluntary Accreditation Standards**

The accreditation process also plays an important role in determining industry standards. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) 1998–1999 Comprehensive Accreditation Manual for Long-Term Care includes standards for chemical restraint use.<sup>67</sup> The standards focus on individual resident needs and individualized assessment.<sup>68</sup> The legal significance of JCAHO standards lies in their admissibility as evidence of the acceptable tort standard of care.<sup>69</sup>

### **Hypothetical Chemical Restraint Case**

The difference between drug use as a form of chemical restraint versus appropriate therapy is demonstrated in the following hypothetical.<sup>70</sup>

#### **Facts**

Ann Jones, an eighty-five-year-old female with dementia, is confined to a wheelchair because of severe arthritis and the amputation of her right foot from complications of diabetes. In the last few weeks she has begun to scream, curse, and grab at staff and visitors. During mealtimes she takes other residents' food and casts her own food off the table. All agree that Ann's behavior is unacceptable and requires the use of a behavior-altering drug.

#### **Solution A**

Ann's new care plan includes pain management and dietary assessment for food preferences and adequacy of portions. Different behavioral strategies are initiated, including increased socialization. Alternate feeding strategies were tried for Ann, including a change in her feeding environment and the type of food offered. After these behavior and feeding strategies proved ineffective, her physician prescribed low doses of Haldol (0.5 milligrams every eight hours). The result was decreased agitation, more cooperation about eating, and less disruption at meals.

#### **Solution B**

The facility isolated Ann in her room where she continued to scream loudly. She ate alone and threw her food on the floor. The staff complained to her physician, describing Ann as an uncooperative nuisance in need of calming down. The physician responded by ordering Haldol (1.0 milligrams every six hours) plus Ativan (2 milligrams every six

hours) as needed. The result was that Ann became a quiet, sleeping, drooling resident in a wheelchair.

#### **Analysis**

In Solution A, the prescribed medication was not used as a chemical restraint because it was appropriately integrated with behavioral and feeding strategies. Most importantly, the dosage of the medication was not excessive. Only enough was prescribed to calm Ann, but not enough to sedate her.

In sharp contrast, Solution B demonstrates inappropriate chemical restraint use (in violation of 42 C.F.R. § 483.13(a)). The medication regimen constituted unnecessary drug therapy (in violation of 42 C.F.R. § 483.25(l)(1)). No behavioral interventions were attempted (in violation of 42 C.F.R. § 483.25(l)(2)(ii)). In addition, multiple medications were inappropriately administered in excessive dosages without monitoring for side effects (in violation of 42 C.F.R. § 483.25(l)). The medication was administered for staff convenience (in violation of 42 C.F.R. § 483.13(a)). Moreover, Ann was not treated with dignity (in violation of 42 C.F.R. § 483.15(a)) and was a victim of involuntary seclusion (in violation of 42 C.F.R. § 483.15(a)). The physician did not appropriately monitor changes in the resident's medical status (in violation of 42 C.F.R. § 483.40).

### **Practice Tips**

#### **Understanding Medical Terminology**

Attorneys who represent nursing home residents must understand medical terminology and know how to read the nursing home record. Unless an attorney possesses a formal education in medicine or nursing, the terminology found in a nursing home record can be perplexing. A medical dictionary such as *Taber's Cyclopedic Medical Dictionary*, *Mosby's Drug Guide for Nurses*, or the *Physician's Desk Reference*<sup>71</sup> can be helpful in understanding the nursing home record, which may differ materially in content and organization from hospital or other medical facility records with which the attorney may be familiar.

#### **Examining the Nursing Home Record**

Nursing home residents' medical charts vary in length and complexity, depending upon the resi-

dent's physical and mental health, the number of persons involved in the resident's care and, to a certain extent, the sophistication of the facility. For example, the level of documentation in a small, rural nursing home may be quite different from the documentation practices of a private, profit-making facility owned by a national chain.

The facility is required to maintain an individual medication record for each resident.<sup>72</sup> Medication refers to all prescription and over-the-counter medications taken by the resident, including dosage, frequency of administration, and recognition of side effects likely to occur in the resident. Though this information need not appear in the resident's assessment, it must be included in the resident's clinical record and care plan. Table 3 reflects some of the terminology typically encountered in a resident's medication record.

Whenever excessive or inappropriate drug use is suspected, the attorney needs to inquire about what drugs, in what strength and what dosage forms, are being administered to the resident. The attorney should also inquire when (such as daily or after meals) and how (by mouth or intramuscular injection, for example) the drugs are administered. Each facility will have a policy relative to dosing schedules. Usually there is an early and late medication pass during an eight-hour shift. The morning is when most doses are administered in long-term care facilities. In practice, one nurse may administer medication for 30 or more residents in what is referred to as the drug administration pass.

