High Risk Roundup: Restraint, Sedation, and Titrations

Thursday, October 19, 2023

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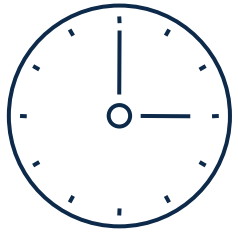

The webinar will start at the top of the hour.

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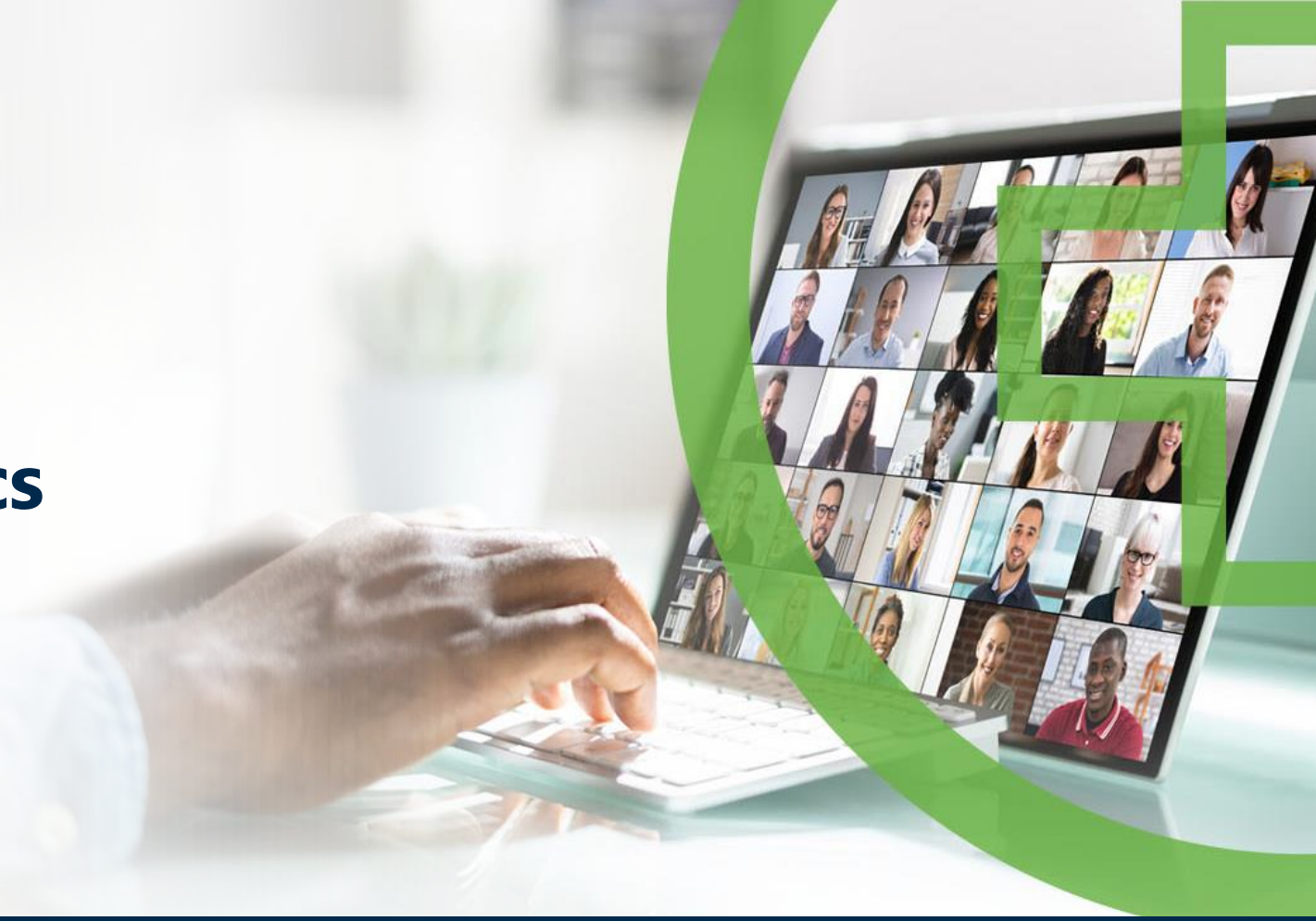

MONTHLY CLINICAL QUALITY INSIGHTS

Webinar Schedule & Topics

THE 3RD THURSDAY OF EVERY MONTH:

10AM Pacific, 1PM Eastern

TODAY

High Risk Roundup: Restraint, Sedation, and Titrations

NOVEMBER

Reducing Burden: What clinical documentation is REQUIRED vs. Self-Imposed?

