Restraints, Enablers and Safety Considerations
Planning Individualized Care and Addressing Risks

Words matter, MDS coding matters, planned clinical care matters, but what really matters is the health and safety of our residents. We have a long history of using restraints for the ‘safety’ of residents to prevent falls and referring to all devices as restraints, but our knowledge has evolved to understand that restraints have potential to cause harm.

The Centers for Medicare & Medicaid Services (CMS) has recognized the danger restraints pose to residents and has initiated national efforts to reduce the use of restraints. According to a letter sent to state survey agency directors from the Center for Medicare & Medicaid Services titled “Clarification of Terms Used in the Definition of Physical Restraints as Applied to the Requirements for Long Term Care Facilities”,

- 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 and a restraint is required to treat the medical symptom, protect the resident’s safety, and help the resident attain or maintain his or her highest level of physical or psychological well-being.
- 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. There is no evidence that supports physical restraint use for falls prevention. Although restraints have been traditionally used as a falls prevention approach, they have major, serious drawbacks and can contribute to serious injuries.

Words matter
We use the words restraint, enabler and accident hazard inter-changeably, but the meaning of these words is different. Not all devices are restraints, but providers are still responsible for addressing potential safety hazards the device may present. Enablers can also pose safety concerns, even though they enable a resident to do things they may otherwise not be able to do.

MDS coding matters
Incorrectly coding a device as a restraint on the MDS can have a negative impact on a facility’s reputation and internal data. It is essential that a device is accurately identified so a true picture is reported to the public as well as state surveyors.

Planned clinical care matters
When a device is not identified accurately, we miss the opportunity to develop a care plan that addresses the potential benefits and risk of the device. Individualized care planning isn’t just a regulation to be followed; it is an opportunity to work with the resident, family and staff to develop a plan to help them reach their goals.
Why It All Matters
You might ask, “Why do I care if this device is called a restraint, enabler, or both if it has a potential accident hazard?” The answer: the words, MDS coding, and accurate information from which to care plan from all matters. If you don’t identify the effect the device has on the resident, how will you adequately care plan the benefits of the device, reason for using the device, and the potential risks.

MDS data drive your survey and have an impact on consumer information, such as your Five Star Rating. Regulatory expectations and internal company policies for restraints require certain processes be followed to maintain compliance. Most importantly, individualized care planning demands we identify the reason for using the device and the effect the device has on the resident.

Knowing all of these issues matter, Primaris, the federally-designated quality improvement organization for Missouri, developed the “Device Decision Guide” to help facilities and the assessor determine the effect a device has on a particular resident. It will step the team through the process of determining if the device has restraining effects, enabling effects and/or accident hazard risks. To download a copy of the Device Decision Guide, go to www.primaris.org.

Many experienced assessors consider a device a restraint because of the accident potential or safety hazard the device puts the resident at risk for, not necessarily the actual restraining or enabling qualities. Understanding that the first step is determining the category of device and then moving on to assess the potential hazards of a device, regardless if it is a restraint, enabler, or both, will help providers provide individualized care, discuss risks and benefits with families, and communicate the decision-making process to state survey teams.

Using the “Device Decision Guide”
The Device Decision Guide has seven steps that must be completed in its entirety. Regional survey teams have expressed concerns providers are only using the first one or two pages of the guide and not continuing through the entire tool to determine safety hazards and care plan appropriately. If your organization decides to use the “Device Decision Guide”, it is expected the tool will be used in its entirety.

The Care Planning Process guidance found on the “Device Decision Guide” will assist staff to identify a medical symptom that warrants the use of a restraint. The guide prompts staff to attempt alternatives, communicate risk/benefits, obtain orders for use of a restraint, document rationale for use, identify goals and time frames for device use, apply it correctly, monitor for impact of device, monitor for complications, and at least quarterly reassess the resident for continued use of the device.

The Device Decision Guide is designed to separate the concepts of restraining, enabling, and risk, which we have tangled together for too long a time and, secondly, aide providers in completing the entire process of assessment and care planning when using any device.
Case Study

The following case study will help illustrate the first three steps of the “Device Decision Guide”. A completed “Device Decision Guide” using the below case study can be found on the following pages.

**Background** - Mr. Brown is a quadriplegic resident who has no functional ability other than slight movements of his right hand. He uses his right hand to guide the hand control on his wheelchair. This allows him to maneuver around the home and outside the home. Physical therapy fitted the wheelchair with a seat belt. He cannot remove the device, but he also has no functional ability to move out of the chair. Interviews with staff report they find him sliding down in his wheelchair if his foot is not positioned correctly, resulting in the seat belt positioned around his chest.

**Summary of findings** - In our case study, Mr. Brown clearly benefited from the use of the seat belt as an enabler; however there were clear safety hazards for strangulation. The need to evaluate the hazard, weigh the benefits, and care plan accordingly is critical to ensure Mr. Brown continues to benefit from the enabling quality of the seat belt but also ensure the significant safety hazards are addressed and appropriate interventions put into place.
DEVICE DECISION GUIDE

Complete all 3 STEPS in order given. After completing these initial 3 steps, any device must be care planned in STEPS 4-8. If device is not used, document rationale and care plan for alternatives.

