Resource Tool-kit

Quality Measure (QM) 409:
Residents who were physically restrained
QM 409: Residents who were physically restrained:

Physical restraints include any method or device which restricts a resident’s freedom of movement or access to his or her body and which the individual cannot remove easily. It is the effect of the method or device on the person that results in it being considered a restraint.

Examples of methods or devices considered physical restraints include:

- Side rails on beds: Note: Sometimes residents use “quarter or half rails” to reposition themselves in bed.
- Limb and waist restraints
- Hand mitts
- Geri-chairs
- Over-the-bed tables and trays that cannot be removed without assistance
- Chairs or recliners from which a resident is unable to get up on his or her own
- Involuntary confinement to a room, except when isolation is medically necessary to protect residents from a contagious disease.

Note: A device that a person cannot remove at will is considered a restraint. Exceptions may include items that are used in the provision of medical care, such as casts, braces and bandages.

One of the primary predictors of using physical restraints is cognitive impairment: Note: In many cases, restraints are used because of the mistaken belief that they are necessary to ensure resident safety, prevent agitation, physically support residents or prevent falls.

Physical restraints are generally harmful to residents because of negative effects on multiple body systems and interference with normal functioning, including a resident’s capacity to walk, get food, get fluids, change position, toilet and socialize.

Physical consequences of using restraints may include death, injuries, falls, physical de-conditioning, incontinence, malnutrition, dehydration, bone demineralization, muscle atrophy, skin tears and pressure injuries, contractures, cardiac rhythm disturbances and infection.

Emotional consequences of restraints include distress and worsening agitation. Individuals with dementia may exhibit marked behavioral disturbances in response to being restrained. People with and without dementia experience emotions ranging from frustration and anxiety to anger and terror when restrained and typically view restraints as barriers to be overcome.

CMS on Physical Restraints:

The Centers for Medicare & Medicaid Services (CMS) is committed to reducing unnecessary physical restraint use in nursing homes and ensuring residents are free of physical restraints unless permitted by regulation. Proper interpretation of the physical restraint definition is necessary in order to understand whether or not nursing homes are accurately assessing devices as physical restraints and meeting the federal requirement for restraint use.

42 C.F.R. 483.13(a) provides that “the resident has the right to be free from any physical or chemical restraints imposed for discipline or convenience, and not required to treat the resident’s
medical symptom.” CMS defines “physical restraints” in the State Operations Manual (SOM), Appendix PP 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.” Albeit for different functions, this same definition is used in the SOM, the Resident Assessment Instrument User’s Manual and subsequently the Minimum Data Set (MDS), and in the Quality Measure (QM). Despite using the same definition, the MDS and QM do not capture all physical restraints used because of the MDS’s limited categories and the QM’s calculation methods. Ultimately, surveyors should focus on the appropriate use of all physical restraints, whether or not those restraints are captured on the MDS or in the QM.

The following clarifications are meant to be used in conjunction with the definition of physical restraints.

“Freedom of Movement” means any change in place or position for the body or any part of the body that the person is physically able to control.

“Remove Easily” means that the manual method, device, material, or equipment can be removed intentionally by the resident in the same manner as it was applied by the staff (e.g., siderails are put down, not climbed over; buckles are intentionally unbuckled; ties or knots are intentionally untied; etc.) considering the resident’s physical condition and ability to accomplish objective (e.g., transfer to a chair, get to the bathroom in time).

“Medical Symptom” is defined as an indication or characteristic of a physical or psychological condition.

Objective findings derived from clinical evaluation and the resident’s subjective symptoms should be considered to determine the presence of a medical symptom. The resident’s subjective symptoms may not be used as the sole basis for using a restraint. In addition, the resident’s medical symptoms should not be viewed in isolation; rather, the symptoms should be viewed in the context of the resident’s condition, circumstances, and environment. Before a resident is restrained, the facility must determine that the resident has a specific medical symptom that cannot be addressed by another, less restrictive intervention and a restraint is required to treat the medical symptom, protect the resident’s safety, and help the resident attain or maintain his or her highest level of physical or psychological well-being.