Past Webinars Available for Streaming

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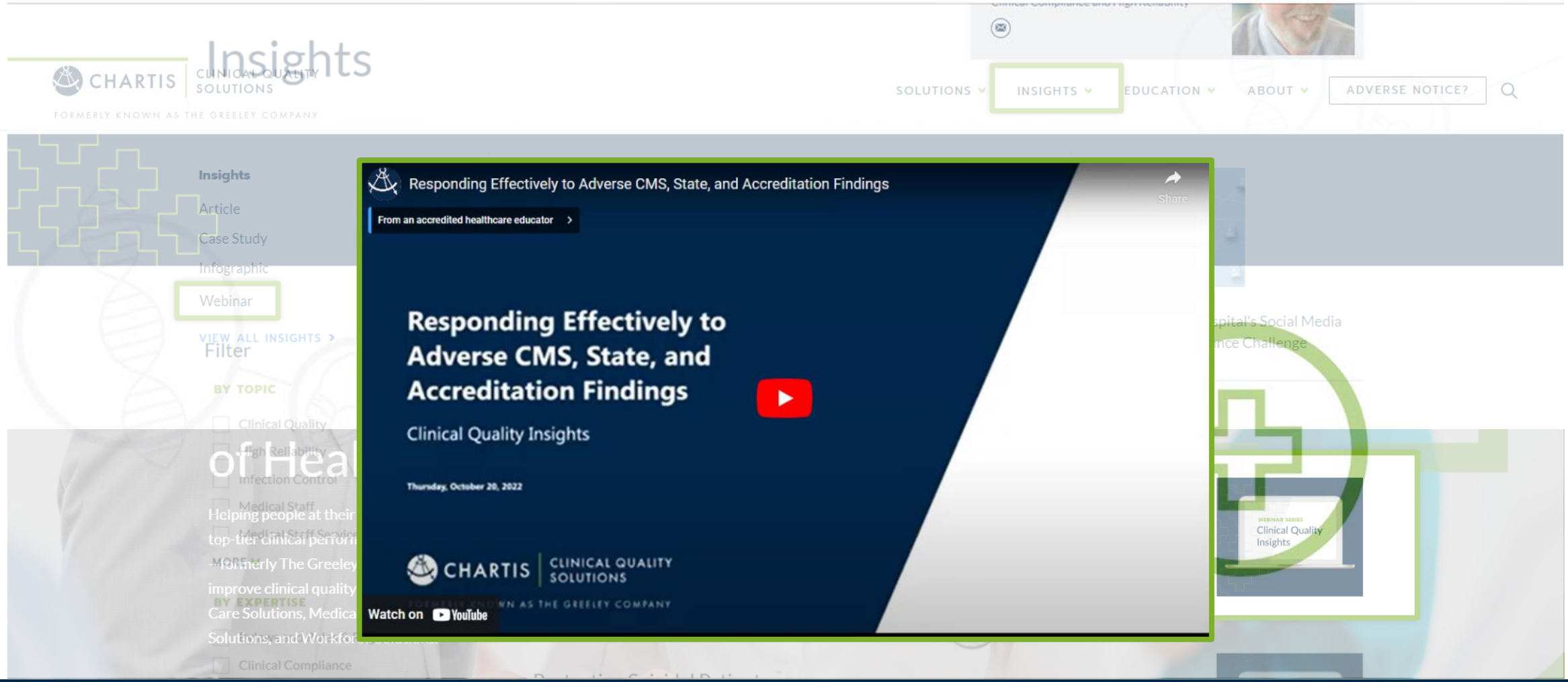

