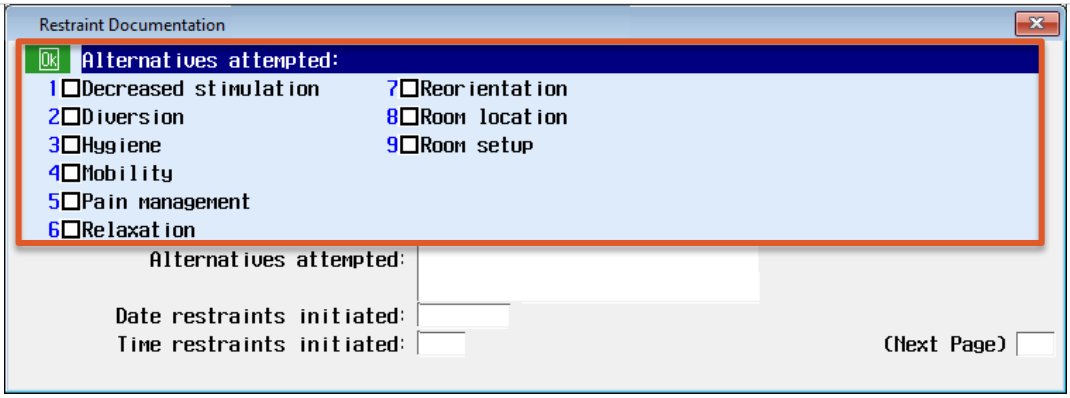
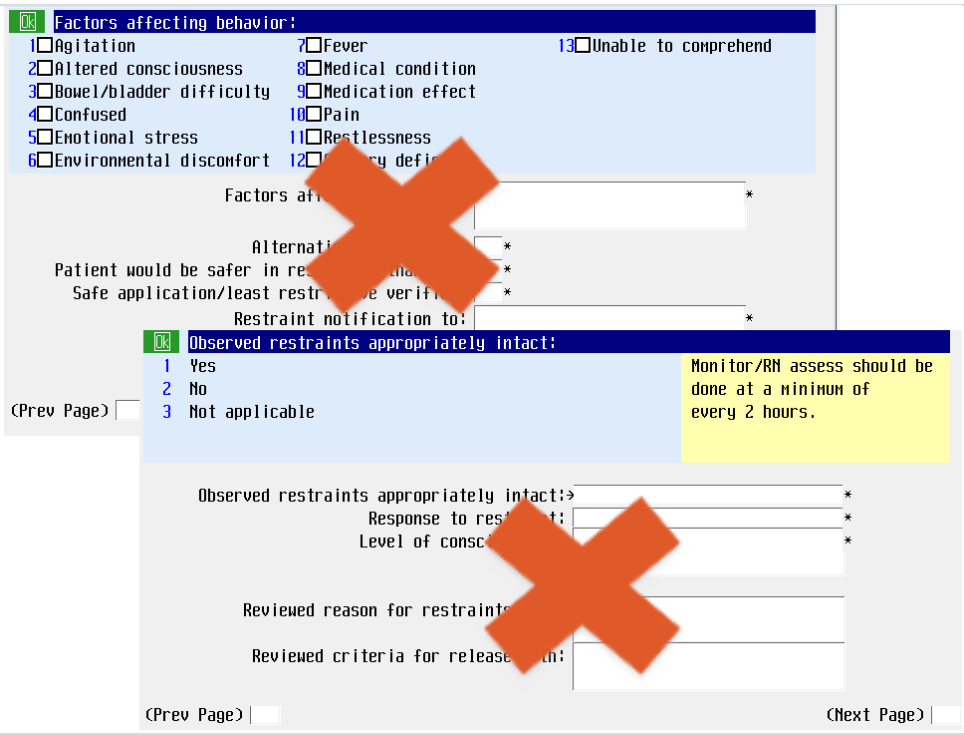
Restraint 2026 Phase 2 Strategic Agenda

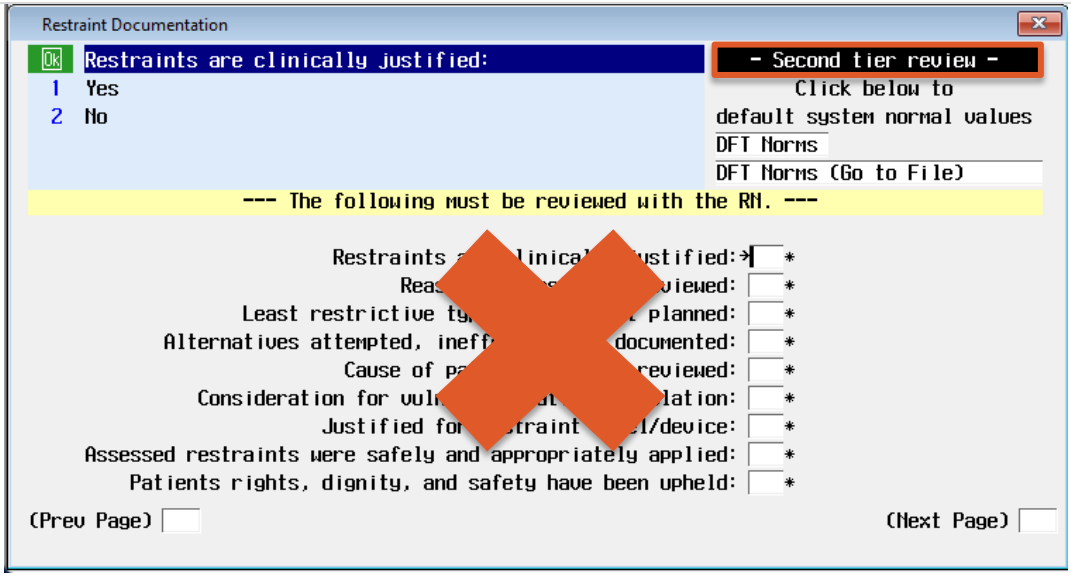
As part of the ongoing Corporate Responsible Restraint Program, the 2026 initiative focuses on refining policies and clarifying clinical practice expectations to ensure alignment with The Joint Commission (TJC) and CMS requirements. Restraint documentation workflows have been streamlined to remove duplicative, outdated, and non-required elements. These updates reduce documentation burden, improve regulatory compliance, and enhance efficiency in both bedside care and EHR documentation. The revised workflow standardizes restraint documentation to reflect current regulatory requirements while maintaining existing system programming across all restraint episodes.



In **Start** workflow, *Alternatives utilized* has been updated to *Alternatives attempted* and the response options have been streamlined to better align with policy.

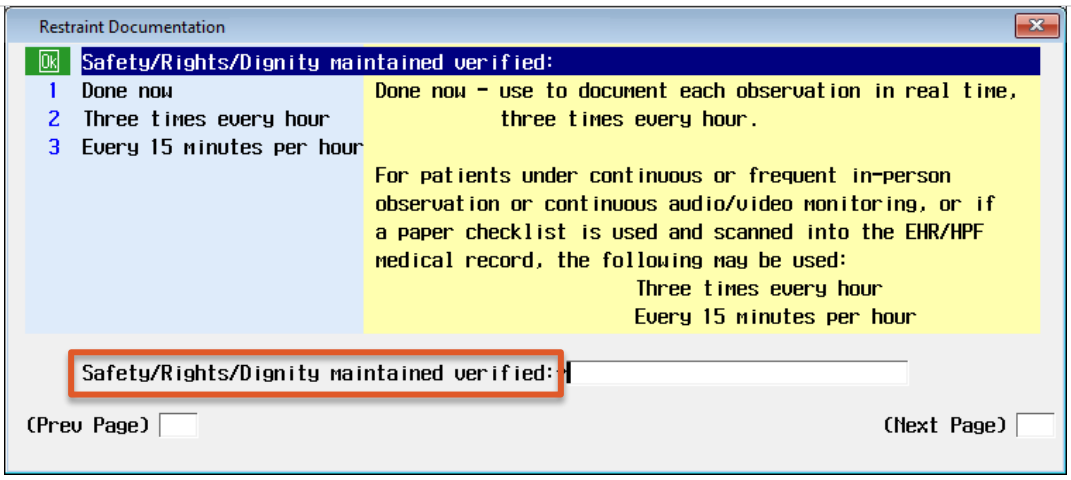


The documentation fields on pages 2 and 3 of the **Start** and **Monitor** workflow have been removed to eliminate duplicative documentation.

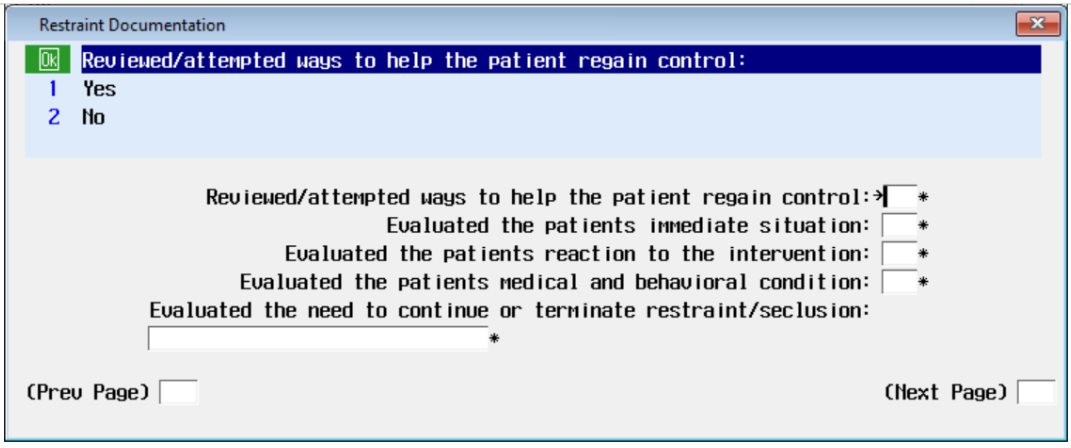


The **Second tier review** documentation has been removed in alignment with recent policy updates.

