

## **Questions and Answers following the Ohio LANE Restraint Webinar #1 (09-11-12)**

### ***Question 1: Is a chair considered a restraint if a resident cannot rise out of a chair?***

**Answer:** In order to answer this adequately, all situations that could be coded as a Chair that Prevents Rising will be covered in this answer.

- Chairs that Prevent Rising: Includes any type of chair with a locked lap board, a chair that places the resident in a recumbent position that restricts rising, or a chair that is soft and low to the floor. Included here are also chairs that have a cushion placed in the seat that prohibits the resident from rising.
- For residents who have the ability to transfer from other chairs, but cannot transfer from a geriatric chair, the geriatric chair would be considered a restraint to that individual and should be coded on the MDS assessment at P0100 G – Chair Prevents Rising.
- For residents who have no ability to transfer independently, the geriatric chair does not meet the definition of a restraint, and should not be coded at P0100H G– other Chair Prevents Rising.
- Geriatric chairs used for residents who are immobile. For residents who have no voluntary or involuntary movement, the geriatric chair does not meet the definition of a restraint.
- Enclosed-frame wheeled walkers, with or without a posterior seat, and other devices like this should not automatically be classified as a restraint. These types of walkers are only classified as a restraint if the resident cannot exit the gate. When deemed a restraint, these walkers should be coded at P0100 G- Chair Prevents Rising.
- Refer to: MDS 3.0 Manual, Section P on page P-3 for Steps for Assessment and P0100, page P-6: Physical Restraints, Coding Tips and Special Populations

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### ***Question 2: Is a self-release seatbelt considered a restraint if the resident is not able to rise unassisted or cannot open the seatbelt and is used as a positioning device?***

**Answer:** The definition of a restraint as written in the MDS 3.0 manual and the State Operations Manual, Appendix PP is: 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.

The seatbelt that the resident cannot open or remove as easily as it was put on, is a restraint regardless of whether it is used as a positioning device or not. This does not have anything to do with the resident not being able to rise from the chair. The answer also applies to such things as "lap buddies". Prior to using any restraint, the nursing home must assess the resident to properly identify the resident's needs and medical symptom's that the restraint is being employed to address. Do not focus on the type of device, intent, or reason behind the use of the device, but rather on the effect the restraint has on the resident's normal function.

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All nursing homes in Ohio must follow the directions for coding the MDS 3.0 assessments which is in accordance with the State Operations Manual (SOM) and also in accordance with State Survey protocol using the QIS which is MDS based.

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### ***Question 3: Is an abdominal binder used to prevent a resident from pulling their tube feeding tube out considered a restraint?***

**Answer:** Abdominal binders can be a restraint. Physical restraints as an intervention do not treat the underlying causes of medical symptoms. Therefore, as with other interventions, physical restraints should not be used without seeking to identify and address the physical or psychological condition causing the medical symptoms. Physical restraints may be used as a symptomatic intervention when they are immediately necessary to prevent a resident from injuring himself/herself and/or to prevent the resident from interfering with life-sustaining treatment when no other less restrictive or less risky intervention exists. When there is a clear link between the restraint use and how it benefits the resident after the restraint assessment, it still must be documented and care planned as the use of a restraint and in this situation it would be coded on the MDS 3.0 under P0100 "other" whether it is used in bed or in chair/out of bed.

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### ***Question 4: If a Resident wears a one piece garment to prevent them from exposing themselves inappropriately due to cognitive losses, would this be considered a restraint even if they are incontinent and have no cognitive ability to toilet self?***

**Answer:** Being incontinent will have no bearing on whether the "jump suit" (with openings in the back that the resident cannot remove and thus has no access to his/her own body) acts as a restraint. The definition of a restraint applies here in that the resident cannot remove the one-piece garment, it does restrict movement or normal access to one's body and so this would be coded as a restraint in P0100 D and/or H – Other.

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### ***Question 5: If bed is against the wall, do we need to complete a restraint assessment?***

**Answer:** If the bed is placed against the wall as a substitute for a bed rail and this has the effect of restraining the resident, then the facility is responsible for assessing the appropriateness of the bed against the wall as a restraint and properly coded on the MDS 3.0 assessment as a restraint.

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***Question 6: Is a low bed considered a restraint since it limits rising, but is used due to falls to prevent injury from frequent falls?***

**Answer:** A restraint can be used for more than one reason; however the assessor must consider the effect the device has on the resident, not the purpose or intent for its use. If the low bed is in fact restraining the resident and it meets the definition of a restraint then it needs to be coded appropriately on the MDS 3.0 and documented in the medical record and care planned.