Past Webinars Available for Streaming

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AVAILABLE FOR STREAMING

- Practical Approaches to Ace Regulatory and Accreditation Surveys
- EMTALA Made Simple
- Protecting Suicidal Patients
- Responding Effectively to CMS, State, and Accreditation Findings
- Avoiding Infection Prevention Survey Catastrophes
- Survey Smarts: Looking Forward to 2023
- Increasing Nurse Efficiency: Documentation Simplification
- Better Meetings Better Results
- Overcoming Persistent Challenges in the Physical Environment
- TJC's Emerging Model for New Standards
- New CMS Interpretive Guidelines for QAPI
- Putting Your Best Foot Forward During Survey
- Connecting Hospital Rankings to Outcomes
- Compliance and Safety Challenges for Psychiatric Hospitals and Units
- CMS and QAPI: A Deeper Dive
- Mid-Point Update … Focusing on Regulatory Changes
- **High Risk Roundup: Restraint, Sedation, and Titrations**

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We are a partner to healthcare organizations nationwide, helping to advance patient safety and clinical quality for the past 30+ years. We help healthcare providers achieve top-tier clinical performance through our four lines of business:

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- Education Solutions
- Chartis Workforce Solutions
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Chartis Clinical Quality Solutions
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Readiness, Response, Reliability

- Rapid Response to Regulatory Emergencies
- Resolving CMS and TJC Adverse Actions
- CMS and Accreditation Survey Readiness
- Environment of Care, Life Safety, and Emergency Preparedness
- Hospital-CMS Systems Improvement Agreements ...the National Leader
- Emergency Department/EMTALA
- Behavioral Health
- Infection Prevention
- Patient Safety
- Process/Policy Simplification
- Streamlined Health Records
- Process Implementation
- Quality Monitoring and Improvement

Integration with other best-in-class consulting services offered by Chartis

SIMPLIFY & COMPLY

What is your role?

- Chief Quality Officer
- Other Executive Leader
- Quality Manager
- Patient Safety Officer
- Risk Manager
- Accreditation/Regulatory Compliance
- Consultant
- Other

TODAY'S DISCUSSION

Updating our community on new issues and trends related to CMS and Accrediting Organizations.

Phillip Boaz, RN, MSN, CIC

Senior Consultant
Clinical Compliance and High Reliability

Cherilyn Ashlock DNP, RN, NE-BC

Advisory Consultant
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Kim Wilson, MS, BSN, RN

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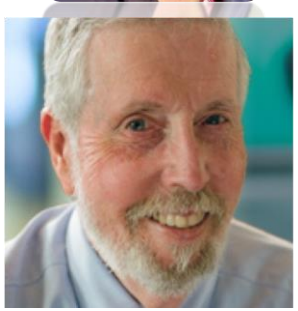


Bud Pate

Vice President - Content/Development,
Clinical Compliance and High Reliability

"Keeping up with Change

Planning for Tomorrow"

Who is your primary accreditor?

- The Joint Commission
- The Accreditation Commission for Health Care (ACHC)
- Det Norske Veritas (DNV)
- Center for Improvement in Healthcare Quality (CIHQ)
- Non-Accredited
- Other

Objectives

- **Discuss common citations and recommendations related to restraint management including orders, monitoring, and discontinuation.**
- **Understand pain management and sedation and best practices to avoid deficiencies in practice and documentation.**
- **Recognize regulatory pitfalls associated with titratable medications in the acute care setting.**

Handouts will be linked to the Chartis Website for post-webinar streamers.

TODAY'S

Agenda

01 Overview

02 Restraint Management

03 Pain and Sedation Management

04 Management of Titratable Medications

Questions should be posted in the webinar interface throughout the presentation.
We will respond to any unanswered questions in writing following the webinar.

Restraints

Why is restraint management high risk in a regulatory survey?