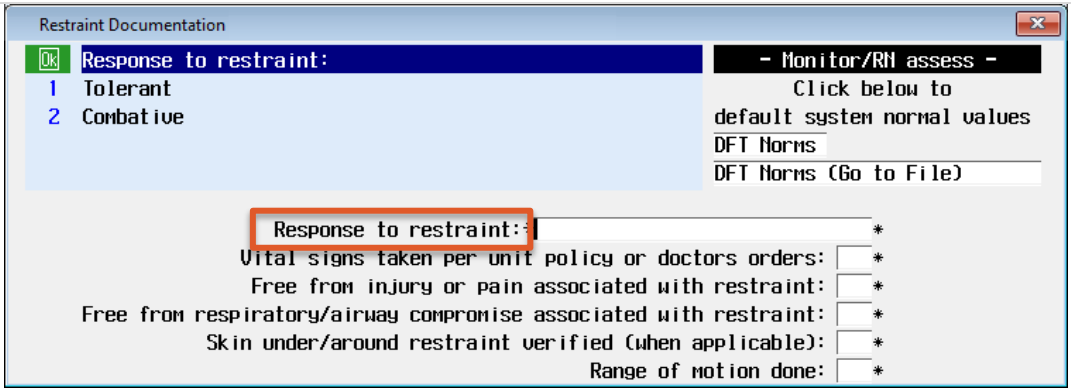
Note: Second tier review has also been removed from the Restraints Report.



Safety/Rights/Dignity documentation is now only available for violent restraint episodes.

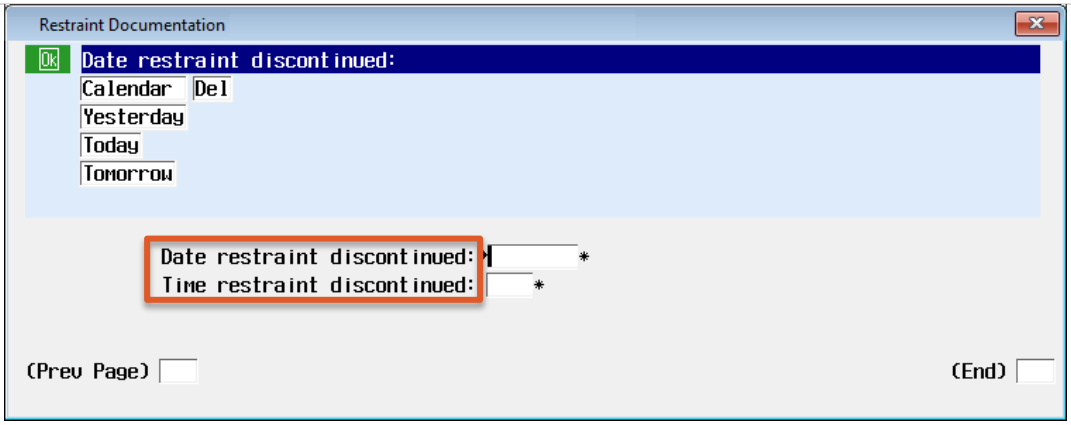


For Violent level of restraints, the one-time **Face to face** documentation has been reduced.

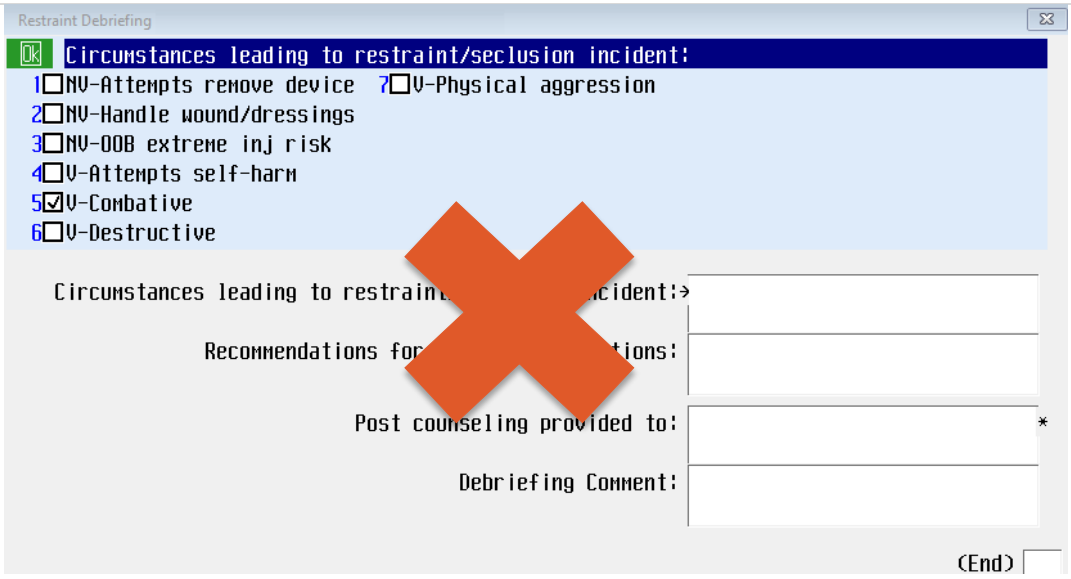


Response to restraint has been added to the **Monitor/RN assess** documentation. Responses continue to allow for selection of 'DFT Norms' and 'DFT Norms (Go to File)'.

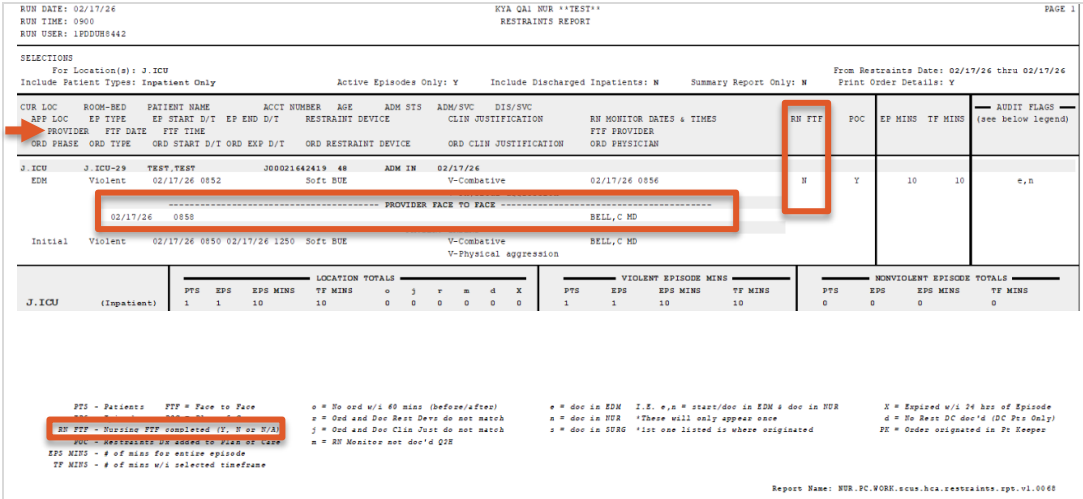
Note: *Monitor/RN assess* may be documented as often as necessary/per policy.



The **Restraint Discontinue** workflow has been updated to require documentation of only the date and time the restraint was discontinued for both Violent and Non-violent workflows.



The **Restraint Debriefing** documentation has been removed from the Violent level of restraint discontinue workflow documentation.



