Long-Term Care Survey Alert

REGULATORY COMPLIANCE: Review The ABCs Of Defining, Assessing, Coding Physical Restraints

When CMS trains surveyors, it's a good idea to study the lessons.

Facilities that don't master the regulatory basics for physical restraints may find themselves in dire straits on their next survey. That's because CMS recently hosted a Webcast on restraints that's mandatory for surveyors.

A key point: The **Centers for Medicare & Medicaid Services** does not require facilities to be restraint-free, but as a best practice, CMS supports the goal of zero restraint use, said **Thomas Hamilton**, director of the Survey and Certification Group for CMS.

Nail Down Restraint Definitions, Clarifications

Surveyors and providers must understand the definition of a physical restraint as defined by the State Operations Manual, advised CMS Webcast presenter **Alfreda Walker, MSN, RN,** with the **Survey & Certification Review Branch** in Region IV (Atlanta). Since the definition is a "mouthful," she advises breaking it down into its components. When evaluating each device to determine if it's a restraint, ask yourself:

• Is this a device attached to or adjacent to the resident's body that the person cannot remove easily?
• Does it restrict the resident's freedom of movement or normal access to the person's body?

Know the clarifications: A June 22 survey and certification memo (see the next page for details) sheds light on what CMS means by the above terms, noted the CMSWebcast. 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 resident can intentionally remove the manual method, device, material, or equipment in the same manner as staff applied it. For example, the resident puts the siderails down rather than climbing over them or can intentionally unbuckle a buckle. Consider the resident's physical condition and ability to accomplish an objective, such as transferring out of a chair or getting to the bathroom in time.

Before you call a device a restraint: Evaluate the effect of the device on the resident--not its intended use, emphasized Walker. "It doesn't matter what the manufacturer or facility calls a device"--for example, a positioning aid, an enabler or assistive device, she said. Surveyors should "focus on the effect the device has on a resident."

Take it to the Next Level

Determining whether a device meets the definition of a physical restraint is only half the job, Walker emphasized. She directed surveyors to review the record to see if the facility has assessed the resident before initiating a restraint. The facility has to "properly identify the resident's needs and the medical symptom the restraint" is being used to address. Weigh "professionally and medically recognized risks of using a device versus the potential risk" of not using it for a specific individual, said Walker.

"The assessment should also consider the feasibility of using an alternative, less restrictive means of accomplishing the desired outcome."

Code the MDS Accurately

The Webcast also focused on coding physical restraints accurately at P4 on the MDS, which drives the physical restraint QI/QM.

Code only those devices in P4 that have the effect of restraining the resident over the seven-day lookback, advised **Ann Spenard, MSN, RN**, senior clinician for **Qualidigm,** Connecticut's quality improvement organization. Again, individual assessment of the effect of the device on the resident is key. **Pointer:** "If the person can remove the device at certain times of the day but not others, code it at P4," Spenard advised. When deciding whether to code siderails as a restraint, look at whether the resident can easily remove them and if they have the effect of restricting his movement. The MDS assessor should not consider why the rails were being used--focus instead on the effect of the rails, says Spenard.

When coding P4e (chair prevents rising): Keep in mind that geriatric chairs or low chairs that are soft and low to the ground may have the effect of restraining a resident, reminds Spenard. Also "note that P4e 'chair prevents rising' should also be coded for framed walkers that the resident cannot easily exit."

Exclude these items: Don't count or code as restraints items typically used in providing medical care, such as catheters, casts, traction, abdominal binders, bandages or leg, arm and back braces, advised Spenard.

A restraint without a category on the MDS is still a restraint if it meets the definition of one in a particular case. In that case, you don't code it but you still have to meet the regulatory requirements for using it.

Care plan it whether there's a category for coding it or not, Spenard advised Webcast watchers.

Get the "rest of the story": While the CMS Webcast simply reviewed restraint assessment and MDS coding requirements, the June survey and certification memo on restraints relays a tougher message that providers might want to consider.

Editor's note: Providers can watch the first of CMS' three-part series on restraints at cms.internetstreaming.com.