

Focus the system  
on a common  
quality agenda

Catalyze  
Spread

Build  
Evidence &  
Knowledge

Broker  
Improvement

Evaluate  
Progress

## Long-Term Care Restraint Indicator Informational Webinar

Friday November 1<sup>st</sup>, 2013

1:30pm – 2:45pm

# Logistics

## Phone and Computer

### Phone:

Toll-free: 1 888 816 4438

-- OR --

Toll: +1 (647) 497-9385

Access Code: 548-440-440

### Log-in instructions:

From Health Quality Ontario's  
[GoToWebinar.Notifications@citrixonline.com](mailto:GoToWebinar.Notifications@citrixonline.com).

## Questions and Slides

- Please submit questions through GoToWebinar “Questions” box.
  - Expand the menu for the Questions box by clicking the orange arrow.



- Questions will be addressed at the end of the webinar
- Slides and Q&A will be posted in English and French on the HQO site.

# Agenda

Item	Duration
<p><b>Welcome &amp; Introduction to Public Reporting</b> Michelle Rey, Director, Performance Measurement &amp; Reporting (HQO)</p>	5 min
<p><b>Overview of Long-Term Care Public Reporting</b> Michelle Rey, Director, Performance Measurement &amp; Reporting (HQO)</p>	5 min
<p><b>Restraint Definitions &amp; Case Study</b> Mary Nestor, Senior Manager, Compliance &amp; Enforcement Performance Improvement and Compliance (MOHLTC) Geri St. Louis, Clinical Specialist (CIHI) John David Stanway, Team Lead, Home and Continuing Care, Data Management (CIHI)</p>	20 min
<p><b>Home-to-Home: Sharing Experiences of Using Restraint Rates in Quality Improvement Initiatives</b> Niko Gregorin, Occupational therapist (Geraldton District Hospital – John Owen Evans Residents) Cathleen Larsen, LTC Nurse Manager (Geraldton District Hospital – John Owen Evans Residents) Doreen Grant, Director of Nursing (Bendale Acres Long-Term Care Home) Wei Wang, RAI Lead (Bendale Acres Long-Term Care Home)</p>	20 min
<p><b>Q&amp;A and Closing</b></p>	15 min

# LTC Restraint Indicator Webinar

## Presenters and Panelists

- **Presenters**

- Michelle Rey, Health Quality Ontario
- Mary Nestor, Ministry of Health and Long Term Care
- Geri St. Louis, Canadian Institute for Health Information
- John David Stanway, Canadian Institute for Health Information
- Niko Gregorin, Geraldton District Hospital – John Owen Evans Residents
- Cathleen Larsen, Geraldton District Hospital – John Owen Evans Residents
- Doreen Grant, Bendale Acres Long-Term Care Home
- Wei Wang, Bendale Acres Long-Term Care Home

- **Panelists**

- Gayle Stuart, Health Quality Ontario
- Sabrina Rooplall-Noseworthy, Specialty Care Inc.
- Carol Holmes, Registered Nurses' Association of Ontario

# About Health Quality Ontario

- HQO works in partnership with Ontario's health care system to support a better experience of care, better outcomes for Ontarians and better value for money.
- HQO's legislated mandate under the [Excellent Care for All Act](#), 2010 is to:
  - Monitor and report to the people of Ontario on the quality of their health care system
  - Support continuous quality improvement
  - Promote health care that is supported by the best available scientific evidence
- HQO is an arms-length agency of the Ontario government.

# *The Excellent Care for All Act, 2010*

- Provides new standards to ensure that Ontarians receive health care of the highest possible quality and value.
- Aims to improve the quality of Ontario's health care system and make sure funding is used to provide the best possible care, so that:
  - The patient is at the centre of the health care system
  - Decisions about care are based on the best evidence and standards
  - The system is focused on quality of care and the best use of resources
  - The main goal of the system is to get better and better at what it does

# Our Mandated Areas: Evidence Development & Standards

- Evidence has become increasingly important in Ontario's health-policy and decision-making environment.
- HQO works with clinical experts, scientific collaborators, panels and field evaluation partners to provide evidence about the effectiveness and cost-effectiveness of health technologies and services in Ontario.
- Requests for HQO's evidence-based reviews come from the Ministry of Health and Long-Term Care and from the broader health system.

# Our Mandated Areas: Continuous Quality Improvement

- HQO is committed to accelerating quality improvement across the health system.
- HQO supports quality improvement across Ontario by facilitating change and assisting in the development of organizational Quality Improvement Plans (QIPs).
- HQO programs and quality improvement advisors provide focused, expert assistance as well as an evidence-informed, integrated quality improvement curriculum that addresses the needs of provincial cross-sector teams, such as Health Links.



# Our Mandated Areas: Monitoring & Reporting on the Quality of the Health Care System

- Ontarians want a sustainable public health care system that helps people stay healthy and delivers excellent quality care when they need it.
- Monitoring and public reporting on quality helps define excellence and provides a clear standard with which to articulate what high-quality care is and what success looks like.
- HQO supports transparency and accountability through objective monitoring and reporting on health system performance.

