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MDS Coding Teleconference

**Coding for Restraints - Item P4
 for SNF providers**

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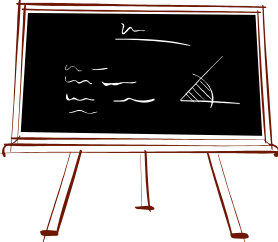
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Objectives

- Clarify definition/regulations surrounding use of restraints
- Accurately code MDS item P4 - Restraints
- Clarify which MDS item(s) flag "Restraints" on the Quality Measure/Quality Indicator report
- Identify resources/tools to address restraint risks, alternatives, & reduction


Time to go back to the drawing board to discuss MDS Restraint definitions, concerns & MDS coding...






MDS Definition: Physical Restraints

- **Physical Restraints**
Any manual method or physical or mechanical device, material, or equipment attached/adjacent to resident's body that:
 - He or she cannot easily remove, and/or
 - Restricts freedom of movement or normal access to one's body
 - See RAI manual, page 3-198
 - See C.F.R 483.13(a) – (Code of Federal Regulations) for survey F tag 221




Definition cont.

- C.F.R 483.13(a) – survey F tag 221, states the intent of this requirement is:
- For each person to attain & maintain his/her highest practicable well-being,
- In an environment that prohibits use of restraints for discipline or convenience, and
- Limits restraint use to circumstances in which a resident has medical symptoms that warrant use of restraints



Restraint errors

- If the use of Restraints is either not coded on the MDS, or not fully assessed, monitored, evaluated and/or care planned, the facility could be subject to a survey deficiency
 - F tag 278 - Inaccurate MDS coding
 - F tag 221 – Right to be free from Restraints
 - Any of the many Quality of Life F tags, or
 - Any of the many Quality of Care F tags


Restraint Definition Problems – blame the English language... 

- Example: in a car accident report, one asks if person was “restrained,”
- Above Example uses name of device or intent, however, this is NOT the criteria for MDS coding. Instead,
- MDS coding criteria is all about the “**effect of an item on the resident,**” and whether or not they can remove it, reposition themselves, or access their body


***Misconceptions ...
True or False MDS coding Question***

- **Question:** Any use of a wheelchair seat belt or geri-chair, is automatically coded in MDS item P4, restraints. T? or F?

FALSE!
It’s the ***effect*** a device has on resident, rather than its name or intended use, which determines whether or not a device, material, or equipment is captured on the MDS, RAPs, or care plan.

Remember... 


- All positioning devices, bed rails, or seat belts, etc. are not *automatically* a restraint, they may, or may not be.....
- You must *always* determine first, the **effect of an item on the resident,** & if they can easily remove it, or access their body
- Only then, can you determine if it meets MDS coding criteria

Remember... 

- Bed rail(s) may be a positioning device for a resident, and not a restraint, – **code G6(b), but, ...**
- May be **both** positioning device **and** restraint for another resident – **code both G6(b) & P4(a) or (b)**
- *Use of side rails prohibited unless necessary to treat resident’s medical symptoms
 - *C.F.R 483.13(a) – survey F tag 221


RAI manual pages 3-201 -202 & SOM, F tag 221

MDS Coding P4 – Restraints

- 7-day look back period 
- **INTENT:**
 - Record frequency in last 7 days, with which resident was restrained by any of the devices listed (**in RAI manual**)
 - At any time, during night or day
 - Determine if device meets MDS definition of a physical restraint, then
 - Code **only** devices that have the effect of restraining the resident

Coding P4 - Restraints

- (a) Full Bed Rails
- (b) Other Types if Bed Rails Used
- (c) Trunk Restraint
- (d) Limb Restraint
- (e) Chair Prevents Rising

There may be a restraint device with no representative category on the MDS 

Coding P4 cont.


- (a) Full bed Rails
 - 1 or more rails along both sides of bed; block $\frac{3}{4}$ of length of mattress; includes bed placed against wall and other side of bed blocked by full rail(s); any enclosed bed system
- (b) Other Types of Bed Rails Used
 - Any combination of partial rails (e.g., $\frac{1}{4}$, $\frac{1}{2}$, $\frac{3}{4}$, etc.) or combination of partial & full rails not covered by above (a). E.g., 1 side = $\frac{1}{2}$ rail, other side = full rail; both sides = $\frac{1}{2}$ rails, etc., etc.
 - Include $\frac{1}{3}$ rails

Coding P4 cont.