STEP 1: Determine Restraining Effect

Does device prevent resident from performing movement otherwise capable or restrict resident’s access to his/her body?

- Yes: Does resident have cognitive AND functional ability to remove device? Resident removes device purposefully.
  - Yes: cognitive=yes, functional=no, quadriplegic resident
  - No: Mr. Brown is a quadriplegic and unable to produce any movement other than slight movement with right hand.
  - No: Proceed to Step 2

- No: Proceed to Step 2

Device is a restraint. If a device is found to have restraining qualities, it is a restraint even if it also has enabling qualities or no safety concerns. If device is used:
- Code MDS P0100
- Record the medical symptom that warrants use
- Proceed to Step 2

Device is not a restraint. If device is used:
- Do not code MDS P0100
- Proceed to Step 2

Resident Name/Room Number: Mr. Brown, Room 101
Device: Wheelchair seat belt
Completed By: M. Mouse, RN

Date: 3/1/12

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STEP 2: Determine Enabling Effect

Enabling Effect
1. Does the device allow the resident to do something that would improve quality of life? **Yes**
2. Does it allow the resident to participate in an activity otherwise incapable of? **Yes**
3. Does it improve physical or emotional status? **Yes**

Device has enabling effect. If the device was determined to not be a restraint on page one, statement of medical necessity not required.

Proceed to Step 3

No enabling effect. If device is used: Proceed to Step 3

Mr. Brown would be unable to remain in his wheelchair without the seat belt. He enjoys the freedom his wheelchair allows him.

Resident Name/Room Number: Mr. Brown, Room 101 Date: 3/1/12
**DEVICE DECISION GUIDE**

Consider all possible negative effects and safety hazards of the device. Devices can be therapeutic and beneficial; but may not be risk free. If resident found in an at risk position with device, discontinue use and reevaluate with team.

**STEP 3: Determine Safety Hazards**

1. **Is resident vulnerable to hazard?**
   - Vulnerability changes. Risk factors: resident’s function, medical condition, cognition, mood, and treatments (e.g., medications), etc.

2. **Does the device place the resident at risk for:**
   - Depression
   - Loss of Dignity
   - Agitation
   - UTIs
   - Decreased mobility
   - Injury from devices not adapted or fitted to resident
   - Injury from defective or improperly used devices
   - Loss of muscle tone
   - Strangulation
   - Incontinence
   - Constipation
   - Pressure Ulcers
   - Asphyxiation
   - Entanglement
   - Pain from lack of movement
   - Skin tears/scrapes/bruises
   - Decreased bone density/increased fractures

3. **Is resident at risk for entrapment?**
   - Residents most at risk:
     - Elderly or frail residents with:
       - Agitation
       - Pain
       - Restlessness
     - Residents using Specialty Mattress: Compression of mattress widens gap between mattress and rail. As resident changes position, mattress may inflate and trap head, chest, neck, or limbs between mattress and side rail resulting in fractures, asphyxiation and death. Follow manufacturer recommendation for inflation based on resident’s weight.

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Device Care Planning Process

Now that you've determined the restraining, enabling, or hazard effect of the device, proceed to STEP 4 of the planning process. The use of any device requires a care plan. The following information should be included in the resident's individual care plan.

STEP 4: Assessment and Problem Recognition

b. Identify triggers for restraint use from MDS and review appropriate CAAs based on medical symptom.
c. Notify practitioner about symptoms requiring device.
d. Identify if problem is chronic/irreversible or acute/reversible.
e. Attempt alternatives to manage the problem. Communicate risk/benefits to resident and family.
f. Document ability to purposefully remove device and resident to perform activity of choosing.

STEP 5: Diagnosis and Identify Cause

a. Identify likely causes (medication side effects or environmental factors) for using a device.
b. Did practitioner help identify specific medical symptoms to use restraint?
c. If the resident was not evaluated for the medical symptom(s) prior to using restraint, document why.
d. For any device that is a restraint, obtain practitioner's order. Orders must reflect presence of medical symptom; however, the order alone is not sufficient to warrant use.

If Family/Responsible party requests device, the facility must evaluate reason for request and impact on resident. Facility can only use to treat a medical symptom. It cannot be used if it violates the regulation.

STEP 7: Monitoring

a. Monitor impact of device on resident and problems or risks for which it was used.
b. Monitor for complications related to device, if present, and stop or adjust use.
c. Document why continued use was needed despite complications.
d. Maintain ongoing monitoring for safety hazard, stop use immediately and reassess if hazard detected.
e. Periodically (at least quarterly) reassess the resident for continued need for device and document in care plan.

STEP 6: Care Plan - Treatment and Management

a. Document attempted alternatives and outcomes.
c. Document how facility manages causes of falling, problematic behavior, or another condition for which a device is used and record medical symptoms that warrant use OR explain why causes could not or should not be managed. Care plan the device.
d. Use device correctly: Apply it correctly, release it at right time, provide for exercise. Identify risk factors and care plan how to minimize.
e. Identify goal with time frames for device use, including least restrictive and reduction (i.e., correction of underlying causes).
f. Implement care plan.

*Be specific! e.g., “Seat belt for positioning” is inadequate. Include cause of positioning problem.

Resident Name/Room Number: Mr. Brown, Room 101
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