PowerChart Restraint Documentation for Inpatient Nursing

Restraint orders and documentation are categorized in 2 types for inpatients. The first, reviewed below, the most common type, “generic” Restraints, is used primarily for patients who are interfering with medical treatment. The second type, Behavioral Health Restraints, is reviewed later in this document. Be sure the correct restraint order has been placed for your patient. See MCGHI’s Restraint and Seclusion Policy 14.90 for details. http://www.hi.mcg.edu/aboutus/PDFPolicies/14_90_r2.pdf

Both types of restraint orders can be found by searching PowerOrders using “rest” and “contains.” A Physician should choose the proper restraint order for the patient. Selecting “Restraint Initiation” from the PowerOrders list, and then “Done” opens the restraint order details. This order contains 2 required fields; Reason for Restraint and Restraint Type. These fields must be completed and the order signed.

Note: MCGHI’s policy for restraint orders states that, “A written order, based on examination of the patient by the physician primarily responsible for the patient’s ongoing care must be entered into the patient’s medical record within one hour of initiation of restraints” (MCG Policy 14.90, Page 3 of 8, 04/2010).
Once the restraint order details are entered and signed, a Restraint Monitoring task will flow to the Task List. Restraint documentation must occur on initiation, at the appropriately prescribed interval for the specific type of restraint, and at restraint discontinuation. Restraint documentation can be done more frequently than required; however, documentation cannot be done less frequently than required.

The Restraint Monitoring task is a “Done/Not Done” task meant as a reminder for the nurse to complete the appropriate restraint charting due at that time. To begin documenting, the Restraint/Seclusion Record must be chosen from the Ad Hoc folder. The form can be retrieved from 5 different folders; All Nursing Forms, Behavioral Health, ICU, PICU, or Specialized Monitoring Records. Beginning a new form is only done on initiation and every night at midnight (2400) while restraints are in use.
Once the form has been started, proper charting is accomplished by charting “Done” to the task on the Task List, selecting the Restraint/Seclusion Record for that day from the Forms Browser, then right clicking and selecting Modify to open the form and document. Correct documentation of restraints will have only one form for every day with all subsequent charting added as modifications to the original form. For restraint charting, each day begins at midnight.

This screenshot shows the Initiation/Reassessment section of restraint charting. This question contains 2 required fields which are highlighted in yellow. Both types of restraints are charted on this form using the appropriate sections on the left. The 2 large white boxes, “Behavior Requiring Medical Restraint/Seclusion” and “Restraint Seclusion/Alternatives Attempted” permit more than one selection in each box. All appropriate behaviors and alternatives should be charted. Verify that the times/dates entered on this section are correct.
After selecting the appropriate time interval for charting from the list on the left (Q2 hours for this example) the following areas are available to chart. MCG policy requires assessment and documentation of the restrained patient at least every 2 hours regarding the physical safety, physical and psychological status, comfort, readiness for discontinuation of restraint or seclusion, and attention to physical needs. The screenshot illustrates what the behavior grid may look like when the initial documentation is done. Note that there is only one line of charting.

Assessment and documentation of patient interventions are done on the Patient Interventions grid below. In this example, several hours of charting have been completed for this patient. Note that there are multiple lines of charting on the same form. When nurses chart on the Restraint Form and sign it, they are only signing their charting, even though the previous charting is on the same form.

The Temporary release column is used to document instances where the restraints are not removed permanently. For example, if the family is at the bedside monitoring the patient and the restraints are released for the time the family is present, this should be documented in the Temporary release column.
The Assessment of Restrained Area grid contains charting options for skin, circulation, and mobility of the restrained area. Charting is only required for the restrained area, so all areas do not need to be charted. A pop-up box will appear after selecting the appropriate area and time. This box permits multiple choices to be charted and comments can be added as needed. After selecting all relevant options, chose OK to close the box.

The questions below should contain any attempted alternatives to restraints and additional monitoring information documentation. Multiple answers may be selected and all applicable restraint alternatives attempted should be chosen. The Additional Monitoring Information question allows for a large volume of comments/additional information to be entered, if needed.

The MCG Restraint and Seclusion Policy states, “the least intrusive means of protecting the patient, staff, or others should be implemented first. Non-physical techniques are the preferred intervention. All possible alternatives to restraint should be explored” (MCG Policy 14.90, Page 2 of 8, 04/2010).
The Education Topics section must be completed at least every 24 hours while the patient remains in restraints. All restraint education, the education recipients, as well as, assessments and teaching methods are documented in this section.