- (c) Trunk Restraint
 - Any device, equipment, or material the resident cannot easily remove (e.g., vest, waist restraints, wheelchair belts)
 - Tucking in sheet, fabric, or clothing tightly so resident cannot easily remove
- (d) Limb Restraint
 - Any device, equipment, or material a resident cannot easily remove, that restricts movement of any part of upper extremity (hand, arm) or lower extremity (foot, leg); includes mittens

Coding P4 cont.


- (e) Chair Prevents Rising
 - Any type of chair with locked lap board or chair that places resident in a recumbent position restricting rising; or chair that is soft & low to the floor (restricting rising)
 - Enclosed framed wheeled walker, with or without, a posterior seat when a resident cannot easily remove the gated device and exit walker; and any lap/seat cushions restricting rising



Coding P4 cont.

- After determining item is a restraint
- For each device type, enter:
 0. Not used in last 7 days
 1. Used, but used less than daily in last 7 days
 2. Used on a daily basis in last 7 days


Remember key words – “effect on resident”



Coding P4 cont.


- Future versions of MDS (MDS 3.0) may have “other” category for additional restraint items
- NOTE: Any device, material, or equipment meeting MDS definition of physical restraint must have:
 - Medical symptom that warrants restraint use
 - Physician’s order for restraint use
 - Care plan in place

RAI manual page 3-199 & the SOM, F tag 221




Physical Restraint Reminders

- Physician’s order alone is not sufficient to warrant the use of restraints
- Resident, family, or legal representative wishes alone for restraints, is not sufficient to warrant the use of restraints
- It is expected, the facility will systematically engage in a gradual process toward reducing restraints, along with continual monitoring and evaluation




Physical Restraints Reminders

- Medical symptom defined as an indication or characteristic of a physical or psychological condition
- Medical symptom(s) that warrant the use of restraints must be documented in medical record, ongoing assessments, & care plans
- Identify what medical symptom led to consideration of restraint use, & can the medical symptom be eliminated or reduced




Physical Restraint Reminders

- Before use of restraint, facility must document how restraint use would treat identified medical symptom, protect resident's safety, & assist in attaining and/or maintaining a resident's highest practicable level of physical/psychological well-being
- Must explain to resident/family potential negative outcomes of restraint use



Physical Restraint Reminders



- After any IDT assessment, if a restraint is deemed appropriate:
- Still required to have systematic, ongoing assessments, care plan, and...
 - Continual, frequent staff monitoring, periodic toileting assistance, call light reminders
 - Check for exercise/therapeutic interventions
 - Risk review for resident functional decline
 - Review to determine if decline is disease progression or an inappropriate use of restraints
 - Monitor care plan consistently implemented

MDS Coding Clarifications – P4


- If resident can easily exit an enclosed framed wheeled walker, but uses it for ambulation assistance, code in G5(a) – cane/walker/crutch
- Carefully assess before considering restraint use with residents who are confused and/or cognitively impaired
- Don't focus solely on intent or reason for device, but on the device's effect on resident

RAI manual, pages 3-198 to 199

Clarifications – P4, cont.

- **Immobile residents:**
 - Side rails – If resident is immobile – cannot voluntarily get out of bed due to physical limitation (not due to the lack of a proper assistive device) = No restraint
 - Geriatric chair – If resident has no voluntary or involuntary movement, or cannot transfer independently = No restraint
 - **However**, if resident can transfer from other chairs, but just **not a geriatric chair**, then **geriatric chair = P4(e) chair prevents rising**

Clarifications – P4, cont.



- **Immobile residents – remember:**
 - Facility is ultimately accountable for resident's care & safety, including clinical decisions and care plan
 - Side rails while not meeting the definition of restraint for the MDS, may constitute an accident hazard and/or affect resident's quality of life (manual page 3-202)
 - Evaluate clinical alternatives


See manual pg. 3-201 and SOM F tag 221

Coding scenarios – Based on just these facts, do you code a restraint in P4?

- Resident who can remove a self-releasing belt when asked
- Immobile resident placed in a tilt-back wheelchair or a geri-chair
- Quadriplegic resident has seat belt in w/c to assist in upright positioning


NO, above examples do not meet MDS definitions/ guidance for MDS coding P4, restraints, BUT.....

Coding scenarios, cont.



- **Just because item does not meet MDS definition for coding in P4, one must still:**
 - Assess and evaluate the situation
 - Monitor device in use with periodic toileting assistance & call light reminders
 - Add to Resident Assessment Protocols (RAPs) and care plan if necessary
 - Check for resident functional decline
 - Review to determine if decline is disease progression or inappropriate use of restraints

Another Coding scenario ...