There must be a link between the restraint use and how it benefits the resident by addressing the medical symptom. Medical symptoms that warrant the use of restraints must be documented in the resident’s medical record, ongoing assessments, and care plans. While there must be a physician’s order reflecting the presence of a medical symptom, CMS will hold the facility ultimately accountable for the appropriateness of that determination. The physician’s order alone is not sufficient to justify restraint use. It is further expected, for residents whose care plans indicate the need for restraints that the facility engages in a systematic and gradual process towards reducing restraints (e.g., gradually increasing the time for ambulation and strengthening activities). This systematic process also applies to recently admitted residents for whom restraints were used in the previous setting.
Physical restraints as an intervention do not treat the underlying causes of medical symptoms. Therefore, as with other interventions, physical restraints should not be used without also seeking to identify and address the physical or psychological condition causing the medical symptom. Restraints may be used, if warranted, as a temporary symptomatic intervention while the actual cause of the medical symptom is being evaluated and managed. Additionally, physical restraints may be used as a symptomatic intervention when they are immediately necessary to prevent a resident from injuring himself/herself or others and/or to prevent the resident from interfering with life-sustaining treatment, and no other less restrictive or less risky interventions exist.

**Note:** Falls do not constitute self-injurious behavior or a medical symptom that warrants the use of a physical restraint. Although restraints have been traditionally used as a falls prevention approach, they have major, serious drawbacks and can contribute to serious injuries. There is no evidence that the use of physical restraints, including but not limited to side rails, will prevent or reduce falls. Additionally, falls that occur while a person is physically restrained often result in more severe injuries.

If the resident needs emergency care, restraints may be used for brief periods to permit medical treatment to proceed, unless the resident or legal representative has previously made a valid refusal of the treatment in question. The resident's right to participate in care planning and the right to refuse treatment are addressed at 42 C.F.R. §§483.10(b)(4) and 483.20(k)(2)(ii) respectively. The use of physical restraints should be limited to preventing the resident from interfering with life-sustaining procedures only and not for routine care.

A resident who is injuring himself/herself or is threatening physical harm to others may be restrained in an emergency to safeguard the resident and others. A resident whose unanticipated violent or aggressive behavior places him/her or others in imminent danger does not have the right to refuse the use of restraints, as long as those restraints are used as a last resort to protect the safety of the resident or others and use is limited to the immediate episode.

**Root Cause Analysis:**
To make improvements in your NF in the areas of restraints, it would be prudent to conduct an RCA to determine why they are being used on the residents. As discussed in the Instruction Manual, there are many different RCA tools that can be used to accomplish this, with brainstorming being one of those tools. In brainstorming, you will bring together a group of staff in the NF that will jointly discuss the issue of restraints in a facilitated manner. The goal of brainstorming is to determine what is going on with residents in the NF to account for the use of restraints in your facility.

In gathering staff for the group, you want to pull together staff from all areas of the NF, direct care staff (CNAs and CMAs), nursing, therapy, etc. These staff members will be able to provide accurate information about the condition of the residents that have restraints being used with them, as they work the closest with the residents. It is important in the brainstorming process for the staff in the group to have some knowledge about restraint use in the NF so that they may be able to come up with ideas on how to fix the problem. You will want to encourage as much
participation from these staff members as possible. This can be accomplished by going around the room and asking staff to throw out an idea without having anyone else provide comments (positive or negative). Have a flip chart and markers available to write down these ideas as staff give them. Also, explain to staff that all ideas are welcome as they will never know which idea is the one that will solve the problem. If this approach doesn’t work, pass around a pad of paper and ask staff to write down all of their ideas, one on each page. Collect all of these papers and work with the team to group together similar ideas and confirm meanings to anything that might not be clear.

**Basic Assessment Tool:**
When a resident is not feeling well or is "just not right", it is important to do a basic assessment of his or her current status. Some of the signs that indicate that something is wrong include:

The resident is:
- more confused than usual
- not eating
- incontinent
- experiencing increased swelling

This is the first diagnostic step. It is followed by basic data gathering and physical exam.

The most common acute geriatric problems:
- UTI (urinary tract infection)
- impaction/obstruction
- pneumonia
- medications
- confusion

These acute problems are superimposed on chronic disease. Example: resident is coughing more and has existing diagnosis of COPD (chronic obstructive pulmonary disease) and CHF (congestive heart failure). What is going on and how do you figure it out?

