# *Meditech Updates*
# *September Updates*
# *Monday, Sept. 24, 2018*

- **EBCD 2018.3 Restraints End User Education**

# Overview

**The EBCD restraint documentation provides a streamlined linear documentation pathway with content and logic that aligns with the corporate policy. This enhancement impacts:**

- Nursing (including Behavioral Health)
- Emergency Room
- OR/PACU setting

**Skip-logic programming guides the user through the proper documentation pathway for violent and non-violent type episodes.**

***The restraint documentation from the old version will not flow to the new version. Therefore, the episode of restraints will need to be ended in the old version and then entered in the new 2018.3 version.***

# Content aligns with the corporate *Patient Restraints Policy*:

**The corporate *Patient Restraints Policy* can be found on the CSG Quality Standards Atlas site.**

**Link:** http://connect.medcity.net/web/clinical-services/clinical-policies

**Corporate patient restraint policy scope:** ***This policy/procedure applies to healthcare professionals operating within HCA facilities that have responsibility for ordering, assessing, care planning, restraining, or monitoring the restrained patient. This policy is applicable to all age groups of patients, including neonates.***


**Patient Restraint Policy CSG.001**

**Patient Restraint Policy**

- CSG.001 Patient Restraint Policy Updated November 30, 2017
- CSG.001 Patient Restraint Policy Updated November 30, 2017 - redline

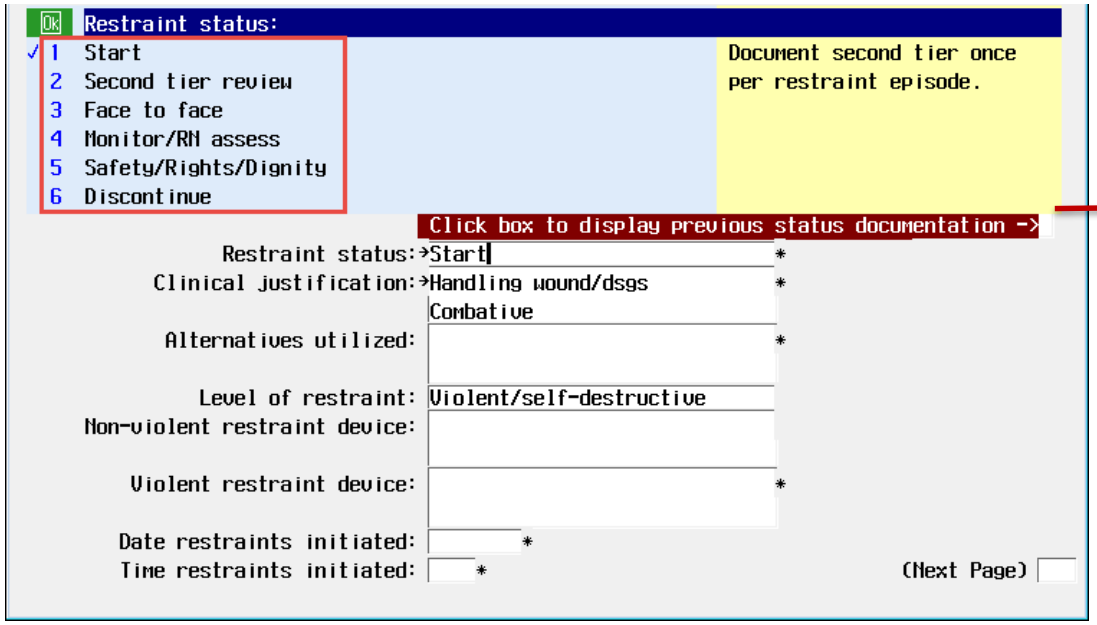
**Restraint Death Reporting**

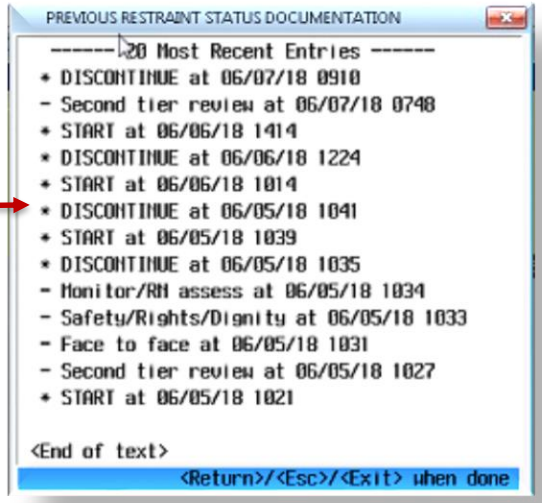
- Corrective Action
- Model CMS Letter
- Report of Hospital Death Associated with Restraint and Seclusion CMS Worksheet
- Retrospective Reporting Restraint Deaths to CMS

- Restraint Formulary - Approved Devices April 2018
- Competency Form Direct Care Staff
- Competency Form for Non-Violent Behavior
- Competency Form for Violent Behavior
- Physician Order for Non-Violent/Non-Self Destructive Restraint
- Physician Order for Violent/Self Destructive Restraint

# Enhancement: Primary Nursing Restraint screen

**Streamlined documentation workflow – mirrors L/D/A flow without utilizing an instance functionality.**
**Logic will guide the correct documentation workflow for both a violent type and non-violent type pathway.**
***Click box* will display previously documented elements.**



