

RESTRAINTS: ACHIEVING SUCCESSFUL SEATING OUTCOMES WHILE ADDRESSING RESTRAINT CONCERNS

At some point during clinical practice, most seating and mobility practitioners will experience situations in which the application of a postural support device (PSD) is called into question as being a physical restraint. Service providers sensitive to regulatory compliance issues surrounding the use of restraints sometimes challenge products intended to provide greater freedom of mobility, lessen the risk of sitting complications, and reduce the development of orthopedic asymmetries. The concerns of these providers are understandable in light of a tightly regulated service environment. This can be a complicated issue as guidelines between regulating agencies can be conflicting, vague and easily over-generalized (*Lange, 2011*).

To address this issue, as well as provide clinical guidance to seating professionals in the field, a number of interested clinical professionals recently worked to develop and disseminate a position paper entitled, “RESNA Position on the Application of Wheelchairs, Seating Systems and Secondary Supports for Positioning vs. Restraint.” The authors of the paper possess extensive experience in long-term care facilities, schools, institutions and hospitals, and recognize this as a relevant concern among practitioners who are working to provide appropriate positioning

equipment to their clients. The intent was to assist practitioners in decision-making and justification by clarifying the concepts of positioning and restraint. It details current regulatory definitions and applies them to the process of providing products intended to enhance function and reduce complications. This article is adapted from the RESNA paper and provides a snapshot of the

critical aspects of the restraint versus positioning discussion. The complete position paper can be found on the RESNA website (http://resna.org/resources/position_papers.dot).

The goal in any setting where restraint issues are of concern is for practitioners to work cooperatively with providers to ensure client needs are met in a way which acknowledges the complex issues surrounding external and internal restraint policies, rules and regulations. As with any regulatory issue, changing definitions, interpretative guidelines, and rulings are not uncommon. As a professional group, we are wise to be out in front of these concerns and ready to thoughtfully and

knowledgeably join conversations with rule-making entities.

One of the interesting aspects related to the understanding of restraint might be the definition of the word itself, which is “an act or the quality of holding back, limiting, or controlling something.” (*Encarta Dictionary: English-North America*). Additionally, a restraining entity (or device) is defined as “something that controls or limits somebody or something.” While this accepted definition of the word itself is fairly straightforward, there are numerous regulations and policies that define a restraint and subsequently limit the use of these devices in many settings. The definition of a restraint can vary depending on the context or setting: community versus institutional, hospital versus long-term care, pediatric versus adult, and so forth. In contrast, a “support” is defined as “a foundation or prop” (*Merriam-Webster Dictionary*). This definition varies greatly in intent from the classical definition of “restraint.” It is important to note that although a practitioner may have an appropriate therapeutic or functional justification for the application of a postural support, he or she may find the support satisfies the definition of a restraint in the specific environment where it is being applied, and may be regulated as such.

Practitioners almost universally refer to PSDs as “supports” rather than “restraints,” despite the fact that many of the components we use may meet the classical definition of “restraint.” Supports, as we know, are used to

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achieve a very specific position or posture of a body part in addition to minimizing migration in a specific direction. Restraints, on the other hand, refer to devices used to limit harmful motion during vehicular transportation, or a device used to prevent harm to oneself or others in carefully controlled settings. The Food and Drug Administration and the Centers for Medicare and Medicaid Services also make definitional references to restraints pertaining to medical procedures or orthopedically prescribed devices. Interestingly, the language contained in these references either implicitly or explicitly exempts orthopedically prescribed devices and PSD's from regulatory consideration as a restraint.

The most oft-cited regulation regarding the use of restraints in facilities comes from the Omnibus Budget Reconciliation Act of 1987 (OBRA). 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 regulations apply to facilities receiving federal funding, although other settings may adopt these regulations, interpret them, and add to them. If a wheelchair or seating component is intentionally used as a restraint, documentation must clearly state why a secondary support (a support used in addition to primary supports, specifically seat and backrest surfaces) is being used as a restraint and documentation must be signed by a physician. Many settings add their own interpretation to current regulations. In this case, it is critical for the practitioner to be familiar with the original federal definitions and regulations.

Documentation may need to address setting-specific requirements. RESNA's position paper provides much more detailed and exact language from regulatory citations for the interested reader.

To complete the exciting discussion on definitions and regulations regarding restraints and supports, we should include as relevant terminology restraint as it is used in motor vehicle transportation. Restraints in a motor vehicle, or "occupant restraints," are used to minimize the risk of serious injuries during normal and emergency driving maneuvers, as well as in motor vehicle crashes. It is important for practitioners and consumers to understand the differences between occupant restraints and postural supports in this environment as they become critical when a person using a wheelchair for mobility and postural support also uses this equipment for transportation in a personal or public vehicle. For more information on this subject please refer to the RESNA Position on Wheelchairs Used as Seats in Motor Vehicles (*Buning, 2012*).