**Sample Assessment:**


**Assessment Log/Intervention Care Plan**

| Event #: Indicate number. Keep numbers consecutive so events are easy to track. |
| When: Indicate date and time. Be specific. Use AM and PM indicators. Indicate if during shift change. Example: 7/4/17, 3:00 p.m., during evening shift change. |
| What/Where: Describe what happened to/with resident. Be specific as to where it occurred. Example: Fell while leaving bathroom, at doorway. Resident found on floor, no injury or cuts. Able to walk. |
| Who/Why: Indicate who else was present and what else was occurring at the time of event. Document any possible causes that may have triggered the incident. Example: No one else present. Attempting to leave bathroom. Floor was wet at doorway. Resident's shoes smooth on bottom and slick when wet. |
| Initials: Indicate initials of person completing the what/where/who/why portion of form. |
| Intervention: What changes were made to help the resident or to keep the event from occurring again? |
  - Ask yourself and document when appropriate: |
    1. Why intervention improves resident function |
    2. How intervention permits access to resident's own body |
    3. How intervention promotes highest level of resident functioning |
  
  Example: Non-skid tape added to floor at doorway. Resident's shoes evaluated for fit and found acceptable. Might consider adding handle bar at doorway if future incidences occur. Patient still able to safely toilet himself.
If intervention is for medical necessity, document what condition is present or treatment is necessary.

Document any time frames when device is to be used or discontinued.

- Assessment of Intervention: Clearly document whether intervention was successful. If intervention was successful, state why. If intervention was not successful, state why it did not work and what will be tried next. Go on to next block on the form if more space is needed.

Expect to try additional interventions until the least restrictive successful intervention is achieved.

Example: No falls in last 48 hours after non-skid tape placed on floor.

- Review and Comment by Charge Nurse/Restraint Committee: Add initials and comments of charge personnel. State agreement, what to consider, or future plans with patient.

Possible Areas for Evaluation are shown below and can be uses in assessing the residents in your facility.

- Falls
- Behavior Problems
- Wandering
- Medical Necessity
POSSIBLE AREAS FOR EVALUATION: FALLS

DO INTERDISCIPLINARY ASSESSMENT/SELECT BEST INTERVENTION

CONSULT PRIMARY CARE PROVIDER, AS APPROPRIATE

FACTORS

COMMON CAUSES

Physiological

Medication

Unstable gait

Cardiovascular insufficiency, Syncope - orthostatic, TIA, arrhythmia, hypotension

Infection

Hyperglycemia/Hypoglycemia

Dehydration

Constipation

Pain

Sleep

Psychosocial

Dementia/cognitive disorders

Denial of impairment/depression

Physical surroundings

Family

Adapted from Rehabilitation Nursing, 15 (1), 22-23, 1990, with permission from the Association of Rehabilitation Nurses.

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Physical Restraints Toolkit August 2017

- Dosage - multiple dosages/multiple medications
- Check drug substitution, interactions, side effects of psychotropics, diuretics, cardiovascular
- Have any new medications been added to regimen which may increase falls?
- Tegretol level
- Dilantin level
- Depakote level
- Neurological checks
- Electrolytes, BUN, creatinine
- Void before tranquilizers/sedatives
- Frequent toileting assist if on diuretics
- Limit long-acting benzodiazepines
- Administer pain meds before transfer & ROM

- Restorative nursing program
- Evaluate clothing for size & length
- Gait training, muscle strengthening for ADL training
- Fracture, arthritis, TIAs, seizures, Parkinson’s, hypothyroidism, anemia
- Evaluate hearing and vision
- Physical therapy--weight bearing
- Walker, cane, merry walker
- Shoe assessment

- Auscultate sitting and walking
- Teach to change position slowly
- Use elastic stockings
- Check pacemaker
- EKG, 24 hr. Holter monitor, O₂ saturation, CXR, electrolytes, BUN, creatinine, orthostatic BP, heart rate, digitals level

- Upper respiratory infection
- Urinary tract infection
- Fever - frequently afibrile, lung sounds, CBC, CXR, UA-C&S, O₂ saturation

- Check blood sugar
- Change in mental status

- Provide 1.5 to 2 qts. of water per day unless otherwise restricted
- Check bowel sounds, abdominal distention, impaction
- Maintain regular schedule
- Structured ADL schedules
- Locate near nurses’ station
- Geriatric Depression Scale

- History of pain
- Quality
- Location
- Onset, duration
- Intensity
- Ability to express pain
- Medications - try pain medications
- Transcutaneous nerve stimulation
- Physical therapy