Even a careful examination of the resident's file may not reveal chemical restraint. Often facility practices may not be reflected in the resident's

chart, or the staff may correct the paper entry rather than the practice. Compare family and resident observations with current signed orders for drug use. There may be fraudulent entries and incomplete charting. Some questions to consider include the following:

- Did a valid order for the administered drug(s) exist?
- Was each drug administered according to the physician's order?
- Was each drug given in the correct strength and by the correct method?
- Was the drug used appropriate for the resident?
- Were any blank spaces detected on the medication administration record (MAR) which is commonly kept in a notebook with the medication cart for convenience in distributing medications to the residents?

### **Reviewing the Nursing Home Survey**

HCFA contracts with state agencies to survey nursing homes to ensure that they meet Medicare and Medicaid participation requirements. As part of this oversight, state agencies are required to record any deficiencies that exist in the homes they survey. When inspectors cite a facility for violating a specific regulation (known as an F Tag), they also rate the scope and severity of the violation. Inspection reports often are difficult to read and may be quite lengthy (over 100 pages). They usually contain professional jargon, medical terminology, and references to nursing home standards. Yet it is important to examine these inspection reports to deter-

**Table 3. Principal Charting Terminology (medical abbreviation followed by definition)**

qh	every hour	qod	every other day	subq	subcutaneous
qd	once a day	qon	every other night	INJ	injection
qm	every morning	prn	as needed	IM	intramuscular
bid	twice a day	hs	at bedtime	C/O	complains of
bin	twice a night	po	by mouth	OTC	over the counter
tid	3 times a day	NPO	nothing by mouth	Rx	prescription treatment
tin	3 times a night	ac	before meals	TO	telephone order
qid	4 times a day	pc	after meals		
qin	4 times a night	subcu	subcutaneous		

mine whether the facility has been cited for any deficiencies or other violations that may relate to suspected chemical restraints.

### **Facility Policy and Procedure**

Evidence that written institutional policies and procedures have not been enforced is often the basis for establishing that the standard of care has not been met. Even if the staff follows the facility procedures, however, it is possible that the nursing home policies and procedures are not in compliance with federal and state regulations. The failure to abide by federal or state laws may not create a private right of action, but facility publications distributed to prospective residents or their families may create contractual obligations that may give rise to a cause of action based on breach of contract. Examine the admissions contract to see if it contains language about the quality of care that may support a claim for damages. Even medical staff bylaw provisions and facility contracts with physicians may contain clauses that address the use of chemical restraint.

### **Constructing the Event Chronology**

When representing an injured or deceased nursing home resident, it is important to appreciate the timeline of events that precipitated the injury or death. Cases involving chemical restraint often unfold over weeks, months, or years, and may involve complex events. These events may include behavioral changes, institutional transfers, assessments and reassessments, multiple injuries, and hospitalizations. A properly constructed chronology navigates the attorney through the discovery process, including the formulation of deposition questions. In addition, the medical chronology assists throughout settlement negotiation and during trial. A good chronology provides more than a summary of medical care. If the case goes to trial, a detailed chronology will introduce the jury to the events that led to the injuries and their sequelae.

### **Assessing Staff Attitude, Knowledge, and Training**

Any attempt at prophylactic actions to reduce or forestall chemical restraint must begin with staff attitudes. The staff must be knowledgeable about the dangers of excessive drug use. They must be aware of when and how to administer medication

and the importance of monitoring for side effects. Training is essential to minimizing use of chemical restraint. The staff, from the governing board to the nurses and nurses' aides, must receive comprehensive, up-to-date training regarding chemical restraints and their alternatives. The subject should be introduced during a new employee's orientation, and thereafter the facility should conduct regular staff training programs.

The American Society of Consultant Pharmacists, a national professional association representing more than 6,300 pharmacists who provide medication distribution and consultant services to manage and improve drug therapy outcomes of individuals residing in long-term care environments, recommends that nurses' aides receive four hours of in-service training per year relating to medication side effects.<sup>73</sup> The American Association of Homes and Services for the Aging agrees with the need for more education and training for all involved parties.<sup>74</sup> The American Medical Directors Association (AMDA), a major association representing physicians committed to the care of nursing facility residents, provides instruction on appropriate drug use in their program to certify long-term care medical directors.<sup>75</sup> The AMDA suggests that at the facility level, surveyors, consultant pharmacists, and physicians should be reminded of the dangers associated with some drugs and be directed to pursue a reduction in their use.<sup>76</sup>

### **Conclusion**

Attorneys who represent residents of nursing homes or the families of such residents must be alert for drug misuse and overuse. Any suspicion of the use of chemical restraints should be aggressively investigated, protested, and, if necessary, prosecuted by civil suit.

