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3	-	P-1	CMS is committed to reducing unnecessary physical restraints in nursing homes and ensuring that residents are free of physical restraints unless deemed necessary and appropriate as permitted by regulation. Proper interpretation of the physical restraint definition is necessary to understand if nursing homes are accurately assessing manual methods or physical or mechanical devices, materials or equipment as physical restraints and meeting the federal requirement for restraint use (see Centers for Medicare & Medicaid Services. [2007, June 22]. Memorandum to State Survey Agency Directors from CMS Director, Survey and Certification Group: Clarification of Terms Used in the Definition of Physical Restraints as Applied to the Requirements for Long Term Care Facilities. Retrieved ~~October 16, 2009~~ December 18, 2012, from http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/downloads/SCLetter07-22.pdf). **Are Restraints Prohibited by CMS?** Federal regulations and CMS guidelines do not prohibit use of physical restraints in nursing homes, except when they are imposed for discipline or convenience and are not required to treat the resident's medical symptoms. The regulation specifically states, "The resident has the right to be free from any physical or chemical restraints imposed for the purposes of discipline or convenience and not required to treat the resident's medical symptoms" (42 CFR 483.13(a)). Research and standards of practice show that physical restraints have many negative side effects and risks that far outweigh any benefit from their use. Prior to using any physical restraint, the nursing home must assess the resident to properly identify the resident's needs and the medical symptom(s) that the restraint is being employed to address. If a physical restraint is needed to treat the resident's medical symptom, the nursing home is responsible for assessing the appropriateness of that restraint. When the decision is made to use a physical restraint, CMS encourages, to the extent possible, gradual restraint reduction because there are many negative outcomes associated with restraint use. While a restraint-free environment is not a federal requirement, the use of physical restraints should be the exception, not the rule.
3	P0100	P-2	**Item Rationale** **Health-related Quality of Life** • Although the requirements describe the narrow instances

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			when physical restraints may be used, growing evidence supports that physical restraints have a limited role in medical care. Physical ~~R~~restraints limit mobility and increase the risk for a number of adverse outcomes, such as functional decline, agitation, diminished sense of dignity, depression, and pressure ulcers. • Residents who are cognitively impaired are at a higher risk of entrapment and injury or death caused by physical restraints. It is vital that physical restraints used on this population be carefully considered and monitored. In many cases, the risk of using the ~~device~~ physical restraint may be greater than the risk of it not being used~~ing the device~~. • The risk of restraint-related injury and death is significant when physical restraints are used. **Planning for Care** • When the use of physical restraints is considered, thorough assessment of problems to be addressed by restraint use is necessary to determine reversible causes and contributing factors and to identify alternative methods of treating non-reversible issues. • When the interdisciplinary team determines that the use of physical restraints is the appropriate course of action, and there is a signed physician order that gives the medical symptom supporting the use of the restraint, the least restrictive ~~device~~ manual method or physical or mechanical device, material or equipment that will meet the resident's needs must be selected. • Care planning must focus on preventing the adverse effects of physical restraint use.
3	P0100	P-3	**Steps for Assessment** 3. Considering the physical restraint definition as well as the clarifications listed below, observe the resident to determine the effect the restraint has on the resident's normal function. Do not focus on the type ~~of device~~, intent, or reason behind its ~~the~~ use ~~of the device~~. 4. Evaluate whether the resident can easily and voluntarily remove ~~the~~any manual method or physical or mechanical device, material, or equipment attached or adjacent to his or her body. If the resident cannot easily and voluntarily do this~~remove the restraint~~, continue with the assessment to determine whether or not the manual method or physical or