# OVERVIEW OF LONG-TERM CARE PUBLIC REPORTING

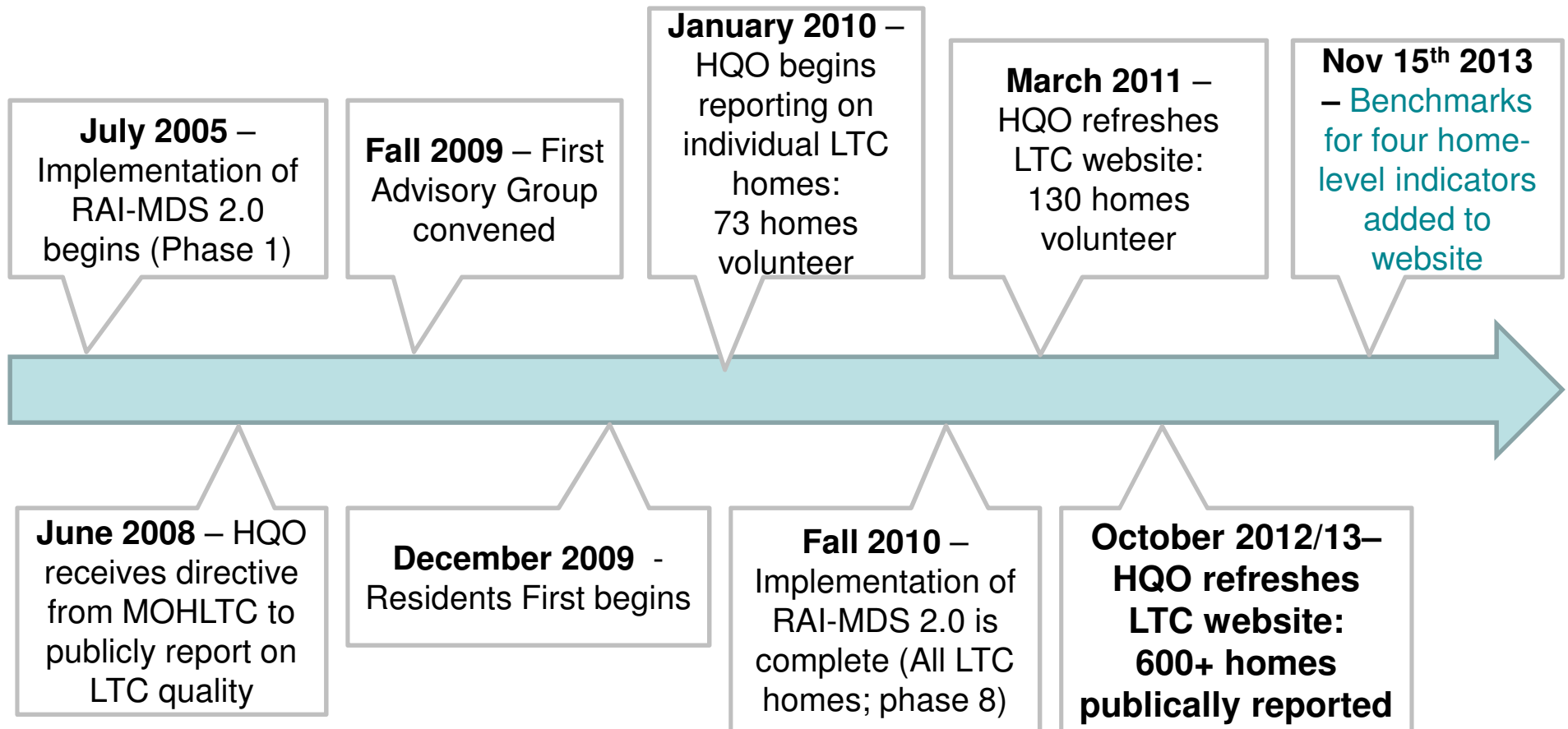
**Michelle Rey**

Director, Performance Measurement & Reporting (HQO)

# Publicly Reported Quality Indicators

Attribute	Health topic	Indicator (*Adjusted CCRS QIs bolded; home-level indicators highlighted in green)
Accessible	Wait times	Median number of days to LTC home placement
Effective	Incontinence	<b>Percentage of residents with worsening bladder control*</b>
	Activities of daily living	<b>Percentage of residents with increasing difficulty carrying out normal everyday tasks*</b>
	Cognitive function	<b>Percentage of residents whose language, memory, and thinking abilities have recently decreased*</b>
	Pain	<b>Percentage of residents with pain that got worse recently*</b>
	Emergency department visits	Number of emergency department visits due to an ambulatory care sensitive condition
Safe	Falls	<b>Percentage of residents who had a recent fall*</b>
	Pressure ulcers	<b>Percentage of residents who had a pressure ulcer that recently got worse*</b>
	Restraints	<b>Percentage of residents who were physically restrained*</b>
	Medication safety	Rate of residents aged 66 years or older prescribed a drug that should never be used among the elderly per 100,000
Appropriately Resourced	Health human resources	Number of injuries causing time away from work per 100 long-term care workers per year
Focused on Population Health	Infections	<b>Percentage of residents with one or more infections*</b>