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### **Endnotes**

1. Jeffrey M. Levine, *Medical and Legal Aspects of Chemical and Physical Restraint Use in the Nursing Home* in 75 AM. J. TRIALS 1 (2000).
2. See TABER'S CYCLOPEDIA MEDICAL DICTIONARY 1557 (17th ed. 1993) (defining polypharmacy as "the excessive use of drugs, overdose of a drug or prescribing many drugs to be given at one time") [hereinafter TABER'S].

3. See Kathryn L. Locatell, *Physician Liability Issues in NURSING HOME LITIGATION: INVESTIGATION AND CASE PREPARATION* 77, 91 (Patricia W. Iyer ed., 1999) (citing R.J. Ackerman & G.B. von Bremen, *Reducing Polypharmacy in the Nursing Home: An Activist Approach*, 8 J. AM. BOARD FAM. PRAC. 195, 205 (May–June 1995)).
4. *Id.* at 91.
5. Draft Surveyor's Guidance interpreting 42 C.F.R. § 483.13(a) (Dec. 1999) (requesting comments to draft language by Jan. 31, 2000).
6. See Surveyor's Guidance interpreting 42 C.F.R. § 483.13(a) (June 1995) (defining chemical restraint as "a psychopharmacologic drug that is used for discipline or convenience and not required to treat medical symptoms").
7. *Id.*
8. *Id.*
9. See TABER's, *supra* note 2, at 1632 (defining psychotropic drugs and listing psychotherapeutic drugs and agents).
10. See Levine, *supra* note 1, at 44; see generally R. Monks & Harold Merskey, *Psychotropic Drugs in TEXTBOOK OF PAIN* (Patrick D. Wall & Ronald Melzack eds., 3d ed. 1994); Sharon L. Jones, *Pharmacology of Pain Management in EXPERT PAIN MANAGEMENT* 31, 63–64 (1997) (discussing pharmacologic agents).
11. See Charlene Harrington et al., *Psychotropic Drug Use in Long-term Care Facilities: A Review of the Literature*, 32 GERONTOLOGIST 822, 822–833 (1992) (reviewing psychotropic drug use in nursing homes from 1978 to 1990).
12. See *Prescription Drug Use in Nursing Homes—Report 2: An Inside View By Consultant Pharmacists* (Nov. 1997) (OEI-06-96-00081) (finding nursing home residents experience adverse reactions as a result of potentially inappropriate prescribing and inadequate administration or monitoring of medications).
13. See Surveyor's Guidance at 123.3 (Rev. July 10, 1999) (citing Mark H. Beers, *Explicit Criteria for Determining Inappropriate Medication Use by the Elderly*, 157 ARCHIVES INTERNAL MED. 1531 (1997)).
14. See Levine, *supra* note 1, at 18–19 (reviewing side effects of psychotropic medication); see also Sarah Greene Burger, *AVOIDING DRUGS USED AS CHEMICAL RESTRAINTS: NEW STANDARDS IN CARE* 41, 41–52 (1994) (relating side effects for antipsychotic, sedative/hypnotics, anxiolytic, and antidepressant medications). Obtain copies from the National Citizens' Coalition for Nursing Home Reform, 1224 M Street, N.W., Suite 301, Washington, D.C. 20005; telephone (202) 393-2018.
15. REIN TIDEIKSAAR, *FALLS IN OLDER PERSONS: PREVENTION AND MANAGEMENT IN HOSPITALS AND NURSING HOMES* 30 (1993).
16. *See id.*
17. See generally, Purushottam B. Thapa et al., *Antidepressants and the Risk of Falls among Nursing Home Residents*, 339 NEW ENG. J. MED. 875, 875–920 (1998); Purushottam B. Thapa et al., *Psychotropic Drugs and Risk of Recurrent Falls in Ambulatory Nursing Home Residents*, 142 AM. J. EPIDEMIOLOGY 202, 202–211 (1995); Wayne A. Ray, *Psychoactive Drug Use and the Risk of Hip Fractures*, 316 NEW ENG. J. MED. 363, 363–369 (1987).
18. See TABER's, *supra* note 2, at 951 and 1571 (defining orthostatic hypotension and postural hypotension respectively).
19. *Id.* at 119.
20. See Levine, *supra* note 1, at 18.
21. See TABER's, *supra* note 2, at 59.
22. *Id.*
23. *Id.* at 595.
24. *Id.* at 1439 (defining Parkinson's disease); see also Susan C. Kalish et al., *Antipsychotic Prescribing Patterns and the Treatment of Extrapyramidal Symptoms in Older People*, 43 J. AM. GERIATRICS SOC'Y 967, 967–973 (1995) (noting that some antipsychotic medications can result in symptoms of Parkinson's disease and that these symptoms have been shown to increase fall risk and warrant immediate discontinuation of the medication); Levine, *supra* note 1, at 18.
25. See TABER's, *supra* note 2, at 590–591 (commenting that tardive dyskinesia is an "undesirable effect of therapy with certain psychotropic drugs").

