Evidence-Based Best Practices: Physical Restraints

Overview

Physical restraints have often been used as an intervention to prevent falls, manage wandering and/or uncharacteristic behaviors, or to prevent tampering with medical devices such as feeding tubes or bladder catheters. However, research has shown that restraints do not prevent falls and that when falls occur while the person is restrained, are more likely to result in serious injury.

In addition, physical restraint use can have negative physical impacts, including physical deconditioning, declines in mobility, incontinence, and pressure injuries. Use of physical restraints can also have psychological impacts such as frustration, increased behavioral disturbances, anger, and fear.

Physical restraint use may, in rare situations, be necessary to treat a specific medical issue. The use of a restraint should be the last resort, even when a justifiable medical indication is present. If a physical restraint is medically justified, the facility must ensure the least restrictive device is utilized and only for the length of time necessary to treat the specific medical issue that prompted the restraint use. Physical restraint must never be used for discipline or for the convenience of facility staff. Close attention to the person's comfort, safety and needs for hydration, elimination, exercise, and social interaction is essential while the restraint is in use.

Definitions

The Centers for Medicare and Medicaid Services (CMS)[a] defines a physical restraint as "any manual method, physical or mechanical device, equipment, or material that meets all of the following criteria:

- Is attached or adjacent to the resident's body;
- Cannot be removed easily by the resident; and
- Restricts the resident's freedom of movement or normal access to his/her body.

‘Removes easily’ means that the manual method, physical or mechanical device, equipment, or material, can be removed intentionally by the resident in the same manner as it was applied by the staff.”

CMS defines a medical symptom as “an indication or characteristic of a physical or psychological condition.” In the Interpretive Guidance for Surveyors, they note that a medical symptom, in and of itself, cannot be the sole reason for the use of a restraint. The facility must be able to link the use of a physical restraint and the benefit received by the person.

Falls are not self-injurious behavior or a medical symptom that would justify the use of a physical restraint.

The Texas Administrative Code (TAC)[a] definition of a physical restraint is similar: “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. The term includes a restraint hold.”

State and Federal Regulations

TAC Title 26, Part 1, Chapter 554, Subchapter G, Rule §554.601 Freedom from Abuse, Neglect, and Exploitation

§554.601(d) Restraints. The facility must ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. If the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.

State Operations Manual, Appendix PP

CFR §483.12 (F604): The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident’s medical symptoms.

Type of Physical Restraints

Examples of devices that could be considered a physical restraint include:

- Side rails (full or partial)

- Seat belts, tray tables or lap cushions that prevent rising
- Limb restraints, such as hand mitts, wrist ties
- Soft ties or vests
- Recliner or reclining wheelchair that when in a fully reclined position prevents free movement by the person
- Floor mattresses or scoop mattresses that can prevent the person from rising

In addition, some practices may be considered restraint, such as:

- Positioning the bed against a wall so that the person is prevented for getting out of bed
- Placing the person in a framed wheeled walker if the person is unable to open the front gate of the walker or exit the device
- Using a chair or bed alarm that makes the person afraid to move in case they set off the alarm
- Tucking bed sheets in tightly to prevent the person from getting out of bed

Key Elements of Best Practice

Assessment

Is a valid medical justification present for the use of a physical restraint? [b]

- A life-sustaining medical device in place that if disrupted would create immediate jeopardy to the person's health
  - Endotracheal tube or other artificial airway
  - Healing percutaneous feeding tube tract created with in the previous four weeks (does not include replacement of a feeding tube into a pre-existing tract)
  - Central venous lines or arterial lines, PICC lines, Port-a-Cath or and interruptible arteriovenous shunt
- Violent behavior posing an immediate threat of injury to self or others
  - Unprovoked or uncontrollable violent physical behavior towards themselves or others, such as person-to-person physical assault or intentional injury to others
  - Temporary use only
  - Does not include resistance to care

- Hip or lower extremity fracture without repair or with repair (e.g., ORIF) with in the previous six weeks and a physician's order for weight bearing limitations
    - Specifically applies to those who have orders for weight bearing limitations, but are not able to adhere to those due to cognitive impairment, etc. during the first six weeks after surgery
    - Generally, total hip replacements do not require weight bearing limitations, so are not included here
- Urethral trauma due to repeated self-removal of an indwelling bladder catheter

While there may be other circumstances that could lead to the use of physical restraints, they are expected to be variations of the indications listed above. Despite the presence of a medical justification for the physical restraint, the facility should continue to re-assess the need for continued use as well as potential alternatives to the physical restraint.

Is a physician's order obtained prior to implementing a physical restraint?

- The specific device to be used
- Time limitations for the use of the device.
    - The time limitation should not exceed 30 days, after which the IDT should re-evaluate the person
    - Instructions for periodic release of the restraint device, including the frequency of release or removal
    - Orders should never be written for "as needed" or PRN use
    - A physician's order alone is not an adequate reason for the use of a restraint.

