



COMMONWEALTH OF VIRGINIA
VIRGINIA BOARD FOR PEOPLE WITH DISABILITIES

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October 30, 2015

TO: Judith McGreal
Licensing Program Consultant
Virginia Department of Social Services

CC: Margaret Schultz
Commissioner

FROM: Heidi L. Lawyer

A handwritten signature in blue ink, appearing to read "Heidi Lawyer".

RE: Proposed Standards for Licensed Assisted Living Facilities

I am writing on behalf of the Virginia Board for People with Disabilities (the Board) to comment on the Proposed Standards for Licensed Assisted Living Facilities. The Board specifically offers comments on 22VAC40-73-710, which addresses the use of restraints in Assisted Living Facilities. The Board commends DSS for limiting the use of restraints in Assisted Living Facilities to instances when they are legitimately used to provide medical/orthopedic support to residents, or when they are used as an emergency measure to prevent serious injury to residents of the facility, staff members, or other third parties. The Board believes, however, that the regulations should be strengthened and offers the following recommendations.

The Board strongly urges DSS to prohibit the use of any restraint technique that restricts the resident's breathing, interferes with the resident's ability to communicate, or applies pressure on the resident's torso, including prone and supine restraints. All restraints are dangerous. Prone and supine restraints, however, pose heightened and well-documented

risks of asphyxiation and other serious physical injuries or death.¹ Given the heightened risks associated with these forms of physical restraint, the Board believes that DSS should prohibit their use in Assisted Living Facilities in Virginia.

Prone and supine restraints have been banned in other contexts and in other states because of the heightened risks associated with them. Texas, for instance, has banned the use of prone and supine restraints in its assisted living facilities.² In Virginia, prone restraints, as well as all other forms of restraint that restrict breathing, interfere with communication, or otherwise cause harm to a child are prohibited in private schools for students with disabilities.³ More recently, the General Assembly directed the Virginia Department of Education (VDOE) to adopt regulations on the use of restraint that are consistent with the Fifteen Principles contained in the U.S. Department of Education's Restraint and Seclusion Resource Document.⁴ The Fifteen Principles caution that prone restraints and other restraints that restrict breathing "should never be used because they can cause serious injury or death."⁵ The Board urges DSS to similarly adopt regulations banning the use of prone and supine restraints, as well as any other restraint that restricts breathing, interferes with communication, or puts pressure on a resident's torso.

The Board urges DSS to remove language from the regulation authorizing the use of restraints to "treat... symptoms from mental illness or intellectual disability."⁶ Restraints are not "treatment" for mental illness or intellectual disability. Rather, the use of restraints to control behavior of persons with mental illness or intellectual disability evidences a failure of treatment. The Board, therefore, asks DSS to remove this language from the regulation, and to replace it with the following:

B. Physical restraints may only be used 1) to provide medical/orthopedic support to a resident pursuant to a physician's written order and with the consent of the resident or his or her legal representative; or 2) in an emergency situation after less intrusive interventions have proven insufficient to prevent imminent threat of death or serious physical injury to the resident or others.

The Board believes that this change would clarify that restraints are not a form of treatment for mental illness or intellectual disability, but rather an intervention of last resort to be used only

¹ For an in-depth discussion of the special risks posed by prone and supine restraints, see Morrison, Leslie, Paul B. Duryea, Chris Moore, and Alexandra Tathanson-Shinn. *The Lethal Hazards of Prone Restraint: Positional Asphyxiation*. Protection and Advocacy, Inc., April 2002. Available at <http://www.disabilityrightsca.org/pubs/701801.pdf>.

² Tex. Admin. Code § 92.41(p)(4)(D).

³ 8VAC20-671-650.

⁴ Va. Code § 22.1-279.1:1.

⁵ Restraint and Seclusion Resource Document. U.S. Dept. of Ed, May 2012. Available at <http://www2.ed.gov/policy/seclusion/restraints-and-seclusion-resources.pdf>.

⁶ This language is contained in 22VAC40-73-710(B) and (C).

after other interventions, including treatment, have failed and there is a threat of imminent harm

The Board recommends DSS more clearly define and delineate between nonemergency (medical/orthopedic) and emergency restraints. The term “nonemergency restraint” as used in the regulations, as well as its accompanying definition, is insufficiently descriptive. The Board also believes the definition of “emergency restraint” contained in the proposed regulations should be made clearer and stronger. Specifically, the Board proposes that the term “nonemergency restraint” be replaced with the term “medical/orthopedic restraint” to highlight that the only acceptable use of devices that have a restraining effect in nonemergency situations is to provide medical/orthopedic support to a resident. Additionally, the Board suggests the following definitions to replace the definitions of “emergency restraint” and “nonemergency restraint,” respectively:

“Emergency restraint” means the use of physical restraint as an emergency intervention of last resort to prevent imminent death or serious physical injury to the resident or others.

“Medical/orthopedic restraint” means the use of a medical or orthopedic support device that has the effect of restricting the resident’s freedom of movement or access to his body for the purpose of improving the resident’s stability, physical functioning, and/or mobility.

The Board also requests DSS clarify the requirements of a physician’s restraint order and more clearly distinguish the requirements of a medical/orthopedic restraint order from the requirements for an emergency restraint order. The language addressing restraint orders in 22VAC40-73-710(C)(2) and (3) is confusing. This language, for instance, prohibits standing orders for restraints; but it also allows a restraint order to be as much as “three months” old. This confusion may stem in part from an attempt to distinguish the requirements of a medical/orthopedic (nonemergency) restraint order from those of an emergency restraint order. The Board recommends the following language to clarify this distinction:

C. Restraints must:

...

2. Be imposed in accordance with a physician’s written order that specifies the condition, circumstances, and duration under which the restraint is to be used.

a. Restraint orders shall not be ordered on a standing, blanket, or “as needed” (PRN) basis.

b. In the case of medical/orthopedic restraints, physician orders must be reviewed by a physician and renewed if the circumstances warranting the use of the restraint continue to exist at least every three months.

c. In the case of emergency restraints, a physician’s order must be obtained within one hour after the initiation of the restraint.

Lastly, the Board recommends requiring the review of a resident's individualized service plan following an emergency restraint and documentation of the steps to be taken in order to prevent the necessity of future emergency restraints. Emergency restraints are drastic events that should be carefully reviewed in order to minimize the risk that the behavior necessitating the restraint will recur in the future. Any instance of emergency restraint should trigger a review of a resident's individualized service plan, the identification of what precipitated the restraint, and identification and documentation of steps that will be taken in order to avoid future restraint incidents. The Board recommends that DSS require such a review be conducted and documented following any incidence of an emergency restraint.

The Board appreciates this opportunity to comment on these important regulations. We applaud DSS's efforts to limit the use of restraints in Assisted Living Facilities in Virginia to those instances when they are necessary to protect residents and others from risk of death or serious injury. The Board believes that these regulations will be made stronger and more effective with the changes proposed in this comment. Please feel free to contact me at Heidi.Lawyer@vbpd.virginia.gov or 804-786-9369 if we can provide any additional information or assistance on this important matter.