- Diet effects
- Physiologic
- Illness
- Maintain regular schedule
- Limit caffeine, cigarettes, etc.
- Avoid napping
- Avoid stimulating drugs
- Room - quiet, cool, no noise

- Sleep/wake patterns
- Meds
- Distraction evaluation
- Hearing/visibility
- Verbal approaches

- Attitude/approach
- Structured ADL schedules
- Bedtime routines/rituals
- Medications
- Medications
- Bed/night
- Night
- TV-remote control
- Accessible call light

- Involve family in care planning
- Teach about predicted course of illness, as appropriate, behavior changes that result from cognitive loss
- Teach about current condition and interventions
- Teach about recent medical procedures, goals, procedures
Possible Areas for Evaluation: Behavior Problems

Factors

Common Causes

- Dosage - multiple dosages/multiple medications
  - Check drug substitution, interactions, side effects of psychotropics, diuretics, cardiovascular
  - Have any new medications been added to regimen which may increase falls?
- Tegretol level
  - Neurological checks
  - Frequent toileting assist if on diuretics
- Dilantin level
  - Electrolytes, BUN, creatinine
  - Limit long-acting benzodiazepines
- Depakote level
  - Void before tranquillizers/sedatives
  - Administer pain meds before transfer & ROM

- Ausculatate sitting and walking
- EKG, 24 hr. Holter monitor, O2 saturation, CXR, electrolytes, BUN,
- Teach to change position slowly
  - Creatinine, orthostatic BP, heart rate, digitalis level
- Use elastic stockings
- Check pacemaker

- Upper respiratory infection
- Urinary tract infection
- Fever - frequently afebrile, lung sounds, CBC, CXR, UA-C&S, O2 saturation

- Check blood sugar

- Provide 1.5 to 2 qts. of water per day unless otherwise restricted
- Change in mental status

- History of pain
  - Quality
- Location
  - Onset, duration
- Intensity
  - Ability to express pain

- Mediations - try pain medications
- Transcutaneous nerve stimulation
  - Massage
  - Heat
  - Physical therapy
- Cold

- Sleep/wake patterns
- Diet effects
- Bedtime routines/rituals
- Physiologic

- Maintain regular schedule
- Limit caffeine, cigarettes, etc.
- Avoid hypnotics
- Avoid stimulating drugs
- Room - quiet, cool, no noise

- Assess agressive behavior
  - Contract with patient
  - Behavior modification

- Assess psychoactive medications
- Cognitive therapy

- Attitude/approach - calm, flexible, guiding (not controlling)
- Verbal approaches - concrete, validate feeling, task segmentation, avoid excess disability
- Non-verbal approaches - attitude contagious, equal/lower position, therapeutic touch

- Music therapy
  - Distraction therapy
  - Recreation
  - Exercise
  - Remotivation

- Call light
- Rocking chair
- Night-time activities
- Avoid sensory overload
- Roommate
- Personalize room
- Assess interpersonal preferences
- Staff: street clothes, decrease turnover, resident chooses caregiver, permanent assignments, use non-nursing as much as possible, consistent scheduling
POSSIBLE AREAS FOR EVALUATION: WANDERING

FACTORS
- Physical
- Psychosocial
- Environmental

COMMON CAUSES
- Medication
- Dementia
- Physical surroundings

DO INTERDISCIPLINARY ASSESSMENT/
SELECT BEST INTERVENTION
CONSULT PRIMARY CARE PROVIDER, AS APPROPRIATE

- If new behavior--do a physical workup - see Falls Evaluation Guide
- Medications may increase restlessness/agitation

- Exit seekers
- Restless
- Distraction
- Way to stimulate self
- Wanders because someone else does
- Non-verbal approaches
- Assess for personal agenda and validate - agenda behaviors
- Attitude/approaches - approach from side or front
- Verbal approaches - gently redirect, use your body to show direction

- Music
- Recreation
- Exercise

Adapted from Rehabilitation Nursing, 15 (1), 22-25, 1990, with permission from the Association of Rehabilitation Nurses.