Is a pre-restraint assessment completed before the use of a physical restraint?

- Medical and social history, any uncharacteristic behaviors that have been identified
- Mobility, ability to perform or assist with activities of daily living
- Cognitive status
- Assessments for pain, fall risk/fall history, continence, nutrition and hydration to identify unmet needs

- Physical examination/assessment to identify the medical justification and the underlying cause of the issue
- Alternatives attempted and the outcomes of those attempts
  - Activities, distraction, re-direction
  - Visual barriers
  - Scheduled exercise, included walking programs
  - Appropriate assistive devices, such as walkers or canes
  - Environmental modifications, such as changes is lighting, noise control, appropriate placement of furniture in bedrooms and common areas
- The clinical outcome or end-point desired
- Person and/or the legally authorized representative (LAR) have been fully informed of the risks associated with restraint use
  - No evidence that physical restraints prevent falls or fall-related injuries
  - People who fall while restrained are more likely to be seriously injured
  - Restraints are associated with a variety of negative outcomes, including muscle atrophy/weakness, joint contractures, incontinence, and pressure injuries.
  - The risk of death from improper restraint use, most often due to strangulation or chest compression

A subjective symptom should not be the sole basis for restraint use. In non-emergency situations, the use of a restraint should be implemented only after a comprehensive assessment demonstrates no safer alternative/setting is available.

When a restraint is being considered in the presence of specific behaviors, the IDT should first evaluate the meaning of the behavior and implement interventions that eliminate/mitigate the underlying cause. This includes an evaluation of not only the person’s behavior, but also that of the staff.

Is the interdisciplinary team (IDT) involved in identifying the underlying issues or needs that led to the use of a physical restraint?

An interdisciplinary approach is key to successful eliminating the use of restraints. Identifying the underlying issue/unmet needs will help the IDT implement person-centered approaches to manage those issues while reducing or eliminating the use of restraints. A thorough assessment should be completed before initiating any restraint reduction or elimination efforts to determine the person’s specific needs and the appropriate interventions.

Is restraint use re-assessed at least every 30 days?

The IDT should re-evaluate the person at least every 30 days to determine whether the physical restraint is still medically necessary. This includes a review of the alternate interventions implemented and the outcomes of those interventions. The IDT should also assess for any negative outcomes related to restraint use.

Care Planning

A person-centered care plan is essential, providing every member of the IDT with a guide to the person's care. To be effective the care plan must reflect not only the person's problems or disabilities, but also their retained abilities, strengths, preferences, and goals. The care plan needs to focus on the **temporary** use of a physical restraint and reducing or eliminating the restraint. The person and/or their LAR must be involved in the care planning process. [c,d]

The care plan should address the following information:

- The **valid** medical justification for the use of a physical restraint
- The specific device to be used and the circumstances that required the use of a restraint
- Measurable goals and timelines for restraint reduction/elimination
- Person-centered interventions and approaches, based on assessment findings, relevant to the specific medical justification for the restraint and consistent with the person's values and preferences
- Measures to prevent complications related to the use of a restraint, including the frequency of observation, release and repositioning as necessary
- Activities that are meaningful to the person
- How often restraint use will be re-evaluated, depending upon the location and extent to which mobility is limited, but should not exceed 30 days

Outcome Management

Outcomes would be consistent with evidence-based best practices if a physical restraint is used as a temporary measure for a justifiable medical reason. Specific outcomes include:

- Person-centered interventions from the care plan are implemented on a consistent basis
- The effectiveness of the interventions is monitored and evaluated routinely

Facility-level outcome measures should be evaluated as well. For example:

- Overall restraint prevalence
- Prevalence by specific device
- Percentage of restraints used with an appropriate medical justification
- Percentage of restraints used without an appropriate medical justification

Resources

CMS - Restraint Reduction: Assessment and Alternatives Help Guide

TMF Networks - Restraint Reduction

Registered Nurses' Association of Ontario - Promoting Safety: Alternative Approaches to the Use of Restraints

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[a] Texas Administrative Code, Title 26, Part 1, Chapter 554 Nursing Facility Requirements for Licensure and Medicaid Certification, Subchapter B, Rule §554.101 Definitions.

[b] Collins LG, Haines C, Perkel RL. Restraining devices for patients in acute and long-term care facilities. Am Fam Physician. 2009 Feb 15;79(4):254, 256. PMID: 19235492.

[c] Tilly J, Reed P. Falls, Wandering and Physical Restraints: Interventions for Residents with Dementia in Assisted Living and Nursing Homes. Alzheimer's Association 2006.

[d] Rothschild Person-Centered Care Planning Task Force. A Process for Care Planning for Resident Choice. February 2015.