Be sure to chart in the Discontinuation section when restraints are removed. Do not chart a temporary release as a discontinuation. A temporary release should be charted in the appropriate column on the Interventions section. Only when the patient has been assessed as ready for release and restraints are being removed permanently should a discontinuation be charted.

“When a restraint or seclusion is terminated before the original time-limited order expires, a new order must be obtained prior to re-initiating restraint or seclusion” (MCG Policy 14.90, Page 3 of 8, 04/2010).

When the restraints are removed permanently, the restraint order should be discontinued.
An alert fires for both physicians and nurses prior to a restraint order expiring. The alert serves as a reminder to reassess the patient for the need for restraints and to renew or discontinue the restraint order.

The physician has 3 options for renewing the order. If the current order has expired, he/she can place a new restraint order or copy the current order when renewing. If the order is still active, he/she should cancel/reorder the original order when renewing. If copying or reordering the order, review the order details to make sure they are still applicable to the patient/situation.

Note: MCGHI’s Restraint and Seclusion Policy states, “Standing orders or PRN orders are not acceptable for restraint or seclusion. The order for restraint or seclusion must state the reason for the restraint or seclusion; acknowledge the less intrusive interventions that were attempted, the type of restraint being ordered, and the time limit for the restraint or seclusion (less than 24 hours). Every 24 hours, a physician primarily responsible for the patient’s ongoing care must see and evaluate the patient before writing a new order for restraint or seclusion” (MCG Policy 14.90, Page 2 of 8, 04/2010).
BEHAVIORAL HEALTH RESTRAINTS

The use of Behavioral Health Restraints is limited to 9N, 3S, ICUs, and the Emergency Department. Seclusion may only be utilized on the Behavioral Health units and in the Emergency Department. Patients placed in this type of restraint or seclusion require monitoring at least every 15 minutes. A patient placed in four-point restraints must also be assessed at least every 15 minutes. A patient who is simultaneously restrained and secluded must be continually monitored by trained staff either in person or through the use of video and audio equipment that is in close proximity to the patient.

If this type of restraint is to be used for a patient, be sure the physician places the correct order. Do not use the “Restraint Initiation” order for this type of restraint/seclusion; use the “Behavioral Health Restraint Initiation.” The time limitations for the orders and the frequencies for monitoring are different for the 2 types of restraints. Both restraint orders contain the same order detail fields.

Restraint or seclusion orders for patients exhibiting violent behavior jeopardizing the immediate physical safety of themselves, staff, or others must be ordered and renewed within the following limits:

- 4 hours for adults 18 years of age or older
- 2 hours for children and adolescents 9 to 17 years of age
- 1 hour for children under 9 years of age
These orders may be a verbal (telephone) order to a licensed nurse based upon the nurse’s most recent assessment of the patient, up to the maximum 24 hour time frame. (MCG Policy 14.90, Page 4 of 8, 04/2010)

An evaluation within one hour of initiation of restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the physical safety of the patient, staff or others must be conducted by a physician or other licensed independent practitioner trained in the use of restraints.

After the restraint order details are entered and the order signed, a Restraint Monitoring task will flow to the Task List. The Restraint Monitoring task is a “Done/Not Done” task meant as a reminder for the nurse to complete the appropriate restraint charting due at that time. Restraint/seclusion documentation must occur on initiation, at least every 15 minutes, and when the restraints or seclusion are discontinued. Documentation can occur more frequently than required; however, it cannot be done less frequently than required.
To begin documenting, the Restraint/Seclusion Record must be chosen from the Ad Hoc folder. The form can be retrieved from 5 different folders; All Nursing Forms, Behavioral Health, ICU, PICU, or Specialized Monitoring Records. Beginning a new form is only done on initiation. Since a behavioral health or seclusion order is only valid for a limited number of hours depending on the age of the patient, each time a new order is placed, a new form should be started.