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Possible Areas for Evaluation: Medical Necessity

Factors

Common Causes

Do Interdisciplinary Assessment/Select Best Intervention
Consult Primary Care Provider, as Appropriate

Evaluate to eliminate risk, if possible
- Cover with Kerlix
- Air splints on arms
- Soft sponges in hands
- Foam mitts
- Bath blanket wrapped around arms to prevent bending arms

IV

Physical

Gastrotomy

- Abdominal binder/band
- Foam mitts

Catheter

- Sweat pants
- Foam mitts
- Supra-pubic abdominal binder

Pharmacological

Oversedation/Undersedation

Evaluate for medical necessity rather than control

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Recommended Practices:

Assessment

- Using assessment to find out each resident’s life history, habits and preferences is critical to restraint-free care.
- Ongoing assessment is an essential strategy for identifying use of restraints and alternatives to their use, as well as to support restraint-free care.
- Residents need regular, comprehensive assessment so that their individual care plans address needs and prevent use of restraints for conditions such as frequent falls, behavioral symptoms or wandering.

Staff Approaches:

- The key to eliminating use of restraints is individualized care, which depends on staff knowing the resident as a person. Consistent assignment of staff to residents promotes individualized care.
- Effective care planning involves knowing a resident’s remaining abilities and understanding how to make use of them to avoid conditions such as wandering and falls that can lead to inappropriate use of restraints. Care planning staff are responsible for trying and documenting various options to avoid use of restraints.
- Staff at all levels need to understand the hazards of using restraints and the process of individualized assessment and care planning to meet each resident’s unique needs.
- Effective staff education about restraints includes:
  - Definition of restraints
  - Restraint-free care and reasons why restraints are unacceptable
  - Myths and misconceptions about restraints, including, for example, the misconception that restraints are an effective and acceptable approach to ensuring resident safety
  - Negative impact of physical restraints on residents and staff
  - Restraint-related assessment strategies
  - Appropriate care for residents with behavioral symptoms
  - Residents’ rights and legal aspects of restraint use
  - Residence restraint policy and protocol for use in emergency situations
- Families need education about restraints to develop an understanding of:
  - The harmful consequences of restraints
  - Why restraints are unacceptable
  - Legal aspects of restraint use
  - Support of resident autonomy and freedom of movement

Example: Provide written educational information regarding restraint use to families upon resident admission.
• Staff, sometimes with the assistance of consultants, can implement creative solutions for identifying and meeting individualized care needs regarding safety, behaviors and postural support. For example:
  ➢ Respond promptly to resident calls and minimize their waiting times.
  ➢ When residents repeatedly slide out of their wheelchairs in an attempt to self-propel, place them in lower height wheelchairs without footrests or with footrests in the closed position that allow their feet to touch the floor.
  ➢ Assign staff to identify and help fatigued residents go to bed when they need rest so they won’t attempt to get into bed unassisted.
  ➢ Use individualized day and nighttime activities to increase resident contentment and decrease behavioral symptoms.
  ➢ Seek assistance from a professional to help reduce use of restraints through evaluation and treatment of physical, cognitive or sensory impairments.
  ➢ Camouflage and protect areas of active wound care so the resident will not disturb dressings or the healing process.
  ➢ Encourage family members and friends to sit with the resident and provide support or reassurance.

• When using restraints during a medical emergency, staff need to obtain orders from the resident’s physician and notify the designated family member or surrogate decision-maker as soon as possible. Staff should begin medical evaluation and appropriate treatment as ordered, call emergency services or transfer the resident to an appropriate health care facility.

• If the residence uses restraints, senior staff need to establish an interdisciplinary team to develop and implement a plan for reducing use of restraints and working toward eliminating restraints.

  **Note:** Nursing homes must have an interdisciplinary team for assessment and care planning. Designing alternatives to using restraints is an integral part of these processes.

• Make the restraint-reduction plan part of the resident’s quality improvement program and include baseline collection of data, measures of progress and rewards for progress.

  **Note:** Elimination of restraints requires that staff are adequately trained, alternative programs are in place, and adequate resources are available to implement individualized care plans.

