REDEFINING RESTRAINTS IN THE SKILLED NURSING FACILITY: WHEN INJURY PREVENTION DEVICES ARE REALLY 'RESTRAINTFUL'

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Introduction

The Centers for Medicare & Medicaid Services (CMS) State Operations Manual defines physical restraints 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."

Many types of devices are utilized in skilled nursing facilities (SNFs) for injury prevention (IP). Some of these are counted as restraints on the Minimum Data Set (MDS) and become triggers for quality indicator (QI) # 11.1 "Residents who were physically restrained". The MDS restraint categories are: "Trunk restraint", "Limb restraint", and "Chair prevents rising". If using only QI reports as restraint indicators, facility leaders can be deceived about the extent of 'restraintful' devices being used in their facility. Examples are: the use of a low bed in which the resident is unable to get out of bed without assistance, but could independently enter and exit a bed of normal height, and the use of ½ , ¾ or full side rails "for mobility". If the intent of the rail is mobility [not safety], a simple grab bar would suffice for most residents. These IP devices are not captured in QI # 11.1.

Method

To help facilities refocus on a broader concept of potential restraints, we have encouraged them to monitor all IP devices. (Exhibit 1) Using June 2007 data for 8 facilities, we compared the prevalence of IP devices for each facility to their January through June 07 QI # 11.1 and to the same 6 month state and national averages. (Exhibit 2)

Exhibit 1: Monthly Injury Prevention Monitoring QA Report

_____
(Facility)

Unit: _____

Month / Year: _____

"Physical restraints are defined 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." MDS 2.0 User's Manual

If a Resident is utilizing a device that is listed but the device does NOT meet the definition of a "restraint" as listed on the left - Please incl the device in the report and circle that entry.

Resident Name	Bed / Chair Personal Alarm	Transfer Bar	1/2 or Partial Side Rails	Full or 3/4 Side Rails	Lap Buddy	Mem Walker	Wheelchair Seat Belt: Self Releasing	Wheelchair Seat Belt: Non Releasing	Gen Chair	Low Bed (potentially Restraintful)	Other Injury Prevention Device	Comments (please inc of "other" res
Total												

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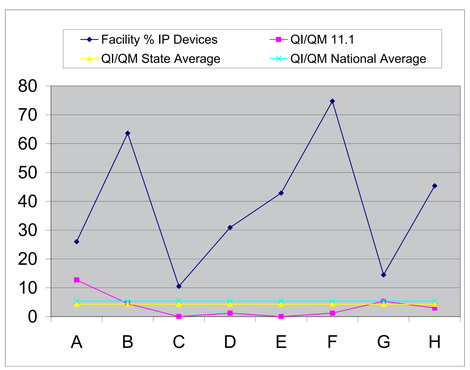
Exhibit 2: Comparison: Injury Prevention Devices / Restraints

Facility Code	June 2007 % Residents with Injury Prevention Devices **Facility % IP Devices**	6 Mo. QM/QI Observed % Residents with Restraints **QI/QM 11.1**	6 Mo QM/QI State Average % Residents with Restraints **QI/QM State Average**	6 Mo QM/QI National Average % Residents with Restraints **QI/QM National Average**
A	25.97	12.7	4.3	5.4
B	63.6	4.5	4.3	5.4
C	10.53	0	4.3	5.4
D	30.88	1.2	4.3	5.4
E	42.86	0	4.3	5.4
F	74.71	1.2	4.3	5.4
G	14.49	5.3	4.3	5.4
H	45.35	3	4.3	5.4



Results

The number of restraints reported in the facility QIs is significantly below the total use of potentially 'restraintful' IP devices in a typical facility. For the 8 facilities included in our project between 10.5% and 74.7% of residents utilized one or more IP devices. Comparatively, their facility specific QI reports showed between 0 to 12.7% of residents were physically restrained, state average was 4.3% of residents, and national average 5.4%.

Additional comparisons were made with the percent of residents who were reported to be physically restrained by:

- Online Survey, Certification and Reporting (OSCAR)
  State average 7.1% and National average 6.2% (June 2007)
- CMS Nursing Home Quality Initiative Quality Measures (NHQI)
  State average 5% and National average 6% (Quarter 4 of 2006)

Conclusion

Remember restraints counted on the QIs grossly underestimate the extent of IP devices found in the facility. By monitoring all devices used for IP, we are able to focus attention to how the facility views and uses devices for resident safety. During monthly quality assurance meetings, we review current data and capitalize on opportunities for educating the facility leadership on these essential issues and their differences. The data also provides an opportunity to address appropriate care planning and education of residents / families to the risks and benefits of the intended safety devices.