

Positioning vs. Restraint

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Frequently Asked Questions:

1. What is a Restraint?

A restraint generally limits movement, though official regulations and policies have specific definitions. Definitions will also vary with specific setting. Seating and Mobility technologies are often used to support a very specific position or posture of a body part in addition to minimizing migration in a specific direction. Restraint typically refers to either a device that is used to limit harmful motion in a vehicular transportation system or a device whose use is carefully controlled in many settings and governed by federal or state regulations or local policies.

Federal Regulations: OBRA

The Omnibus Budget Reconciliation Act of 1987 (OBRA) regulations cite that the individual's preference regarding use of a restraint must be met, if possible (Social Security, 1987). An individual may prefer specific seating interventions (that may be misconstrued as a restraint) for functional purposes or to minimize the risk of injury. If the individual requests such intervention it can be used despite other policies that may be in place. For example, an adult with cerebral palsy who has significantly increased muscle tone may be able to drive his power wheelchair with his chin mounted joystick if his/her arms are strapped to the arm support. He/she does not consider these straps to be restraints and has requested their use. Removing the arm straps, in this case, would be restraining, as the individual would no longer be independently mobile in his/her powered mobility device.

OBRA regulations state: "Restraints may only be imposed, 1) to ensure the physical safety of the resident or other residents, and 2) only upon written order of a physician that specifies the duration and circumstances under which restraints are to be used" (OBRA).

OBRA regulations apply to facilities receiving federal funding, though other settings may adopt these regulations, interpret them, and add to them.

Federal Definitions: FDA & HHS

Both the FDA and the Department of Health and Human Services (HHS) have defined the word "restraint" in their program regulations. The FDA defines a "protective restraint" in 21 CFR Section 880.6760 as "a device, including but not limited to a wristlet, anklet, vest, mitt, straight jacket, body/limb holder, or other type of strap that is intended for medical purposes and that limits the patient's movements to the extent necessary for treatment, examination, or protection of the patient or others." (FDA, 2013). This definition applies specifically to devices that attach directly to the person for the specific intent of controlling the movement of a person or a part of the person. The FDA **regulates products when restraint is a specific intent of a product**, but does **not** define as restraints any other products or devices that may be adjacent to a person and also used to control movement of a person. As such, the **FDA regulations do not apply to wheelchairs, seating systems and secondary supports when the intent is to provide postural support, stability, pressure distribution and pressure relief.**

The Department of Health and Human Services includes a definition of a restraint in 42 CFR Section 482.13 that pertains to the regulation of restraint use in hospitals and other health facilities, including long term care. (GPO, 2013). CFR 42 Part 482.13 (e) (Patient Rights) states:

"All patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time". As such, **this definition does not apply to wheelchairs, seating systems and secondary supports when used to provide postural support, stability, pressure distribution and pressure relief**, as opposed to a means of "coercion, discipline, convenience, or retaliation by staff."

Further, "A restraint is—any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely" (CFR 482.13(e)(1)). However, 482.13(e)(1)(i)(C) clarifies that "a restraint does not include devices, such as orthopedically prescribed devices..." (typically used for medical surgical care). As such, **this definition does not apply to**

wheelchairs, seating systems and secondary supports when used to provide postural support, stability, pressure distribution and pressure relief, as opposed to intentionally immobilizing or reducing movement. Movement may be limited by this seating technology, however the **intent** is postural support, stability, pressure distribution and pressure relief for improved function, not limitation of movement.

The Interpretative Guidelines for this standard further clarify that a mechanical support used to achieve proper body position, balance, or alignment so as to allow greater freedom of mobility than would be possible without the use of such a mechanical support is **not** considered a restraint (CMS, 2013). As such, wheelchairs, seating systems and secondary supports are used to achieve proper body position, balance and alignment. Depending on the complexity of the client's needs, mobility may not be improved, however the **intent** is not to limit movement (Rader J, 1999).

The issue of physical restraint regulation and interpretation becomes further complicated when some agencies continue to use definitions that are not current. Until 2007, a physical restraint was considered to be "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" (OBRA). The language of "adjacent to" and "cannot remove easily" can certainly raise concerns among facility administrators when extensive supports are added to a wheelchair, despite the documented clinical benefits. It should be noted that nowhere in these regulations is the issue of specific supportive wheelchair components addressed. This leaves an even greater gap between our experience of restraints' hazards and risks—and our concrete knowledge of the clinical applications of postural supports. As regulations have evolved over the last decade, there has been a shift conceptually from discussion of a particular device (a bedrail, for example) and its intended use—to a discussion of the device's overall effect on the individual. For example, there may be significant functional improvements from the use of a device; however it may also have the effect of restraining the individual (at times unnecessarily).