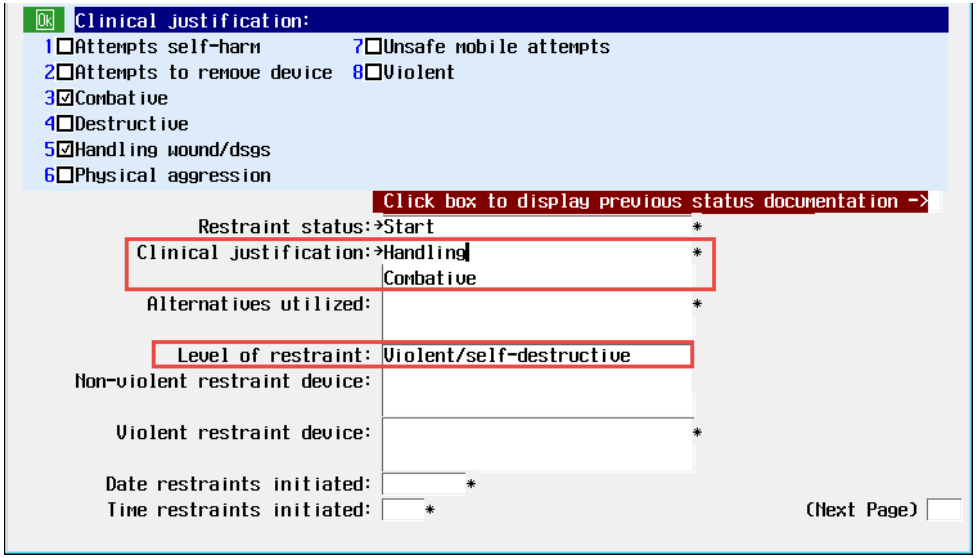
# Enhancement: Clinical justification and restraint device options

***POLICY: 6. Application of Restraints (a) Restraints are applied by staff with demonstrated competence in restraint application. (d) The restraint type for violent or self-destructive behavior shall be non-locking synthetic, quick release (Velcro or buckle), and with the product ability to be cleaned with antimicrobial cleaning product between uses. No synthetic leather, locking or hard restraint such as handcuffs will be permitted for use in the application of restraints for violent or self-destructive behaviors. Additional non-approved restraint devices include spit sock hoods, vest restraints and full body net restraint devices.***

**Clinical justification – the nurse will select the behavior as opposed to the clinical restraint type, then the programming logic will classify the level of restraint (violent or non-violent type).**

**If the user selects both a violent and non-violent clinical justification type, the programming logic will classify the level of restraints as a violent type.**

**The restraint device options will vary depending on the restraint type, and based upon your facility's settings.**

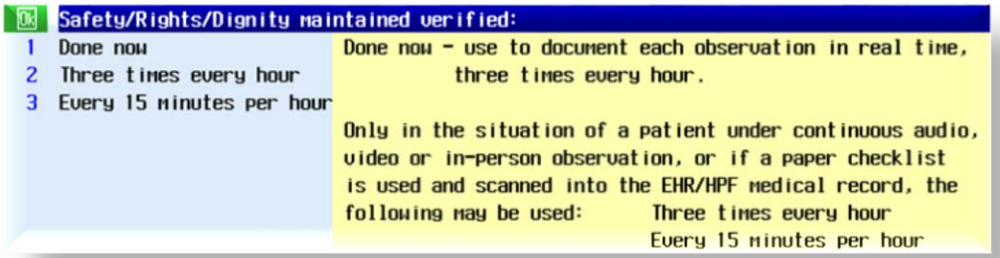


# Enhancement: Safety/Rights/Dignity

***POLICY: 7. (d) A trained staff member monitors each patient in restraint or seclusion at least three (3) times an hour for safety, and to confirm that the patient's rights and dignity are maintained. This check will be documented in either electronic record or on paper. If a paper checklist is used as a summary, recording time and observation from each of the three (3) times an hour check, may be recorded at the end of the shift and the checklist scanned into the EHR/HPF patient record. (e) For patients under continuous audio, video or in-person observation (e.g., ICU), care is rendered in real time, but documentation that safety, rights, and dignity were maintained for the defined period of time may be entered at end of the shift. (f) Monitoring is based on the individual needs of the patient. Variables of the patient's condition, cognitive status, and risks associated with the chosen intervention may require more frequent evaluations.***

**Safety/Rights/Dignity – clarification of documentation requirements**

- Done now: Use only for real time documentation at a frequency defined by the corporate restraint policy and/or state requirements.
- Three times every hour: Frequency aligns with the corporate patient restraint policy. Document during the shift only in the situation of a patient under continuous audio, video or in-person observation, or if a paper checklist is used and scanned into the EHR/HPF medical record .
- Every 15 minutes per hour: Frequency is greater than the corporate policy, and is required in certain states. Document during the shift only in the situation of a patient under continuous audio, video or in-person observation, or if a paper checklist is used and scanned into the EHR/HPF medical record .

