

Course Title: Medical Restraint Use and Patient Rights in Ambulatory Surgery Centers

Course description: Ambulatory Surgery Centers (ASCs) that receive funding from CMS must comply with federal and state regulations regarding the use of medical restraints. In this course, we will discuss the ramifications of restraint use in terms of the law, the health provider, and the patient, and why ongoing training and review is necessary. We will highlight the CMS Standards regarding use of restraints, focusing on those which are relevant in the ASC setting. Finally, we will review important points to consider when ordering, applying, monitoring, discontinuing, and documenting restraint use in ASCs.

Learning Objectives

At the end of this activity, participants will be able to:

1. Identify potential implications and complications of restraint use to the patient, the health care provider, and the ASC facility.
2. Describe the CMS Standards that must be followed when considering medical restraints for patients.
3. Analyze clinical considerations regarding restraint use and alternatives to restraint use.

Section 1: Restraints in the ASC--- Protecting Patients' Rights

One might expect restraint use would be minimal to nonexistent in an Ambulatory Surgery Center (ASC). The procedures performed in ASCs are often elective or uncomplicated, performed on healthier patients. Admissions are usually less than 24 hours. Still, the Centers for Medicare & Medicaid Services (CMS) require ASCs to maintain policies and procedures on the use of restraints.

A restraint policy might not seem to be a priority in this setting, but it should be. One may rarely see a patient highly agitated or delirious, let alone violent, in the ASC. However, it could happen. Patients that are anesthetized and/or medicated can have unexpected reactions that cause behavioral changes. In addition, patients with behavioral, cognitive, or other vulnerabilities also get same-day surgeries, and could very well be treated at an ASC. The stress of having a procedure could increase the risk of these vulnerable patients acting out in the ASC. The mere possibility warrants maintaining a sound restraint policy aligned with CMS Standards and guidelines.

In this program, we will discuss the use of restraints in ASCs, focusing on CMS Standards and Interpretive Guidelines. The Interpretive Guidelines flesh out the Standards, providing context, insight, and nuance. They are directed to surveyors to help them fulfill their protocol, but they can also be used by health administrators to guide internal processes and maintain compliance with CMS.

Standards and Interpretive Guidelines for ASCs

Ambulatory surgery centers can provide many surgical services at much lower cost to both patients and payers. An ASC is defined by the CMS as a *“distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization and in which the expected duration of*

services would not exceed 24 hours following an admission. An unanticipated medical circumstance may arise that would require an ASC patient to stay in the ASC longer than 24 hours, but such situations should be rare." (Ambulatory Surgery Centers | CMS, n.d.)

CMS codifies the requirement for ASCs to submit quality data under the Medicare Improvements and Extension Act of 2006, in 42 U.S. Code § 1395I - Payment of Benefits, section 1833 (7).

In establishing quality reporting Standards for ASCs, Section 1833 (7)(B) defines ASC reporting requirements as parallel to requirements for facilities providing equivalent services, as follows: *"any reference to a hospital, outpatient setting, or outpatient hospital services is deemed a reference to an ASC, the setting of an ASC, or services of an ASC, respectively."* (SSA, n.d.) As such, ASCs, like hospitals, are required to adhere to the same Standards and guidelines on restraint use.

The CMS State Operations Manual (SOM) contains the standards and Interpretive Guidelines used by site surveyors. Appendix A focuses on hospital Standards, while Standards specific to ASCs are covered in Appendix L. Standards focusing on restraint use are found in Appendix A, but as stated above, ASCs are bound by these, when applicable.

QAPI and Restraints in the ASC

Standards 482.213(e), (f), and (g), cover the use of restraint and seclusion, and can be found in the SOM, Appendix A.

Guidelines to Standard 482.213(e) state that hospital leadership should include monitoring and documentation of restraint use through its Quality Assurance and Performance Improvement (QAPI) program. The guidelines specify that leadership should facilitate the following steps:

- Assess and monitor the use of restraint or seclusion in their facility.
- Implement actions to ensure that restraint or seclusion is used only to ensure the physical safety of the patient, staff and others; and
- Ensure that the hospital complies with the requirements set forth in this standard as well as those set forth by State law and hospital policy when the use of restraint or seclusion is necessary.

