DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Center for Medicaid and State Operations/Survey and Certification Group

Ref: S&C-07-22

DATE: **June 22, 2007**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Clarification of Terms Used in the Definition of Physical Restraints as Applied to the Requirements for Long Term Care Facilities

Memorandum Summary

- Clarifies the phrases "remove easily" and "freedom of movement" as related to the physical restraints definition.
- Further clarifies the meaning of "medical symptom."

Issue

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.

Background

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.

Discussion

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).

The definition of "medical symptom" has not changed. The information below is a combination of current SOM guidance and some additional clarifications.

"**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.[1]

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.

Conclusion

Although the requirements describe the narrow instances when physical restraints may be used, growing evidence supports that physical restraints have a limited role in medical care. Restraints limit mobility and increase the risk for a number of adverse outcomes. Physical restraints certainly do not eliminate falls. In fact in some instances reducing the use of physical restraints may actually decrease the risk of falling.[2]

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[1] American Geriatrics Society, British Geriatrics Society, and American Academy of Orthopaedic Surgeons Panel on Falls Prevention. Guideline for the prevention of falls in older persons. Journal of the American Geriatrics Society. 49(5):664-72, 2001 May.
Neufeld RR, Libow LS, Foley WJ, Dunbar JM, Cohen C, Breuer B. Restraint reduction reduces serious injuries among nursing home residents. J Am Geriatr Soc 1999;47:1202-1207.
Si M, Neufeld RR, Dunbar J. Removal of bedrails on a short-term nursing home rehabilitation unit. Gerontologist 1999;39:611-614.
Hanger HC, Ball MC, Wood LA. An analysis of falls in the hospital: can we do without bedrails? J Am Geriatr Soc 1999;47:529-531.
Tinetti ME, Liu YB, Ginter S. Mechanical restraint use and fall related injuries among residents of skilled nursing facilities. Ann Intern Med 1992;116:369-374.
Capezuti E, Evans L, Strumpf N, Maislin G. Physical restraint use and falls in nursing home residents. J Am Geriatr Soc 1996;44:627-633.
Capezuti E, Strumpf NE, Evans LK, Grisso JA, Maislin G. The relationship between physical restraint removal and falls and injuries among nursing home residents. J Gerontol A Biol Sci Med Sci 1998;53:M47-M52.

[2] University of California at San Francisco (UCSF)-Stanford University Evidence-based Practice Center Subchapter 26.2. Interventions that Decrease the Use of Physical Restraints" of the Evidence Report/Technology Assessment, No. 43 entitled, "Making Health Care Safer: A Critical Analysis of Patient Safety Practices." The full report can be accessed at: http://www.ahrq.gov/qual/errorsix.htm

Effective Date: The information contained in this memorandum clarifies current policy and must be implemented no later than 30 days after issuance of this memorandum. The information will be incorporated into the State Operations Manual, Appendix PP.

Training: This clarification should be shared with all survey and certification staff, surveyors, their managers, and the state/RO training coordinator. Please direct any question or comments to Jeane Nitsch at Jeane.Nitsch@cms.hhs.gov.

/s/
Thomas E. Hamilton

cc: Survey and Certification Regional Office Management
Quality Improvement Organizations