

***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.medicity.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.

The screenshot shows the 'Restraint status' screen with a list of steps on the left and a form on the right. A red box highlights the list of steps, and a red arrow points from a 'Click box to display previous status documentation ->' button to a 'PREVIOUS RESTRAINT STATUS DOCUMENTATION' window.

**Restraint status:**

- ✓ 1 Start
- 2 Second tier review
- 3 Face to face
- 4 Monitor/RN assess
- 5 Safety/Rights/Dignity
- 6 Discontinue

Document second tier once per restraint episode.

Click box to display previous status documentation ->

Restraint status: Start \*

Clinical justification: Handling wound/dsgs \*

Alternatives utilized: Combative \*

Level of restraint: Violent/self-destructive

Non-violent restraint device:

Violent restraint device: \*

Date restraints initiated: \*

Time restraints initiated: \*

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**PREVIOUS RESTRAINT STATUS DOCUMENTATION**

----- 20 Most Recent Entries -----

- + DISCONTINUE at 06/07/18 0910
- Second tier review at 06/07/18 0748
- + START at 06/06/18 1414
- \* DISCONTINUE at 06/06/18 1224
- + START at 06/06/18 1014
- \* DISCONTINUE at 06/05/18 1041
- + START at 06/05/18 1039
- \* DISCONTINUE at 06/05/18 1035
- Monitor/RN assess at 06/05/18 1034
- Safety/Rights/Dignity at 06/05/18 1033
- Face to face at 06/05/18 1031
- Second tier review at 06/05/18 1027
- + START at 06/05/18 1021

<End of text>

<Return>/<Esc>/<Exit> when done

## 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.

The screenshot shows a web-based form for clinical justification. At the top, there is a header 'Clinical justification:'. Below it are several checkboxes for justification types: 1 Attempts self-harm, 2 Attempts to remove device, 3 Combative (checked), 4 Destructive, 5 Handling wound/dsgs (checked), 6 Physical aggression, 7 Unsafe mobile attempts, and 8 Violent. A red box highlights the 'Click box to display previous status documentation ->' button. Below this are several input fields: 'Restraint status: Start', 'Clinical justification: Handling' (with 'Combative' listed below it), 'Alternatives utilized:', 'Level of restraint: Violent/self-destructive', 'Non-violent restraint device:', 'Violent restraint device:', 'Date restraints initiated:', and 'Time restraints initiated:'. A '(Next Page)' button is visible at the bottom right.

## 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 .

Safety/Rights/Dignity maintained verified:	
1 Done now	Done now - use to document each observation in real time, three times every hour.
2 Three times every hour	
3 Every 15 minutes per hour	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, the following may be used: Three times every hour Every 15 minutes per hour

## 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.

Restraint Documentation 06/11 1656 J00021041398 WHITE,TEST

**Observed restraints appropriately intact:**

- 1 Yes
- 2 No

Monitor/RN assess should be done at a minimum of every 2 hours.

Observed restraints appropriately intact:  \*

Response to restraint:  \*

Level of consciousness:  \*

Reviewed reason for restraints with:

Reviewed criteria for release with:

Safety/Rights/Dignity maintained verified:

(Prev Page)  (Next Page)

Restraint Documentation 06/11 1656 J00021041398 WHITE,TEST

**Vital signs taken per unit policy or doctors orders:**

- 1 Yes
- 2 No

**- Monitor/RN assess -**

Click below to default system normal values

DFT Norms

DFT Norms (Go to File)

Vital signs taken per unit policy or doctors orders:  \*

Free from injury or pain associated with restraint:  \*

Free from respiratory/airway compromise associated with restraint:  \*

Skin under/around restraint verified (when applicable):  \*

Range of motion done:  \*

Circulation distal to restraint verified (when applicable):  \*

Offered nutrition/hydration:  \*

Offered comfort measures:  \*

No cognitive changes:  \*

Least restrictive restraint in use:  \*

Meets criteria for release:  \*

(Prev Page)  (Next Page)

## Enhancements: Second-tier

**POLICY: 4. Second Tier of Review<sup>2</sup>** 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.

Restraint Documentation 06/27 0929 J00021134721 BELLITT,MODSED

Restraints are clinically justified:

1 Yes  
2 No

Click below to default system normal values  
DFT Norms   
DFT Norms (Go to File)

--- The following must be reviewed with the RN. ---

Restraints are clinically justified: >  \*

Reason for restraint reviewed:  \*

Least restrictive type of restraint planned:  \*

Alternatives attempted, ineffective and documented:  \*

Cause of patient behavior reviewed:  \*

Consideration for vulnerable patient population:  \*

Justified for restraint level/device:  \*

Assessed restraints were safely and appropriately applied:  \*

Patients rights, dignity, and safety have been upheld:  \*



## 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:<sup>8</sup>**

- *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."<sup>9</sup>**

## 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 of motion, is not considered a discontinuation of restraint or seclusion.

