Nursing Management of Restraints: Incorporating Clinical Decision Support (CDS) Tools into Flowsheet Design to Reduce Documentation Gaps, Improve Quality Data Collection, and Achieve Regulatory Compliance

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Problem Statement: Many health care institutions continue to face the challenge of choosing and implementing electronic restraints documentation tools that support nursing workflow and help to meet regulatory requirements. In the last 10 years our hospital has had many failed attempts at converting restraints documentation from paper to an electronic workflow within the electronic medical record (EMR) system. Some persistent problems included a lack of coordination between the physician and nurse workflow, delay in care related to excessive use of phone and verbal communication between care providers, frequent gaps in nursing documentation, and inaccurate and poor audit results. About 40-50% of the audited charts had documentation gaps and potentially exposed the hospital to the risk of possible regulatory violations. The objective of the project was to facilitate incorporating CDS tools into the design and implementation of an electronic restraints flowsheet that will support nursing workflow for better patient outcomes. At the end of this presentation, participants will be able to identify key steps that are essential to planning, designing and implementing an electronic restraints flowsheet for nurses that truly supports evidence based care of patients in restraints, and helps to reduce documentation gaps, as well as meet regulatory requirements. **Methods:** A multidisciplinary task force that included representatives from nursing informatics (NI), information systems (IS), nursing end users, nursing leadership, and risk management, was set up and charged with developing and designing an electronic restraints flowsheet for nurses that will help tackle the identified problems. The NI team designed a home grown flowsheet in accordance with stipulated hospital policies and guidelines. The IS team built and incorporated CDS rules that auto populated physician restraint order details into the nursing flow sheet to avoid discrepancies. The rules also generated alerts, warnings, instructions, and hard stops for incorrect documentation of critical observations. End users tested and approved the flow sheet for a 3-month pilot during which a designated IS analyst was available to make critical changes in real time. A NI support clinician was also assigned for end user around-the-clock support. Reminders were created for nurses on big display screens to flag missing documentation in real time. **Results:** Post implementation audits for the last quarter of 2015 showed that less than 20% of audited charts had documentation gaps, a 50% error reduction. The new flow sheet also required less time for charting and allowed nurses more time to deliver care to their patients. Finally, real time reminders and reports empowered nurses and directly assisted them to accurately document the care provided. **Significance:** Through collaboration and innovation, a NI led multidisciplinary team developed and designed a nursing restraints flow sheet that helped to reduce documentation gaps, improve quality data collection and achieve regulatory compliance. This was validated by a recent regulatory mock survey with no findings and concerns in the management and documentation of restraints.