2. When is a seating component a Restraint or a Positioning device?

A positioning device is designed to maintain alignment with the primary support surfaces (the seat and back), provide stability and postural support and to promote function. A restraint is intended to limit movement to protect the client and/or others.

3. What Seating and Mobility Technologies are often misconstrued as a Restraint?

Tilt in Space and reclining wheelchairs are sometimes seen as a restraint, as a very tilted or reclined position may hinder the client exiting the wheelchair. Positioning components that are sometimes seen as a restraint include primarily anterior supports such as pelvic positioning belts, anterior trunk supports, anterior knee blocks and forehead straps. Medial knee abductors, ankle straps, trays and arm straps are also frequently seen as limiting client egress from a mobility base – even if that client does not have the motor ability to stand and ambulate.

4. A client I work with needs a wheelchair or seating components that are misconstrued as Restraints in my work setting. Can I still recommend this equipment and, if so, what is required to comply with regulations?

All secondary postural support devices are actually intended to block or limit movement – either movement which is a result of the force of gravity (postural collapse), or active movement (voluntary or involuntary). The use of any secondary postural support component, or PSDs, is indicated only when it is NECESSARY to:

1. Minimize the risk of body postures which impair safety or health, such as those that:
 - a. Increase the risk of skin breakdown.
 - b. Increase pain.
 - c. Increase the risk of orthopedic complications/deformity/contractures.
2. Restrict and stabilize one body area in order to allow/increase functional movement in another body area (Clark, Morrow, & Michael, 2004).
3. Support or maintain a specific posture or alignment which the individual cannot achieve or maintain on their own, but which is necessary to optimize their health, comfort or overall functional abilities (Gregory) (Zollars, 2010) (Presperin Pedersen & Lange, 2001) (Ryan 2005).

If a postural support device is necessary for a particular individual to meet the indications 1, 2 or 3 above, provision of this is very specific to individual client needs and a specialty clinical evaluation is necessary.

Many secondary postural support devices are misconstrued as a restraint as these components may limit an individual from getting up and out of the mobility base. However, many individuals using seating and mobility equipment are unable to safely rise, stand, and walk away from the mobility base. Some individuals may lack the cognition and/or judgment to understand or remember this, resulting in the potential for falls and injuries.

Documentation must justify the clinical indicators for each seating component. Most regulations look at the intent of the component to determine whether this is being used as a restraint. For example, “a pelvic positioning belt is being recommended to maintain a neutral pelvic position which, in turn, will facilitate a more upright trunk and head position.” If your setting continues to question these recommendations, review pertinent definitions, regulations and policies. Find out what your settings specific requirements are. Does the facility use OBRA regulations or other definitions? Are these regulations the most current? Have these been modified?

5. Is the intentional use of seating and mobility technologies as a Restraint ever clinical indicated?

There are situations when the intentional use of secondary support components as a restraint could be clinically indicated for safety reasons, either to minimize the risk of falls or to limit self-abusive behaviors (Pierz). In this case, the term “restraint” refers to limiting movement, but not to 1) minimize the risk of body postures which impair safety or health, 2) restrict and stabilize one body area in order to allow/increase functional movement in another body area, or 3) support or maintain a specific posture or alignment which the individual cannot achieve or maintain on their own. The purpose of using a secondary support component intentionally as a restraint is also not for “coercion, discipline, convenience, or retaliation by staff”. The goal is to minimize the risk of injury to the individual in the wheelchair and/or others. Per OBRA regulations, use of a “restraint” is acceptable under these circumstances in a long term care setting.

Use of any component to intentionally restrain a client should be avoided if possible, alternative options should be explored (i.e. increased supervision, stimulation), and any restraint should be minimized.

If a wheelchair or seating component is intentionally used as a restraint, documentation must clearly state why a secondary support is being used as a restraint and that documentation must then be signed by a physician. Following these guidelines will also reduce clinician liability.

For seating and mobility practitioners to be effective in environments where restraint guidelines can be misinterpreted, particular attention must be paid to documenting the clinical indications as well as risks and benefits for each seating intervention provided. Practitioners would be prudent to include exact language from existing regulations that exempt mechanical postural supports from consideration as physical restraints. Finally, it is important to communicate the beneficial effects of postural supports which distinguish them from physical restraints that are used only in the most regulated circumstances. Seating and mobility practitioners should be viewed as a resource people who not only support the health and well-being of individuals, but also as partners in regulatory compliance.

Adapted from the RESNA Position on the Application of Wheelchairs, Seating Systems, and Secondary Supports for Positioning vs. Restraint. 11/2013.