# Long-term Care Performance Measurement: Quality Improvement and Transparency

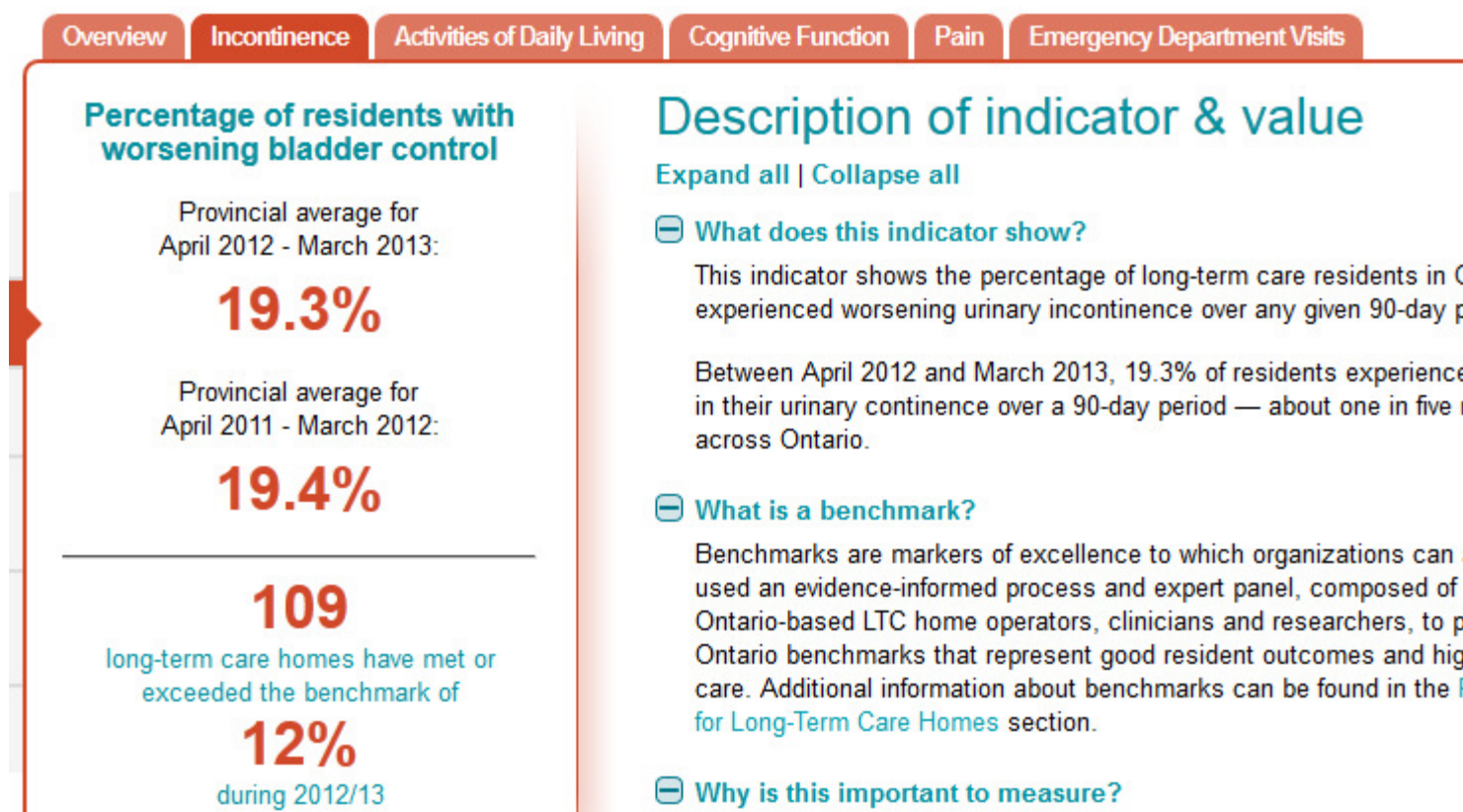


# LTC Public Reporting Website

- Current LTC website content:
  - LTC Public Reporting Website
    - Provincial results
    - Individual long-term care home results
    - Aspirational benchmarks established to represent good resident outcomes and high-quality care
- Updates to LTC website:
  - November 15<sup>th</sup> 2013 website refresh of all homes and provincial 2012/13 data
  - Aspirational benchmarks presented alongside of homes and provincial data
- 2014:
  - Work towards future quarterly reporting and development of new indicators

# LTC Public Reporting Provincial Website

- Features of LTC Reporting Website
  - Annual provincial results for 12 indicators (4 of which also have results at the home level)
  - <http://www.hqontario.ca/public-reporting/long-term-care>



# LTC Public Reporting Website: Home-level indicators

- Four indicators are reported at the home-level:
  - Falls
  - Incontinence
  - Pressure Ulcers
  - Restraints
- Indicator results are
  - CCRS New Generation Quality Indicators
  - Supplied to HQO by CIHI
  - Risk-adjusted
  - Currently reported annually (Q4)

## Indicator results for this home

YEAR	PERCENTAGE OF RESIDENTS WHO HAD A RECENT FALL	PERCENTAGE OF RESIDENTS WITH WORSENING BLADDER CONTROL	PERCENTAGE OF RESIDENTS WHO HAD A PRESSURE ULCER THAT RECENTLY GOT WORSE*	PERCENTAGE OF RESIDENTS WHO WERE PHYSICALLY RESTRAINED
2012-13	18.2 %	17.3 %	1.9 %	16.8 %
2011-12	18.4 %	23.3 %	1.6 %	13.9 %
Provincial Average 2012/13	13.6%	19.3%	2.9%	11.0%
Benchmark	9%	12%	1%	3%

### Legend :

N/A: This home was not publicly reporting during the given year.

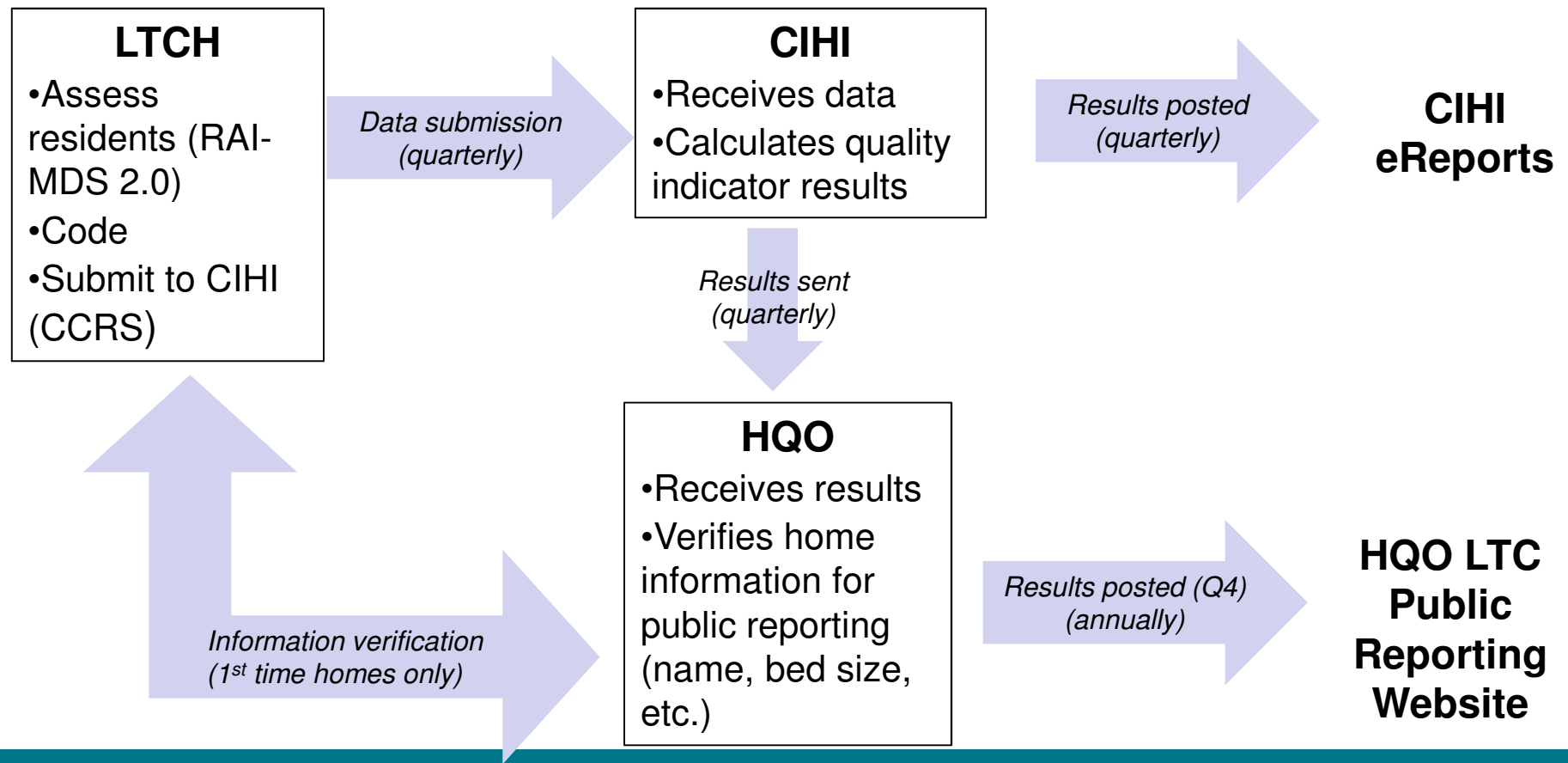
— : Indicator result is not publicly reported. Indicators can only be calculated and publicly reported if the denominator meets a certain size (minimum of 30 resident assessments). Small homes may not always meet this reporting criterion.