(Som107ap_a_hospitals.Pdf, n.d.-a)

Due to the nature of the population served, an ASC may rarely face the dilemma of having to place a patient in restraints. However, this does not mean it can never happen, and because of the potential risks involved in the use of restraints, ASCs should maintain policies and training on restraint use. Every use of restraints should be documented in the patient's chart, and also in a log, even if there are all zeros in the log.

CMS Definitions---What is a Restraint?

Restraints are regulated by CMS not as a medical intervention, but as a patient's rights issue. Indeed, in the CMS SOM, restraint-use Standards fall under §482.13, Condition of Participation: Patient's Rights. (*Som107ap_a_hospitals.Pdf*, n.d.-a)

In Appendix A, CMS provides the following definition of a restraint, as follows:

§482.13(e)(1) Definitions. (i)(A) *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.* (*Som107ap_a_hospitals.Pdf*, n.d.-a)

The above definition pertains to physical and mechanical restraints. But patients can also be restrained chemically, with medications. This type of restraint also needs to be defined, and CMS does so, as follows:

§482.13(e)(1)(i)(B) *[A restraint is -] A drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.* (*Som107ap_a_hospitals.Pdf*, n.d.-a)

What is Not a Restraint?

Appendix A also provides clarity on what **IS NOT** a restraint, as follows:

§482.13(e)(1)(i)(C) — *A restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort).* (*Som107ap_a_hospitals.Pdf*, n.d.-b)

CMS also provides a detailed definition of seclusion, which is a type of restraint. Seclusion would not be an intervention used in an ASC, so this program will not be discussing standards specifically related to the use of seclusion.

Restraints Harm Patients

There have been several studies looking at the dangers of restraint use. An analysis published in 2012 looked at autopsy reports in Munich from 1997 to 2010, and found that among 27,353 autopsies, 22 reported deaths were caused by physical restraint. Half of these patients died by strangulation and 8 by chest compression, while 3 involved dangling in a head-down position. In 19 of 22 cases, the restraints were tied improperly, or jerry rigged. In one case, the restraint was applied properly, but the patient's neck was compressed when the patient tried to escape from the restraint. None of the patients were under continuous observation. (Berzlanovich et al., 2012)

The CMS standards and guidelines on restraints and seclusion follow The Joint Commission's (TJC) release of Sentinel Event Alert 8, Preventing Restraint Deaths, in 1998. The alert followed two years of sentinel-event tracking which found 20 restraint-related deaths. Twelve of these deaths occurred in psychiatric hospitals, 6 in general hospitals, and 2 in long-term care facilities. In 40 % of the deaths, asphyxiation was the cause. In some cases, suffocation was caused by excessive weight or pressure on the back of a prone patient. In other cases, a towel or sheet was placed over the patient to

prevent spitting or biting, asphyxiating the patient. Others died from being restrained in a choke hold, compressing the neck. (*Sea_8pdf.Pdf*, n.d.)

The remaining deaths were caused by strangulation, cardiac arrest, or fire. Several patients were strangled by vest restraints. Some patients were strangled when trying to squeeze through split side rails while wearing vest restraints. Several patients died by fire after smoking or using a lighter to try to burn off the restraint. (*Sea_8pdf.Pdf*, n.d.)

Restraints used in 40% of these cases included two-, four- and five-point restraints. Thirty percent were attributed to “therapeutic hold”. Vest restraints were used in 20% and waist restraints in 10% of the cases. (*Sea_8pdf.Pdf*, n.d.)

Less dramatic but still serious adverse effects of restraints include deconditioning, DVTs, incontinence, skin injury and pressure sores, infections, reduced appetite, behavioral changes, isolation, and depression. (*Physical Restraints - American Academy of Nursing Main Site*, n.d.)

While restraints can lead to death and physical injury, they can also cause psychological injury. To help us understand the experience of being restrained in the health care setting, Yale interviewed 25 patients who had been restrained in ERs. (Ambrose H. Wong et al., 2020) While the situational context of the ER is different from that of the ASC, being restrained is a commonality. It is helpful when thinking about restraints to understand how people feel before, during, and after they are restrained.

