Physical Restraints: Regulation and the Quality Measure

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Outline of Presentation…

• What is included in the Physical Restraint QM

• RAI Manual, CMS Guidance, QIS Critical Element Pathway and the Interpretive Guidelines

• Recommended Strategies / Approaches
What is your QAPI Process?

Consider the following questions…

• Does your facility use any devices that meet the definition of a “physical restraint”?

• If so, does your facility have a process to minimize the use of physical restraints?

• Does your facility understand the QM specifications for physical restraints?

• Does your appropriate staff understand the impact of the MDS coding on your publically-reported quality measure for physical restraints?
The primary sources of information for this presentation are...

- CMS’s RAI Version 3.0 Manual
- Surveyor Interpretive Guidelines – Appendix PP of the State Operations Manual (Rev. 12, 10-14-05)

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Consider both sides of the equation…

The QM is calculated from a “pool” of residents….

• **Numerator**
  
  • Long-stay residents with a selected target assessment that indicates daily physical restraints,
    where:
    
    • trunk restraint used in bed (P0100B = [2]), OR
    • limb restraint used in bed (P0100C = [2]), OR
    • trunk restraint used in chair or out of bed (P0100E = [2]), OR
    • limb restraint used in chair or out of bed (P0100F = [2]), OR
    • chair prevents rising used in chair or out of bed (P0100G) = [2]).

(Also known as “triggers”)

MDS 3.0 Quality Measure User’s Manual v8.0  04-15-2013
Numerator...

<table>
<thead>
<tr>
<th>Physical Restraints</th>
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<tbody>
<tr>
<td>Physical restraints are 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</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Enter Codes in Boxes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Used in Bed</td>
</tr>
<tr>
<td>☐ A. Bed rail</td>
</tr>
<tr>
<td>☐ B. Trunk restraint</td>
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<tr>
<td>☐ C. Limb restraint</td>
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<td>☐ D. Other</td>
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<table>
<thead>
<tr>
<th>Coding:</th>
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<tbody>
<tr>
<td>0. Not used</td>
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<tr>
<td>1. Used less than daily</td>
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<tr>
<td>2. Used daily</td>
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</table>

<table>
<thead>
<tr>
<th>Used in Chair or Out of Bed</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ E. Trunk restraint</td>
</tr>
<tr>
<td>☐ F. Limb restraint</td>
</tr>
<tr>
<td>☐ G. Chair prevents rising</td>
</tr>
<tr>
<td>☐ H. Other</td>
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</table>
Trunk and Limb Restraints...

- **Trunk restraints** include any manual method or physical or mechanical device, material or equipment 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, material or equipment 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.

- **Trunk or limb restraints**, if used in both bed and chair, should be marked in both sections.
Chair Prevents Rising...

- **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, chairs that 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.

  - 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 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 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 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.
Consider both sides of the equation…

The QM is calculated from a “pool” of residents….

- Denominator
  - All long-stay residents with a selected target assessment, except those with exclusions*.

*With this particular quality measure, the only exclusions are if any of the MDS items (listed in the numerator) contain a (-)… meaning that the item was not assessed.

\[
\text{Numerator / Denominator} \times 100 = \text{Quality Measure} \%
\]
Numerator ("triggers")...

There are 2 "conditions" that must be met...

- The "device" must meet the definition of a "restraint".
  - Physical restraints are 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. (Section P of the MDS 3.0)

- The "device" must have been **used daily** during the entire 7-day look-back period for the MDS.
“Physical Restraint” Regulations...

• 42 C.F.R. 483.13(a) provides that “the resident has the right to be free from any physical or chemical restraints imposed for discipline or convenience, and not required to treat the resident’s medical symptom.”

• CMS defines “physical restraints” in the State Operations Manual (SOM), Appendix PP as, “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.”

CMS’s RAI Version 3.0 Manual
Steps for Assessment…

• The RAI Manual continually mentions the word “effect”

• … “observe the resident to determine the effect the restraint has on the resident’s normal function”

• “Remember, the decision about coding any manual method or physical or mechanical device, material, equipment as a restraint depends on the effect it has on the resident.”

• “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.”
The Impact of Physical Restraints…

While physical restraints were once regarded as necessary for the safety of some residents, research has proven that restraints increase the likelihood of injury and may cause serious health problems.