\*: Includes residents who developed a new pressure ulcer (stage 2 to 4) and residents whose pressure ulcer

# Restraint Indicator and HQO Public Reporting

- **What restraint indicator does HQO publically report?**
  - HQO uses RAI-MDS restraint indicator for public reporting

## LTC reporting cycle





# Learning Objectives

By the end of this session, we hope you will come away with a better understanding of the following:

- The daily physical restraint use indicator definition based on the RAI-MDS 2.0 and the legislative requirements on restraint use
- Restraint coding practices
- How the indicator is calculated by CIHI for the HQO's public reporting
- How your restraint indicator results can inform quality improvement initiatives

# RESTRAINT DEFINITIONS & CASE STUDY

Mary Nestor, Senior Manager, Compliance & Enforcement  
Performance Improvement and Compliance (MOHLTC)

Geri St. Louis, Clinical Specialist (CIHI)

John David Stanway, Team Lead, Home and Continuing Care, Data  
Management (CIHI)

# Long-Term Care Homes Quality Inspection Program (LQIP)

## Restraints ~ Legislative Requirements

Performance Improvement & Compliance Branch  
Ministry of Health and Long-Term Care



## Important Reference Documents

1. **Legislation:** *Long-Term Care Homes Act, 2007* and Regulation 79/10
2. “A Guide to the *Long-Term Care Homes Act, 2007* and Regulation 79/10”, June 2012, Pages 2-84 to 2-100 ⇒ available on: [www.ltchomes.net](http://www.ltchomes.net)
3. **LQIP Inspection Protocol:** Minimizing of Restraining
  - ✓ available on: [www.ltchomes.net](http://www.ltchomes.net) ⇒ Long-Term Care Homes Quality Inspection Program (LQIP) Compliance Transformed ⇒ LQIP Information ⇒ Inspection Protocols
4. **Slide deck:** “Minimizing of Restraining Provisions”, August 2010
  - ✓ joint presentation by Colleen Sonnenberg/MOHLTC and Jane Meadus/ACE
  - ✓ available on: [www.ltchomes.net](http://www.ltchomes.net) ⇒ LTCHA 2007 Implementation ⇒ Webinars and Webcasts ⇒ LTCHA Webcast Series ⇒ August 31<sup>st</sup>: The Fundamentals of the *Long-Term Care Homes Act, 2007*’s Minimizing of Restraining Provisions

# Legislative and Regulatory Requirements

## ***Long-Term Care Homes Act, 2007 (LTCHA) and Ontario Regulation 79/10:***

- Proclaimed into force July 1, 2010
- Single legislative authority for safeguarding residents' rights, improving the quality of care and the accountability of LTC homes for the care, treatment and well-being of LTCH residents.

### ***Requirements***

*[Reprinted from: "Minimizing of Restraining Provisions", August 2010, joint presentation by MOHLTC & ACE]*

- LTCHA: sections 29 to 36
- Regulation 79/10: sections 109 to 113
- Set out the requirements re:
  - ✓ minimizing of restraining of residents
  - ✓ when and how physical devices to restrain a resident are to be used in homes
  - ✓ when and how personal assistance services devices (PASDs) are to be used
- The requirements relating to the use of physical restraints to restrain a resident and PASDs address resident safety issues

# Legislative and Regulatory Requirements

## *Key considerations*

- A person is not considered to be restrained using a physical device if the resident is able to release it him/herself –the resident understands how to release the device and is physically able to do so
- The resident must be able to easily remove the device – if the resident must struggle or takes an extended period of time to remove the device, they are considered to be restrained with a physical device
- Other requirements specified in the regulations that support the minimizing of restraining include:
  - ✓ Requirements to develop strategies and interventions to deal with **responsive** and **other behaviours** may reduce or eliminate the need for restraining – ref. sections 53 and 55 of the Regulation.
  - ✓ An effective **falls prevention** and management program may help to reduce the need for restraining – ref. section 49 of the Regulation.