Most of the patients interviewed in the Yale study were at the ER during crisis, and some had been brought there involuntarily, so agitation and distress was often already escalated. This is less likely to be the case in the ASC, as the latter sees scheduled patients who, most likely, are there voluntarily and prepared for the visit. Still, one cannot predict or control every patient situation that shows up at the ASC. Restraint use is an emergency tactic, and emergencies need to be anticipated and prepared for.

Of the 25 Yale study participants, 88% reported mental illness and/or substance abuse as an aggravating factor leading to restraint use. Some described complex medical problems that were difficult to manage and some felt the health care system was “unresponsive, unavailable, and inconsistent.” Many had pain that was inadequately treated prior to the ER crisis. Determinants such as social and economic pressures and history of abuse often contributed to the stress these patients were under before they arrived at the ER. After being restrained, many felt lasting negative effects such as mistrust of the health care system and exacerbated anxiety and PTSD symptoms. (Ambrose H. Wong et al., 2020)

Disparities in Restraint Use

Racial disparities in the use of restraints were found when looking at data from 13,507 residents at 1,174 nursing homes. The study noted that “black residents are more likely than white residents to be restrained with bed rails, side rails, and trunk restraints.” (Cassie & Cassie, 2013) Disparities like these can lead patients to mistrust the health care system, as can feeling “violated and dehumanized, with a lack of connection to and understanding of the clinical decisions, process, and events leading up to the use of restraints”, as described in the Yale interviews. (Ambrose H. Wong et al., 2020) Lack of trust often leads patients to avoid the health care system, compounding medical and psychological issues, and conferring lasting effects. (“Traumatic as Hell,” 2020)

Older people are also disproportionately at risk for being restrained, especially in busy long-term care (LTC) settings. (*Physical Restraints - American Academy of Nursing Main Site*, n.d.) LTC residents may have cognitive and physical impairments that put them at risk for wandering, elopement, and falls. In an easily imagined scenario, a patient with hemiparesis and aphasia secondary to a stroke, has the urge to urinate but is unable to verbalize her need to go to the bathroom. She stands up to go by herself but left-sided paralysis causes her to fall. To prevent this dreaded possibility, a busy nurse applies a restraint. However, assessing for and anticipating needs can go a long way in preventing nightmare scenarios like this. Alternatives to restraints in this case might include implementing a toileting schedule and improving the patient's ability to communicate by leaving the call bell in reach and providing a communication board.

While this scene isn't exactly what one finds at an ASC, it is probable that the facility will treat patients with similar cognitive and physical impairments. Some patients may be escorted by care givers or family who bring them to the ASC restrained in a vest or wheelchair. Others may have mental health or substance abuse issues that could be exacerbated by the stress of the procedure and other triggers. Patients are treated throughout recovery from anesthesia, with the possibility of developing confusion or acute delirium secondary to anesthesia or other medications given at the ASC. Again, anticipating needs by thoroughly evaluating the patient, and then, thinking about what might happen before and after the procedure, can help reduce the use of restraints.

Restraints and Health Care Workers

It can be argued that most health care workers enter the field, at least in part, because they want to help people. Therefore, it would be reasonable to predict that many would experience dysphoric feelings related to restraint use. In a focus group studying the use of restraints in a New York City emergency department, one physician stated "you need to protect yourself, but you also need to make sure when we're doing all this we're not hurting the patient." (Ambrose Hon-Wai Wong et al., 2017)

On the other hand, workplace violence is a real threat, and can range from "*verbal harassment to serious traumatic injuries.*" (Ambrose Hon-Wai Wong et al., 2017) While this study interviewed workers from the ER, a notably dangerous workplace, complacency toward this issue should not be indulged in any medical setting. Emergencies can happen anywhere, and staff at ASCs should be trained in the safe use of restraints and in the use of alternatives to restraints, such as diversion, distraction, and de-escalation.