RUN DATE: 02/17/26
RUN TIME: 0900
RUN USER: 1PDDUH8442

KYA QA1 NUR **TEST**
RESTRAINTS REPORT

PAGE 1

SELECTIONS
For Location(s): J.ICU
Include Patient Types: Inpatient Only
Active Episodes Only: Y
Include Discharged Inpatients: N
Summary Report Only: N
From Restraints Date: 02/17/26 thru 02/17/26
Print Order Details: Y

CUR LOC / APP LOC / PROVIDER / ORD PHASE	ROOM-BED / EP TYPE / FTF DATE / ORD TYPE	PATIENT NAME / EP START D/T / FTF TIME / ORD START D/T	ACCT NUMBER / EP END D/T / ORD EXP D/T	AGE / RESTRAINT DEVICE / ORD RESTRAINT DEVICE	ADM STS / CLIN JUSTIFICATION / ORD CLIN JUSTIFICATION	ADM/SVC / RN MONITOR DATES & TIMES / FTF PROVIDER / ORD PHYSICIAN	DIS/SVC	RN FTF	POC	EP MINS	TF MINS	AUDIT FLAGS (see below legend)
J.ICU / EDM	J.ICU-29 / Violent	TEST,TEST / 02/17/26 0852	J00021642419 /	48 / Soft BUE	ADM IN / V-Combative	02/17/26 / 02/17/26 0856		N	Y	10	10	e,n
		PROVIDER FACE TO FACE										
		02/17/26 0858				BELL,C MD						
Initial	Violent	02/17/26 0850	02/17/26 1250	Soft BUE	V-Combative V-Physical aggression	BELL,C MD						

	LOCATION TOTALS									VIOLENT EPISODE MINS				NONVIOLENT EPISODE TOTALS			
	PTS	EPS	EPS MINS	TF MINS	o	j	r	m	d	X	PTS	EPS	EPS MINS	TF MINS	PTS	EPS	EPS MINS	TF MINS
J.ICU (Inpatient)	1	1	10	10	0	0	0	0	0	0	1	1	10	10	0	0	0	0

PTS - Patients
FTF = Face to Face
RN FTF - Nursing FTF completed (Y, N or N/A)
POC - Restraints DX added to Plan of Care
EPS MINS - # of mins for entire episode
TF MINS - # of mins w/i selected timeframe

o = No ord w/i 60 mins (before/after)
r = Ord and Doc Rest Devs do not match
j = Ord and Doc Clin Just do not match
m = RN Monitor not doc'd Q2H

e = doc in EDM I.E. e,n = start/doc in EDM & doc in NUR
n = doc in NUR *These will only appear once
s = doc in SURG *1st one listed is where originated

X = Expired w/i 24 hrs of Episode
d = No Rest DC doc'd (DC Pts Only)
PK = Order originated in Pt Keeper

Report Name: NUR.PC.WORK.ncus.hca.restraints.rpt.v1.0068

Note: RN FTF has been added to the legend.

The Restraints Report has been updated with the following changes:

- Face to face column has been updated to RN FTF.
- A new header and row have been added to indicate when the Face-to-face was completed by a provider. It will display the provider's name along with the date and time documented. If the documentation is completed using PK, then that will be displayed in lieu of the provider's name.

This update affects the following interventions:

Nursing	Emergency Department	Surgery
Restraint Documentation +	Restraint Documentation	SURG: Restraints Documentation Pre-op +
		SURG: Restraints Documentation Intra-op+
		SURG: Restraints Documentation PACU +

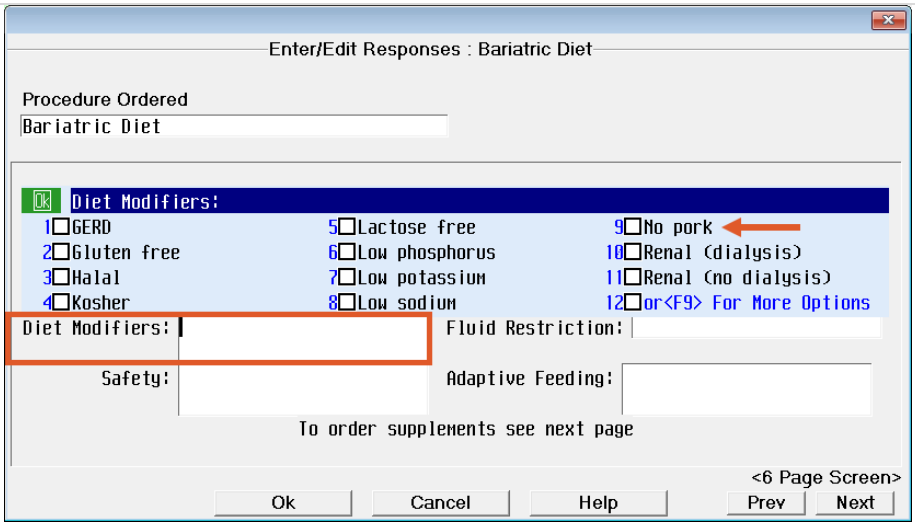
Standard Diet Orders Update

MEDITECH CPOE Update

EHR 2026.2 Update

Standard Diet Order Updates: Modifiers/Supplements

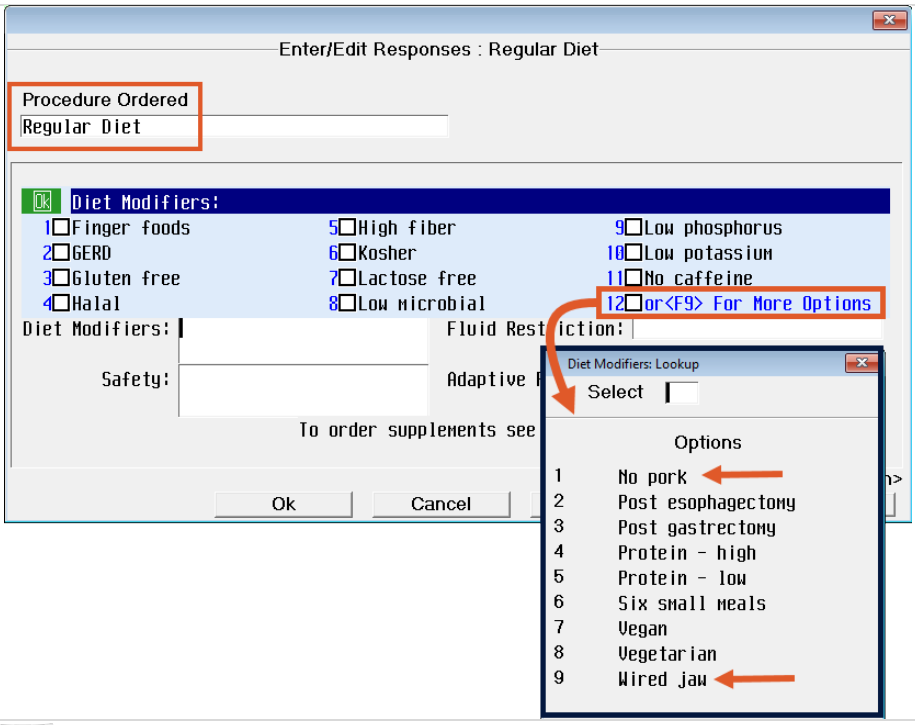
Updates have been made to the Standard Diet Orders, Modifiers, and Supplements to more accurately capture patient nutrition needs.



Diet Modifiers

The following standardized diet orders has been updated with the new 'No pork' modifier field response:

- Bariatric Diet
- Cardiac/Heart Healthy Diet
- Clear Liquid Diet
- Consistent Carb/Diabetic Diet
- Dysphagia/IDDSI Diet
- Fiber Restricted Diet
- Full Liquid Diet
- Low Fat Diet
- Low Sodium Diet
- Pediatric Diet
- Regular Diet
- Renal Diet
- Adult tube feeding
- Pediatric tube feeding



In addition, the 'Wired jaw' modifier field response has been added to **Regular Diet** *only*.

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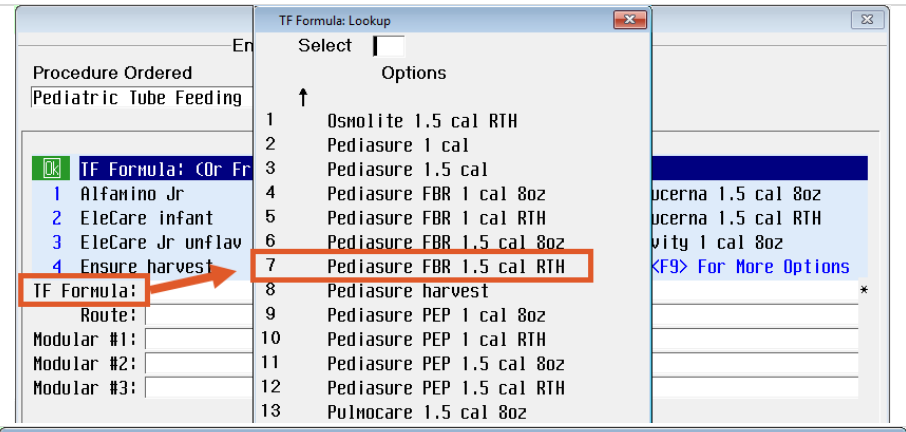
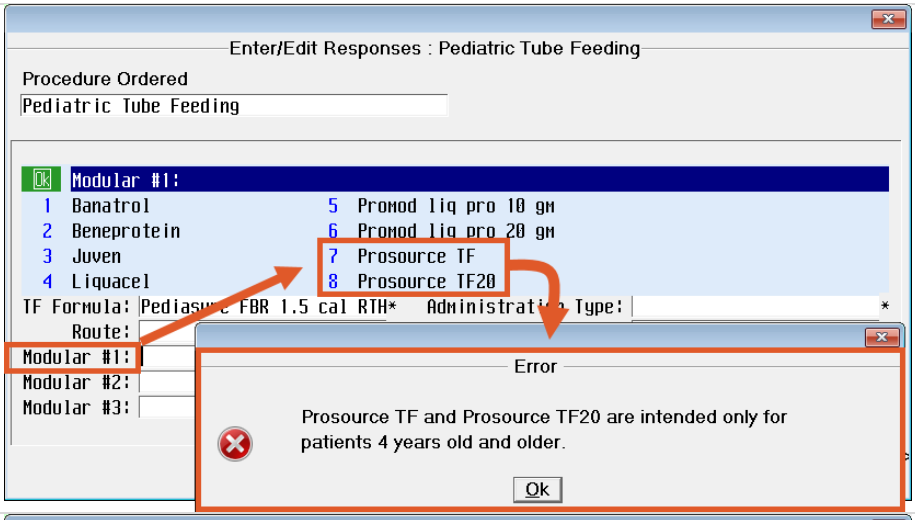