*Reprinted from: “Minimizing of Restraining Provisions”, August 2010, joint presentation by MOHLTC & ACE*

# Legislative and Regulatory Requirements

## *Additional Key considerations*

- Residents' Bill of Rights
- Mission Statement of LTCH
- Plan(s) of Care
  - ✓ **integrated interdisciplinary approach** to care planning and delivery with the involvement of the resident and if the resident is incapable, the resident's substitute decision-maker (SDM)
  - ✓ Completed **at admission**, when **reassessment** is required and at **regular intervals**
  - ✓ **care conference** with the resident and any SDM (if required) within 6 weeks after admission and annually afterwards to review and discuss the plan of care and matters of importance to the resident and any SDM

## **General Requirements for Programs**

- The following must be complied with:
  - ✓ **Written description** including goals and objectives, relevant policies, procedures, protocols and provides for methods to reduce risk and monitor outcomes
  - ✓ Use only **appropriate** equipment, supplies, devices, etc. based on resident's condition
  - ✓ **Evaluate** and **update** at least annually (written record)

## **Helpful Tools**

Inspection Protocol: Minimizing of Restraining  
Physical Restraints ~ Requirements at a glance



## Inspection Protocols *(reminder & refresh!)*

- Serve as inspection tools, utilized during all inspection types (RQI, Complaints, Critical Incident inspections, Follow-ups)
- Contain inspection instructions, guidance, probes and questions for inspectors to determine status of a LTC home's compliance with legislative requirements
- Responses to questions lead directly to a determination of compliance or non-compliance
- All questions within the IPs are:
  - ✓ directly linked to provisions in either the *Long-Term Care Homes Act, 2007* or Regulation 79, or both
  - ✓ the cross-walk between QCLIs (Quality of Care and Quality of Life Indicators) and the Act and Regulations
- 31 distinct documents

# Inspection Protocols

## *Uses by long-term care homes*

- To **enhance understanding** of:
  - ✓ the inspection process and methodology
  - ✓ legislative requirements
- Contribute to LTCHs' **quality management** activities:
  - ✓ carry out “mock” or practice inspections based upon IP content and other educational and inspection-related materials available on [ltchomes.net](http://ltchomes.net)
  - ✓ test own level of compliance
- Assist staff and residents to become **comfortable and familiar** with inspection process and topics being addressed by inspectors

# Inspection Protocol Summary (31)

Home-Related	Additional Home-Related	Resident-Related
<ol style="list-style-type: none"> <li>1. Admission Process</li> <li>2. Dining Observation</li> <li>3. Family Council Interview</li> <li>4. Infection Prevention and Control</li> <li>5. Medication</li> <li>6. Quality Improvement</li> <li>7. Resident Charges</li> <li>8. Residents' Council Interview</li> </ol>	<ol style="list-style-type: none"> <li>1. Accommodation Services: Housekeeping</li> <li>2. Accommodation Services: Laundry</li> <li>3. Accommodation Services: Maintenance</li> <li>4. Critical Incident Response</li> <li>5. Food Quality</li> <li>6. Hospitalization and Death</li> <li>7. Prevention of Abuse, Neglect, and Retaliation</li> <li>8. Reporting and Complaints</li> <li>9. Safe and Secure Home</li> <li>10. Snack Observation</li> <li>11. Sufficient Staffing</li> <li>12. Training and Orientation</li> <li>13. Trust Accounts</li> </ol>	<ol style="list-style-type: none"> <li>1. Continence Care and Bowel Management</li> <li>2. Dignity, Choice and Privacy</li> <li>3. Falls Prevention</li> <li>4. Minimizing of Restraining**</li> <li>5. Nutrition and Hydration</li> <li>6. Pain</li> <li>7. Personal Support Services</li> <li>8. Recreation and Social Activities</li> <li>9. Responsive Behaviours</li> <li>10. Skin and Wound Care</li> </ol>

\*\* summarizes legislative requirements; inspection & CQI tool

## Physical Restraints ~ Requirements at a glance

	Restraint by physical device	PASD	Common law duty
<b>Who can order or approve?</b>	MD, RN (EC)	MD, RN, RPN, OT, PT	
<b>Consent</b>	Prior to application	Prior to application	Following use, explain the reason to resident/ SDM
<b>Application</b>	Staff under instruction of MD, RN (EC)	Staff as outlined in plan of care	Immediate action to prevent serious bodily harm to the person or others
<b>Reassessment</b>	At a minimum q8hr by MD, RN (EC) or RN/RPN	At a minimum q6mos by interdisciplinary team	At a minimum q15min by MD, RN (EC) or RN/RPN
<b>Monitoring</b>	At a minimum q1hr by RN/RPN or authorized staff	As outlined in plan of care	ongoing
<b>Release / repositioning</b>	Minimum q2hr for repositioning	Minimum q2hrs if dependent on staff for repositioning	As necessary based on resident's condition or circumstances
<b>Removal</b>	As soon as no longer necessary	As soon as no longer required for activity of living	As soon as no longer necessary

Reprinted from: "Minimizing of Restraining Provisions", August 2010, joint presentation by MOHLTC & ACE

## RAI-MDS 2.0 – Section P4 (Devices and Restraints)



### Definition:

Any manual method, or any physical or mechanical device, material, or equipment that is attached or adjacent to the resident's body, that the resident cannot remove easily, **and** that restricts the resident's freedom of movement or normal access to his/her body.



## RAI-MDS 2.0 – Section P4 (Devices and Restraints)



### Coding:

If the resident has no voluntary movement, specifically is comatose or quadriplegic, code P4c (Trunk Restraint), P4d (Limb Restraint) and P4e (Chair Prevents Rising) “0” (Not Used).

If the resident does not have the physical or cognitive capacity to rise from ANY chair, code P4e (Chair Prevents Rising) “0” (Not Used).



# RAI-MDS 2.0 – Section P4 (Devices and Restraints)



- It is the effect the device has on the person – not the name nor purpose of the device
- Some Personal Assistive Safety Devices **may** meet the definition of a restraint
- Observation period is the last seven days – day and night
- P4c (Trunk Restraint), P4d (Limb Restraint) and P4e (Chair Prevents Rising) **only** are used in the calculation of the quality indicators

# Case Study

Mrs. Smith resides in a long term care home. She requires the physical assistance of one staff member with some of her ADL functions and has mild cognitive impairment. She is able to locomote in the home by self-propelling her wheelchair. She will sometimes require the physical assistance of one staff to push her wheelchair if she becomes fatigued. Mrs. Smith has had a pressure related wound on her coccyx in the past and as a preventative measure she is tilted in her wheelchair four times each day for one hour each time. She is unable to reposition herself to an upright position once tilted. Mrs. Smith has no problem rising from a non-restricting upright chair.