Restraint Management	Implications & Considerations
Patient Rights Multi-faceted condition leading to death by 1000 cuts	Restraint management is surveyed under the Patient rights condition along with items such as grievances, consent, interpretive services, etc and deficiencies add up quickly.
Regulation Misunderstanding Overinterpretation, Surveyor Misunderstanding, Clinical Caregiver Misunderstanding	The regulations were not designed to address the need to restrain patients who are acutely ill, therefore the details of the requirements receive disproportionate attention. These regs are highly overinterpreted, and both surveyors and clinicians suffer from misunderstanding.
Monitoring and Documentation Complicated and Burdensome	Restraint policy requirements vary from organization to organization, are typically more complicated than necessary and difficult to operationalize, and the self-imposed documentation requirements are burdensome to staff and difficult to comply with during complex situations.
Violent vs. Non-Violent Right Restraint for Right Indication	We often find inappropriate use of both non-violent and violent restraints, or a mismatch of patient presentation and restraint type. For example, be alert for patients in clinical restraints with an indication of “agitation” or “aggressive” behavior.
Safety Face to Face, Application, and Patient Assessment/Observation	Restraints are, by nature, a high-risk safety situation, often for both the patient and care team. Most frequently, we see deficiency in evidence of the face-to-face evaluation, monitoring, and addressing the clinical needs of the patient.
Orders Onerous Time Requirements, EMR Challenges	Often, the manual restraint order renewal process in the EMR dictated by policy makes organizations vulnerable for citation.

Common Restraint Related Citations

Orders for Restraints

Citations related to missing orders, not renewed correctly or timely, orders placed for the wrong type of restraint, or the restraint type/location order does not match what the patient has placed, missing renewal of orders, orders viewed as PRN

Face to Face Evaluation

Citations related to who is qualified, what competency is necessary, what timeframe and frequency is required by the organization, etc.

Education and Competency of Care Providers

Citations related to the documented education and competency of those monitoring patients in restraints, of those completing face to face evaluation, and the ongoing competency documentation for this high risk process.

Failure to Monitor and Document

Citations related to failure to follow hospital policy for the frequency of monitoring, release, evidence of necessity and ongoing necessity, alternatives used, sitter documentation, etc.

The use of “chemical restraints”

Citations around the use of medication to chemically restrain patients vs. medically mange patients requiring medication to support behaviors to protect their safety and address their medical needs. Policy often mis-uses this terminology.

Strategies for Success: Restraint Management

Policy Management

Simplify and Comply

Simplify

- ***Observe clinical practice and simplify the policy to reflect what is operationally efficient, compliant and possible***
- ***Consider criteria-based restraint implementation (model policy) with discontinuation built in***
- ***Move from 24hrs to calendar day order renewals***

Face to Face

- ***Consider qualifying RNs who are more readily available to completely perform FTF evaluations***

Reduce Documentation Burden

Simplify as Much as Possible

Ensure the EMR is working for you vs. working for the EMR

- ***Maximize prompts, reminders, and decision support***
- ***Consider block charting for monitoring***

Consider the difference between assessment and concurrent documentation

- ***Allow policy to drive attestation to monitoring and assessment in the record vs. requiring documentation to take place concurrently q2 hours, q15 min, etc.***

Realtime Monitoring

Retrospective Review vs. Care Facilitation

Sustained Non-compliance

- ***Retrospective review does not allow for correction but instead often demonstrates sustained non-compliance***

Care Facilitation

- ***Establish teams that can monitor care and documentation in real time***
- ***Real time review allows just-in-time education and correction to meet policy requirements***

De-Escalation and Medical Management

Partner with Providers and Other Clinical Experts

De-Escalation

- ***Train to and implement de-escalation techniques***

Medical Management

- ***Always consider if the patient is properly medically manged and work together with care teams to maximize medical treatment***

Work together to consider alternatives

- ***Restrictions on the location of restraints***
- ***BERT teams***
- ***Behavior plans***
- ***Family support***

Sedation and Pain Management

Why is pain and sedation management high risk in a regulatory survey?

Highly Complex Processes with Little Help from EMRs

- Policies often over complicate the assessment/reassessment processes with time sensitive documentation requirements
- Multiple stakeholders managing processes
- EMRs are not built in an intuitive manner or with compliance in mind

Regulation Overinterpretation

- Policies are always more prescriptive than the regulation.
- Sedation processes are over complicated and do not necessarily follow the care process.
- Misinterpretation of standards regarding pain management and a perceived requirement that treat we patients to “zero pain” and the intolerance of “range orders” lead to non-compliance

Low Hanging Fruit

- Surveyors have a level of confidence in these regulations
- Common chief complaint or patient issue so readily available for both real time and retrospective review

Common Pain and Sedation Related Citations

Initial and Reassessment According to Policy

Incomplete Orders, Duplicative Therapy, Missing Parameters

Staff Scope Of Practice

Sedation Management: Vacations, Lack of Protocols in EMR, Process Complexity

Incomplete H/P, immediate pre-sedation check, consent, etc.