- Resident has unpredictable spasms of lower legs. Has “soft velcro straps,” padding, and use of foot rests while in wheelchair. Should this be coded in P4(d) – limb restraint?


Cannot tell by these facts alone. Why?
 Facts here do not tell us what effect the velcro straps have on resident. **MUST** determine if resident can easily remove straps and/or reach their body whenever they want to. **Only** then can you determine if you code in P4. **Still** a nursing issue, RAPs, care plan, etc., etc.



*Some reasons Residents may attempt to leave a bed/chair, despite risk of injury**


- Agitation
- Delirium
- Desire to Toilet
- Pain
- Discomfort
- Nocturnal hypoxia
- Hunger or Thirst
- Orthopnea
- Wakefulness
- Boredom

* Feinsod F. in Medical-Legal Aspects of Long-Term Care. Ed. JM Levine. Lawyers and Judges Publishing Company, Inc. Tucson, AZ.



Adverse Effects of Restraints


- Increased agitation or mental distress requiring additional medications
- Functional decline
- Head trauma
- Fractures
- Entrapment injuries to extremities
- Death by asphyxiation



Alternatives to Bedrails

- Low bed in proper height for efficient bed egress
- Low bed that can be raised for transfers for ADL care
- Mattress with raised edges
- Alarm(s)
- Physical therapy – muscle strengthening

Involve direct care nursing staff, therapist, activities, physician, pharmacist



Alternatives to Bedrails (cont.)


- Grips (hand grips or Trapeze bars)
- High impact mat at bedside
- Hip protectors
- Anticipation of resident needs
- Assessment / analysis of resident behaviors
- Modify resident's environment and/or routine

Involve direct care nursing staff, therapist, activities, physician, pharmacist




MDS item P4 & the QM/QI report

- How does it trigger?
- Does every restraint coded cause a trigger?
- What exclusions are there?
- What does the QM/QI report mean to providers and surveyors?
- QM/QI user's manual at QTSO website
- www.qtso.com





MDS Restraint Specifications & the QM/QI report



- **Numerator** - Residents physically restrained **daily** on target assessment
 - OBRA assessments only
 - 6 month default period used
- Coded as: P4(c) trunk restraint; P4(d) limb restraint; or P4(e) chair prevents rising


Bedrails not used in this QM/QI calculation




MDS Restraint Specifications & the QM/QI report 

- **Denominator** – all residents with a valid target assessment (after any exclusions)
- Exclusions –
 - Target assessment is an Admission MDS
 - P4c, P4d, or P4e are missing on target assessment

Bedrails not used in this QM/QI calculation



Misconceptions ... about use of QM/QI reports 

- Use QM/QI reports to “grade” facilities on how well they are doing. T? or F?

False. QM/QI reports are not to be considered in isolation, but in conjunction with all pertinent information about the facility.


- QM/QI reports can be used prior to survey; to plan internal QI initiatives; make care planning decisions. T? or F?

True.




Team approach

- Goal of reducing or minimizing restraint use has become central to both clinical practice, and State & Federal laws
- Ensure the interdisciplinary team (IDT) is involved in both education and continual restraint assessment, identification, and reduction efforts




Resources - Restraint MDS coding, correction, or regulatory issues

- **Betty Keen, RN - MDS/RAI Coordinator**
 > Clinical & MDS coding – 303-692-2894
- **Danielle Branum – MDS Coordinator**
 > Automation - 303-692-2913
- **Jennifer McCants, MS, RD -**
 > LTC Survey Program Manager- 303-692-2899
- **Current RAI manual - MDS version 2.0 & the State Operations Manual (SOM)**



Resources/tools to address restraint risks, alternatives, reduction

- For help with Quality Improvement Projects, **Colorado Foundation for Medical Care (CFMC)** assists healthcare providers by providing a knowledge forum
- MedQIC is an example – various QIO interventions, literature, study tools, clinical material, & power point presentations
- **Contact Shari Ward, Project Manager**
 > 303-669-9581
 > E-mail: sward@coqio.sdps.org



Conclusion

- Key Focus: Clarify Restraint MDS definition for coding & Resident care issues
- Accurately code MDS item P4 - Restraints
- Clarify MDS item(s) for the QM/QI report
- Identify restraint risks, alternatives, and resources for information
- **Questions & Answer time...**

Thank you for attending this presentation