26. See Levine, *supra* note 1, at 18.
27. See Marshall B. Kapp, *State of the Law: Nursing Homes*, 18 L. MED. & HEALTH CARE 282, 282 (1990).
28. See Pub. L. No. 100-203, §§ 4201–4218, 101 Stat. 1330, 160-22; see also 56 Fed. Reg. 48,826 (1991).
29. See 42 U.S.C. § 1395i-3 (applying to any facility that accepts Medicare reimbursement); 42 U.S.C. § 1396r (applying to any facility that accepts Medicaid reimbursement).
30. See, e.g., 63 Fed. Reg. 337 (Medicare application requiring health care provider to certify that the provider is “familiar with and agree[s] to abide by the Medicare or other federal health care program laws and regulations that apply to my provider/supplier type”).
31. See 42 C.F.R. §§ 483.5 to 483.75.
32. 42 U.S.C. §§1395i-3(c)(1)(A)(ii), 1396r(c)(1)(A)(ii); see also 42 C.F.R. § 483.13(a) (using similar language); H.R. Rep. No. 100-391(I) at 458 (1987), reprinted in 1987 U.S.C.C.A.N. 2313-1, 2313-278 (“psychotropic drugs are being used to manage residents for the convenience of nursing facility staffs in a manner that is wholly inconsistent with high quality care or an adequate quality of life”).
33. 42 U.S.C. §§ 1395i-3(c)(1)(A)(ii), 1396r(c)(1)(A)(ii); 42 C.F.R. § 483.13(a).
34. 42 U.S.C. §§ 1395i-3(b)(2), 1396r(b)(2); 42 C.F.R. § 483.25.
35. See Draft Surveyor’s Guidance interpreting 42 C.F.R. §483.13 (Dec. 1999).
36. See 42 C.F.R. § 483.20(k)(2)(ii).
37. See 42 C.F.R. §§ 483.10(b)(4), 483.20(d)(2)(ii).
38. See Steven Zlotnik, *Pharmacology and the Elderly*, in NURSING HOME INVESTIGATION AND CASE PREPARATION 251, 256 (Patricia W. Iyer ed., 1999).
39. See 42 C.F.R. § 483.25(f) (noting that facility must be prepared to deal with resident mental and psychosocial behavioral problems).
40. See 42 C.F.R. § 483.10(a)(3)–(4); Draft Surveyor’s Guidance interpreting 42 C.F.R. § 483.13 (Dec. 1999).
41. See Draft Surveyor’s Guidance interpreting 42 C.F.R. § 483.13 (Dec. 1999).
42. See 42 U.S.C. §§ 1395i-3(c)(1)(E), 1396r(c)(1)(E); 42 C.F.R. §§ 483.10(b)(4), 483.10(b)(8).
43. 42 U.S.C. §§ 1395i-3(c)(1)(A)(ii), 1396r(c)(1)(A)(ii).
44. See 42 U.S.C. §§ 1395i-3(c)(1)(A)(i), 1396r(c)(1)(A)(i); Draft Surveyor’s Guidance interpreting 42 C.F.R. § 483.13 (Dec. 1999).
45. 42 C.F.R. § 483.25(l)(1).
46. Surveyor’s Guidance interpreting 42 C.F.R. § 483.25(l)(1) (July 1999).
47. See 42 C.F.R. § 483.25(l)(1).
48. See Surveyors’ Guidance interpreting 42 C.F.R. § 483.25(l)(1) (June 1995).
49. See Patricia W. Iyer, *Nursing Home Liability Issues*, in NURSING HOME INVESTIGATION AND CASE PREPARATION 151, 186 (Patricia W. Iyer ed., 1999) (citing Lewis Laska, *Elderly Manic Depressive Patient Given Excessive Doses of Lithium for Three Weeks*, MED. MALPRACTICE VERDICTS SETTLEMENTS & EXPERTS 39 (Oct. 1996)).
50. See *id.*
51. See Draft Surveyor’s Guidance interpreting 42 C.F.R. § 483.13(a) (Dec. 1999).
52. Surveyor’s Guidance interpreting 42 C.F.R. § 483.25(l)(2)(ii) (June 1995); accord 42 C.F.R. § 483.25(l)(2)(ii).
53. See Surveyor’s Guidance interpreting 42 C.F.R. § 483.25(l)(1) (June 1995).
54. See Surveyor’s Guidance interpreting 42 C.F.R. § 483.25(l)(1) (July 1999).
55. See Surveyor’s Guidance interpreting 42 C.F.R. § 483.25(l)(1) and (2)(ii) (July 1999).
56. See generally Eugenia L. Siegler et al., *Effect of a Restraint Reduction Intervention and OBRA ’87 Regulations on Psychoactive Drug Use in Nursing Homes*, 45 J. AM. GERIATRICS SOC’Y 791, 791–796 (July 1997) (documenting the significant reduction of psychoactive drug use in nursing homes post-OBRA); Ronald I. Schror et al., *Changes in*