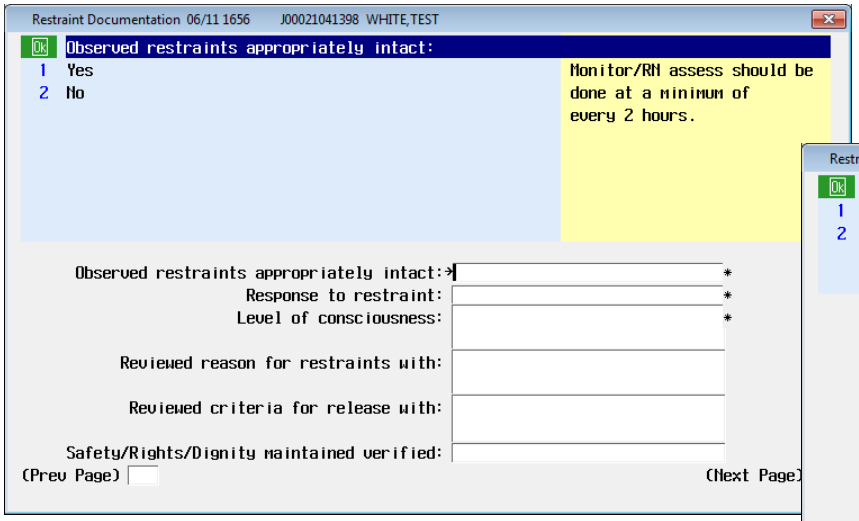


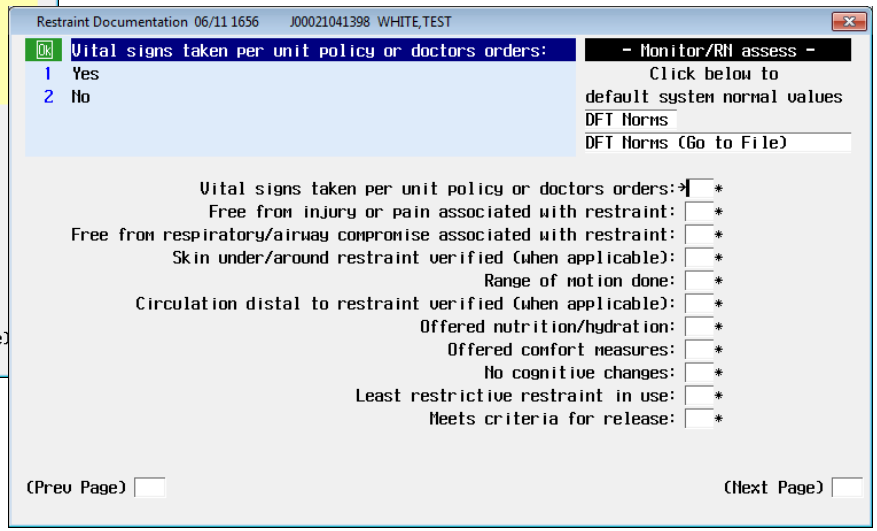
# Enhancements: Monitor/Assess

***POLICY: 7. (a) Patients are assessed by an RN immediately after restraints or seclusion are initiated to assure safe application/initiation of the restraint or seclusion. (b) An RN will assess the patient at least every two (2) hours.***

**Elements related to monitor/assess are now incorporated into the Start documentation through skip logic as well as the Monitor/RN assess documentation pathway.**

**The second page of the monitor/assess elements are captured through a default norm functionality which will flow to HPF.**



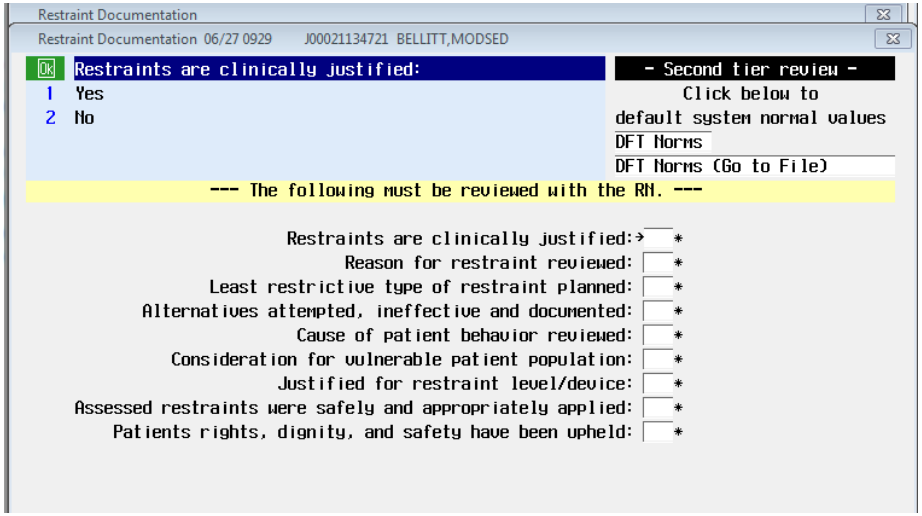
# Enhancements: Second-tier

***POLICY: 4. Second Tier of Review[2] A member of nursing administration/management (e.g., nursing supervisor/manager, charge nurse, manager/director, CNO, etc.) will review the need for restraint or seclusion with the RN who has determined that the patient requires restraint or seclusion. The second tier of review will occur with the initial application of restraint or seclusion. Renewals of restraint or seclusion orders do not require a second tier of review. Note: In an emergency application of the restraint or seclusion, the above review will be done immediately after the application of restraint.***

**Logic to prevent a user that documented the restraint application from also documenting the second-tier review.**

**Second tier elements are now captured through a default norm functionality which will flow to HPF.**

***Corporate team has developed the ability to define approved second-tier reviewers in the MADGEN parameters.**



# Enhancements: Face-to-Face

***POLICY: 9. Face-to-face assessment by a Physician or LIP: (a) A face-to-face assessment by a physician or LIP, RN or physician assistant with demonstrated competence, must be done within one (1) hour of restraint or seclusion initiation or administration of medication to manage violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others. At the time of the face-to-face assessment, the LIP/physician/RN/PA will:[8]***

- *Work with staff and patient to identify ways to help the patient regain control*
- *Evaluate the patient's immediate situation*
- *Evaluate the patient's reaction to the intervention*
- *Evaluate the patient's medical and behavioral condition*
- *Evaluate the need to continue or terminate the restraint or seclusion*
- *Revise the plan of care, treatment and services as needed*