Protocols with Conflicting Orders

CIWA vs RASS vs Pain Score example

Strategies for Success: Restraint Management

Policy Management

Simplify and Comply

Simplify

- ***Observe clinical practice and simplify the policy to reflect what is operationally efficient, compliance***
- ***Review the CCQS Model Policy for Management of Pain: 5 components***
- ***Who should be assessed and frequency?***
- ***Appropriate tool for assessment***
- ***Reassessment frequency***
- ***Reassessment after intervention or clinical change***
- ***Patient and family engagement***

Improve EMR Capability

Technology Optimization

Ensure the EMR is working for you vs. working for the EMR

- ***Maximize prompts, reminders, and decision support***
- ***Ensure protective mechanism from EMR decision support and the MD order, pharmacy review, and nurse delivery***

Consider the difference between assessment and concurrent documentation

- ***Allow policy to drive attestation to monitoring and assessment in the record vs. requiring documentation to take place concurrently***

Order Standardization

Order Sets and Oversite

Order Sets

- ***Ensuring that pain medication orders are built to include all essential components and limit the use of free text or "one off" orders***

Culture

Partner with Providers and Other Clinical Experts

Escalation of Concerns/Clarification

- ***Psychological safety to question or clarify orders***
- ***Provide clarity to ensure maximum use of nursing judgement and assessment driven management***

Work together to consider alternatives

- ***Address overburdensome requirements and limit the frequency and documentation of pain to those who present with pain as a primary concern or who report pain on assessment***

Titratable Medications

Why are Titratable Medications High Risk?

Medication Ordering Issues

- Ambiguous Orders (breakthrough pain meds)
- Conflicting Orders (nurses making decisions)
- Incomplete Order Sentences (missing targets, start dose, max dose, titration ranges, etc)
- Multiple drips ordered for the same indication (Propofol and Versed for RASS) - but RASS targets are different

Easily Identifiable

- Titrations errors are easy to identify in a medical record

Highly Complex Acuity

- Often critically-ill patients on 5+ drips that are simultaneously being titrated
- Multiple providers with competing priorities