Section 2 : Standards and Guidelines Regarding Restraint Use in the ASC

As stated above, CMS regards the use of restraints as a patients' rights issue, and such rights are protected in every covered setting; violating these rights via inappropriate restraint use would be considered a condition level deficiency. (*Som107ap_a_hospitals.Pdf*, n.d.-b)

The State Operations Manual, Appendix A, acknowledges the universality of standards on restraint use: *“The requirements contained in this standard are not specific to any treatment setting within the hospital. They are not targeted only to patients on psychiatric units or those with behavioral/mental health care needs. Instead, the requirements are specific to the patient behavior that the restraint or seclusion intervention is being used to address.”* (Som107ap_a_hospitals.Pdf, n.d.-b)

Restraints are a Last Resort

The CMS Standards on restraint use fall under the broader category of Standards, §482.13 Condition of Participation: Patient's Rights.

The first Standard on restraints frames the intervention as a patient's rights issue as follows:

§482.13(e) Standard: Restraint or seclusion. *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.* (Som107ap_a_hospitals.Pdf, n.d.-b)

This Standard covers a lot of ground. It clearly calls out *“physical and mental abuse”* and *“coercion, discipline, convenience, or retaliation”*, which have no place in the health care setting. This Standard also indirectly protects the patient's right to a safe environment. (Som107ap_a_hospitals.Pdf, n.d.-b)

This Standard is elaborated further to state that restraints may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, a staff member, or others from harm. If restraints are found to be necessary, one must choose the least restrictive type or method of restraint that will be effective in protecting the patient and others. The restraint should then be discontinued at the earliest possible time.

Ordering and Documenting Restraints

If restraints are ordered, they should be implemented safely, in accordance with manufacturer directions, hospital policy, and State and Federal law. (Som107ap_a_hospitals.Pdf, n.d.-b)

Aligning hospital policy to the laws and CMS standards protects the patients but also protects the hospital and everyone who works there.

CMS Standards define parameters around ordering and documenting restraints, as summarized below:

- Physicians and other licensed practitioners authorized to order restraints in accordance with hospital policy and State law must have a working knowledge of hospital restraint policy.
- The attending physician should be consulted as soon as possible if not the one ordering the restraint.
- Restraints can never be ordered PRN or as a standing order.
- The patient's written plan of care must be modified as per hospital policy to include documentation of the restraint use.

(Som107ap_a_hospitals.Pdf, n.d.-a).

There are exceptions to the rule on PRN orders. A patient that requires a Geri chair to sit out of bed safely does not need a new order every time they get out of bed. The same is true for the patient with an order for four raised bedrails while in bed; a new order is not needed every time the patient gets back in bed. Finally, in rare cases where patients repetitively self-harm, variations in this parameter can be applied on an individualized basis. (Som107ap_a_hospitals.Pdf, n.d.-a).

A 2020 Revision

In 2020, revisions were made to the language in the Standards, which are due to be implemented in 2/2021. Standard §482.13(e)(5) states that the “*use of restraint or seclusion must be in accordance with the order of a physician or other **licensed practitioner** who is responsible for the care of the patient and authorized to order restraint or seclusion by hospital policy in accordance with State law*”, **Independent Practitioner**, which has now been replaced with **Licensed Practitioner**, in this and all the standards regarding restraint use”. (Som107ap_a_hospitals.Pdf, n.d.-a)

This change was made to reduce confusion over whether Physician Assistants (PAs) can order restraints, as scope of practice varies with State law. Most Final Rule commenters argued that facilitating use of PAs would decrease cost and time expenditure burden for the health care system and its employees, while increasing access for patients. (Som107ap_a_hospitals.Pdf, n.d.-a)

Monitoring the Patient and Discontinuing the Restraints

While the scenario of the violent patient is perhaps unlikely, it is still important to understand that, as per §482.13(e)(12), when restraints are used for the management of behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others, the patient must be seen face-to-face, within 1 hour after the initiation of the restraints, by a physician, other licensed practitioner, or appropriately trained Registered Nurse. (Som107ap_a_hospitals.Pdf, n.d.-a)

If restraints must be implemented, as per §482.13(e)(10), the condition of the patient who is restrained or secluded must be monitored by a physician, other licensed practitioner or staff that has completed appropriate training.

