Could new government regulations lead to increased use of physical restraints?

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Over the past 20 years, the health care system has made tremendous progress in reducing the use of physical restraints among hospitalized elderly patients, a positive change that has had numerous numerous ripple effects, improving outcomes, maintaining mobility and preserving dignity and independence for these individuals.

But, a new Congressional mandate changing hospital reimbursement made by the U.S. Centers for Medicare and Medicaid Services (CMS) could inadvertently reverse these positive steps, according to Beth Israel Deaconess Medical Center (BIDMC) gerontologist Sharon Inouye, MD, MPH, writing in tomorrow's issue of The New England Journal of Medicine (*NEJM*). Inouye, a Professor of Medicine at Harvard Medical School and Director of the Aging Brain Center at Hebrew Senior Life, points out in a "Perspective" editorial, that in an attempt to keep patients safe from falls, the CMC's good intentions may have adverse consequences.

"In 2005, in response to disturbing and widely cited findings by the Institute of Medicine about the prevalence of life-threatening conditions acquired by patients in U.S. hospitals, Congress authorized the CMS to implement payment changes designed to encourage the prevention of such conditions," write Inouye and coauthors Cynthia Brown, MD, of the University of Alabama and Mary Tinetti, MD, of Yale University. As such, Medicare will reduce reimbursement rates to hospitals if one of eight hospital-acquired conditions develops during the patient's stay; hospital falls and trauma were included as one of these eight.

"Our greatest concern is that the heightened focus on fall prevention will have unintended consequences," notes Inouye. These are likely to include a decrease in mobility and a resurgence in the use of physical restraints and other restraining devices, such as bed alarms, in what Inouye calls "a misguided effort to prevent fall-related injuries.

"While hospitals are understandably concerned about reductions in reimbursement as well as the public reporting of fall rates that could emanate from this mandate, the use of physical restraints can create other problems," she adds.

Physical restraints have long been used because they are believed to prevent falls. But studies have consistently shown that not only are restraints ineffective in reducing the risk of falls and related injuries, they are actually associated with increased rates of medical complications, including immobility, functional loss, delirium, agitation, pressure sores (which are themselves one of the non-reimburseable hospital-acquired conditions), asphyxiation, and death. Moreover, accumulating evidence suggests that restraints may actually increase the risk of falling or sustaining an injury from a fall.

"At present, there are no proven strategies that are documented to be effective in preventing falls in the hospital setting," explains Inouye. However, she adds, because previous studies have indicated that a change in mental status is the leading risk factor for falls in the hospital, strategies that incorporate multiple components may prove beneficial.

"In writing this 'Perspective,' my coauthors and I wanted to emphasize that there are alternatives to physical restraints that can help keep patients safe," says Inouye. One such program is the Hospital Elder Life Program (HELP), which prevents the onset of delirium through a number of interventions targeted at maintaining mobility, orientation, hydration and sleep. Early evidence lends strong support that this

program is also effective in preventing falls.

"A guiding principle of medicine is 'First, do no harm,'" she adds. "Unfortunately, a resurgence in the use of physical restraints and restraining devices would erode over two decades of work to reduce the use of these devices and to enhance the safety of elderly patients during hospitalization."

Source: Beth Israel Deaconess Medical Center