***Note: A telephone call or telemedicine methodology does not constitute face-to-face assessment.***

***(b) When the one (1)-hour face-to-face is performed by a RN or physician assistant with demonstrated competence, the following must occur: The RN or physician assistant with demonstrated competence must consult the attending physician or LIP who is responsible for the care of the patient as soon as possible after the completion of the one (1)-hour face-to-face evaluation. ("As soon as possible" is to be as soon as the attending physician is able to be reached by phone or in-person.) A consultation that is not conducted prior to renewal of the order would not be consistent with the requirement "as soon as possible."[9]***

# Enhancements: Face-to-Face

**Face-to-face review only needs to be completed once per violent type restraint episode.**

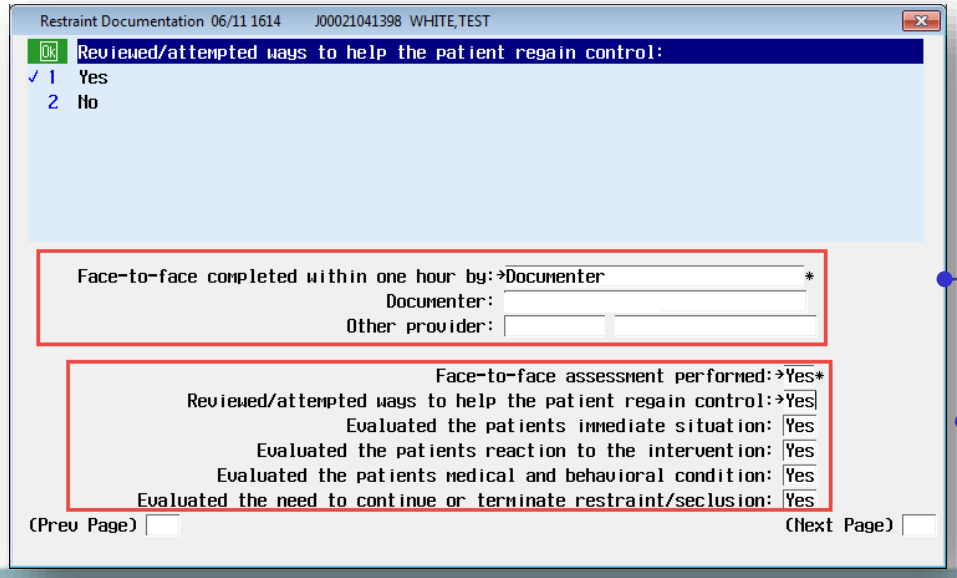
**Face-to-face documentation needs to be documented within one hour of restraint initiation.**

**In the event a patient quickly recovers prior to a provider completing a face-to-face within an hour of initiation:**

***POLICY: 9(b)(3) *If a patient who is restrained or secluded for aggressiveness or violence quickly recovers and is released before the physician arrives to perform the face-to-face assessment, the physician must still see the patient face-to-face to perform the assessment within 24 hours after the initiation of restraint or seclusion.***

**If another provider has completed the face-to-face in the PDoc note the RN may view the note in Clinical Review.**

**Face-to-Face elements can be captured if completed by an RN with demonstrated competency, and will flow to HPF (only required for violent type episode).**

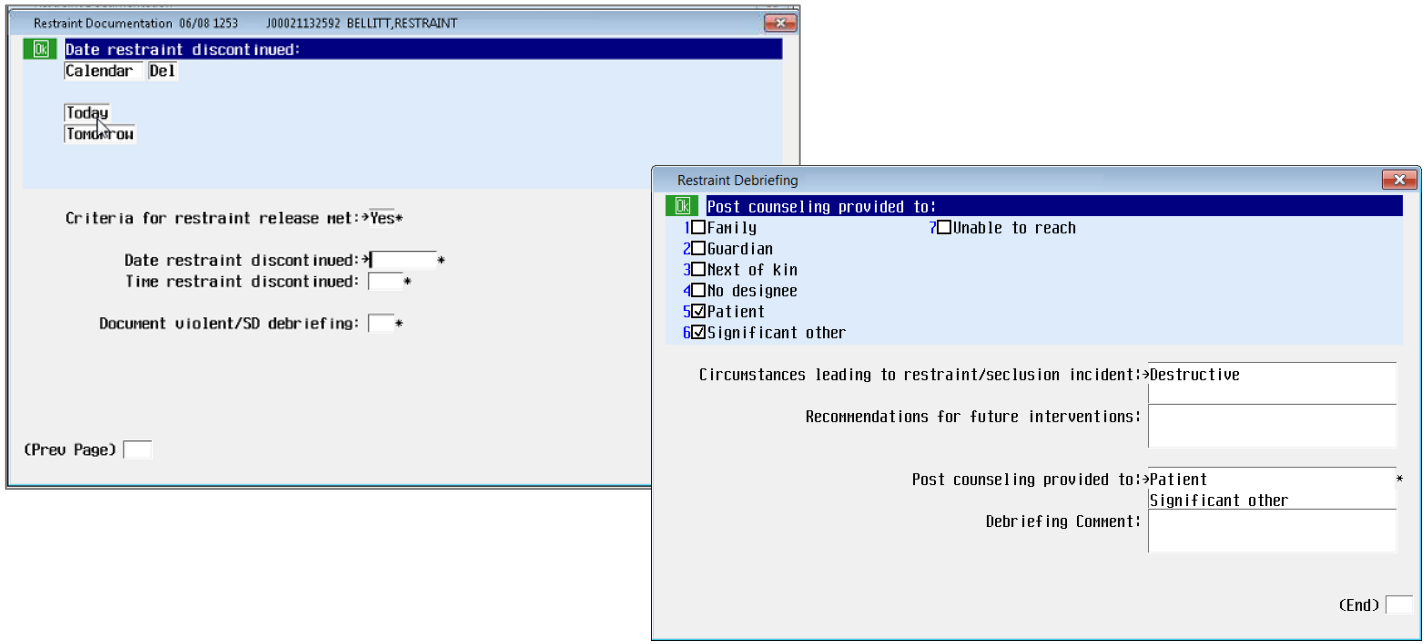



- Captures if the documenter or another provider completed the face-to-face.
- Face-to-face elements are required when a nurse is completing the face-to-face.

