



Restraint Documentation

Kyle Walton, Consultant, McKesson Practice

The Joint Commission Standards addressing the use of restraints and seclusion in acute care hospitals and behavioral health facilities have historically been somewhat confusing to interpret, but the intent has always been to provide a safe and secure environment of care even when the patient is unable or unwilling to cooperate. Innovative use of clinical documentation software combined with a logical policy/procedure and workflow can make the *right* thing to do the *easy* thing to do for the busy clinician. The bottom line for your facility? A closely-monitored restraint process that respects patient dignity coupled with an opportunity to improve regulatory compliance with electronically-extractable support documentation.

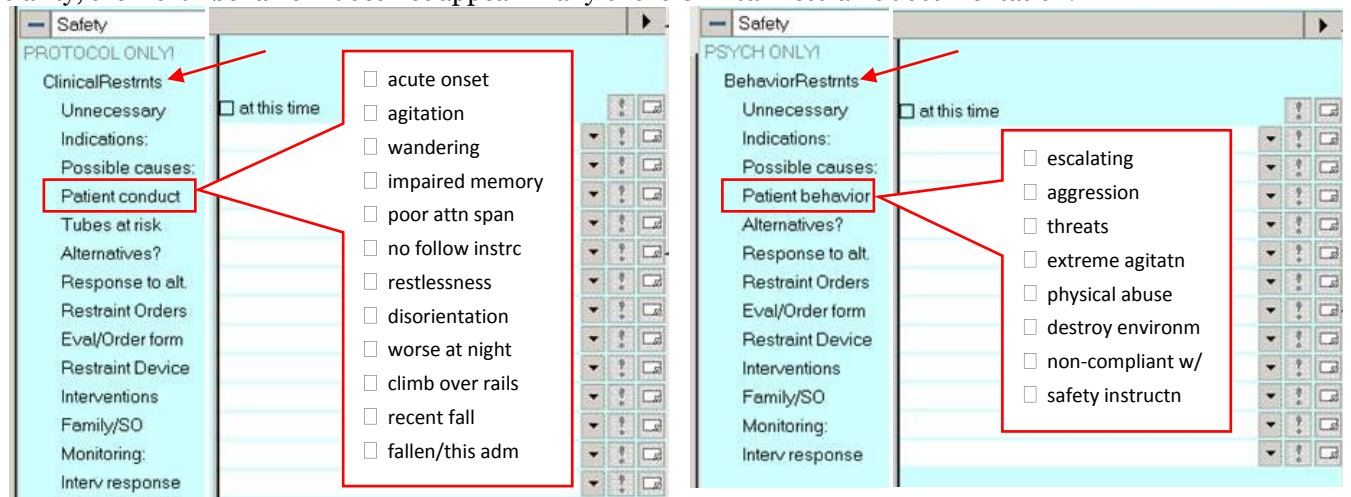
Design is the key to success: Better policy. Better workflow. Better documentation. Better outcomes.

Where to begin? The first step is *always* the same: Establish a policy/procedure with a logical workflow that incorporates all the required elements of performance. Once the process is defined, it is time to design clinical charting that supports the policy statements. Follow that with intensive staff education and routine quality monitoring with immediate staff feedback.

The following example was built in McKesson's *Horizon Expert Documentation*[™] (ER 7.6 SP2) for a small community hospital. A multidisciplinary committee studied The Joint Commission Standards and then clearly defined in policy the differences between episodes of Clinical Restraints and Behavioral Restraints. Four pre-approved Clinical Restraint Protocols were established, but all episodes of restraint were based on an individual assessment of need rather than on a diagnosis.

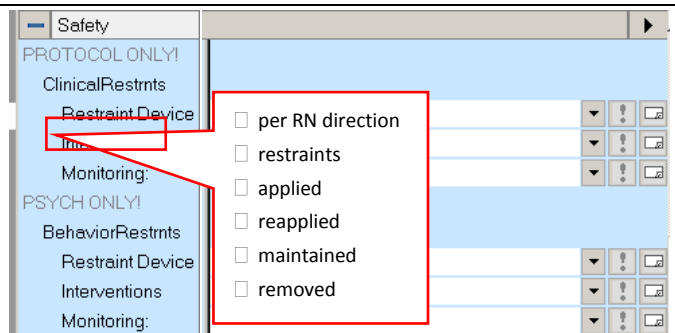
RN restraint documentation is separated into two distinct categories within a Safety class.