<table>
<thead>
<tr>
<th>Poor Circulation</th>
<th>Pressure Ulcers</th>
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<tr>
<td>Constipation</td>
<td>Poor Appetite</td>
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<tr>
<td>Incontinence</td>
<td>Infections</td>
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<td>Weak Muscles and Bones</td>
<td>Agitation / Depression</td>
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<tr>
<td>Decline in ADLs / ROM</td>
<td>Increased Confusion</td>
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<tr>
<td>Feelings of Panic / Fear</td>
<td>Loss of Dignity</td>
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Benefits of Eliminating Physical Restraints…

• Improvement in Quality of Life

• Greater Autonomy (The respect for a resident's autonomy is considered a fundamental ethical principle.)

• Reduction in the use of anti-psychotic medications

• Less skin breakdown

• Reduction in the seriousness of injuries due to falls
• **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 solely based on a resident, legal surrogate or representative’s request or approval.” The SOM goes on to state, “While Federal regulations affirm the resident’s right to participate in care planning and to refuse treatment, the regulations do not create the right for a resident, legal surrogate or representative to demand that the facility use specific medical interventions or treatment that the facility deems inappropriate. Statutory requirements hold the facility ultimately accountable for the resident’s care and safety, including clinical decisions.”
§483.13(a) of the Interpretive Guidelines…

Determine if the facility follows a systematic process of evaluation and care planning prior to using restraints. This systematic approach should answer these questions:

• What are the medical symptoms that led to the consideration of the use of restraints?
• Was there rehabilitative/restorative care?
• Are meaningful activities provided?
• Were there attempts to manipulate the resident’s environment, including seating?
• Can the cause(s) of the medical symptoms be eliminated or reduced?
• If the cause(s) cannot be eliminated or reduced, then has the facility attempted to use alternatives in order to avoid a decline in physical functioning associated with restraint use?

Appendix PP of the State Operations Manual (Rev. 12, 10-14-05)
§483.13(a) of the Interpretive Guidelines…

This systematic approach should answer these questions (cont.):

• If alternatives have been tried and deemed unsuccessful, does the facility use the least restrictive restraint for the least amount of time?
• Does the facility monitor and adjust care to reduce the potential for negative outcomes while continually trying to find and use less restrictive alternatives?
• Did the resident or legal surrogate make an informed choice about the use of restraints? Were risks, benefits, and alternatives explained?
• Has the facility re-evaluated the need for the restraint, made efforts to eliminate its use and maintained residents’ strength and mobility?

Appendix PP of the State Operations Manual (Rev. 12, 10-14-05)
To be in compliance, the physical restraint...

- **Must** be necessary to treat a *medical symptom*;
- **Must not** be used to discipline a resident or for staff convenience in the absence of a medical symptom;
- **Must not** be used because of family request in the absence of a medical symptom; and
- **Must** be the least restrictive device possible, in use for the least amount of time per day possible; and
- The facility **must** have an active plan in place to decrease usage or for eventual removal of the restraint.
June 22, 2007

Subject: “Clarification of Terms Used in the Definition of Physical Restraints as Applied to the Requirements for Long Term Care Facilities”

(4-page memorandum)

Search on the Internet for “S&C-07-22”
CMS Definitions…

“Freedom of Movement” means any change in place or position for the body or any part of the body that the person is physically able to control.

“Remove Easily” means that the manual method, device, material, or equipment can be removed intentionally by the resident in the same manner as it was applied by the staff (e.g., siderails are put down, not climbed over; buckles are intentionally unbuckled; ties or knots are intentionally untied; etc.) considering the resident’s physical condition and ability to accomplish objective (e.g., transfer to a chair, get to the bathroom in time).

“Medical Symptom” is defined as an indication or characteristic of a physical or psychological condition.

Objective findings derived from clinical evaluation and the resident’s subjective symptoms should be considered to determine the presence of a medical symptom.

The resident’s subjective symptoms may not be used as the sole basis for using a restraint.

Before a resident is restrained, the facility must determine that the resident has a specific medical symptom that cannot be addressed by another, less restrictive intervention.

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.

Restraints may be used, if warranted, as a temporary symptomatic intervention while the actual cause of the medical symptom is being evaluated and managed.

CMS Clarifications on “Medical Symptom”…

There must be a link between the restraint use and how it benefits the resident by addressing the medical symptom.

Medical symptoms that warrant the use of restraints must be documented in the resident’s medical record, ongoing assessments, and care plans.