# Enhancements: Discontinue and Debriefing

***Policy: 11. Discontinuation of Restraint or Seclusion: (a) The patient in restraint or seclusion is evaluated frequently and the intervention is ended at the earliest possible time. The time-limited order does not require that the application be continued for the entire period. (b) When an RN determines that the patient meets the criteria for release in the restraint order, restraints or seclusion are discontinued by staff with demonstrated competence. (c) Once restraints or seclusion are discontinued, a new order for restraint or seclusion is required to reapply or reinitiate. (d) A temporary release that occurs during patient care, e.g. toileting, feeding or range or motion, is not considered a discontinuation of restraint or seclusion.***

**Debriefing is to occur upon discontinuation of a violent type restraint episode.**

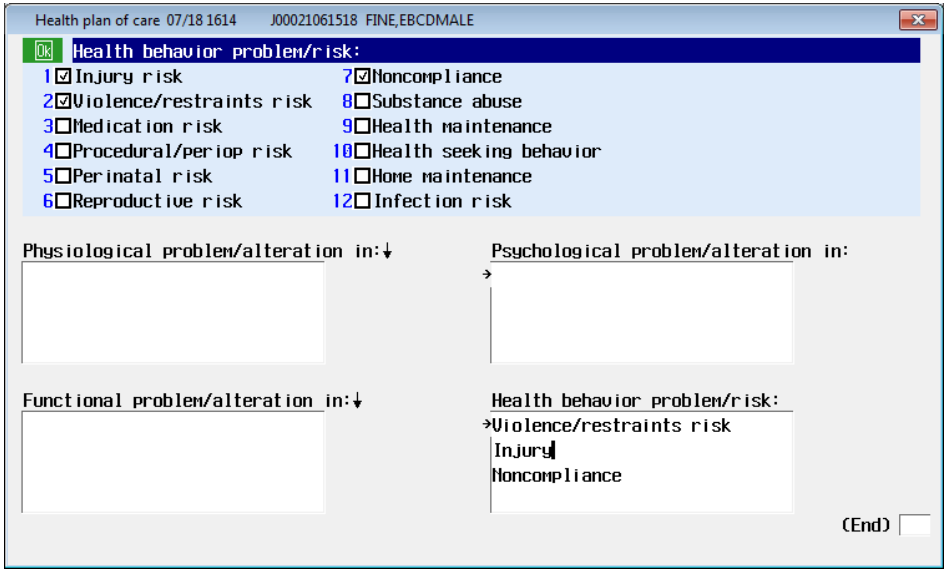


# Plan of Care

***POLICY: Care of the Patient/Plan of Care:[10] (a) The plan of care will clearly reflect a loop of assessment, intervention, and evaluation for restraint, seclusion and medications. (b) Patients and/or families should be involved in care planning to the extent possible and made aware of changes to the plan of care.***

**Examples of documentation locations (in addition to the *Plan of Care* intervention) that demonstrate the loop of assessment, intervention and evaluation:**

- System Assessment – May be a focused or general assessment
- Teach/Educate – Provided to patient and family/others
- Manage/Refer/Contact/Notify – Notification to family, provider, etc.
- Routine Daily Care - Activity, hygiene, etc.
- I/O – Fluid intake and output
- RASS/CAM (Critical Care)
- eMAR
- Pain Assessment
- Suicide/Homicide Assessment
- Broset Violence Checklist
- VS (including LOC)
- Language Assist



# Restraint NPR Reports

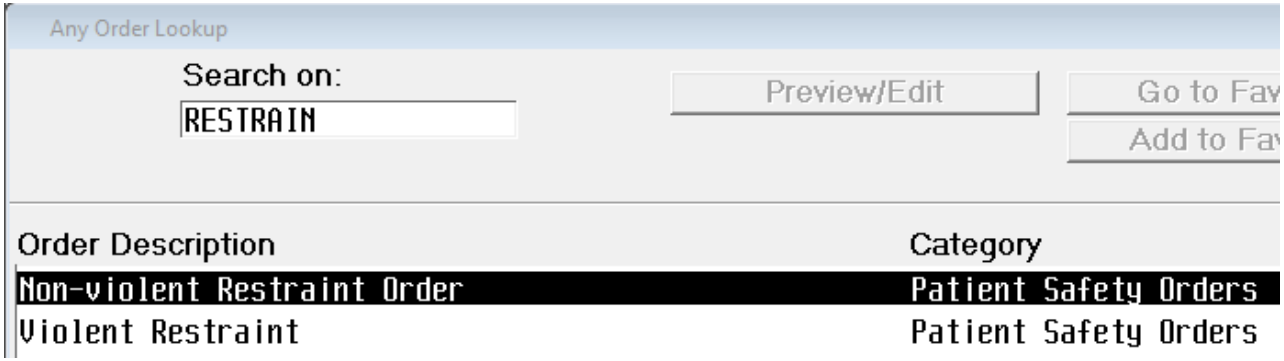
**There are 3 restraint NPR reports available. The functionality and names have not changed from their previous version; they have just been updated with the new queries from the new documentation screens.**