The frequency of the monitoring and the parameters that need to be monitored and documented are determined by hospital policy and physician discretion based on the individual patient. The patient’s medical condition, cognitive status, and the risks associated with the use of the chosen intervention, all factor into the care plan. In some cases, patients will need to be continuously monitored while others may need every 15- minute or 1-hour checks. Vital signs need to be checked as per hospital policy. Patients should be monitored for changes in cognitive function, affect, neurovascular status, pain, skin integrity, hunger, thirst and need to eliminate. Range of motion should be maintained. (Som107ap_a_hospitals.Pdf, n.d.-a)

The patient must be continuously monitored in order to determine the need to either continue or terminate the intervention, as restraints must be discontinued at the earliest possible moment, regardless of the length of time identified in the order. (Som107ap_a_hospitals.Pdf, n.d.-a)

CMS Requirements for Staff Training on Restraint Use

Standard §482.13(e)(10) states that “*the condition of the patient who is restrained or secluded must be monitored by a physician, other licensed practitioner or trained staff that have completed the training criteria specified in paragraph (f) of this section at an interval determined by hospital policy.*” (Som107ap_a_hospitals.Pdf, n.d.-a)

While training requirements should be specified in hospital policy, essential components of the training can be found in the Standards and Interpretive Guidelines, especially in section §482.13(f), as stated above. (Som107ap_a_hospitals.Pdf, n.d.-a) Section (f) establishes that training should cover the following, as summarized:

- The use of nonphysical interventions
- The use of the least restrictive intervention
- The correct application of the hospital’s available restraint devices and techniques
- Monitoring for psychological and physiological distress
- How to tell when restraints are no longer needed

Staff caring for restrained patients need to know BLS. Training of all staff needs to be documented, and training needs to be reinforced on a regular schedule. (Som107ap_a_hospitals.Pdf, n.d.-a)

Death Reporting Requirement

Even with greater awareness of restraint safety, deaths still occur, and death associated with restraint use is a sentinel event. Standard §482.13(g) details the requirements for reporting of death proximal to restraint use. Except for cases where only a “soft, cloth-like two-point restraint” was used, deaths occurring while restrained, or within 24 hours after removal of the restraint, must be reported via phone or electronic submission, by the end of the following business day. Deaths occurring within a week of restraint use, when it is “reasonable to assume that the use of restraint or seclusion contributed directly or indirectly to the patient’s death”, must also be reported, although this depends on if the hospital is informed of the death. Standard §482.13(g) also has a detailed guideline on documenting and logging a death associated with restraints.

Section 3: Clinical Considerations and Restraints in the ASC

The language of policy tries to make the rules crystal clear, but life is not always that way. While science suggests that restraints are more hazardous than no-restraints, people still use them far too often.

A 2019 paper reported on an observational study, examining attitudes of health care staff toward the use of restraint and restrictive interventions on the 78-bed Acute Medical and Frailty Ward at Queen Elizabeth Hospital in Woolwich, UK. The researchers found that staff are aware that restraints should

seldom be used, but they also continue to use them because they feel like they keep patients safe. (Gunawardena & Smithard, 2019)

The researchers also conducted a literature review to learn more about health care workers' attitudes toward restraints. It found that restraints were often applied proactively, to prevent the possibility of a patient getting out of bed and falling. This was more likely to happen with cognitively impaired older patients. However, UK regulations, as in the US, call for restraints to be applied only when the need is imminent. Furthermore, the National Institute for Health and Care Excellence (NICE) recommend promoting "freedom of movement and the minimization of the use of restraint in patients living with dementia and delirium." (Gunawardena & Smithard, 2019)

Staff at the hospital rarely used wrist restraints, as these are associated with negative associations and well-known hazards. However, to protect safety, staff often used methods that they didn't consider to be restraints. Tables pushed against a patient in a chair or raised bed rails may be intended to keep a patient from falling but these are still restraints. Sometimes patients were tucked in so tightly that they couldn't move, or "passive restraint" methods, such as leaving mobility aids out of reach, were employed. (Gunawardena & Smithard, 2019)

Bedrails

Bedrails were the most commonly used restraint at Queen Elizabeth Hospital.