- Antipsychotic Drug Use in Nursing Homes during Implementation of the OBRA '87 Regulations*, 271 J. AM. MED. ASS'N 358, 358-362 (1994); Robert L. Kane et al., *Restraining Restraints: Changes in a Standard of Care*, 14 ANN. REV. PUB. HEALTH 545, 545-584 (1993) (finding that the Nursing Home Reform Law has reduced the use of psychotropic medications by up to one-third).
57. See, e.g., Siegler et al., *supra* note 56.
58. See generally Maria D. Llorente et al., *Use of Antipsychotic Drugs in Nursing Homes: Current Compliance with OBRA Regulations*, 46 J. AM. GERIATRICS SOC'Y 198, 198-201 (Feb. 1998) (examining the degree and patterns of compliance with OBRA '87 regulations regarding the use of antipsychotic drugs in nursing homes).
59. See, e.g., SARAH BURGER ET AL., *NURSING HOMES: GETTING GOOD CARE THERE* 84, 84-86 (1996) (noting the improper use of chemical restraints).
60. See *State Actions*, 23 MENTAL & PHYSICAL DISABILITY L. REP. 437, 437 (May/June 1999).
61. See *Id.*
62. See *id.*
63. N.Y. COMP. CODES R. & REGS. tit. 10, §§ 415.4(a) (1999) (covering physical restraints) and 415.12(1) (covering psychotropic drugs); see generally, Margaret M. Flint, *Nursing Homes*, 266 PRACTISING L. INST. 559 (1998) (considering restraint use in New York nursing homes).
64. See Bd. of Directors of the Am. Ass'n for Geriatric Psychiatry, Clinical Practice Committee of the Am. Geriatrics Soc'y, and Committee on Long-Term Care and Treatment for the Elderly, Am. Psychiatric Ass'n., *Psychotherapeutic Medications in the Nursing Home*, 40 J. AM. GERIATRICS SOC'Y 946, 949 (Sept. 1992).
65. *Id.* at 946.
66. See Robin Elizabeth Margolis, *Healthtrends*, 9 HEALTHSPAN 28, 28 (Apr. 1992).
67. See, e.g., Standards TX.8, TX.8.1 and RI.2.6, *Comprehensive Accreditation Manual for Long-term Care*, JOINT COMM'N ON ACCREDITATION OF HEALTHCARE ORG. (1998-1999).
68. See *id.*
69. See MARSHALL B. KAPP, *GERIATRICS AND THE LAW: PATIENT AND PROFESSIONAL RESPONSIBILITIES* 163 (2d ed. 1992).
70. See Levine, *supra* note 1, at 12-13.
71. See also RUBIN BRESSLER & MICHAEL D. KATZ, *GERIATRIC PHARMACOLOGY* (Rubin Bressler et al., eds. 1993).
72. See 42 C.F.R. § 483.75(1)(5).
73. See AM. SOC'Y CONSULTANT PHARMACISTS, *PRESCRIPTION DRUG USE IN NURSING HOMES—REPORT 3: A PHARMACEUTICAL REVIEW AND INSPECTION RECOMMENDATION*, Appendix E at 1, 6 (Nov. 1997) (OEI-06-96-00082).
74. See *id.* at 16, 18.
75. See *id.* at 26.
76. See *id.* at 30.