# MOHLTC comments re Case Study

## *Scenario: physical restraint*

- Resident unable to reposition or propel herself independently once the chair is tilted  
⇒ becomes 2 physical restraint at this point
- Mild cognitive impairment & may not be able to request assistance, etc.

## *Key considerations:*

- **Physical device** – restrain or assist a resident with ADL ⇒ depends upon purpose device is used at that point in time **\*\* important concept**
- Not restraining by physical device if resident able to release (understands & able)
- The fact that PASDs limit/inhibit body movement (LTCHA s. 33) may make it potentially dangerous unless precautions are taken
- **PASD** that limit/inhibit freedom of movement must be removed as soon as it is no longer required to support ADL (if not, considered a restraint)
- **Reminder!** Prohibited devices – (O. Reg. s. 112, e.g. roller bars on Wheelchairs, jacket restraints, any device with locks release by a separate device etc.)



## How to Complete P4 (Devices and Restraints) for Mrs. Smith

P4a to P4d would be coded **'0' (Not Used)**

P4e (Chair Prevents Rising) would be coded **'2' (Used Daily)**

- Mrs. Smith is neither comatose nor quadriplegic. She can rise from an upright chair
- She is placed in a chair in a recumbent position daily and she is unable to rise from that chair





# What is a Quality Indicator?

It is always the percent of assessments that show a specific issue

But...

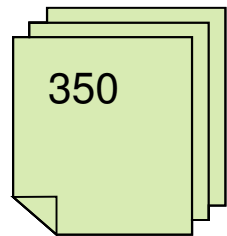
- We don't count admission assessments.
- Sometimes we exclude other assessments, too, if it makes no sense to include them. e.g. for the restraints indicator, assessments marked as comatose or quadriplegic aren't counted.
- We use the assessments from four quarters. The reason is that some of the things we use for calculations don't occur very often (weight loss or feeding tubes), so smaller facilities won't have enough information for a meaningful result.

# How is the restraints QI calculated?

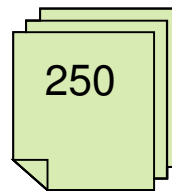
Consider a fictional facility where we're calculating the restraints QI

First, get the assessments from the most recent quarter and the previous three: One year's worth.

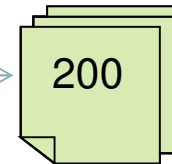
350 assessments over the course of a year.



100 admission assessments; throw them out.



50 comatose (B1) or quadriplegic (I1bb); throw them out.



Of those left, 50 assessments coded 2 (daily) on at least one of

- P4c Trunk Restraint
- P4d Limb Restraint
- P4e Chair Prevents Rising

$$QI = \frac{50}{200} = 0.25 = 25\%$$

# Risk Adjustment



- 3,000 facilities in the U.S. and Canada were combined into one big population, the “standard reference population”.
- When your QI is risk-adjusted, the question being asked is, “Sure your QI is 25% for *your* residents, but what *would* it have been if your residents had been more like the ‘standard reference population’?”.
- This can get complicated, but the restraints QI is the simplest one. Your population is matched to the reference population in only one way: The ADL long form scale.

ADL score range	What percent of the standard reference population is in this range?*	Suppose your facility has 50 assessments and they’re distributed this way	Do you have more or less than the reference population in that ADL range?
0 to 9	25%	5	You have less than 25%
10 to 23	50%	25	You have 50%
24 to 28	25%	20	You have more than 25%

So even though you only have 5 people in this **group**, it’s going to count for 25%. So each of these people is going to be weighted more than people **here**.

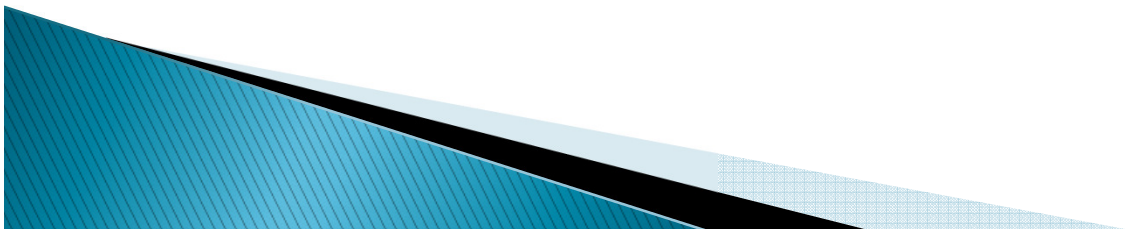
\*Actually, the numbers are slightly different, but this will get you close enough.

# Geraldton District Hospital John Owen Evans Residence

- ▶ Rural Hospital
- ▶ Bed size 19 LTC beds
- ▶ 9 residents require moderate help with care
- ▶ 4 residents require maximum help with care
- ▶ 6 residents are dependent on staff for all physical activity and care
- ▶ 3/19 residents require this help due to physical decline however are doing well cognitively
- ▶ 16/19 of these residents have a diagnosis of dementia

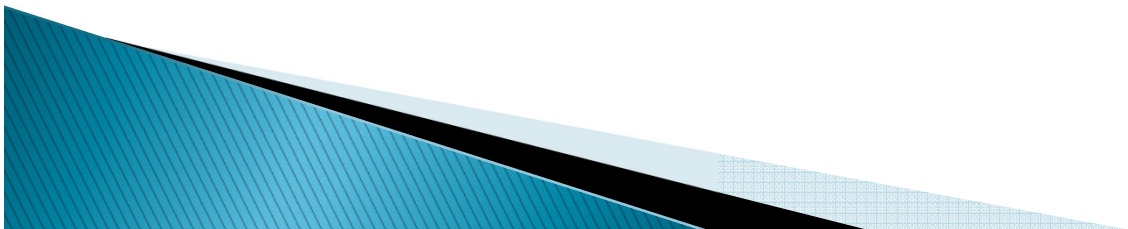
# Challenges in reconciling the differences between the LTC ACT and RAI-MDS restraint definitions

- ▶ The use of positioning devices has been a challenge for e.g.: Wheel chair seat belts to prevent one from slipping downward. Unless the resident can successfully undo this device, it is considered a restraint
- ▶ Understanding the LCTHA minimal restraint definition
- ▶ Compliance officer's understanding of LTC ACT and the minimal restraint use vs. no restraint use.