***Question 7: How do we try to keep the number of restraints down so we do not look bad on the web, when we have tried numerous other measures to provide safety for those who do not realize that they cannot walk without falls?***

**Answer:** Restricting the number of restraints used in a nursing home can come about by knowing the residents very well. For residents who fall easily, investigate the reasons for the falls and work on that instead of using restraints. This brings about the main purpose of OBRA which is to assist residents in attaining and maintaining their highest practicable level of well-being. In this situation, you could consider starting Restorative Nursing to assist with walking, which can then be coded on the MDS 3.0 assessment under O0500F, Walking. The resident's subjective symptoms may not be used as the sole basis for using a restraint. While a restraint-free environment is not a federal requirement, the use of restraints should be the exception, not the rule.

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***Question 8: Are wander guards a type of restraint? Are they a restraint if the elevator will not go down?***

**Answer:** Wander guards are not usually considered a type of restraint. While alarms can help to monitor a resident's activities, staff must be vigilant in order to respond to them in a timely manner. Alarms do not replace necessary supervision. Per SOM F323: Tools or items such as personal alarms can help to monitor a resident's activities, but do not eliminate the need for adequate supervision.

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***Question 9: Do we count a locked unit on the MDS as a restraint under "other"?***

**Answer:** A locked unit is not coded on the MDS but should be care planned. If the stated purpose of a unit which prevents residents from free movement throughout the facility is to provide specialized care for residents who are cognitively impaired, then placement in the unit is not considered involuntary seclusion, as long as care and services are provided in accordance with each resident's individual needs and preferences rather than for staff convenience, and as long as the resident, surrogate, or representative (if any) participates in the placement decision, and is involved in continuing care planning to assure placement continues to meet resident needs and preferences.

**Tag 272 Assessment:** Review the RAI, the history and physical, and other information such as physician orders, progress notes, nurses' notes, pharmacist reports, and any flow sheets or forms the facility uses to document the resident's history; including the assessment of the resident's over all condition. Determine if the facility assessment is

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consistent with or corroborated by documentation within the record and comprehensively reflects the status of the resident for placement on the locked unit.

**Tag F279 Comprehensive Care Plan:** Determine whether the facility developed a plan of care based on the resident's assessment. Determine whether the care plan addresses the needs identified in the comprehensive assessment for placement and retention on the secured unit.

**Tag F280 Care Plan Revision:** Look for evidence that the care plan was reviewed and revised as necessary. Look for evidence that the resident or representative was afforded the right to participate in care planning or was consulted about placement on the locked unit.

(<http://www.odh.ohio.gov/~media/ODH/ASSETS/Files/lrc/nursing%20homes%20-%20facilities/lockedspecializedcareunits.ashx>)

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***Question 10: Where do we find the rules for locked units, and what do we need to do to register a locked unit with the State of Ohio?***

**Answer:** Please refer to question #9. There is no registration required for a locked unit in a nursing home in Ohio.

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***Question 11: What is the timeframe for using an emergency physical or chemical restraint, or isolation?***

**Answer:** There is no specific time frame involved. If a resident is receiving emergency short-term monitored separation due to temporary behavioral symptoms (such as brief catastrophic reactions or combative or aggressive behaviors which pose a threat to the resident, other residents, staff or others in the facility), this is not considered involuntary seclusion as long as this is the least restrictive approach for the minimum amount of time, and is being done according to resident needs and not for staff convenience.

New medication order as an emergency measure: When a resident is experiencing an acute medical problem or psychiatric emergency (e.g., the resident's behavior poses an **immediate risk** to the resident or others), medications may be required. In these situations, it is important to identify and address the underlying causes of the problem or symptoms. Once the acute phase has stabilized, the staff and prescriber consider whether medications are still relevant. Subsequently, the medication is reduced or discontinued as soon as possible or the clinical rationale for continuing the medication is documented. The resident's right to participate in care planning and the right to refuse treatment are addressed at §§483.20(k)(2)(ii) and 483.10(b)(4), respectively, and include the right to accept or refuse restraints. Restraints may not be used for staff convenience. However, if the resident needs emergency care, restraints may be used for brief periods to permit medical treatment to proceed unless the facility has a notice indicating that the resident has previously made a valid refusal of the treatment in question. If a resident's unanticipated violent or aggressive behavior places him/her or others in imminent danger, the resident does not have the right to refuse the use of restraints.

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### ***Question 12: Does Ohio have a specific definition for elopement?***

**Answer:** Ohio follows the SOM which says:

Elopement occurs when a resident leaves the premises or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so. A resident who leaves a safe area may be at risk of (or has the potential to experience) heat or cold exposure, dehydration and/or other medical complications, drowning, or being struck by a motor vehicle. Facility policies that clearly define the mechanisms and procedures for monitoring and managing residents at risk for elopement can help to minimize the risk of a resident leaving a safe area without authorization and/or appropriate supervision. In addition, the resident at risk should have interventions in their comprehensive plan of care to address the potential for elopement. Furthermore, a facility's disaster and emergency preparedness plan should include a plan to locate a missing resident. The facility needs to provide and maintain a secure environment to prevent negative outcomes (eloping through exit doors) for residents who exhibit unsafe wandering and/or elopement behavior (regardless of whether ambulatory, in wheelchair or using walker).