Tube Feeding Orders

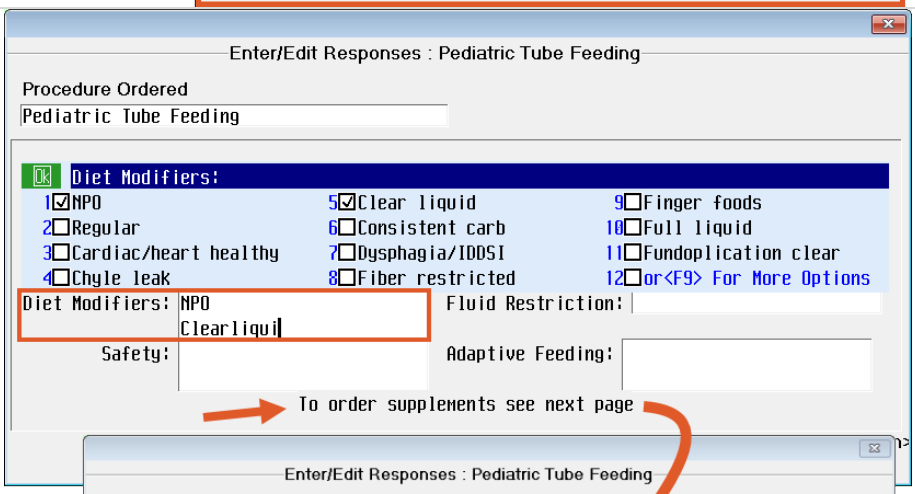
'Pediasure FBR 1.5 cal RTH' has been added to the **Pediatric Tube Feeding** formula list.

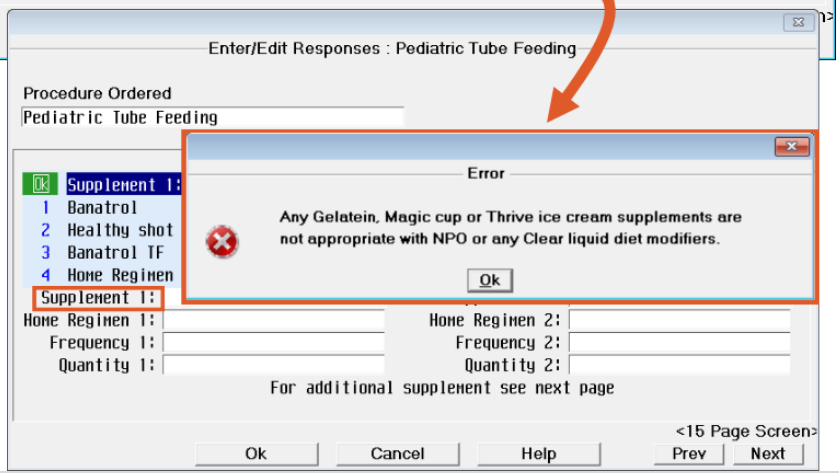
'Prosource TF' and 'Prosource TF20' have been added to both **Adult** and **Pediatric Tube Feeding Modulars**. <see below>



An "Age-Appropriate" **Error Message** has been added to 'Prosource TF' and 'Prosource TF20' that will prohibit ordering these items for patients who are under 4 years of age.

Prosource TF and Prosource TF20 are intended only for patients 4 years old and older.





Supplements

Order Rule Logic has been added to all 'Supplement' fields. If 'NPO', 'Clear liquid', 'Fundoplication clear' or 'Bariatric clear liquid' (*Adults Only*) is entered as a 'Diet Modifiers' and inappropriate supplements are selected, the following **Error Message** will display:

Any Gelatein, Magic cup or Thrive ice cream supplements are not appropriate with NPO or any Clear liquid diet modifiers.

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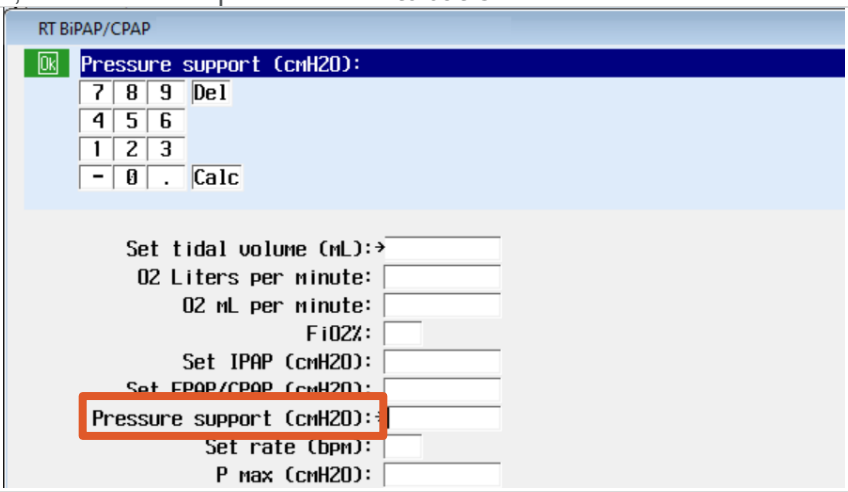
Supplements Added	Supplements Removed
The following *New* supplements/flavors have been added and are available for selection if appropriate: • Juven pineapple coconut • Magic cup van redu sugar • Prosource no carb **Note**: *If the supplement is not appropriate for the ordered diet it will be unavailable in Look-Ups.*	The following supplements have been removed from ***ALL*** supplement selections: • Ensure plus HP • Prosource TF

Nursing, EDM & SUR Modules

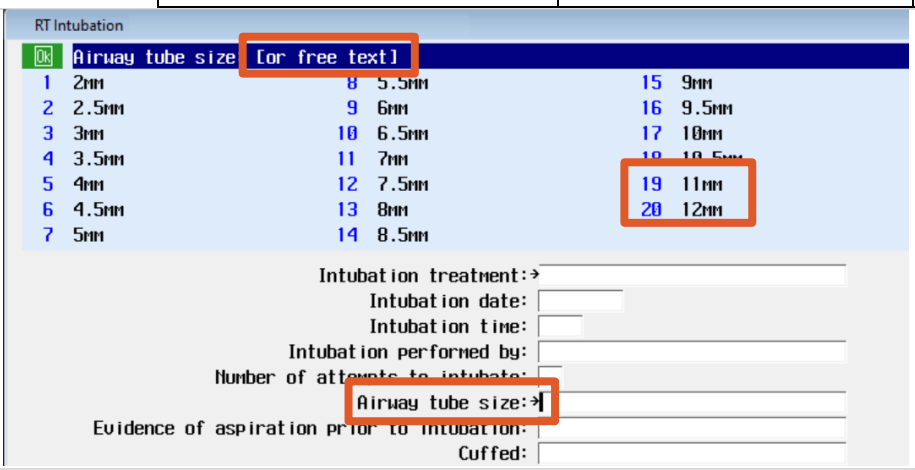
Pressure Support and Airway Tube Size Update

Current documentation workflows for Respiratory Therapists do not include structured fields for documenting pressure support in BiPAP/CPAP interventions or a response option for airway tube sizes greater than 10.5mm for Intubation interventions. This update adds a *Pressure support* field to all **BiPAP/CPAP** interventions and expands the *Airway tube size* responses to include 11mm, 12mm, and free text option for all **Intubation** interventions.



The *Pressure support (cmH20)* has been added to all **RT: BiPAP/CPAP** interventions.

Nursing		Emergency Department
RT: BiPAP/CPAP Initial	RT PED: BiPAP/CPAP Initial	RT: BiPAP/CPAP
RT: BiPAP/CPAP Subsequent	RT PED: BiPAP/CPAP Subsequent	
RT: BiPAP/CPAP		



Additional responses have been added to the *Airway tube size* field within all **RT: Intubation** interventions:

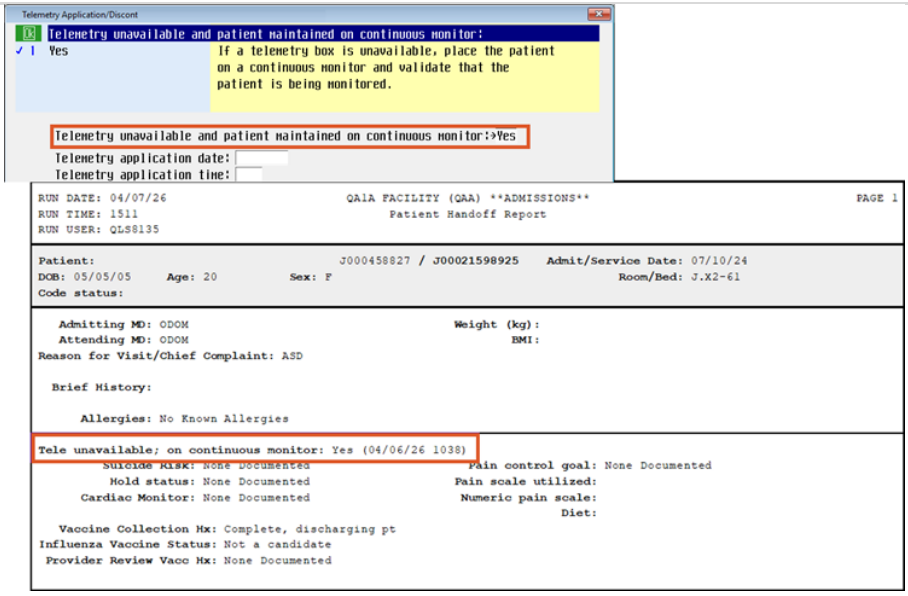
- Free text
- 11mm
- 12mm

Nursing		Emergency Department	Surg
Lines/Drains/Airways	RT: Intubation Assist- Inpatient	Intubation	SURG: Lines/Drains/Airways Intra-op
Critical Care Flowsheet	RT: Intubation Assist- Outpatient	Newborn Stabilization	SURG: Lines/Drains/Airways PACU
RT: Intubation- Inpatient	RT PED: Intubation Assist- Inpatient	RT: Intubation Assist- Output	SURG: Lines/Drains/Airways Pre-op
RT: Intubation- Outpatient	RT PED: Intubation Assist- Outpatient	RT: Intubation- Output	
RT PED: Intubation- Outpatient	RT: Ventilator Flowsheet	RT: Neonatal Intubation	
RT: Neonatal Intubation	RT PED: Ventilator Flowsheet	RT: Ventilator Flowsheet	
RT PED: Neonatal Intubation			

