



Oklahoma State
Department of Health
Creating a State of Health

NEWS YOU CAN USE

Oklahoma State Department of Health
Quality Improvement & Evaluation Service (405) 271-5278
Nancy Atkinson, Chief



Special points of interest:

- Physical Restraints—Section P4—The Assessment Process
- MDS Accuracy Quick Check—Section P4—Physical Restraints
- The MDS Connection
- Automation Tips, Reminders & Updates

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Physical Restraints Section P4—The Assessment Process

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Research and standards of practice show that the belief that restraints ensure safety is often unfounded. In practice, restraints have many negative side effects and risks that, in some cases, far outweigh any possible benefit that can be derived from their use. Physical restraints not only may not prevent falls, but can cause greater harm including strangulation, loss of muscle tone, decreased bone density (with greater susceptibility for fractures), pressure sores, decreased mobility, depression, agitation, loss of dignity, incontinence, constipation, and in some cases, resident death. Benefits of

refraining from the use of physical restraints have been well documented in long-term care literature; they include improvement in residents' quality of life, greater independence and functional capacity, use of fewer

antipsychotic medications, less skin break down, and fewer serious injuries due to falls. Because restraints cause so many negative outcomes, it is crucial clinicians properly assess residents for the medical necessity causing restraint consideration. Therefore, to enhance accurate MDS coding following restraint assessment, the focus for this quarter's newsletter will be on MDS Section P4—Physical Restraints.



GOAL
Highest Practicable Level of
Functioning

Physical Restraints are **DEFINED** as any manual method or physical or mechanical device, material, or equipment
(Continued on page 2)



MDS Accuracy Quick Check—Section P4

If this MDS Item is:

- **P4a or P4b = 1 or 2**

Does your staff know if the resident is immobile and cannot voluntarily get out of bed due to a physical limitation and not due to a restraining device or because proper assistive devices were not present, the bed rails do not meet the definition of a restraint?

- **P4e = 1 or 2**

Does your staff know for a resident who has no volun-

tary or involuntary movement, the geriatric chair does not meet the definition of a restraint and should not be coded at Item P4e. If the resident has the ability to transfer from other chairs, but cannot transfer from a geriatric chair, a geriatric chair is a restraint to that individual, and should be coded at Item P4e. If the resident has no ability to transfer independently, then the geriatric chair does not meet the definition of a restraint. (Reference, RAI Manual Chapter 3 page 202.

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Physical Restraints—P4

The Assessment Process *(continued from page 1)*

The only reason for using a restraint is to treat a Medical Symptom

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.

The Code of Federal Regulation (CFR) at 42 CFR483.13 (a), states "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." In other words, the only reason for using a restraint is to treat a Medical Symptom.

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

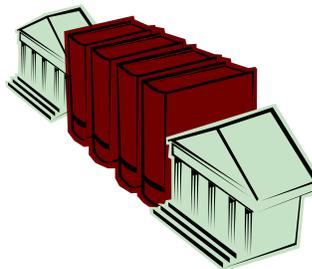
resident's medical symptoms. That is, the facility may not use restraints in violation of the regulation solely based on a legal surrogate or representative's request or approval."

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 intervention or treat-

ment that the facility deems inappropriate. Statutory requirements hold the facility ultimately accountable for the resident's care and safety, including clinical decisions."

The **INTENT** of MDS Section P4 is to record the frequency, over the last seven days, with which the resident was restrained by any of the devices listed below at any time during the day or night. The intent is to evaluate as part of the assessment process whether or not a device meets the definition of a physical restraint, and then to code only those devices categorized in section P4 that have the effect of restraining the resident.

P4 assesses these 5 different restraint types: **a) Full Bed Rails**—full rails may be one or more rails along both sides of (Continued on Page 3)



Statutory requirements hold the facility ultimately accountable



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The MDS Connection

Section P4—Physical Restraints



If P4e—(Chair Prevents Rising) = 1 or 2

Then review this MDS item:

- **G5a—(Cane/walker/crutch)**

An enclosed framed wheeled walker with or without a posterior seat is coded at P4e (Chair Prevents Rising) if the resident is not able to easily open the front gate and exit the device. Coding the device at Item P4e, however, does not preclude the facility from also coding the device at Item G5a if the resident used the

device to walk during the last 7 days.

