Aligning Changes in Regulatory Requirements for Restraints with Documentation

Lee Williams, PhD(c), RN-BC, Sara Gibbons, MSN, RN-BC

Boston Children's Hospital, Boston, MA

Keywords: Clinical Documentation, Regulatory

Introduction/Background

Integration of changes in regulatory language[1] into a complex electronic documentation system that is customized to optimize workflows throughout diverse clinical settings presents many challenges. The process requires collaboration among many teams including Clinical Informatics, Quality and Professional Practice, Clinical Education and Information Services. Careful coordination among these groups is required to ensure that changes to policy, practice and documentation occur simultaneously. We will describe the response to recent changes in regulatory language about restraints. This change in regulatory language was enacted to increase clarity around the reason for restraint. Previous language was ambiguous and caused confusion in both ordering and documentation.[1]

Methods

Responding to this change required collaboration among the Restraint Subject Matter Expert (SME) group, policy and procedure leadership, and the clinical informatics specialist. This collaboration facilitated the orchestrated transition of restraint terminology changes. The SME group met regularly, to ensure that all aspects of the changes were ready and coordinated to ensure an on-target go-live. The policy stakeholders validated the naming convention changes, which were approved by senior nursing and medical leadership. The clinical informatics specialist shared mock ups of EHR changes for validation. The SME group, which included nursing end users, worked with the clinical informatics team to understand the go-live turnover impact on active restraint documentation. The SME leadership also worked in collaboration with end user educators to create a communication leveraging the standard SBAR (Situation, Background, Assessment and Recommendation) format, online learning management system modules for prescribers, and just in time intranet announcements. Upon go-live, the policy was published and accessible to end uses, and the EHR change conversion occurred. The SME leadership distributed a report listing admitted patients with active restraint orders to the informatics specialist so that end users could be contacted directly to support the transition of documentation for these patients. This report was repeated the day after go-live to ensure all active orders in the EHR were consistent with the new naming convention and policy.

Results

Based on daily reports reflecting restraint ordering, there has not been evidence of either an increase or decrease in restraint ordering accuracy. A subject matter expert who represents the nursing staff on the units states, "Renaming the behavioral and medically necessary restraints has been seamless due to the education to all prescribers and nursing staff."

Discussion/Conclusion

We believe that this successful effort was based on managing the SME group's expectations and setting realistic timelines to align with requirements/requests to balance with the technical build demands. It is also essential to engage subject matter experts to design and validate changes. A constant consideration that is essential for the alignment of regulatory practice and changes is to ensure collaborative expertise to align the implementation of changes throughout the system[2].

References

1. The Joint Commission (2017). Standard PC.03.05.05 The hospital initiates restraint or seclusion based on an individual order. The Joint Commission E-dition. Retrieved from https://e-dition.jcrinc.com/MainContent.aspx
2. Nelson-Brantley, H., & Ford, Debra. (2016). Leading change: a concept analysis. Journal of Advanced Nursing, 73(4), 834-846. Doi: 10.1111/jan.13223