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

The image shows two overlapping software windows. The background window is titled 'Restraint Documentation 06/08 1253 J00021132592 BELLITT,RESTRAINT'. It has a header 'Date restraint discontinued:' with a calendar icon and a dropdown menu showing 'Today' and 'Tomorrow'. Below this are fields for 'Date restraint discontinued: >| \*', 'Time restraint discontinued: | \*', and 'Document violent/SD debriefing: | \*'. A '(Prev Page) |' button is at the bottom left.

The foreground window is titled 'Restraint Debriefing'. It has a header 'Post counseling provided to:' with a dropdown menu showing 'Family', 'Guardian', 'Next of kin', 'No designee', 'Patient', and 'Significant other'. There are checkboxes for 'Family', 'Guardian', 'Next of kin', 'No designee', 'Patient', and 'Significant other'. Below this is a text field for 'Circumstances leading to restraint/seclusion incident: >Destructive'. There are text fields for 'Recommendations for future interventions:', 'Post counseling provided to: >Patient \*', and 'Debriefing Comment:'. An '(End) |' button is at the bottom right.

## Plan of Care

**POLICY: Care of the Patient/Plan of Care:<sup>10</sup>** (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

Health plan of care 07/18 1614 J00021061518 FINE,EBCDMALE

Health behavior problem/risk:

1 <input checked="" type="checkbox"/> Injury risk	7 <input checked="" type="checkbox"/> Noncompliance
2 <input checked="" type="checkbox"/> Violence/restraints risk	8 <input type="checkbox"/> Substance abuse
3 <input type="checkbox"/> Medication risk	9 <input type="checkbox"/> Health maintenance
4 <input type="checkbox"/> Procedural/periop risk	10 <input type="checkbox"/> Health seeking behavior
5 <input type="checkbox"/> Perinatal risk	11 <input type="checkbox"/> Home maintenance
6 <input type="checkbox"/> Reproductive risk	12 <input type="checkbox"/> Infection risk

Physiological problem/alteration in: ↓

Psychological problem/alteration in: →

Functional problem/alteration in: ↓

Health behavior problem/risk: →

Violence/restraints risk  
Injury  
Noncompliance

(End)

## 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

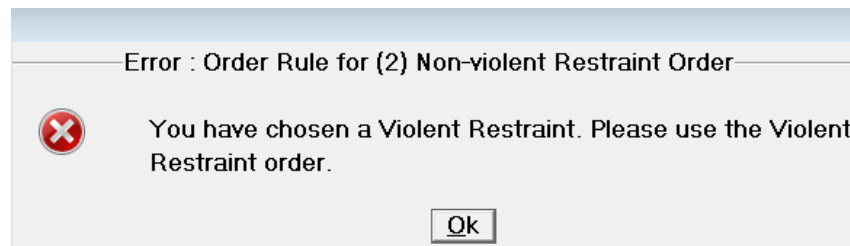
Any Order Lookup

Search on:

Order Description	Category
Non-violent Restraint Order	Patient Safety Orders
Violent Restraint	Patient Safety Orders

**\*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)

Clinical justification:

1 <input type="checkbox"/> Attempts self-harm	5 <input type="checkbox"/> Handling wound/dsgs
2 <input type="checkbox"/> Attempts to remove device	6 <input type="checkbox"/> Physical aggression
3 <input type="checkbox"/> Combative	7 <input type="checkbox"/> Unsafe mobile attempts
4 <input type="checkbox"/> Destructive	8 <input type="checkbox"/> Violent

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

<input checked="" type="checkbox"/> Violent restraint device:	
1 <input type="checkbox"/> Enclosure	5 <input type="checkbox"/> Mitten +
2 <input type="checkbox"/> Freedom splints +	6 <input type="checkbox"/> Physical holding
3 <input type="checkbox"/> Geri-chair	7 <input type="checkbox"/> Quick release synthetic
4 <input type="checkbox"/> Medication	8 <input type="checkbox"/> or<F9> For More Options
<del>Violent Restraint Time Limit</del>	

1	Restrictive positioning
2	Seclusion
3	Seclusion/restraint
4	Soft +
5	Tightly tucked sheets
6	Waist

## Enhancements: Restraints Order

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

Clinical justification:	
1 <input type="checkbox"/> Attempts self-harm	5 <input type="checkbox"/> Handling wound/dsgs
2 <input checked="" type="checkbox"/> Attempts to remove device	6 <input type="checkbox"/> Physical aggression
3 <input type="checkbox"/> Combative	7 <input type="checkbox"/> Unsafe mobile attempts
4 <input type="checkbox"/> Destructive	8 <input type="checkbox"/> Violent