Nursing & EDM Modules

Telemetry Unavailable Optimization

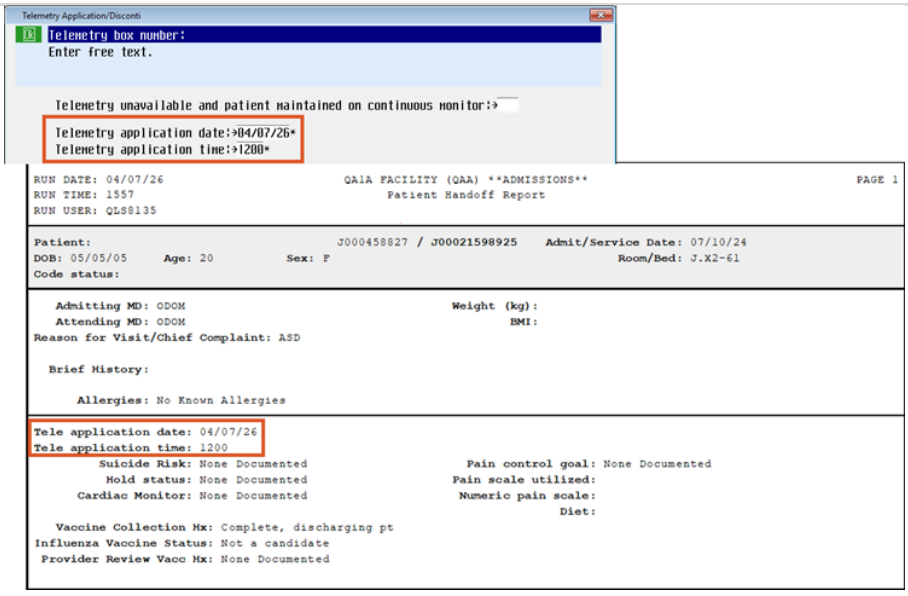
In 2024, the field *Telemetry Unavailable and patient maintained on continuous monitor* was added to the EDM Telemetry intervention to allow clinicians to document situations where telemetry is ordered, but a telemetry box is not available. This field will now be included in the nursing module. The field has been moved to be the first question to enhance workflow.



If telemetry is unavailable and patient is on a continuous monitor, 'Yes' would be documented in the field.

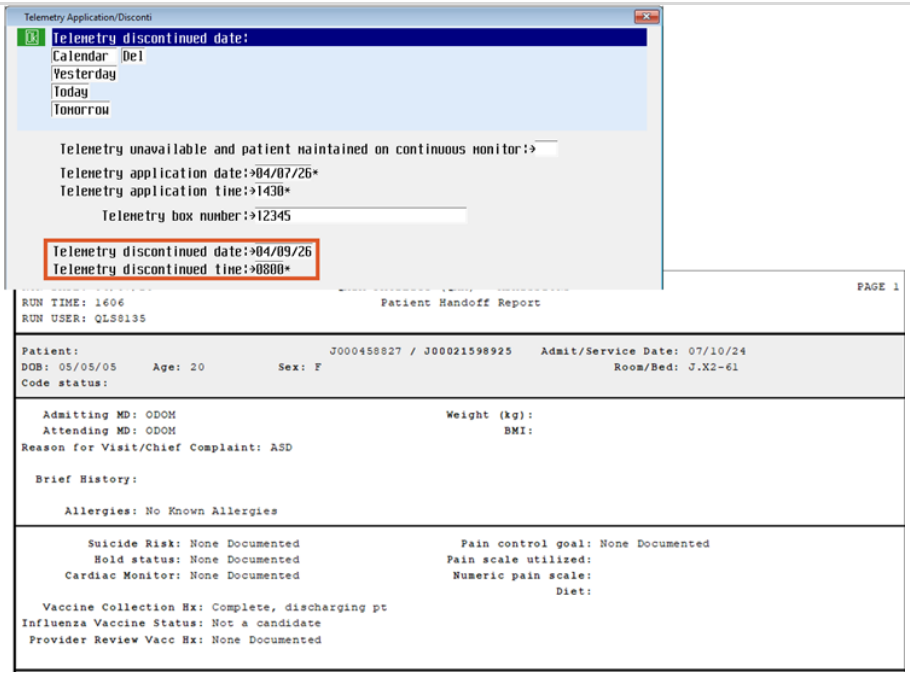
If 'Yes' is documented:
The rest of the queries on the screen will be bypassed.

Telemetry unavailable will display on the SBAR report with the date and time the intervention was filed.

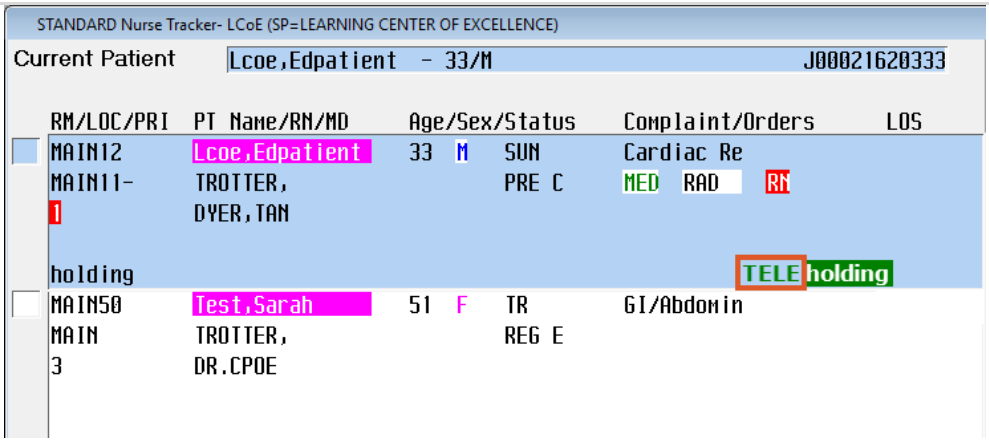


The documented T*elemetry application date and time* will continue to be displayed on the SBAR report.

Note: When the *Telemetry application date and time* are documented, the previous T*elemetry unavailable* response will be automatically removed from the SBAR report.



Once the *Telemetry discontinued date and time* is documented, the telemetry fields will no longer be displayed on the SBAR report.



ED TRACKER

For ED patients on Inpatient Hold with a Telemetry Initial Order, a TELE indicator displays on the ED Tracker. Click the indicator to open the charting screen. Refer to the *ED INPT HOLD Telemetry Administrator Guide* for additional details.

Nursing Intervention	Emergency Department Treatment
Tele App/Discon *ORDER REQUIRED*	Telemetry Application/Disconti