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			mechanical device, material or equipment ~~the device~~ restrict~~s~~ freedom of movement or restrict the resident's access to his or her own body. 5. ~~A d~~Any manual method or physical or mechanical device, material or equipment should be classified as a restraint only when it meets the criteria of the physical restraint definition. This can only be determined on a case-by-case basis by individually assessing each and every manual method or physical or mechanical device, material or equipment (whether or not it is listed specifically on the MDS) attached or adjacent to the resident's body, and the ~~its~~ effect it has on the resident. 6. Determine if the manual method or physical or mechanical device, material, or equipment meets the definition of a physical restraint as clarified below. Remember, the decision about coding any manual method or physical or mechanical device, material, equipment~~, or physical or manual method~~ as a restraint depends on the effect it ~~the device~~ has on the resident. 7. Any manual method or physical or mechanical device, material, or equipment that meets the definition of a physical restraint must have: **Clarifications** • **"Remove easily"** means that the manual method~~,~~ or physical or mechanical device, material, or equipment can be removed intentionally by the resident in the same manner as it was applied by the staff (e.g., side rails are put down or not climbed over, buckles are intentionally unbuckled, ties or knots are intentionally untied), considering the resident's physical condition and ability to accomplish his or her objective (e.g., transfer to a chair, get to the bathroom in time).
3	P0100	P-4	• **"Medical symptoms/diagnoses"** are defined as an indication or characteristic of a physical or psychological condition. Objective findings derived from clinical evaluation of the resident's subjective symptoms and medical diagnoses ~~and subjective symptoms~~ should be considered when determining the presence of medical symptom(s) that might support restraint use. **The resident's subjective symptoms may not be used as the sole basis for using a restraint. In addition, the resident's medical symptoms/diagnoses should not be viewed in isolation; rather, the medical symptoms identified should become the context in which to determine the most appropriate**

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			method of treatment related to the resident's condition, circumstances, and environment, and not a way to justify restraint use. • The identification of medical symptoms should assist the nursing home in determining if the specific medical symptom can be improved or addressed by using other, less restrictive interventions. The nursing home should perform all due diligence and document this process to ensure that they have exhausted alternative treatments and less restrictive measures before a physical restraint is employed to treat the medical symptom, protect the resident's safety, help the resident attain or maintain his or her highest level of physical or psychological well-being and support the resident's goals, wishes, independence, and self-direction. • **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**. • Physical r~~R~~estraints 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 when no other less restrictive or less risky interventions exist. • Therefore, a clear link must exist between ~~the~~ physical restraint use and how it benefits the resident by addressing the specific medical symptom. If it is determined, after thorough evaluation and attempts at using alternative treatments and less restrictive methods, that a physical restraint must still be employed, the medical symptoms that support the use of the restraint~~s~~ must be documented in the resident's medical record, ongoing assessments, and care plans. There also must be a physician's order reflecting the use of the physical restraint and the specific medical symptom being treated by its use. The physician's order alone is not sufficient to employ the use of a physical restraint. CMS will hold the nursing home ultimately

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			accountable for the appropriateness of that determination.
3	P0100	P-5	**Coding Instructions** *Identify all physical restraints that were used at ~~anytime~~ any time (day or night) during the 7-day look-back period.* After determining whether or not an item~~a device~~ listed in (P0100) is a physical restraint and was used during the 7-day look-back period, code the frequency of use: • Code 0, not used: if the item~~device~~ was not used during the 7-day look-back **or** it was used but did not meet the definition. • Code 1, used less than daily: if the item~~device~~ met the definition and was used less than daily. • Code 2, used daily: if the item~~device~~ met the definition and was used on a daily basis during the look-back period. **Coding Tips and Special Populations** • Any manual method or physical or mechanical device, material or equipment, that does not fit into the listed categories but that meets the definition of a physical restraint, and has not been excluded from this section, should be coded in items P0100D or P0100H, Other. These devices, although not coded on the MDS, must be assessed, care-planned, ~~and~~ monitored, and evaluated. • In classifying any manual method or physical or mechanical device, material or equipment as a physical restraint, the assessor must consider the effect it ~~the device~~has on the resident, not the purpose or intent of its use. It is possible that~~for~~ a manual method or physical or mechanical device, material or equipment, may~~to~~ improve ~~a~~the resident's mobility but~~and~~ also have the effect of physically restraining him or her. — ~~Bed rails used as positioning devices~~*Bed rails used as positioning devices*. If the use of bed rails (quarter-, half- or three-quarter, one or both, etc.) meet~~s~~ the definition of a physical restraint even though they may improve the resident's mobility in bed, the nursing home must code their use as a restraint at P0100A. — ~~Bed rails used with residents who are immobile~~*Bed rails used with residents who are immobile*. If the