## Highlight quality improvement initiatives that continue to be in place to reduce restraint rates

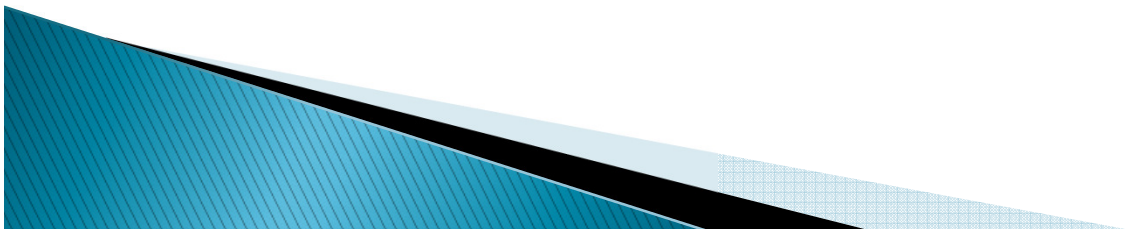
- Ongoing education on fall prevention strategies and equipment to support and improve monitoring of residents who are at high risk of falling
- Transparent non repetitive documentation
- Transparent communication among staff , interdisciplinary team and family members
- Solving one problem at a time





## Highlight supports, resources, and resident/ family participation

- ▶ Geriatric behavior specialist from Thunder Bay, as well workshops on how to manage residents with dementia
- ▶ During family meetings, education was provided on the movement toward minimizing of restraint use
- ▶ Video material available on minimizing restraint use for staff and families

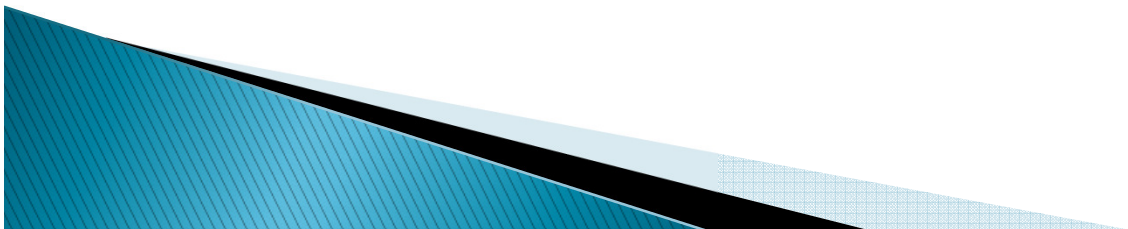


# Challenges faced in the home during the progress of the initiative

- ▶ Determining what is not considered a restraint (some of our residents prefer to have their bed against the wall, which is considered a restraint (RAI), as well wheelchair equipment as positioning belt or just safety belt, some residents want to have all bed rails up)
- ▶ Residents having poor insight and understanding due to decreased cognitive level. Inability to safely ambulate and transfer
- ▶ Determining how we would monitor the residents and which interventions to implement;
- ▶ deciding at which point the interventions used are ineffective and resort to using a restraint.
- ▶ Regarding RAI, the definition of restraining a resident includes having a bed against the wall; regardless if this is a residents wish.
- ▶ Organizing the increased paper work, education to staff for buy in of strategies to be applied.

## Challenges faced in the home during the progress of the initiative

- ▶ Findings: Increased falls however a decrease in the severity of injury; family resistance due to restraint removal; staff buy-in due to fear of increase in injuries to residents



# Reducing Restraints in Long Term Care

## Bendale Acres Long Term Care Home

Doreen Grant, Director of Nursing

Wei Wang, RAI Lead

# Bendale Acres Demographics

- 302-bed Home with 2 beds for respite care
- 17-bed secure unit for management of exit seeking behaviour of Alzheimer's dementia
- 15-bed secure unit for residents with aggressive responsive behaviours
- Behaviour Support Team
- Age ranges from 27 to 100+
- 37-bed French language service unit

# Restraining devices differences

## In RAI-MDS

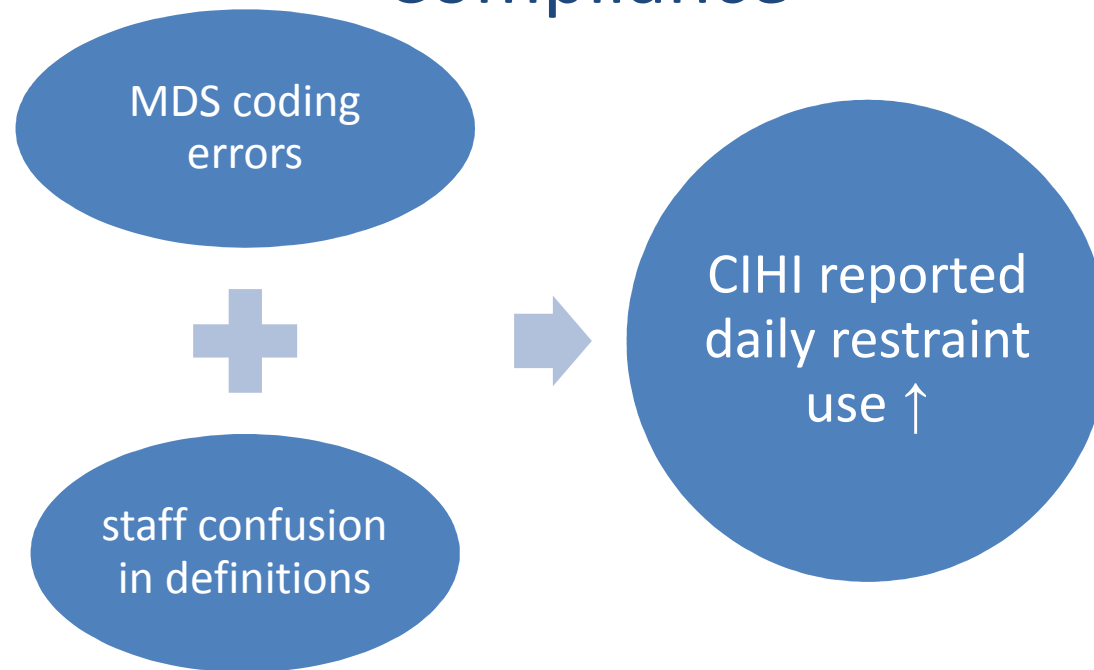
- Trunk restraint: vest or waist restraint
- Limb restraint: restricts movement of any part of an upper extremity; such as hand, or leg
- **Chair prevents rising:** locked lap board or chair that restricts resident from rising; such as bean bag chair

