White Paper
Physical Restraints

The resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident’s medical symptoms. The intent of these requirements is for each person to attain and maintain his/her highest practicable well-being in an environment that prohibits the use of restraints for discipline or convenience and limits restraint use to circumstances in which the resident has medical symptoms that warrant use of restraints.

“Physical restraints” are 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. Many different devices or items can restrict a resident’s freedom to the point that they become a restraint. Included are things that are specifically designed to be restraints and things that are not commonly thought of as restraints. The determination that something is a restraint cannot be based on the object or device that is being used, but must always be based on the effect the object or device has on the individual resident. Evolving professional standards of practice continue to identify treatment options and approaches that tend to be more effective and safer than restraints.

Background

In a study by Capezuti et al. (1996) non-confused ambulatory residents were almost never restrained while confused ambulatory residents were restrained 37% of the time. The most recent data shows that in 1999, about 16 percent of nursing home residents were restrained at some point during their stay -- that's about 240,000 people. The percent of residents who were physically restrained in the U.S., according to the Chronic Care Physical Restraint Quality Measure, was a national mean of 8% for the third quarter of 2003. These studies figure demonstrates a decline in restraint use, however, the need for continued quality improvement in this area is apparent.

There are many adverse physiological and psychological consequences associated with the use of physical restraints on nursing home residents including urinary incontinence, increased agitation, circulation impairment, skin breakdown, decreased mobility (Williams & Finch, 1997), physiologic stressors, social isolation, and reduced sensory and perceptual input (Sullivan-Marx, 2001).

Legal Considerations, Legal / Risk Management Considerations

Potential negative outcomes of restraint use include, but are not limited to: declines in the resident’s physical functioning (e.g., ability to ambulate) and muscle condition, contractures, increased incidence of infections and development of pressure ulcers, delirium, agitation, and incontinence. Moreover, restraint use may constitute an accident hazard. Restraints have been found in some cases to increase the incidence of falls or head trauma due to falls and other accidents, most particularly strangulation and entrapment.

Regulatory Considerations

- F323 Accidents/Supervision
- F222 – 483.13 Restraints
- CMS S&C-07-22 Clarification of Physical Restraint Definition ODH SNF licensure rule 3701-17-15 Restraints
- ODH Division of Quality Assurance Guideline for Restraint Use Decision Tree (02/23/07)

Policy/Process Considerations

- Establish a process for determining if devices, material or equipment that meets the definition of a physical restraint are:
  - based on a medical symptom that warrants the use of the restraint.
  - based on a physician’s order for use
  - care planned whether or not there is a category to code the physical restraint on the MDS.
  - reassessed quarterly (or upon significant change) for opportunities for reduction of use.
  - assessed whether the resident is capable of independently removing the device and whether the device restricts the resident’s freedom of movement.
• Care planning should address: restorative care to prevent decreased bone and muscle strength; meaningful activities to prevent isolation, withdrawal and increased depression; modifications to the environment and efforts to eliminate the use or reason to continue until next assessment.
• If a restraint is used, it must be the least restrictive for the least amount of time – consider short-term or time-limited orders.
• An alert resident may request and have a restraint – but the restraint protocol must still be followed.
• explain, in the context of the individual resident’s condition and circumstances, the potential risks and benefits of all options under consideration including using a restraint, and alternatives to restraint use.
  o also explain the potential negative outcomes of restraint use
• In the case of a person who is incapable of making a decision, the surrogate or representative cannot require the use of a restraint in the absence of a medical symptom. Legally authorized persons have the authority to act on behalf of the resident to refuse treatment that has been offered under 42 CFR 483.10 (b)(4). There is no corresponding right to authorize treatment that is not necessary to treat a medical symptom.
• bed rails as restraints is prohibited unless they are necessary to treat a resident’s medical symptoms
  o consider only adding bed rails when a resident’s assessment indicates that a rail or rails would assist with mobility and transfers;
  o bed rails should not automatically be applied to all beds.
  o When bed rails are used, an assessment of the mattress and bed frame for gaps should be completed.

**Purchase Considerations**
- Reputable suppliers
- Tested products
- Least restrictive
- Follow manufacturers guidance/instruction – maintain this information readily accessible to direct care staff who will utilize them

**Educational Considerations**
- Regulatory requirements
- Facility policies
- Cited studies
- GPRA (Government Performance Results Act of 1993) was to improve public confidence in the federal government by holding federal agencies accountable for the achievement of program results that are publicized
- CMS’s 2006 goals, adopted 4/1/06 are to reduce restraints+ pressure sores in NFs – utilizing Quality Measures/MDS data

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**GRPA Goals 2006 – Restraints:**
- National baseline 6.4
- National Goal 5.9
- Stretch National Goal 4.7
- Region V Baseline 4.8
- Region V Goal 5.9
- Stretch Region V Goal 4.7

**Ohio Restraint QM**
- July 2006 Baseline 6.3
- 3rd Quarter 2006 5.79
- 4th Quarter 2006 5.74
- 1st Quarter 2007 5.60
- 2nd Quarter 2007 5.46
- 3rd quarter 2007 = 5
- Ohio has decreased restraint use by 13% since July 2006
  (source: Carla Brumby, ODH, November 2007)

**Resources**
- OHCA Fall Reduction and Injury Mitigation White Paper & Fall Manual: [http://www.ohca.org/content/view/409/](http://www.ohca.org/content/view/409/)
- CDC Community Based Fall Prevention: [http://www.cdc.gov/ncipc/preventingfalls/](http://www.cdc.gov/ncipc/preventingfalls/)
- ODH Falls Requirements for Nursing Homes: [http://www.odh.ohio.gov/odhPrograms/ltc/nurhome/pubs/nhpubs1.aspx](http://www.odh.ohio.gov/odhPrograms/ltc/nurhome/pubs/nhpubs1.aspx)