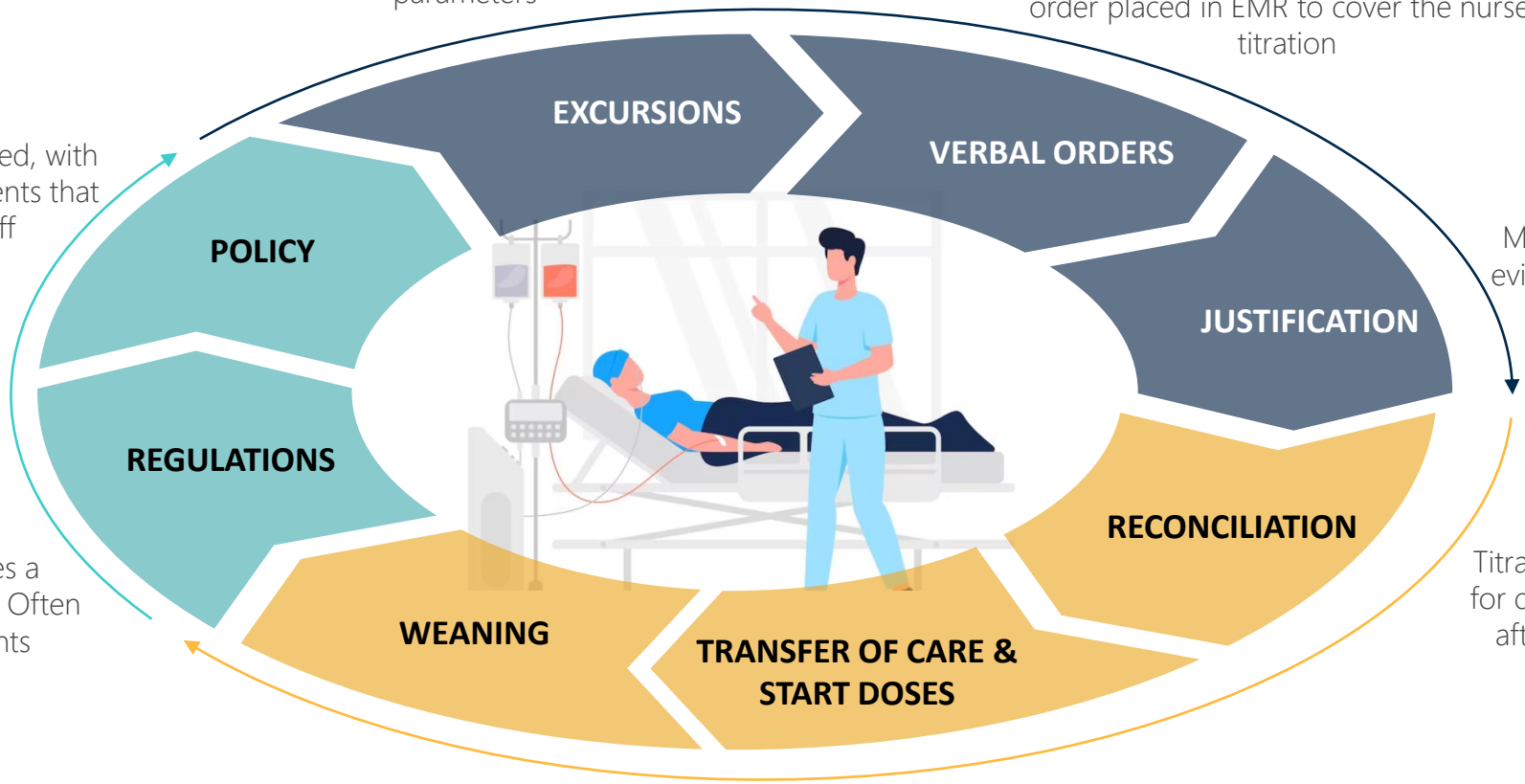
Cultural

- Providers stand at bedside and dictate rate changes in the absence of orders (extremely typical)
- Provider convenience to switch between general sedation to procedural sedation

EMR Limitations

- Difficult to build flexibility for rapidly-changing titrations into an order set
- Most of the care given in critical care settings is not visible during a review of the EHR (hard to understand WHY titrations occurred)

Most Common Citations Related to Titratable Medications



Titrating outside the ordered range/order parameters

Provider at bedside giving verbal orders – no order placed in EMR to cover the nurse's titration

Missing RASS, POSS, MAP – No evidence to support the titrations

Titration orders remain profiled for days/weeks and are re-used after being off for extended periods of time

Transferred from ED, OR with infusing going but have orders with conflicting start dose

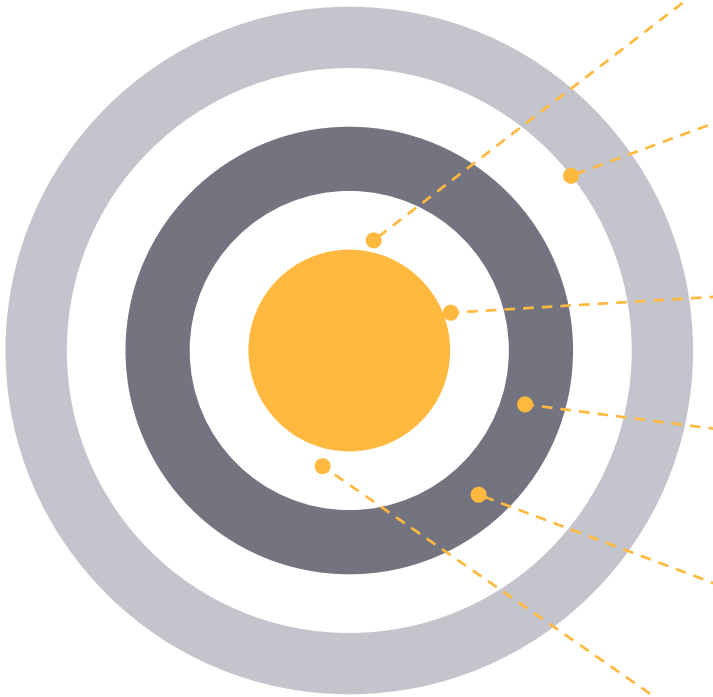
Vent weaning trials (sedation vacation) - nurses stopping drips, re-starting, titrating without orders to do so