**CNA Role in Restraint Reduction:** CNAs are an important asset when working to reduce the use of restraints. The CNA should:

• Work with in the facility under the thought that restraints are rarely used and are reserved for extreme circumstances.
• Look for patterns of behavior that lead to the necessity for a restraint.
• Keep water close to a resident and take residents to the bathroom often to prevent falls.
• Look for restless behavior, agitation and pain that can lead to resident wandering unsafely.
• Recognize that resident behaviors may reflect emotions or physical conditions such as pain or infection.
• Determine the triggers for agitated behaviors in each resident, and learn how to prevent them.
• Learn what calms a resident, and use that as an intervention to prevent and minimize restless behaviors, such as:
  ➢ Doing an activity that he or she enjoys; ask activity staff for ideas to keep restless resident engaged;
  ➢ Sit with a resident for a few minutes holding his or her hand and visit;
  ➢ Offer a resident a snack or something to drink; or
  ➢ Redirect or distract a resident with Alzheimer’s.
• Check the care plans for specific interventions that calm residents.
• Be aware that the resident might be in pain, and discuss this with the charge nurse.
• Volunteer to be a part of the facility restraint-free committee.
• If a restraint must be used, be on the lookout for pressure areas, urinary tract infections, decrease in other functional abilities, and behavioral changes of your resident that may occur during the use of a restraint.
• Follow your facility’s protocols for restraint use.
• Participate in in-services related to restraints.
• Talk to the charge nurse if you have a suggestion that you think would work better for a resident and prevent use of a restraint.

Nursing’s Role: The nursing staff in the facility have a very important role in the reduction of restraints, just as the CNAs do. The first role would be to conduct an assessment at the first sign of behavioral changes, instances of distress, and/or changes in medical condition. Secondly, the nurse should be able to anticipate, identify, and address problems with the resident’s usual routine, behavior, and care prior to them leading to the use of restraints. The nurse should be sure to implement any alternate interventions available to reduce the need for restraint use with the resident. If the need for restraints is unavoidable, then the nurse should be sure to conduct proper assessments to ensure that the resident is not harmed by their use.

Environment
• The environment can be modified to move toward a restraint-free environment. Examples of such modifications include:
  ➢ Using chairs that are at the right height, depth and level of backing for each resident to have comfortable and safe seating; individualize the time a resident spends sitting up in a chair.
  ➢ Individualizing each chair a resident uses in his or her room, public place or dining room.
  ➢ Using a wheelchair only when needed for transportation.
  ➢ Providing visual cues that are meaningful to a resident to deter him or her from entering the rooms of other residents.

Additional Resources:

Using a restraint should be the last resort, even when a justifiable medical indication is present. 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. Additional resources to assist your facility in reducing the use of restraints include:
• Tools: Physical Restraints: includes information about basic assessment, assessment tools, falls, behavior problems, wandering and medical necessity:
• Restraint Clinical Tools & Resources: can help nursing facilities reduce physical restraint use with technical assistance and interventions directed at process and system redesign:
  http://qio.ipro.org/nursing-homes-hac/clinical-topics-tools-resources/restraint-clinical-tools-resources
• Dementia Care Practice Recommendations for Assisted Living Residences and Nursing Homes: is a guide for providing quality care to residents with dementia, and include recommendations for providing care without the use of physical restraints:
  http://www.alz.org/national/documents/brochure_DCPRphases1n2.pdf
• Alzheimer’s Association; Campaign for Quality Residential Care. Dementia Care Practice Recommendations for Assisted Living Residences and Nursing Homes. 2006:
  http://www.alz.org/national/documents/brochure_DCPRphases1n2.pdf
• NCCNHR; Restraints: The Exception, Not the Rule. October 2007:
  http://www.health.nv.gov/HCQC/Restraints-TheExceptionNotTheRule.pdf
• MedQIC: The Medicare Quality Improvement Community; Restraint Reduction
• New Mexico Medical Review Organization (NMMRO) Physical Restraints
• The Pennsylvania Restraint Reduction Initiative (PARRI) Process for Eliminating Restraints in Long Term Care
• The Colorado Foundation for Medical Care
  http://209.197.249.121/nh/nh_restraint.aspx
• QIO IPRO Physical Restraints Resources
  http://qio.ipro.org/nursing-homes-hac/clinical-topics-tools-resources/restraint-clinical-tools-resources
• Texas Medical Foundation:
• Texas Department of Aging and Disability Services, Reducing the Use of Restraints in Texas Nursing Homes.
  http://www.dads.state.tx.us/qualitymatters/qcp/restrainreduction/index.htm
• College of Nurses of Ontario (2009). Standards of Care-Restraints.
  http://www.cno.org/Global/docs/prac/41043_Restraints.pdf
  http://rnao.ca/bpg/guidelines/promoting-safety-alternative-approaches-use-restraints