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

Non-violent restraint device:		Options
1 <input type="checkbox"/> Enclosure	5 <input type="checkbox"/> Mitten +	
2 <input type="checkbox"/> Freedom splints +	6 <input type="checkbox"/> Quick release synthetic	1 Soft +
3 <input type="checkbox"/> Geri-chair	7 <input type="checkbox"/> Restrictive positioning	2 Tightly tucked sheets
4 <input type="checkbox"/> Medication	8 <input type="checkbox"/> or<F9> For More Options	3 Waist



## 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.

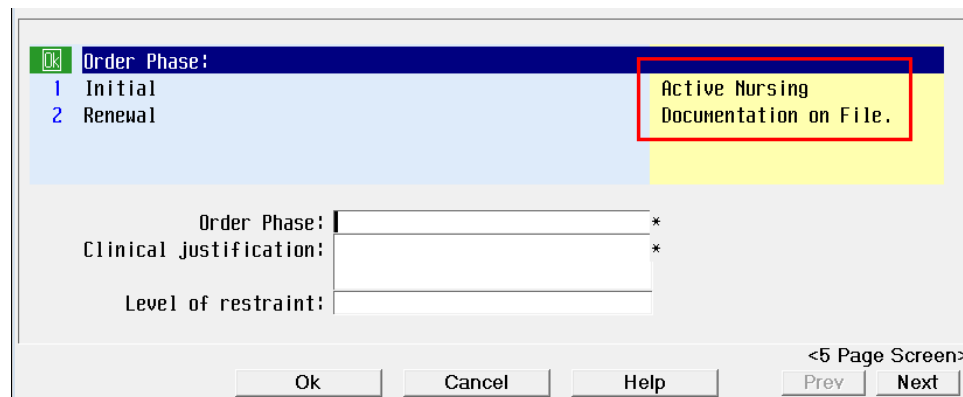
Users can review the applicable nursing documentation in the yellow info box when applicable.

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".



The screenshot displays a software interface for placing a restraint order. At the top, there is a blue header bar with a green 'OK' icon and the text 'Order Phase:'. Below this, a list shows two options: '1 Initial' and '2 Renewal'. A yellow information box is overlaid on the right side of the screen, containing the text 'Active Nursing Documentation on File.' which is enclosed in a red rectangular border. Below the list, there are three input fields: 'Order Phase:' with an asterisk, 'Clinical justification:' with an asterisk, and 'Level of restraint:'. At the bottom of the screen, there are several buttons: 'OK', 'Cancel', 'Help', '<5 Page Screen>', 'Prev', and 'Next'.

## 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.

The screenshot shows a software interface for placing a restraint order. At the top, there is a title bar with an 'OK' button and the text 'Clinical justification:'. Below this, there are two columns of checkboxes for clinical justifications:
 

- 1  Attempts self-harm
- 2  Attempts to remove device
- 3  Combative
- 4  Destructive
- 5  Handling wound/dsgs
- 6  Physical aggression
- 7  Unsafe mobile attempts
- 8  Violent

 To the right of these checkboxes is a yellow box with a red border containing the text: 'Nursing Documentation from 06/08/18 at 1605: Attempts self-harm Handling wound/dsgs'. Below the checkboxes are three input fields: 'Order Phase: Initial', 'Clinical justification: ', and 'Level of restraint: '. At the bottom right, there are navigation buttons: '<5 Page Screen>', 'Prev', and 'Next'. At the bottom center, there are 'Ok', 'Cancel', and 'Help' buttons.

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

This screenshot is similar to the previous one, but the 'Level of restraint' field is now populated with the text 'Violent/self-destructive'. The 'Clinical justification' field now contains the text 'Attempts self-harm'. The 'Nursing Documentation' box and other interface elements remain the same as in the previous screenshot.

## 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.

**Non-violent restraint device:**

1 Enclosure       5 Mitten +  
 2 Freedom splints +       6 Quick release synthetic +  
 3 Geri-chair       7 Restrictive positioning  
 4 Medication       8 or <F9> For More Options

No Active Nursing  
Documentation on File.

Non-violent Restraint Time Limit  
24 hours \*

Non-violent restraint device:  
\*

<5 Page Screen>  
Ok Cancel Help Prev Next

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.

**Criteria for release of restraints is met when patient stops:**

1 Attempts self-harm       5 Handling wound/dsgs  
 2 Attempts to remove device       6 Physical aggression  
 3 Combative       7 Unsafe mobile attempts  
 4 Destructive       8 Violent

Criteria for release of restraints is met when patient stops:  
Attenpharm \*

<5 Page Screen>  
Ok Cancel Help Prev Next

***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**