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### ***Question 13: Many hospices are now using Haldol for nausea. How can we justify this in Long Term Care and avoid a survey issue for using the medication for off-label use, even if they feel it is effective?***

**Answer:** Because haloperidol is marketed as an antipsychotic, most physicians are not familiar with the use of haloperidol for nausea despite wide experience in the hospice community with this selective agent. For MDS 3.0, refer to page O-4, O0100K – Hospice Care and also page 2-21 for Significant Change in Status Assessment (SCSA) when Hospice Care is chosen or revoked. For coding the MDS for N0410A, Antipsychotic (page N-6) count long-acting medications such as haloperidol decanoate, that are given every few weeks or monthly **ONLY** if they are given during the 7 day look-back period. In addition, from the SOM: **Medication Exception:** When antipsychotic medications are used for behavioral disturbances related to Tourette's disorder, or for non-psychiatric indications such as movement disorders associated with Huntington's disease, hiccups, nausea and vomiting associated with cancer or cancer chemotherapy, or **adjunctive therapy at end of life**. When a LTC facility resident who is documented to have 6 months or less to live, has also elected the Medicare hospice benefit, the hospice and the nursing home must communicate, establish, and agree upon a coordinated plan of care for both providers which reflects the hospice philosophy, and is based on an assessment of the individual's needs and unique living situation in the facility. The plan of care must include directives for managing pain and other uncomfortable symptoms and be revised and updated as necessary to reflect the individual's current status. This coordinated plan of care must identify the care and services which the SNF/NF and hospice will provide in order to be responsive to the unique needs of the patient/resident and his/her expressed desire for hospice care.

The SNF/NF and the hospice are responsible for performing each of their respective functions that have been agreed upon and included in the plan of care. The hospice retains overall professional management responsibility for directing the implementation of the plan of care related to the terminal illness and related conditions.

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For a resident receiving hospice benefit care:

- The facility must have completed a MDS Significant Change in Status Assessment (SCSA) when the resident elected the hospice benefit;
- The facility must have completed a MDS Significant Change in Status Assessment (SCSA) when the resident revoked the hospice benefit;
- The plan of care reflects the participation of the hospice, the facility, and the resident or representative to the extent possible;
- The plan of care includes directives for managing pain and other uncomfortable symptoms and is revised and updated as necessary to reflect the resident's current status;
- Medications and medical supplies are provided by the hospice as needed for the palliation and management of the terminal illness and related conditions.
- The hospice and the facility communicate with each other when any changes are indicated to the plan of care;
- The hospice and the facility are aware of the other's responsibilities in implementing the plan of care;
- The facility's services are consistent with the plan of care developed in coordination with the hospice, (the hospice patient residing in a SNF/NF should not experience any lack of SNF/NF services or personal care because of his/her status as a hospice patient); and
- The SNF/NF offers the same services to its residents who have elected the hospice benefit as it furnishes to its residents who have not elected the hospice benefit. The resident has the right to refuse services in conjunction with the provisions of 42 CFR 483.10(b)(4), Tag F155.

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### ***Question 14: Can a person with a diagnosis of dementia with psychosis be prescribed an antipsychotic?***

**Answer:** An antipsychotic medication should be used only for the following conditions/diagnoses as documented in the record and as meets the definition(s) in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Training Revision (DSM-IV TR) or subsequent editions):

- o Schizophrenia
- o Schizo-affective disorder
- o Delusional disorder
- o Mood disorders (e.g. mania, bipolar disorder, depression with psychotic features, and treatment refractory major depression)
- o Schizophreniform disorder

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o *Psychosis NOS*

o *Atypical psychosis*

The Federal Tag for surveyors investigating the proper use of medications is as follows: (from the SOM)

### **Synopsis of Regulation (F329):**

The unnecessary medication requirement has six aspects in order to assure that medication therapy is appropriate for the individual resident. The facility must assure that medication therapy (including antipsychotic agents) is based upon:

- An adequate indication for use;
- Use of the appropriate dose;
- Provision of behavioral interventions and gradual dose reduction for individuals receiving antipsychotics (unless clinically contraindicated) in an effort to reduce or discontinue the medication;
- Use for the appropriate duration;
- Adequate monitoring to determine whether therapeutic goals are being met and to detect the emergence or presence of adverse consequences; and
- Reduction of dose or discontinuation of the medication in the presence of adverse consequences, as indicated.

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***Question 15: Please clarify antipsychotics not having proper documentation. Does this refer to not having the proper diagnosis or to the monitoring of behaviors?***

**Answer:** Please refer to the answer for Question #14.

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