Alteplase - Alignment with Large Volume IV Pump Library

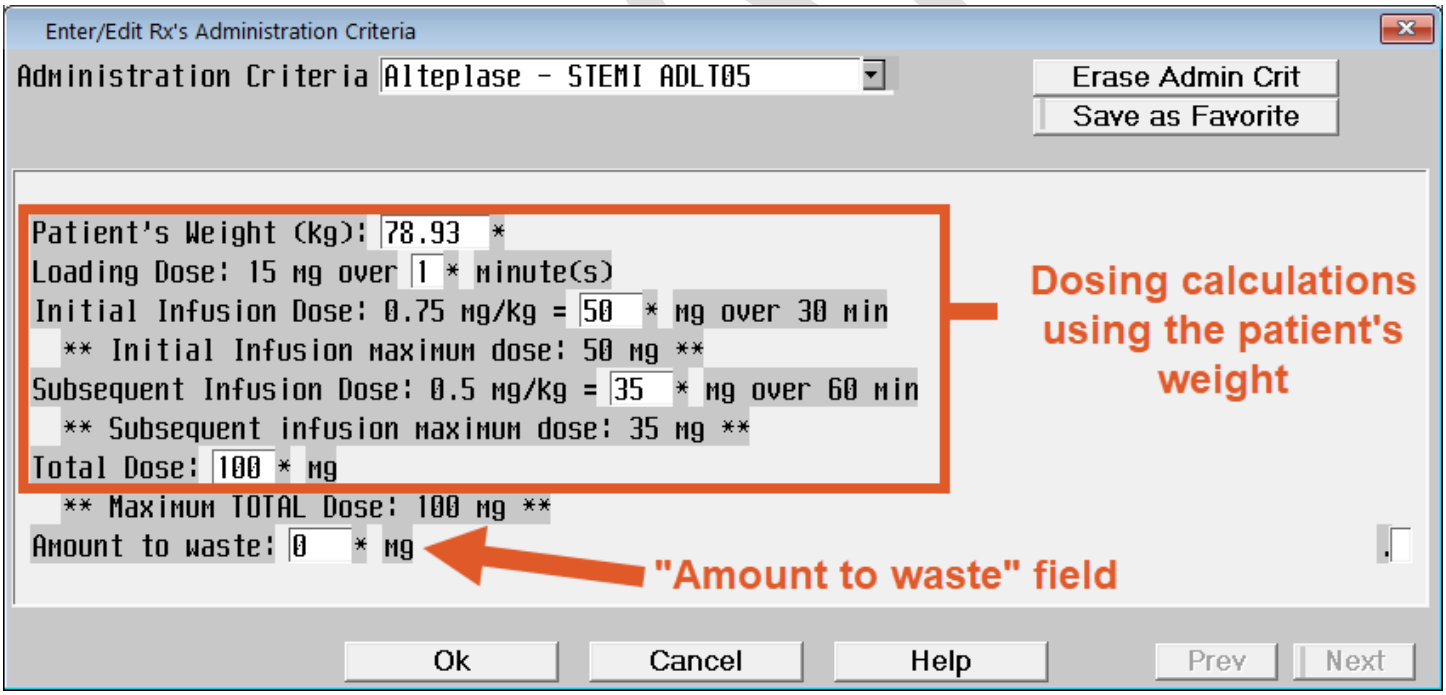
Alteplase is a high alert medication with risk of bleeding adverse events including intracranial hemorrhage. Multiple indications and multiple dosing strategies pose increased patient safety risk. This enhancement will update v5 adult admin criteria with new screens for alteplase for new indications to align with the IV pump standardization.

The new enhancements consist of the following:

- Two additional screens have been created for Alteplase to treat STEMI and Frostbite.
- The new screens will include dosing calculations using the patient's weight.
- New screens will calculate the amount to waste for doses that are less than 100 mg.

New Screens – Provider View

Alteplase – STEMI



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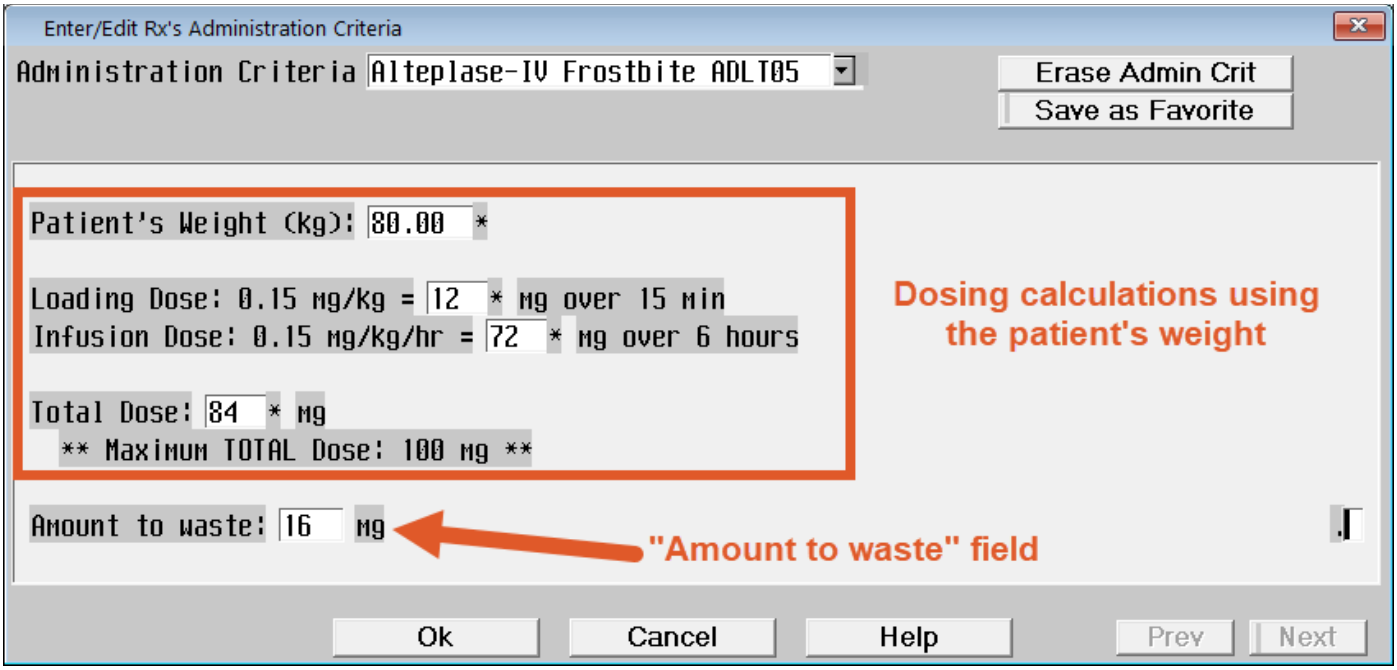
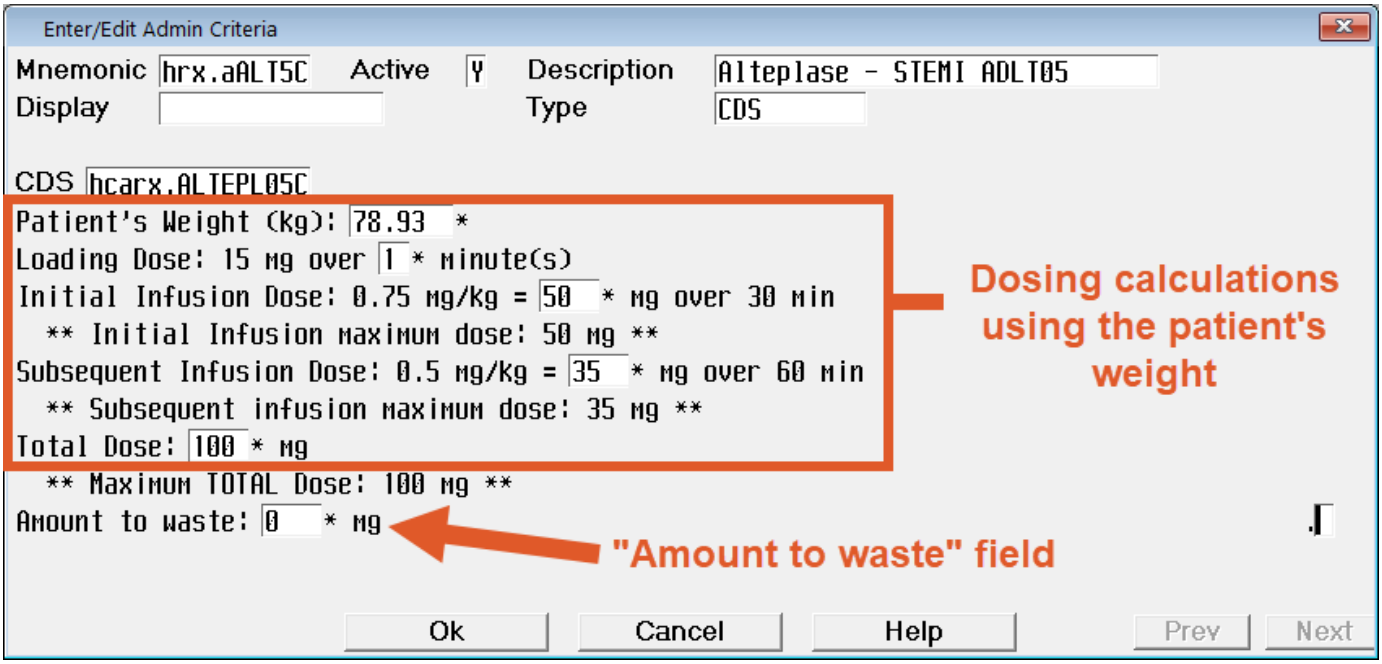
Alteplase - IV Frostbite