Once the form has been started, proper charting is accomplished by charting “Done” to the task on the Task List, selecting the appropriate Restraint/Seclusion Record from the Forms Browser, then right clicking and selecting Modify to open the form and document. Correct documentation of behavioral health restraints will have only one form for every order with all subsequent charting added as modifications.
This screenshot of the Initiation/Reassessment section shows 2 required fields highlighted in yellow. Both types of restraints are charted on this form using the different sections on the left. The 2 large white boxes, “Behavior Requiring Medical Restraint/Seclusion” and “Restraint Seclusion/Alternatives Attempted” permit more than one answer to each question. All appropriate behaviors and alternatives should be charted. Verify the times/dates entered in this section are correct.

After selecting the appropriate time interval section for charting (Q15 minutes for this example), the following areas are available to chart. If the patient is in behavioral health restraints or seclusion for longer than 2 hours, MCG policy requires that at least every 2 hours, the restrained patient must be assessed and documentation completed for physical safety, physical status, comfort, readiness for discontinuation of restraint or seclusion, and attention to physical needs. The behaviors grid containing psychological status and behavior information must be documented every 15 minutes.
This screenshot illustrates what the grid may look like when the initial documentation is completed. Note that there is only one line of charting. All subsequent charting will be added to this form by selecting and modifying the form from the form browser. The behavioral health/seclusion monitoring section is comprised of four one hour grids divided into 15 minute intervals. If documentation is required more frequently than the Q15 minute intervals provided by the flowsheet, use the “Comment” column to add any additional charting or notes necessary.

<table>
<thead>
<tr>
<th>Monitoring</th>
<th>Monitoring</th>
<th>Monitoring</th>
<th>Monitoring</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>15 Min</strong></td>
<td><strong>Awake/Distressed</strong></td>
<td><strong>Calm</strong></td>
<td><strong>Combatant/Aggressive</strong></td>
</tr>
<tr>
<td><strong>30 Min</strong></td>
<td><strong>X</strong></td>
<td><strong>X</strong></td>
<td><strong>X</strong></td>
</tr>
<tr>
<td><strong>45 Min</strong></td>
<td><strong>X</strong></td>
<td><strong>X</strong></td>
<td><strong>X</strong></td>
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<tr>
<td><strong>1 Hour</strong></td>
<td><strong>X</strong></td>
<td><strong>X</strong></td>
<td><strong>X</strong></td>
</tr>
</tbody>
</table>

From this point, restraint/seclusion documentation should be completed in the same manner for all restraints or seclusion, regardless of the type of restraints. Please refer to pages 4 through 7 of this document for further explanation of the remaining sections of behavioral health restraint/seclusion documentation.
Deaths Associated With the Use of Restraint / Seclusion

Specific guidelines must be followed in the event of a death of a patient in restraints or seclusion. The following excerpt is from the MCGHI Restraint and Seclusion policy.

1. Within the death packet that is completed at the time of death, the nurse will provide the following restraint related information:
   a. Patient was in restraint or seclusion at the time of death
   b. Patient had been in restraints or seclusions within 24 hours of his/her death
   c. Patient was in restraints within one week of his death.

If the death meets (a) or (b) noted above, the nurse caring for the patient must complete the ‘Hospital Restraint/Seclusion Death Report Worksheet’ and fax it to the Nursing Supervisor.

2. Quality Management staff will check the Nursing Supervisor’s office Monday – Friday for such reports. When found, Quality Management will review to validate and prepare report for submission based on the initial worksheet submitted.

3. If restraint death validated, VP for Patient Care, Quality and Safety, will be notified and will review, notifying the CEO of reportable restraint death. Once approval given, Quality Management will notify CMS of the restraint death.

4. Quality Management Department will document CMS notification (day and time) in the medical record. This will be accomplished through email notification to Director of HIMS or Assistant Director of HIMS to make an entry into the medical record in the progress notes.

5. Quality Management will also notify Risk Management Department of a restraint death notification to CMS.

6. A notification log will be maintained in Quality Management to record all submissions to CMS of ‘restraint deaths’

7. Additionally a death known to the hospital that occurred within one week after restraint or seclusion when it was reasonable to assume that the use of restraints or seclusion contributed directly or indirectly to the patient’s death, will be validated by Quality Management. If determined to meet criteria for reporting the VP for Patient Care, Quality and Safety will notified and review, notifying the CEO of any reportable restraint death in this category. Once approval given, Quality Management will submit the required report to CMS and document the report in the CMS Restraint Death Notification Log. (MCG Policy 14.90, Page 5 of 8, 04/2010)