- Restraint Summary Report
- Restraint Summary with Order Audit (This report is available in two versions depending on whether your facility uses the MEDITECH EDM module)

**The reports are designed for use with the current version of the screens and are backward compatible for previous queries.**

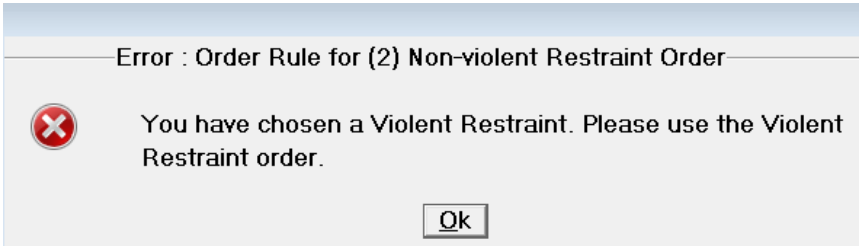
# Enhancements: Restraints Order

## From OM choose either Non-Violent or Violent order




***Must select appropriate clinical justification (documented inside the order) to match type of restraint order selected in OM; violent justifications must be selected for a Violent Restraint order and non-violent justifications must be selected for a Non-Violent Restraint order.**

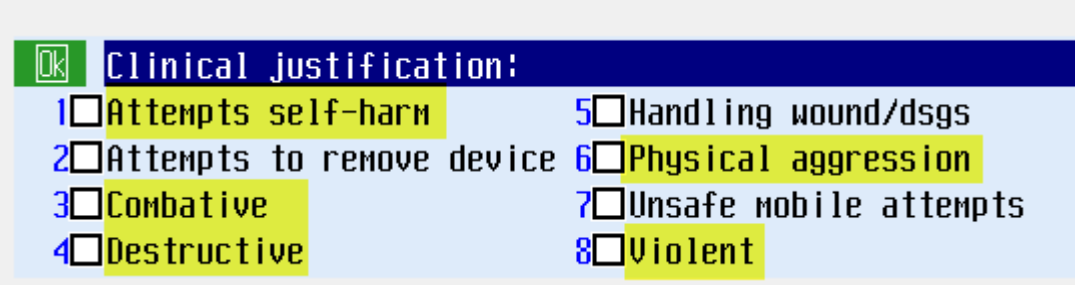
***An error will prevent the order from being filed if incorrect justification is chosen for the type of restraint order selected.**



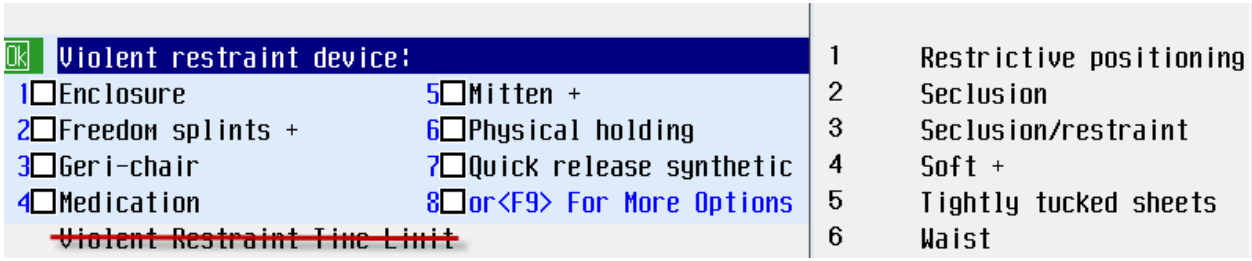
# Enhancements: Restraints Order

The restraint device type (violent or non-violent) is determined by which clinical justification/s are selected when ordering