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			resident is immobile and cannot voluntarily get out of bed because of a physical limitation ~~and not due to a restraining device~~ or because proper assistive devices were not present, the bed rails ~~do not~~do not meet the definition of a physical restraint.
3	P0100	P-6	For residents who have no voluntary movement, the staff need to determine if there is an appropriate use of bed rails. Bed rails may create a visual barrier and deter physical contact from others. Some residents have no ability to carry out voluntary movements, yet they exhibit involuntary movements. Involuntary movements, resident weight, and gravity's effects may lead to the resident's body shifting toward the edge of the bed. When bed rails are used in these cases, the resident could be at risk for entrapment. For this type of resident, clinical evaluation of alternatives (e.g., a concave mattress to keep the resident from going over the edge of the bed), coupled with frequent monitoring of the resident's position, should be considered. While the bed rails may not constitute a physical restraint, they may affect the resident's quality of life and create an accident hazard. • **Trunk restraints** include any manual method or physical or mechanical device, material or equipment ~~or material~~ attached or adjacent to the resident's body that the resident cannot easily remove such as, but not limited to, vest or waist restraints or belts used in a wheelchair that either restricts freedom of movement or access to his or her body. • **Limb restraints** include any manual method or physical or mechanical device, ~~or~~ material or equipment ~~or material~~ that the resident cannot easily remove, that restricts movement of any part of an upper extremity (i.e., hand, arm, wrist) or lower extremity (i.e., foot, leg) that either restricts freedom of movement or access to his or her own body. Hand mitts/mittens are included in this category.~~Included in this category are mittens.~~ • **Chairs that prevent rising** include any type of chair with a locked lap board, that places the resident in a recumbent position that restricts rising, ~~or a~~ chairs that ~~is~~are soft and low to the floor, chairs that have a cushion placed in the seat that prohibit the resident from rising, geriatric chairs, and enclosed-frame wheeled walkers. ~~Included here are chairs that have a cushion placed in the seat that prohibit~~

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			~~the resident from rising.~~ — For residents who have the ability to transfer from other chairs, but cannot transfer from a geriatric chair, the geriatric chair ~~would be considered a restraint~~would be considered a restraint to that individual, and should be coded as P0100G–Chair Prevents Rising. — For residents who have no ability to transfer independently, the geriatric chair ~~does not~~does not meet the definition of a restraint, and should not be coded at P0100G–Chair Prevents Rising. — Geriatric chairs used for residents who are immobile. For residents who have no voluntary or involuntary movement, the geriatric chair ~~does not~~does not meet the definition of a restraint. — Enclosed-frame wheeled walkers, with or without a posterior seat, and other devices like it should not automatically be classified as a physical restraint. These types of walkers are only classified as a physical restraint if the resident cannot exit the walker via opening a gate, bar, strap, latch, removing a tray, etc. When deemed a physical restraint, these walkers should be coded at P0100G–Chair Prevents Rising. • **Restraints used in emergency situations.** If the resident needs emergency care, physical restraints may be used for brief periods to permit medical treatment to proceed, unless the
3	P0100	P-7	— A resident who is injuring himself/herself or is threatening physical harm to others may be physically 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 physical 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. **Additional Information** • **Restraint reduction/elimination.** It is further expected, for residents whose care plan indicates the need for physical restraints, that the nursing home engages in a systematic and gradual process towards reducing (or eliminating, if possible) the restraints (e.g., gradually increasing the time for ambulation and strengthening

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			activities). This systematic process also applies to recently-admitted residents for whom physical restraints were used in the previous setting. • **Restraints as a fall prevention approach.** Although physical restraints have been traditionally used as a fall prevention approach, they have major drawbacks and can contribute to serious injuries. Falls do not constitute self-injurious behavior nor a medical symptom supporting the use of physical restraints. There is no evidence that the use of physical restraints, including but not limited to side rails, will prevent, reduce, or eliminate falls. In fact, in some instances, reducing the use of physical restraints may actually **decrease** the risk of falling. Additionally, falls that occur while a person is physically restrained often result in more severe injuries. • **Request for restraints.** While a resident, family member, legal representative, or surrogate may request use of a physical restraint, the nursing home is responsible for evaluating the appropriateness of that request, just as they would for any medical treatment. As with other medical treatments, such as the use of prescription drugs, a resident, family member, legal representative, or surrogate has the right to refuse treatment, but not to demand its use when it is not deemed medically necessary. According to 42 CFR 483.13(a), "The resident has the right to be free from any physical or chemical restraints imposed for the purposes of discipline or convenience and not required to treat the resident's medical symptoms." CMS expects that no resident will be physically restrained for discipline or convenience. Prior to employing any physical restraint, the nursing home must perform a prescribed resident assessment to properly identify the resident's needs and the medical symptom the physical restraint is being employed to address. The guidelines in the State Operations Manual (SOM) state, "...the legal surrogate or representative cannot give permission to use restraints for the sake of discipline or staff convenience or when the restraint is not necessary to treat the resident's medical symptoms. That is, the facility may not use restraints in violation of regulation