## Compliances

- **Full bed-rails**
- Roller bars
- Vest and jacket restraints
- Any device with locks that can only be released by a separate device, such as a key or magnet.
- Four point extremity restraints
- strips or bandages

# Challenges in practice

Due to differences between RAI-MDS and  
Compliance



# BA Quality improvement initiatives

Diagnose root cause for high rate of restraint

- Staff lack of knowledge on MDS coding in P4
- Families and residents lack of knowledge on restraint devices and use



# BA Quality improvement initiatives

Develop a plan focusing on the key issues

- Educate staff
- Identify behaviours that can be mitigated through other interventions
- Prevent falls
- BSO team works with residents who used tilted chair to control behaviour and to prevent falls
- Provide health teaching/information to family members/residents

# BA Quality improvement initiatives

To reduce restraint rate:

- Measures: RAI assessment coding in P4 and # of full bed-rails use in BA
- Aim/target: safe environment with least restraint
- Time frame: approximate one year

# BA restraints stats on CIHI report

Metrics: Adjusted Rate, Sector:

C. Quality Indicators (QI)

Residential

Facility	Indicator Category	Indicator	Fiscal Quarter	2011 Q2	2011 Q3	2011 Q4	2012 Q1	2012 Q2	2012 Q3	2012 Q4	2013 Q1
City of Toronto - Bendale Acres											
	Safety										
		Daily physical restraints		5.9%	2.4%	1.9%	0.8%	0.7%	1.0%	1.1%	1.1%

# BA Quality improvement initiatives

## Resident and family engagement in the initiatives

- Education material: Restraint Release pamphlet
- Annual review on restraint policy at Resident Council and Family Council

# BA Quality improvement initiatives

## Staff and management engagement in the initiatives

- Comprehensive assessment at admission for need on restraint
- Risk-benefit assessment when restraint is considered

# BA Quality improvement initiatives

## Resources and external support in BA

- Physiotherapy: seating assessment
- Occupational therapy: PASD use
- Hi-Lo bed instead of bed rails: fall prevention
- Body pillow and gym mat

# Challenges to QI initiatives

- Bed rails use: alert residents consider it as a safety device when in bed
- Question from family: prevalent use of bed rail in hospitals
- MDS coding error on restraint: in-service for nursing staff
- Definition confusion regarding Compliance

# What are the next steps?

- Maintain low percentage of restraint use in BA
- Audit on quality indicator quarterly
- Ongoing teaching session on restraint definition and MDS coding
- Continue to provide information to new admissions and families r/t bed rail use
- Ongoing assessments on residents who need restraints to ensure safety and appropriateness



# Our suggestions to you

- The strategies BA used to improve coding accuracy
- Home specific interventions to decrease number of falls and dementia-related behaviours
- Efficient alternatives to physical restraint BA has applied

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# Key Messages

- The publicly reported daily physical restraint use indicator is based on RAI-MDS assessments. The indicator includes the daily use of limb restraints, trunk restraints and chairs that prevent rising
- The legislative requirements of physical restraints are similar, but not identical to the definitions as per the RAI-MDS. Therefore, it may be appropriate to code restraint use differently for RAI-MDS and compliance depending on the situation
- Accurate coding of RAI-MDS assessment and a good understanding physical restraint indicator and benchmarks can contribute to restraint use reduction quality improvement initiatives
- Homes are encouraged to contact peers for support in quality improvement initiatives

# Acknowledgements

HQO would like to acknowledge the time and contribution of the LTC Restraint Webinar Working Group and today's presenters and panelists.

- **Presenters**

- Michelle Rey, Health Quality Ontario
- Mary Nestor, Ministry of Health and Long Term Care
- Geri St. Louis, Canadian Institute for Health Information
- John David Stanway, Canadian Institute for Health Information
- Niko Gregorin, Geraldton District Hospital – John Owen Evans Residents
- Cathleen Larsen, Geraldton District Hospital – John Owen Evans Residents
- Doreen Grant, Bendale Acres Long-Term Care Home
- Wei Wang, Bendale Acres Long-Term Care Home

- **Panelists**

- Gayle Stuart, Health Quality Ontario
- Sabrina Rooplall-Noseworthy, Specialty Care Inc.
- Carol Holmes, Registered Nurses' Association of Ontario

# Membership of LTC Restraint Webinar Working Group

- Michelle Rey, Health Quality Ontario
- Gayle Stuart, Health Quality Ontario
- Mary Nestor, Ministry of Health and Long Term Care
- Karen Simpson, Ministry of Health and Long Term Care
- Geri St. Louis, Canadian Institute for Health Information
- John David Stanway, Canadian Institute for Health Information
- Sabrina Rooplall-Noseworthy, Specialty Care Inc.
- Carol Holmes, Registered Nurses' Association of Ontario

# Please submit questions online using GoToWebinar Message Box



- Presenters and panelists encourage participants to ask questions that are applicable to the greater audience.
- Questions that has privacy concerns (Eg. Resident information) and specific cases may not be addressed by our presenters. HQO will follow-up offline to respond to any of these questions in the next couple of weeks.

# Additional Resources

If you have specific questions that were not addressed at the webinar session, we encourage you to contact the respective organizations listed below for clarification.

Canadian Institute for Health Information:

[CCRS@cihi.ca](mailto:CCRS@cihi.ca)

Ministry of Health and Long-Term Care:

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LTC team in Health Quality Ontario:

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# Thank you

Please give us your feedback for today's webinar at the following link:

<https://www.surveymonkey.com/s/3S89TYJ>



[www.hqontario.ca](http://www.hqontario.ca)