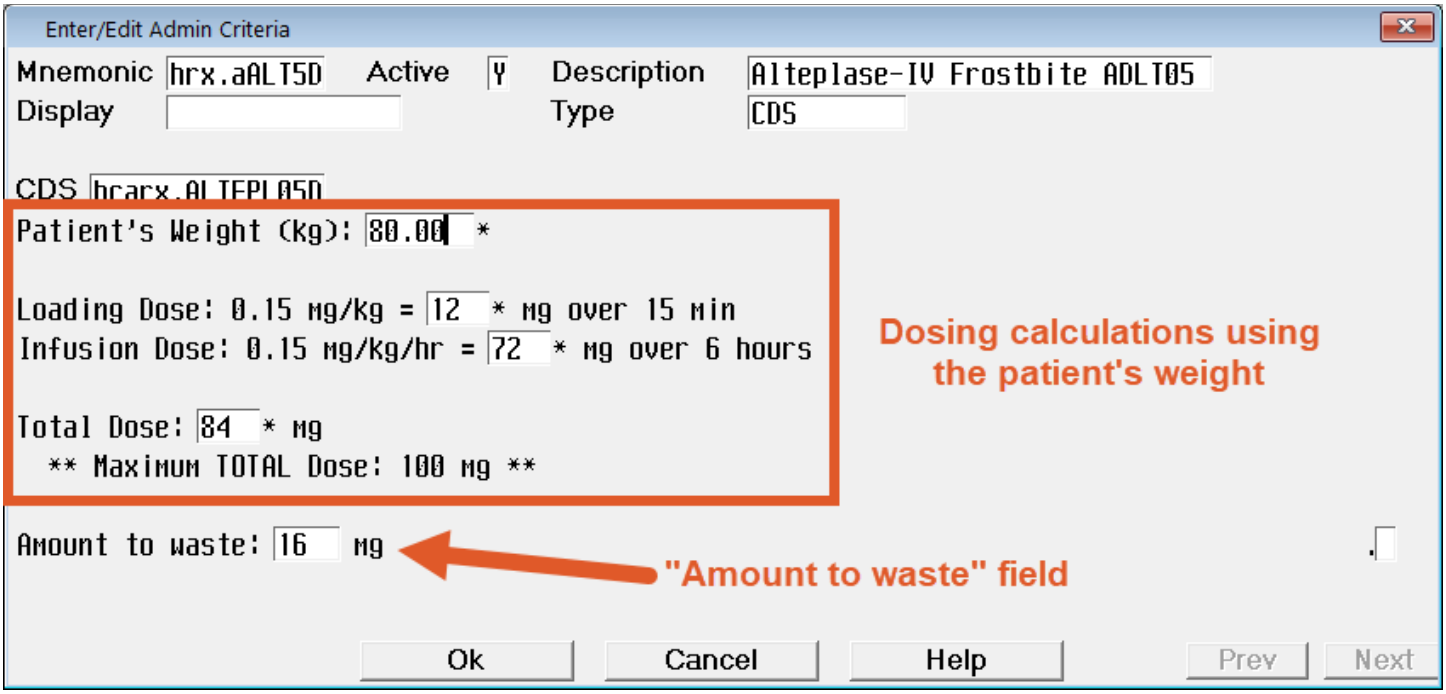


New Screens – Pharmacy View

Alteplase – STEMI



Alteplase – IV Frostbite



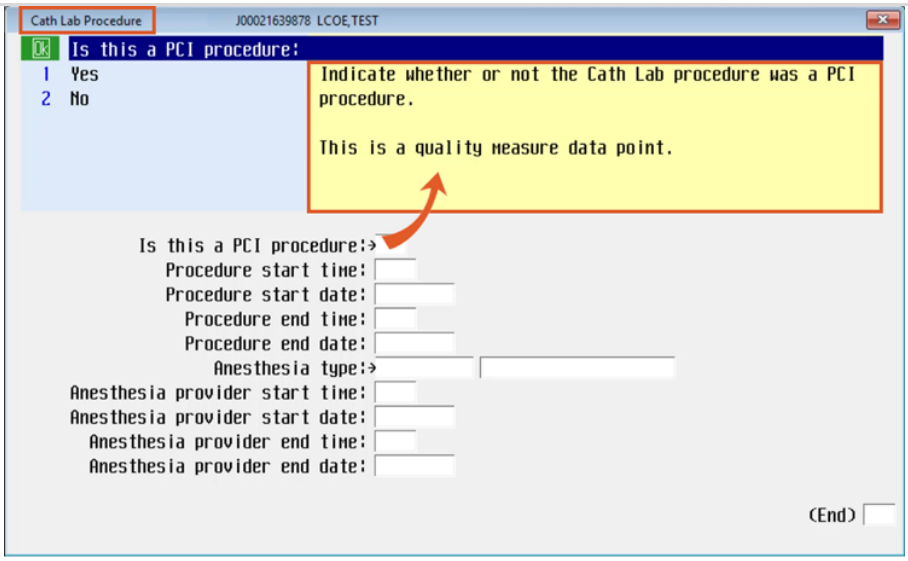
Nursing & SUR Modules

2026 eCQM HH-PRF (Hospital Harm Postoperative Respiratory Failure)

Currently, identification of Cath Lab patients who receive anesthesia and subsequently experience postoperative respiratory failure during the same hospitalization relies on non-standardized procedural data sources from third-party applications. These complications, including unplanned intubation or delayed extubation occurring outside of the procedural or surgical setting, are difficult to consistently capture without a clear indication of when the patient was in a procedural area.

This update will establish a standardized, EHR-based approach within Meditech to capture procedural timing and related anesthesia events at the point of care. By clearly identifying when a patient is in a procedural setting, Quality teams can more reliably identify, track, and analyze postoperative respiratory failure events, supporting improved clinical oversight, quality monitoring, and eCQM reporting.

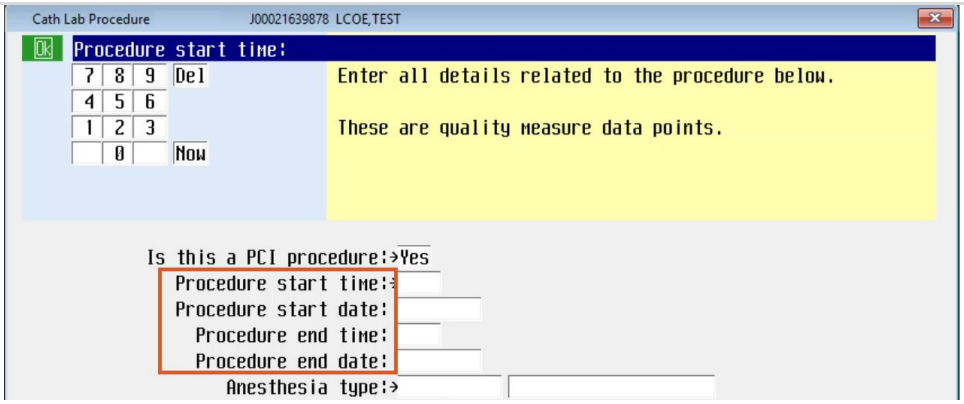
Procedural and PACU staff play a critical role in this process by documenting the required intervention in Meditech. Accurate and timely documentation ensures the procedural context is clearly defined, enabling reliable eCQM measurement and reporting.



The new intervention, **Cath Lab Procedure +**, will replace the **PCI Procedure** intervention.

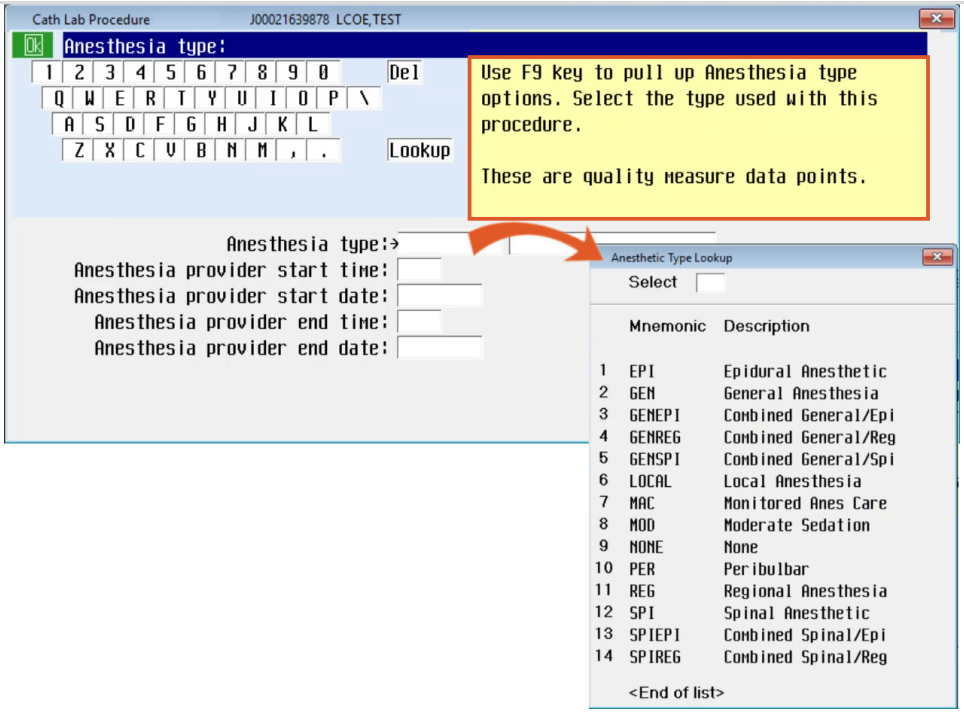
Is this a PCI procedure has a 'Yes' or 'No' response.

Note: The yellow information box stating, "This is a quality measure data point," is available on most fields in this intervention.