What constitutes a completed order? Often missing elements

Policies are too complicated, with overly complex requirements that can't be met by staff

Strategies to Avoid Titration Findings

A targeted approach that addresses the issues



1. **CLARIFY:** Obtain clarification orders when orders are ambiguous, conflicting or have missing elements!
2. **AUDITS:** Real-time monitoring of compliance, providing education and support
3. **ACCOUNTABILITY**: Educate providers and hold staff accountable for ensuring safe titration management occurs
4. **POLICY:** Update policies that support workflow and facilitate capturing patient stories
5. **ROUNDING:** Multidisciplinary rounding with a focus on drip management & reconciliation
6. **EMR:** Use block charting to manage excursions & considered required "target" documentation for each titratable. Build order sets that are pre-populated with required fields

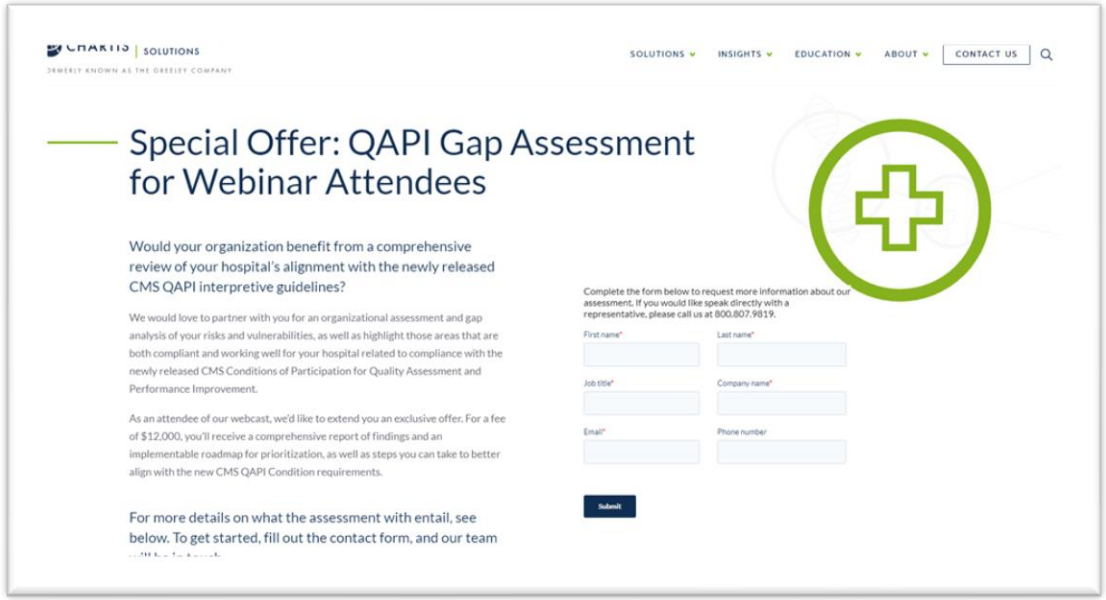
Expert Tip: EMR Navigators

- All of these are difficult to retrospective review
- We teach them how to input data, but rarely can they do an effective look back.
- Need to identify and train an expert navigator(s) to be able to find these commonly reviewed items in the clinical record.
- PRACTICE, PRACTICE, PRACTICE

Webinar Attendees Special Offer: Discounted Regulatory Rehearsal

Would your organization benefit from a comprehensive regulatory rehearsal in preparation for your next accrediting organization unannounced survey?

We would love to partner with you for an organizational assessment and gap analysis of your risks and vulnerabilities, as well as highlight those areas that are both compliant and working well for your hospital as you prepare for your next survey.



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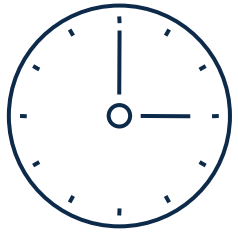

Thank you for participating in today's webinar.