If P4a (Full bed rails on all open sides of bed) or P4b—(Other types of side rails used) = 1 or 2

Then review this MDS Item:

- **G6b—Bed rails used for bed mobility or transfer**

While bed rails may serve more than one function, the assessor should code Items P4a or P4b when the bed rails meet the definition of a restraint. When a bed rail is both a restraint *and*

a transfer or mobility aid, it should be coded at Item P4 (a or b, as appropriate) *and* at Item G6b (Bedrails used for mobility or transfer). **Remember the coding instructions for G6b, "Do not check this item if resident did not use rails for this purpose."** You do not code for intent, (i.e., the resident must actually use the rail for bed mobility, not that you raised the rail with the intent the resident use them).

Reference: RAI Manual, Chapter 3, pages 112, 198-202

Physical Restraints—P4

The Assessment Process (Continued from page 2)



Bed rails used for mobility (G6b) may also be a restraint at P4

the resident's bed that block three-quarters to the whole length of the mattress from top to bottom. This definition also includes beds with one side placed against the wall (prohibiting the resident from entering and exiting on that side) and the other side blocked by a full rail (one or more rails); **b) Other Types of Bed Rails Used**—Any combination of partial rails (e.g., 1/4, 1/3, 1/2, 3/4, etc.) or combination of partial and full rails not covered by the above “full bed rail” category (e.g., one-side half rail, one-side full rail, two-sided half rails, etc.); **c) Trunk Restraint**—Includes

any device or equipment or material that the resident cannot easily remove (e.g., vest or waist restraint, belts used in wheelchairs); **d) Limb Restraint**—Includes any device or equipment or material that the resident cannot easily remove, that restricts movement of any part of an upper extremity (i.e., hand, arm) or lower extremity (i.e., foot, leg). Include mittens in this category; **e) Chair Prevents Rising**—Any type of chair with locked lap board or chair that places resident in a recumbent position that restricts rising or a chair that is soft and low to the floor. Include in this category enclosed framed wheeled

walkers with or without a posterior seat and lap cushions that a resident cannot easily remove.

Review clinical records, consult nursing staff, observe the resident, and evaluate whether or not the resident can easily remove the device, material, or equipment. If the resident cannot easily remove the item, continue with the assessment to determine whether or not the device meets the other provisions of the definition of a physical restraint. Do not focus on the intent or reason behind the use of the device but on the effect the device has on the resident.

Reference: RAI Manual Chapter 3, page 198-202



ALERT! MDS Manual Revision—

March 2007

Be sure to check the web for quarterly MDS Manual Revisions

To Download Manual

www.cms.hhs.gov/nursinghomequalityinits/20_nhqimds20.asp

Nursing Home Goal—Highest Practicable Level of Functioning Stay Informed—Section P4—Physical Restraints

The experience of many health care providers suggests that facility goals can often be met without the use of physical restraints. In part, this involves identifying and treating health, functional, or psychosocial problems. This may be accomplished through resident care management alternatives, such as modifying the environment to make it safer; main-

taining an individual's customary routine; using less intrusive methods of administering medications and nourishment; and recognizing and responding to residents' needs for psychosocial support, responsive health care, meaningful activities and regular exercise. It is crucial the RN-MDS Coordinator use the Resident Assessment Protocol (RAP) guide-

lines to accurately assess the resident's medical symptom causing restraint consideration. Be sure to review & discuss all possible alternatives to restraints with the resident.