As we enter into discussion of specific supports that may be misinterpreted as restraints in some settings, it is helpful to distinguish between primary postural supports and secondary postural supports (*Presperin Pedersen & Lange, 2001*). Primary supports can be thought of as the "bare minimum" of postural supports, without them the person would likely fall out of the wheelchair or other mobility device and sustain injury – that is, seat and backrest surfaces, as well as foot supports. There is little controversy that primary supports are not physical restraints, as they have the beneficial effect of maintaining an individual upright and supported in sitting. Secondary supports are typically those used to help maintain a very specific posture or position of a certain body part or area, such as a person's upper torso, extremities or head, while the basic seated position is maintained by the primary supports. Indications for the use of secondary supports is well-documented in the literature (*Presperin Pedersen & Lange 2001, Zollars 2010*), but we can summarize these as: 1) minimizing the risk of body postures that impair safety or health, such as skin breakdown, pain, and orthopedic complications; 2) stabilization to allow increase function; and/or 3) accommodation of fixed asymmetrical postures necessary for optimal health (*Hsieh, 2011, Clark 2004, Zollars 2010*). All secondary postural support devices are actually intended to block or limit movement – either movement that is a result of the force of gravity (postural collapse), or active movement (voluntary or involuntary). These components have the potential to be identified as physical restraints in some settings. The number and type of secondary support components will vary widely depending on the voluntary and involuntary movement characteristics of the person using them. Individuals with a significant lack of voluntary control will require a very different body support system than a person with voluntary, functional movement. Through the use of established and sound evaluation processes, practitioners and suppliers work to minimize the use of secondary supports, both to lessen costs and to limit the equipment load on users and caregivers. The fact that fewer secondary supports lead to more rational discussion of restraint versus support in some settings is certainly an added benefit.

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To minimize the use of secondary supports as much as possible, the evaluation process should always include a discussion of therapeutic interventions that could positively impact an individual's seated position (Zollars, 2010). I frequently encounter individuals who appear to be profoundly limited in basic motor skills such as head and trunk control. However, during the physical assessment we discover the person may actually have motor skills that have diminished over time from disuse or from limited opportunities for practice. The discussion of seating intervention may lead to recommendations for activities to promote the use of these skills in out-of-chair settings. For example, we might assist in the design of sitting, standing or other gross motor activities, not only to promote health, wellness, interaction and cognitive alertness, but also to reduce dependence on secondary wheelchair postural supports. Other interventions might include, but are not limited to, contracture management, muscle strengthening, tone management, and pain management. Intervention can also be provided to address behavioral issues or sensory seeking by a team enhanced by clinicians who have experience and training in these areas (Rappl, 2000).

When recommending seating interventions, the decision-making process should include consideration of the least restrictive secondary support devices that still meet the individual's needs. Trial with the recommended seating system may help to determine if the level of intervention is adequate for postural support, stability, and function while minimizing restriction of movement (Presperin Pedersen & Lange, 2001). An example of this is the use of tilt-in-space as a postural intervention. Tilt/recline technology is a major advancement in management of individuals with complex positioning needs and an appropriate intervention in many clinical situations (Dicianno, 2009). However, with careful selection of primary support surfaces along with strategically placed secondary supports, some individuals may function well in a fixed orientation, reducing costs and the associated equipment load on the user and caregivers. For more information on the clinical indications for tilt and recline seating systems, please refer to the RESNA Position on the Application of Tilt, Recline and Elevating Legrests for Wheelchairs – as tilt and recline strategies can be misapplied and therefore interpreted as physical restraints in some settings.

The authors of the position paper identified some circumstances that may call into question the provision of seating and mobility equipment not specifically intended for postural support. There are situations in which special seating is employed in settings where the goal of the product is to provide proprioceptive input, or to help a child understand boundaries and facilitate modulation in a therapeutic environment – not to restrain the individual. Seating and mobility bases are also sometimes used in the community with ambulatory individuals who lack judgment and may otherwise stray from their caregivers, possibly into a dangerous situation (Yonkman, 2013). In both of these scenarios, although the goal of the seating system is not primarily postural control, it still may have clinical and safety goals.

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, 2013). In these cases, the use of the component does not meet any of the three clinical indicators outlined above. A very common scenario is a person with cognitive impairment who is at risk for serious injury if they were to attempt to stand from their wheelchair unassisted (Chaves, 2007). Due to cognitive impairment, this client may not remember or understand that they are unable to stand without falling. In these cases an anterior pelvic support could be indicated for fall prevention, however, the concern arises for some individuals who are able to independently release the belt closure mechanism. Prior to 2007, this was of great concern as OBRA regulations were specific that if a device could not be released independently, it was considered a restraint. Since the operational definition of restraint does not now include this criteria, we are able to better assess the seriousness, and consequences of, an individual's fall risk in order to recommend strategies that may involve devices such as closures only a caregiver can operate. These strategies are not to be taken lightly as there could be a tendency for over utilization as a convenience for staff, or a substitute for less restrictive approaches. In the setting in which I practice, the use of a restraining secondary support is thoroughly vetted by a multidisciplinary specialty team that includes the individual and guardian. Alternative approaches (alarms, signaling devices, asking for assistance) are considered, however if the consequences of a fall may be catastrophic, the team will usually recommend a pelvic belt with

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modified closure be implemented concurrent with other therapeutic strategies designed to lessen the person's fall risk.

In conclusion, 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.

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