For consistency, the look and flow of each Restraint category is very similar although the charting group choices are specific to the type of Restraint. The verbiage is extracted directly from Policy statements. For the sake of clarity, the word “behavior” does not appear in any of the Clinical Restraint documentation.



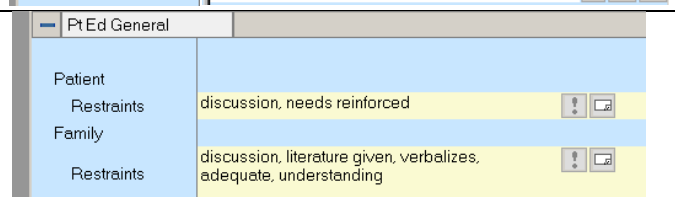
Associated Nurse Tech Charting

Per Policy, certain aspects of monitoring and care of the restrained patient may be delegated to a Nurse Tech (NT). Although the three NT charting results for each type of restraint are shared with the same three RN charting results, their charting options are unique to the NT. To clearly demonstrate an RN-directed plan of care, each result begins with the phrase “per RN direction”.



Patient/Family Education

Per Policy, an educational hand-out is provided to the family/SO of every restrained patient. Charting restraint education is kept simple.



Sample RN Charting

Safety		Safety	
PROTOCOL ONLY!		PSYCH ONLY!	
Clinical Restrnmts		Behavior Restrnmts	
Indications:	less restrictive, alternatives, attempted, ineffective, Unable to comply, safety instructn	Indications:	less restrictive, alternatives, attempted, ineffective, Assessed to be, intentional, danger to others
Possible causes:	dementia, med changes, environment chg	Possible causes:	intoxication, behavior disorder
Patient conduct	acute onset, impaired memory, poor attn span, no follow instrc	Patient behavior	escalating, aggression, threats, extreme agitatr, non-compliant w/, safety instructn
Tubes at risk	Due to conduct, oxygen, NG tube, Foley cath	Alternatives?	closer observatr, close to station, dec environ stim, family @ bedside, behavior modifcn, de-escalation
Alternatives?	address cause, anticipate needs, closer observatr, frequent rounds, "hide" tube/wire	Response to alt.	unchanged, losing control
Response to alt.	unchanged	Restraint Orders	situation eval'd, MD notified, immediatly, per phone
Restraint Orders	MD notified, per phone, PROTOCOL ORDER, InvasiveCatheter	Eval/Order form	completed, on chart
Eval/Order form	completed, on chart	Restraint Device	leastRestrictive, yet effective, device selected, soft wrist (R), soft wrist (L), soft ankle (L)
Restraint Device	leastRestrictive, yet effective, device selected, siderails X 4, soft wrist (R), soft wrist (L)	Interventions	situation eval'd, q4hr (for adult), restraints, maintained, trial release, unsuccessful
Interventions	restraints, maintained, trial release, unsuccessful	Family/SO	aware, of situation, teaching done
Family/SO	aware, of situation	Monitoring:	freq obsv/eval, CMS check, ROM/positioning, fluids offered, food offered, toileting offerd, q2h per policy, No problem found
Monitoring:	CMS check, ROM/positioning, fluids offered, food offered, toileting offerd, q2h per policy, No problem found	Interv response	unchanged
Interv response	tolerated		

A documentation design that separates the charting of the two types of restraints makes it simple to query any charting done against those results with a basic Business Objects XI (BOXI) report. The BOXI query can be configured to run and e-mail itself to Clinical Supervisors for staff feedback and to Quality Analysts for statistics.

***Keep it relevant. Keep it simple.
Avoid dependence on free-text entries.***

A design that incorporates point-and-click, step-by-step charting will lead the clinician through the required elements of defined processes. The likelihood of missing vital steps is decreased while the quality of the supporting documentation is increased. *Quality documentation does not need to be time-consuming or complicated.*

If you would like more information about Horizon Expert Documentation or McKesson solutions provided by VCS, please contact us at 610.444.1233 or vcs@getvitalized.com. Additional information about the services and solutions offered by VCS can be found at our website, www.getvitalized.com.