While there must be a physician’s order reflecting the presence of a medical symptom, CMS will hold the facility ultimately accountable for the appropriateness of that determination.

The physician’s order alone is not sufficient to justify restraint use.

It is further expected, for residents whose care plans indicate the need for restraints that the facility engages in a systematic and gradual process towards reducing restraints (e.g., gradually increasing the time for ambulation and strengthening activities). This systematic process also applies to recently admitted residents for whom restraints were used in the previous setting.

Falls **do not** constitute self-injurious behavior or a medical symptom that warrants the use of a physical restraint.

Although restraints have been traditionally used as a falls prevention approach, they have major, serious drawbacks and can contribute to serious injuries. There is no evidence that the use of physical restraints, including but not limited to side rails, will prevent or reduce falls. Additionally, falls that occur while a person is physically restrained often result in more severe injuries.
Critical Element Pathway...

15 Pages...

- Observation
- Interviews
  - Resident/Family
  - Staff
- Assessment
- Care Planning & Implementation
- Care Plan Revisions
Observe whether staff consistently implement the care plan over time and across various shifts. Staff are expected to assess and provide appropriate care from the day of admission. During observations of the interventions, note and/or follow up on deviations from the care plan as well as potential negative outcomes.
Surveyor Determination...

Observe…

• The type of restraint in place
• The resident’s reaction to the restraint
• Whether the restraint is applied correctly
• If the restraint affects position and body alignment; the resident is positioned appropriately.
Surveyors are instructed to interview staff on various shifts to determine:

Knowledge of specific interventions for the resident, including:

- The restraint(s) being used (and when use was initiated);
- How often and under what circumstances the restraint(s) is used;
- When, and for how long, the restraint is released;
- The potential risks of using the restraint;
- How the resident is monitored when the restraint is in use;
- Interventions that are in place to minimize or eliminate the medical symptom or underlying problems causing the medical symptom.
To Be In Compliance...

Surveyors are instructed to interview staff on various shifts to determine:

Knowledge of facility-specific guidelines/protocols, including:

- Whether the nurse monitors for the implementation of the care plan, and the frequency of review and evaluation of changes in the effectiveness or resident response to the restraint.
- What the resident’s functional ability is such as bed mobility and ability to transfer between positions, to and from bed or chair, and to stand and toilet; and
- Any changes over the past year such as increased incontinence, decline in ADLs or ROM, increased confusion, agitation, and depression.
The Bottom Line is…

There are VERY FEW \textit{valid} reasons, if any, to apply a physical restraint…

more reasons to \textbf{NOT} apply a physical restraint…

and an exhaustive list of requirements for the facility and staff that must be in place before a physical restraint is used.
To Summarize “Key Points”…

• To “trigger” on the physical restraint quality measure, the “use” had to be daily for the entire 7-day look-back period.

• Pay attention to the definition of a “physical restraint” and how that applies to each individual resident.

• Become very familiar with the regulation that mandates a “systematic and gradual process to reduce physical restraints”.

• Remember... the MDS is an “assessment process”.
Some Things to Consider…

• Consider trialing a “restraint holiday” for any resident currently being physically restrained.

• Understand that a successful “restraint holiday” means 24 hours without the application of a physical restraint.

• Consider trialing a “restraint holiday” during the MDS 7-day look-back period for that resident.

• A successful “restraint holiday” within the 7-day look-back period would equate to a code of “less than daily” on the MDS. (A “trigger” on the Quality Measure is “Used Daily”.)
Next Steps…

• Review your “real-time” data for all residents currently being coded on the MDS with a physical restraint.

• Review the MD documentation for mandated requirements related to a specific “medical symptom”.

• Apply the official physical restraint definition to each individual resident to assess for accuracy. Correct coding where applicable.

• Formalize and implement the required “systematic and gradual process towards reducing restraints” through scheduled restraint holidays during the MDS assessment period.
The Role of Consistent Assignment…

• Many residents are more comfortable with caregivers who know and understand their personal preferences and anticipate needs.

• Consistent assignment is a key step in giving care that is centered on the resident.

• Staff who work with the same residents most of the time are more likely to notice slight changes in health, mood or routine.

• Think about the value and role of consistent assignment in your plan to minimize and eliminate physical restraints.

• For more information on consistent assignment – www.nursinghomes.ipro.org
For more information

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