The U.S. Food and Drug Administration (FDA) has reported that between 1985 and 2009, there were 803 incidents of patients getting trapped and/or strangled in bedrails, and of these, 480 people died, 138 had nonfatal injury, and 185 were not injured because staff intervened. Most of these patients were older and cognitively impaired and frail. (Health, 2019)

To reduce these tragic consequences, the FDA has several suggestions. Beds should be kept locked and in the low position when the patient is not receiving care. Mats can be used on the floor, and patients can be given appropriate mobility aids. Mattresses should fit the bed so there are no gaps in the side. One rail should be left down so that the patient won't feel the need to squeeze between split rails. (Health, 2019)

Still, though statistics support using safer alternatives, it doesn't always feel right intuitively, and habits are hard to break. Education may be lacking, when it needs to be prioritized. There can also be organizational issues like short staffing or inadequate resources hindering even the most knowledgeable, hard-working, and dedicated employees, leading to pressured decision making, lapses in judgement, and short-cuts.

Restraints are Not Fall Prevention

In Appendix A, CMS states that restraints should not be used as part of a fall prevention program: *"There is no evidence that the use of physical restraint, (including, but not limited to, raised side rails) will prevent or reduce falls. Additionally, falls that occur while a person is physically restrained often result in more severe injuries."* (Som107ap_a_hospitals.Pdf, n.d.-a)

Instead, falls can be prevented by anticipating needs. This is as true in an ASC as it is in the long-term care setting. Patients should be monitored frequently and needs anticipated, so that patients do not feel impelled to get out of bed without assistance. Help with toileting should be offered regularly and often, as per hospital policy and specific patient needs. Patients should also be checked frequently for hunger, thirst, and pain. Emotional needs can be anticipated and addressed, as well.

Increased Risk in the Restrained Patient

In the unfortunate situation when restraints must be used, the risks must be kept in mind. The Joint Commission determined factors that increase risk of death in restrained patients. Patients who smoke are at increased risk, as are patients with deformities that make it impossible to properly apply the restraint. This is especially true with vest restraints, as people with postural weakness may slip out of the bottom of the vest. Restraining patients in a supine position can lead to aspiration, especially when the head of the bed is not elevated. Restraining a person in the prone position can cause compression of the chest and suffocation, especially in an obese patient. Restraining a patient in a location where continuous observation is not possible, also increase risk of death. (*Sea_8pdf.Pdf*, n.d.)

Medication should not be used to restrain patients. CMS states that *“drugs or medications that are used as part of a patient's standard medical or psychiatric treatment and are administered within the standard dosage for the patient's condition are not restraints.”* Medications are not restraints if they are intended to increase and improve the patients functioning. Thus, a sedating medication such as a benzodiazepine is not considered a restraint if it enables a patient to function more effectively, by decreasing anxiety or promoting sleep, for example.

However, it is not safe or ethical to give sedating drugs to patients to control their behavior or to keep them in bed, i.e., by “knocking them out.” Of course, sedation necessary to perform a procedure, such as anesthesia, is not considered a restraint. Anesthesia is, of course, common in the ASC, and while it is documented as a medication and not a restraint, frequent monitoring and anticipation of needs still improves safety.

Indeed, whether a device or method is “technically “ a restraint or just a safety measure, if the end result is that a patient’s agency is restricted, then this patient needs to be monitored as a restrained patient.

Burden Reduction and Patient Safety in the ASC

CMS in its attempt to reduce burden on patients and providers has eliminated the previous requirement for ASCs to conduct a comprehensive history and physical exam within 30 days before the scheduled procedure. They now require that the ASC develop a policy to perform a less intensive presurgical assessment, with more discretion left to physician judgement. The presurgical assessment, along with the operating physician’s judgment now determine which patients need the comprehensive physical exam and medical history. The presurgical assessment is required to include consideration of factors

related to, at minimum, patient age, diagnosis/es, type and number of procedures scheduled to be performed, known comorbidities, and planned anesthesia level. (*Som107ap_L_ambulatory.Pdf*, n.d.)

As demand for ASCs' services continue to increase due to perceived value, there is a pull to reduce burden. However, reducing burden should never mean taking dangerous shortcuts. The presurgical assessment should be thorough and sensitive enough to pick up relevant patient risks.

Furthermore, thorough, targeted, staff training is essential to perform thorough, targeted assessments, implementation, monitoring, and documentation. These are safety steps to protect patients from adverse events secondary to restraint use. While it might seem that restraint policy and training can sit on the back burner at your ASC, it only takes one tragedy to shift one's perspective.

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