HCFA, Joint Commission Show Some Restraint

by Michelle Dougherty, RHIA

Patient safety, physical restraints, least-restrictive devices, medical justification—these are all terms that acute care hospitals, behavioral health facilities, and long-term care facilities will be focusing on in 2001 due to the recent changes in Joint Commission on Accreditation of Healthcare Organizations standards and Health Care Financing Administration (HCFA) regulations.

In 2001, the Joint Commission has agreed to incorporate HCFA's restraint requirements into its survey process. For providers, this means updating policies to assure compliance with both the Joint Commission standards and HCFA regulations. With a few exceptions, the Joint Commission standards are more stringent than HCFA, but both have a similar philosophy on restraint use: restraints should only be applied in emergency situations where patients are dangerous to themselves, staff, or others, or there is clinical justification.

Hospitals and Behavioral Healthcare Settings

The 2001 Joint Commission standards on restraint and seclusion (TX.7.1 through TX.7.1.16) apply to all accredited behavioral healthcare facilities such as psychiatric units in general hospitals, free-standing psychiatric hospitals, and residential treatment centers. Non-behavioral health settings (including acute care hospitals and emergency departments) that use restraints or seclusion for behavioral health reasons are required to follow standards TX.7.1.4.1, TX.7.1.5, TX.7.1.6 through TX.7.1.8, TX.7.1.10, and TX.7.1.11.

In general, the standards require that the facility exhaust all reasonable alternatives before a patient is placed in restraints or seclusion. Further, the facility must have adequate justification and documentation for the use of restraints or seclusion.

Following are two examples of Joint Commission standards that are less stringent than HCFA requirements for hospitals and behavioral healthcare settings:

- TX.7.1.5: A licensed independent practitioner (LIP) must order the use of a restraint or seclusion. HCFA requires that restraints be administered in accordance with an order from a physician or LIP, which implies that an order be obtained prior to implementation. This may be a change for some facilities that implement a restraint after an assessment by an RN and contact the physician within a specified period of time.
- TX.7.1.6 and HCFA's "One-Hour Rule": An LIP must see and evaluate the patient in person when a restraint is applied. HCFA requires that an LIP evaluate a patient within one hour of the decision to initiate restraints in response to violent and aggressive behavior. There should be documentation in the medical record of the evaluation within the one-hour time frame for a restraint applied for behavior management purposes.

The restraint standards require reevaluation of a patient who is restrained or in seclusion. HCFA allows an order to be written authorizing a restraint for up to four hours for an adult. The order can be renewed in four-hour increments not to exceed 24 hours. The Joint Commission adds that the LIP must evaluate a patient in restraints every eight hours for individuals 18 years and older and every four hours for those under age 17 (which is a change from the past).

Hospitals are required to use performance improvement (PI) strategies to identify ways to reduce the use of restraints. Hospitals must collect data on restraint and seclusion use to monitor and improve the process, because the Joint Commission is looking for aggregate data and analysis on restraint use. HCFA does not require data collection or a specific performance improvement process, but does look for restraint reduction efforts.

Long-Term Care Facilities

For nursing homes, Transmittal 20 will require changes in facility policy and programs for the use of restraints. Transmittal 20 revised the guidance to surveyors for five federal tag numbers found in Appendix PP of the State Operations Manual. The revisions made by HCFA affect regulations F221, F222, F223, F280, and F323.

The changes define the type of devices that are considered restraints. A physical restraint is 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." This definition would consider siderails a restraint if they are used to keep a resident from voluntarily getting out of bed. Other examples include using Velcro or tucking clothing or a sheet so tightly that it restricts movement, using devices (such as trays, tables, bars, or belts) in conjunction with a chair to restrict movement, placing a resident in a chair that prevents rising, or placing a chair or bed so close to the wall that a resident is prevented from rising.

Facilities must document in the medical record the medical symptoms that justify the use of the restraint. The medical symptoms cannot solely be subjective, but should be objective and derived from clinical evaluation. Physician orders should document the symptoms, but cannot be relied on solely to justify the use of a restraint. Through assessment and care planning, the facility should be able to show how the restraint treats the symptom, protects the resident safety, and assists the resident in attaining or maintaining his or her highest practicable level of physical and psychosocial well-being.

The risks and benefits of restraint use must be spelled out for residents or their legal representative when the decision to use a restraint is being considered. This "informed consent" must include the risks and benefits of all treatment options under consideration: using a restraint, not using a restraint, and using alternatives to a restraint. In addition, facilities must explain how the restraint would treat the medical symptoms as well as the potential negative outcomes from using a restraint.

Surveyors have eight new probes to use in determining if restraint use is appropriate:

1. What are the medical symptoms that led to consideration of the use of restraints?

2. Are these symptoms caused by failure to:

- meet individual needs in accordance with the resident assessments including, but not limited to, background information and customary daily routines found on the MDS?
- use rehabilitative and restorative care?
- •provide meaningful activities?
- manipulate the resident's environment, including seating?

3. Can the cause(s) of the medical symptoms be eliminated or reduced?

4. If the cause(s) cannot be eliminated or reduced, has the facility attempted to use alternatives to avoid a decline in physical functioning associated with restraint use?

5. If alternatives have been tried and deemed unsuccessful, does the facility use the least restrictive restraint for the least amount of time? Does the facility monitor and adjust care to reduce the potential for negative outcomes while continually trying to find and use less restrictive alternatives?

6. Did the resident or legal surrogate make an informed choice about the use of restraints? Were risks, benefits, and alternatives explained?

7. Does the facility use the Physical Restraint RAP to evaluate the appropriateness of restraint use?

8. Has the facility reevaluated the need for the restraint, made efforts to eliminate its use and maintained residents' strength and mobility?

The challenge and the bottom line for long-term care facilities under the new guidelines is that regardless of what the physician orders or the family demands, facilities are held accountable to ensure that restraints are applied appropriately. The new guidelines provide an opportunity to review and improve your facility's policies and procedures.

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