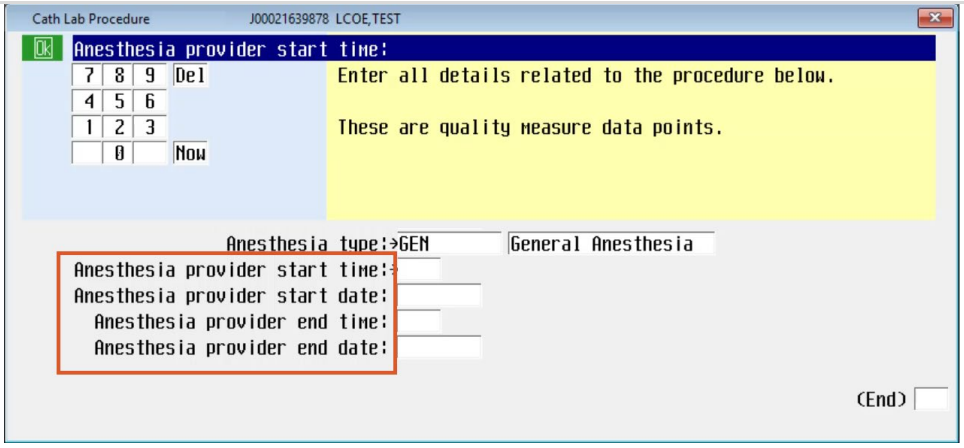
The following fields are time and date related responses for:

- Procedure start time
- Procedure start date
- Procedure end time
- Procedure end date



Anesthesia type will look up into the facility specific Anesthesia Types available. Below is an example of responses:

- Epidural Anesthetic
- General Anesthesia
- Combined General/Epi
- Combined General/Reg
- Combined General/Spi
- Local Anesthesia
- Monitored Anes Care
- Moderate Sedation
- None
- Peribulbar
- Regional Anesthesia
- Spinal Anesthesia
- Combined Spinal/Epi
- Combined Spinal/Reg



The following fields are time and date related responses for:

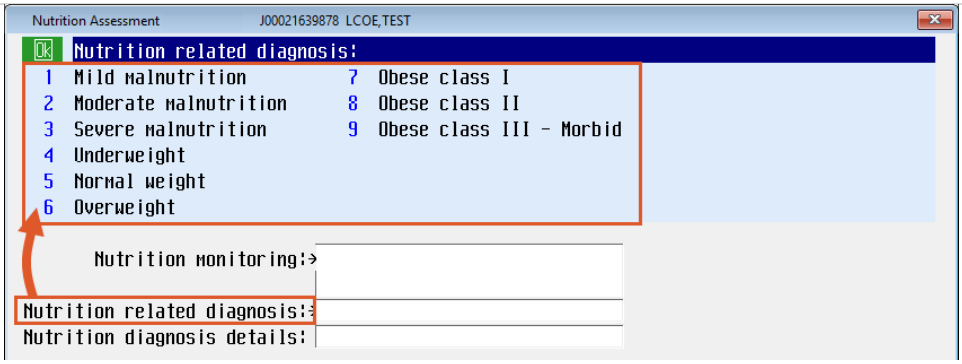
- Anesthesia provider start time
- Anesthesia provider start date
- Anesthesia provider end time
- Anesthesia provider end date

Nursing	SURG
Cath Lab Procedures +	SURG: Cath Lab Procedure Intra-op+ & PACU

Nursing & Ancillary Modules

Nutritional Related Diagnosis

The response options for *Nutrition related diagnosis* were not sufficiently defined to meet CMS guidelines. This update introduces more detailed response options to support precise documentation that can be included in provider documentation and ensures CMS compliance.



Note: A malnutrition response for adult patients in *Nutrition related diagnosis* will skip the *Nutrition diagnosis details* field.

Responses for the *Nutrition related diagnosis* field have been updated to include:

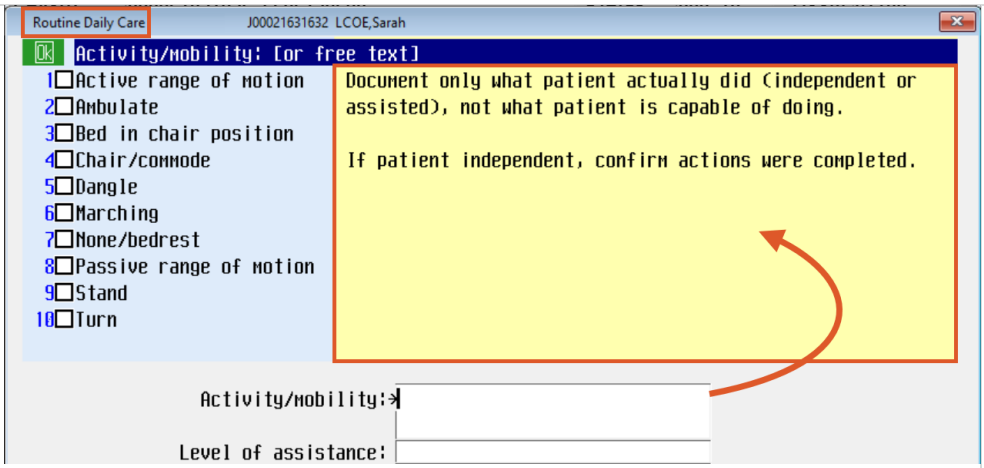
- Mild malnutrition
- Moderate malnutrition
- Severe malnutrition
- Underweight
- Normal weight
- Overweight
- Obese class I
- Obese class II
- Obese class III - Morbid

Nursing
Nutritional Assessment

Nursing Module

Mobility Nursing Strategic Agenda Enhancements

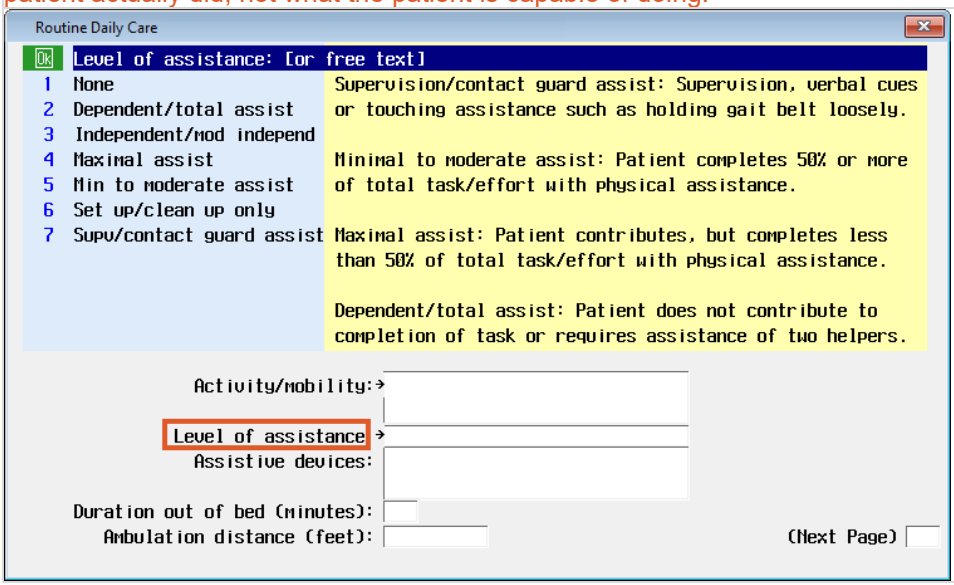
This update will enhance documentation in the **Routine Daily Care** to standardize capture of patient activity/mobility and level of assistance, improving multidisciplinary communication, visibility into functional status, and correlation with outcomes including length of stay, falls, NVHAP, CAUTI/CLABSI, restraint use, and pressure injuries.



Note: The yellow information box has been updated to document only what the patient actually did, not what the patient is capable of doing.

The *Activity* field has been modified to *Activity/Mobility* and the group responses have been updated to include:

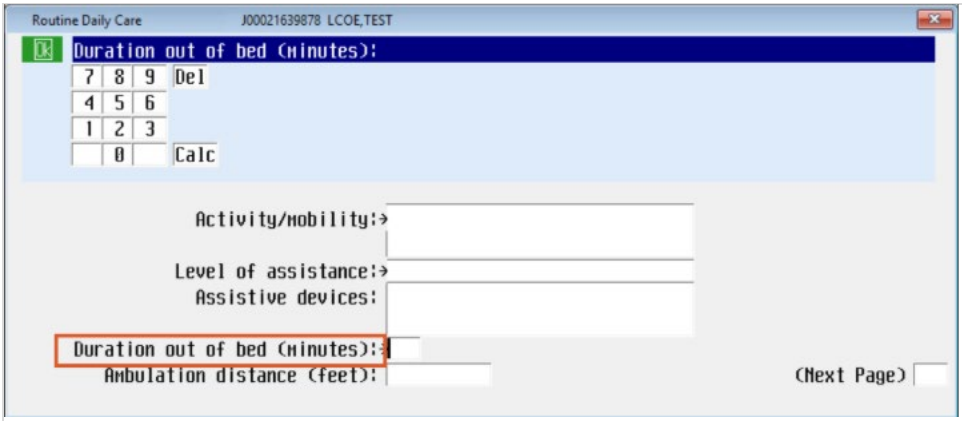
- Active range of motion
- Ambulate
- Bed in chair position
- Chair/commode
- Dangle
- Marching
- None/bedrest
- Passive range of motion
- Stand
- Turn
- Free text



For *Level of assistance*, the group responses have been updated to include the following:

- None
- Dependent/total assist
- Independent/mod independ
- Maximal assist
- Min to moderate assist
- Set up/clean up only
- Supv/contact guard assist
- Free text

Note: The yellow information box defines levels of assistance.



A new field for *Duration out of bed (minutes)* has been added in place of *Ambulation duration (minutes)*.

Nursing
Routine Daily Care