**VIOLENT** clinical justifications (highlighted)

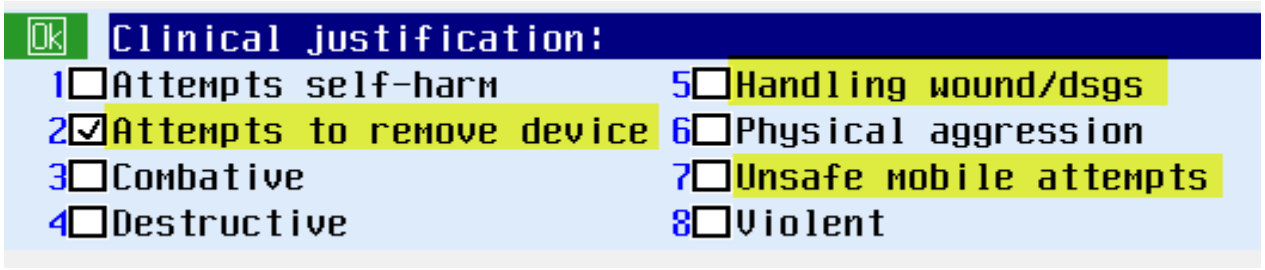



**VIOLENT** restraint devices (*options allowed may differ by facility)

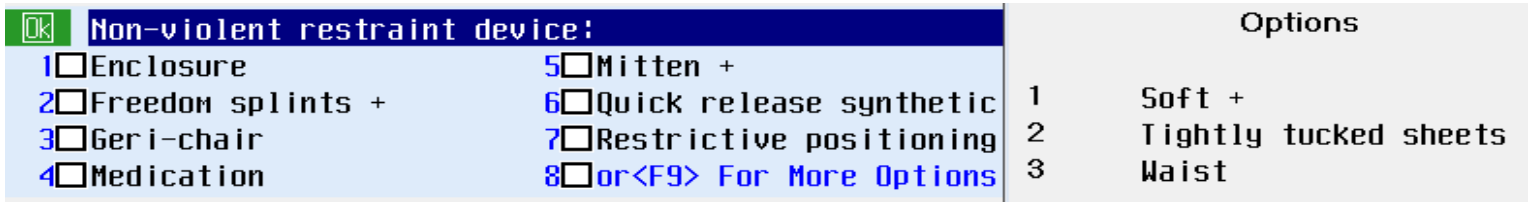


# Enhancements: Restraints Order

**NON-VIOLENT** clinical justifications (highlighted)




**NON-VIOLENT** restraint devices (*options allowed may differ by facility)



# Enhancements: Restraints Order

**The restraint order queries no longer include defaults/shared information from the nursing assessment.**

- However the same information from the previous restraints order screen defaults into the nursing assessment.

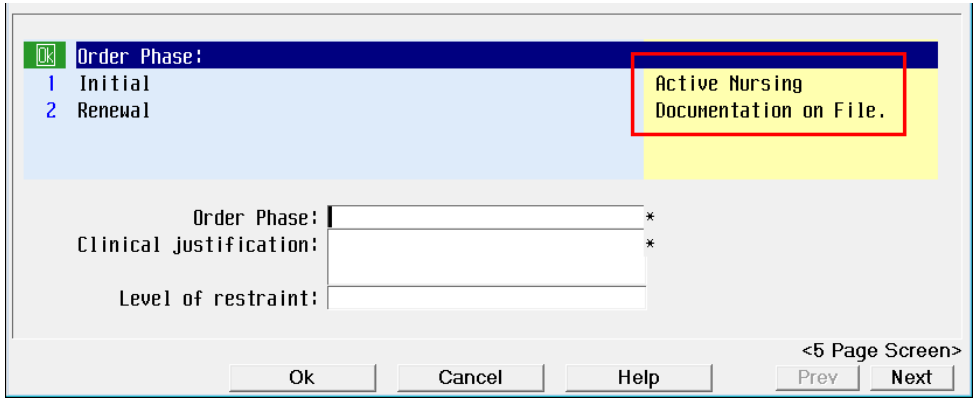
**Users can review the applicable nursing documentation in the yellow info box when applicable.**

**When end users access the restraints order screen, they will notice in the yellow reminder box if there is an active nursing assessment on the patient's account.**

- An "Active" assessment would include any assessment on the patient account that is NOT in a "Discontinue" status.

**If a patient has active nursing assessment documentation on their account, the yellow reminder reads "Active Nursing Documentation on File" when the cursor is on the "Order Phase" query.**

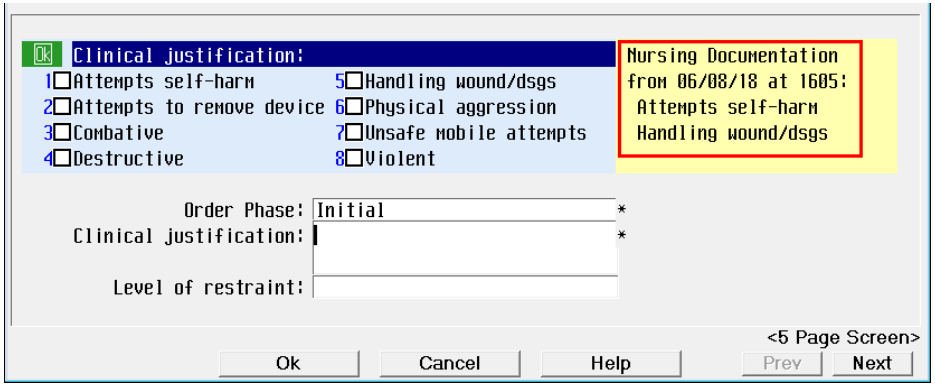
- If no active nursing documentation exist on the patient account, the yellow reminder would read "No Active Nursing Documentation on File".



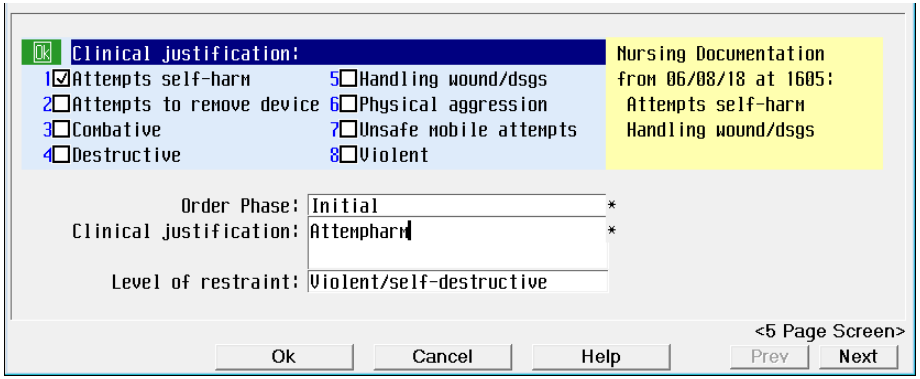
# Enhancements: Restraints Order

**If there is active nursing documentation on the patient's account, when the user selects the "Clinical justification" query, the yellow reminder box informs the user the clinical justifications entered on the nursing assessment.**

- The end user can decide whether or not to use the documentation when placing the order.



