



Nursing Home Quality
Initiative

FAST FACTS: PHYSICAL RESTRAINTS Evaluation

JUNE 2006

USE OF PHYSICAL RESTRAINTS

“The indiscriminate use of physical restraints is no longer an accepted standard of care in long-term care facilities. Federal regulations provide clear guidelines for the use of physical restraints, which stress the need to try less restrictive approaches first and to use restraints only to try to maintain or improve – not reduce – a patient’s function.” ([AMDA, 2003](#))

The use of physical restraints is not prohibited in nursing homes, except when used for discipline or convenience and not required to treat a resident’s medical symptoms. “While a restraint-free environment is not a Federal requirement, the use of restraints should be the exception, not the rule.” ([RAI, 2006](#))

PRIOR TO INITIATION OF RESTRAINTS

Prior to initiation of any restraint, a facility should assess the resident’s medical, psychosocial and/or functional decline issues, specific needs, risks and problems to determine if treatment would alleviate issues precipitating restraint use (e.g. gait instability, medication side effects, infection, sleep disturbance).

[Capezuti](#) et al (1998) recommends a comprehensive individualized assessment prior to employing a physical restraint or when evaluating a resident for restraint reduction. The assessment should include:

- Review of the resident’s history – (e.g. falls, wandering, decreased cognition) to identify risk factors that may lead to restraint use
- Physical examination - to identify potential underlying causes of behavior, gait disturbance (e.g. metabolic disturbances, drug side effects) so interventions can be aimed at reducing/eliminating these causes without using restraints
- Assessment of environmental characteristics – (e.g. loud overhead paging, placement of room furniture) to identify irritants in the resident’s environment that may escalate behavior or contribute to difficulty with mobility
- Identification of resident specific problems – (e.g. forgetfulness, decreased ADL function) to determine if resident needs are being met and appropriate treatment/rehabilitation interventions and alternatives to restraints have been explored

EVALUATION OF PHYSICAL RESTRAINT USE

If it is determined that a resident requires a restraint to treat a medical symptom, the facility must assess the appropriateness of the restraint being used, determine “how the use of restraints would treat the medical symptom, protect the resident’s safety, and assist the resident in attaining or maintaining his or her highest practicable level of physical and psychosocial well-being.” ([SOM, 2006](#)) Staff should also make sure that the device used is the least restrictive device to treat the medical condition.

EVALUATION OF
PHYSICAL RESTRAINT
USE (CONT.)

[Strumpf](#) et al. (1998) suggests these standards of practice regarding evaluation of restraint use:

- In the rare circumstance where a restraint is applied, this should only occur as a result of collaborative decision-making among nurse, physician, interdisciplinary team members, the resident (if able) and family members
- Restraints should never be used as a substitute for observation
- If for any reason restraints are to be used, then use is as a short-term measure only and as a last resort
- When short-term use is unavoidable, attention to safety, comfort, and needs for food, hydration, elimination, exercise and social interaction are imperative

FURTHER READING
AND WEB
RESOURCES

A more detailed overview of physical restraints can be obtained by contacting your state Quality Improvement Organization (QIO). Visit:
<http://www.medqic.org/QIOListings>

Quality Measures Resource Manual, February 2006, Version 5.0.
Physical Restraints – Available: <http://www.medqic.org/Chapter6K>

Revised Long-Term Care Resident Assessment Instrument User's Manual, December 2002, Version 2.0, Revised March 2006; pp. 3.198-3.202. Available:
<http://www.cms.hhs.gov/RAI>

Centers for Medicare & Medicaid Services. State Operations Manual, Guidance to Surveyors for Long Term Care Facilities, Appendix PP, Rev. 15, Updated June, 2006. F221 Physical Restraints (pp 54-60). Available:
http://cms.hhs.gov/manuals/Downloads/som107ap_pp_guidelines_ltcf.pdf

U.S. Department of Health and Human Services. (2001, October) *42 Code of Federal Regulations, Part 483 Subpart B, Requirements for Long Term Care Facilities*, U.S. Government Printing Office and National Archives and Records Administration Office.

American Medical Directors Association, Falls and Fall Risk Clinical Practice Guideline. Columbia, MD: 2003; 9. Available: www.amda.com.

Capezuti E, Talerico KA, Strumpf N, Evans L. Individualized Assessment and Intervention in Bilateral Siderail Use. *Geriatric Nursing*. 1998; 19(6):322-230.

Strumpf NE, Patterson JE, Wagner J, Evans LK. 1998. *Restraint-Free Care: Individualized Approaches for Elders*. New York: Springer.