Remember, “the resident has the right to be free from any physical or chemical restraint... not required to treat a medical symptom”. Reference: RAI Manual, Appendix C, page 101-103

SCENARIO QUIZ—Section P4—Physical Restraints



Mrs. P uses her half side rail for bed mobility. However before the half-rail was raised on her bed, she could safely exit her bed without assistance. Now with the half-rail raised each night, she must ask for assistance to exit the bed to go

to the bathroom. Additionally, Mrs. P uses an enclosed framed wheeled walker with a posterior seat to increase her mobility around the nursing home. Arthritis in Mrs. P's hands prevent her from opening the gate of the walker and she cannot step

away from it on her own. She must ask for assistance whenever she wants to sit down in a chair or go to the bathroom. She uses this walker daily.

How will you code Section P4a-e?

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 Quality Improvement & Evaluation
 Service (QIES)
 Room 1212
 1000 N. E. 10th Street
 Oklahoma City, OK 73117-1299
 Phone: (405) 271-5278
 Fax: (405) 271-1402

Website:
<http://www.health.state.ok.us/PROGRAM/qies/mds/index.html>

MARK YOUR CALENDAR!



Upcoming MDS Training

- **April 4, 2007**
Pressure Ulcer RAP
- **May 22-24, 2007**
3-Day Clinical
- **August 7, 2007**
ADL RAP

For more, see Training Calendar at: www.health.ok.gov/PROGRAM/qies/mds/index.html

MDS Automation Tips

Bob Bischoff Program Manager, MDS/OASIS Automation

Oklahoma's top 5 Automation errors directly linked to Timeliness and Increased Risk for Deficiencies. (Timeframe 1-1-2006 through 12-31-2006)

1 Message 377 Record Submitted Late	8.75%
2 Message 70 Assessment Completed Late	3.73%
3 Message 71 Inconsistent Record Sequence	2.36%
4 Message 226 R2b date late (>14 days)	1.18%
5 Message 217 VB2 date late (>14 days)	1.02%



Order your MDS Error Summary Report through Certification And Survey Provider Enhanced Report, (CASPER) using the same date criteria above.

NATIONAL PROVIDER NUMBER

Required at W1, effective May 23, 2007. Obtain online at www.nppes.cms.hhs.gov or call toll free 1-800-465-3203.

Answer: Scenario—Section P4

P4a—Full bed rails on all open sides of bed = 0

P4b—Other types of side rails used
2

P4c—Trunk restraint = 0

P4d—Limb restraint = 0

P4e Chair Prevents Rising 2

Rationale:

Even though Mrs. P uses the half rail for bed mobility and is coded as such at G6b, she is unable to exit the bed without assistance. Prior to the rail being raised, she could exit the bed safely without assistance. Additionally, even though the wheeled walker increases her mobility, she still cannot exit it without assistance. Therefore, both these devices **have the effect** of restraining.

How to Utilize The Roster Report

Don't restrain yourself from using the Roster Report.

The Roster report lists all residents appearing as active in your facility. This report should be reviewed monthly to ensure all assessment or tracking forms were received in the State Repository. The report contains the resident ID, social security #, resident name, date and type of last assessment completed and received. Review the last record completed information (target date A4a or A3a) for each resident listed and compare to your internal list of assessments/tracking forms due and completed. Discrepancies should be researched in order to remain compliant. Once your roster report is current and accurate, you can easily determine which assessment is next due. This report will appear with your Validation reports on the 7th of each month and will reflect all activity through the last day of the prior month. The report that would be available April 7, 2007 is named RR032007.txt. The next reporting month would appear as RR042007.txt. on May 7, 2007. Be aware the past due assessments appearing on the roster report may appear on the QI/QM reports, which are reviewed prior to survey.

Popular Helpdesk Question

We receive numerous calls about what to do when an Omnibus Budget Reconciliation Act (OBRA-non skilled) assessment is missed.

Solution: Set your assessment reference date in today's timeframe, complete the assessment, and review care plan. This process allows the clinician to appropriately assess and care plan for the residents current needs.

Reference: RAI Manual Chapter 2, pages 1-40

Automation Tip: National Provider Number

According to CMS, facilities transmitting without a national provider ID number will receive a fatal error message effective May 23, 2007.