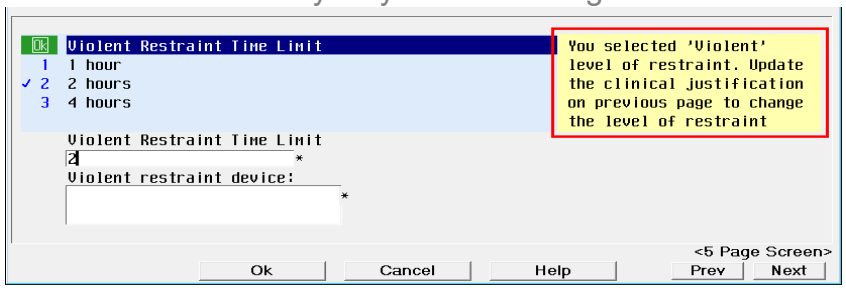

**After the user selects the "Clinical justification" the "Level of restraint" query populates with either "Violent" or "Non Violent".**



# Enhancements: Restraints Order

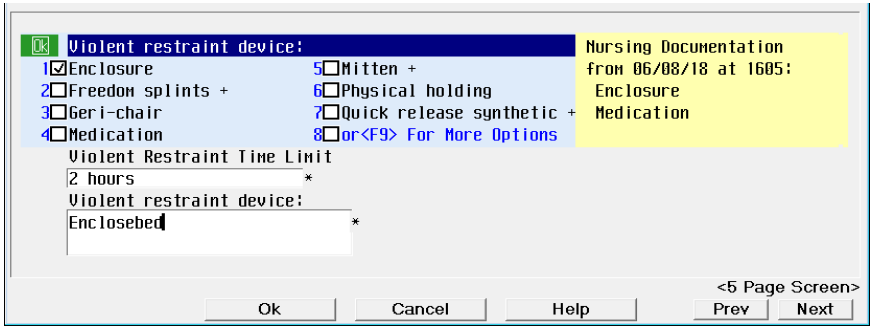
**If the end user selected a "Violent" restraint, they are directed to the "Time Limit" and "Device" for the violent restraint.**

- When the cursor is in the "Time Limit" field, the yellow box reminds the end user they have selected a violent restraint and to return to the screen if they only want to change to a "Non Violent" restraint.



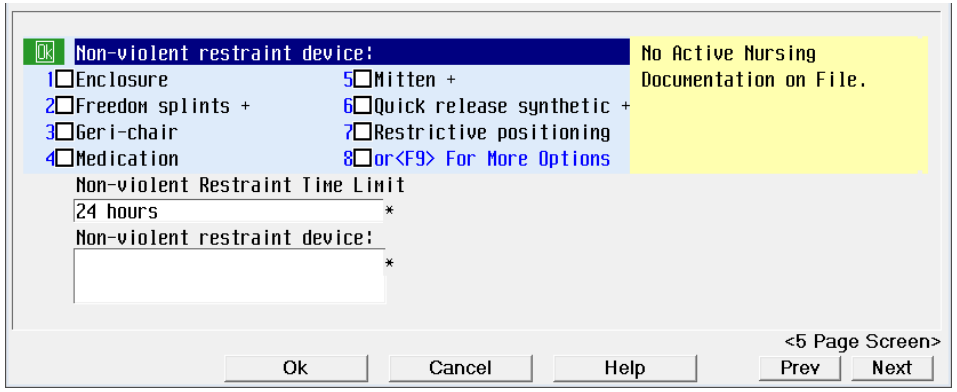

**Once the "Time Limit" is determined by the end user, the "restraint device" field in yellow box reminds the user the restraint device documented in nursing.**

- Again, the user does not have to select the options outlined in the yellow reminder box:

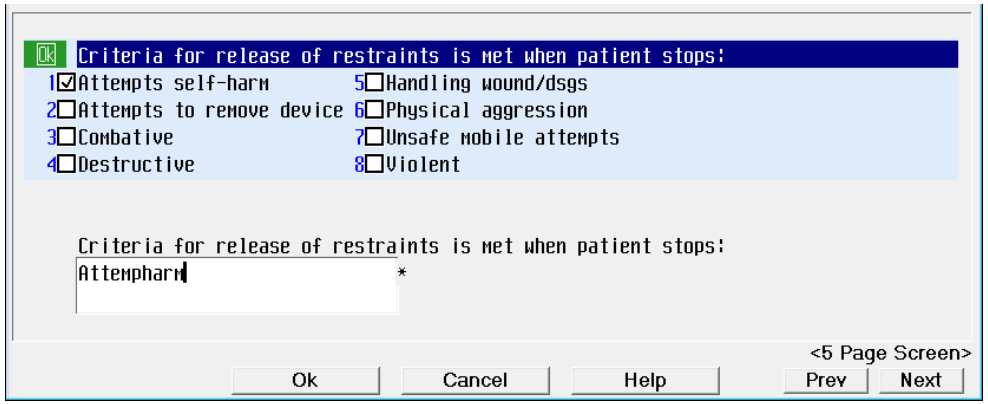


# Enhancements: Restraints Order

**If the end user selects the a “Non Violent” Clinical Justification, they will be directed to a “Restraint Time Limit” and “Device” query specifically for non violent options.**




**Lastly, the user is presented with the “Criteria for release of restraints is met when patient stops:” query, which defaults from the users previous “Clinical justification” response.**



# Thank you for reviewing the 2018 Meditech September Updates.

**New screens are tentatively scheduled to become active on**
**Monday, September 24, 2018**

**For questions or issues please contact the Service Desk at 816-276-HELP**