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|  |  | **Organizational Identifiers** |  |  |
|  | VAMCCONTROLQICBEGDTEREVDTE | Facility IDControl NumberAbstractor IDAbstraction Begin DateAbstraction End Date | Pre-fillQI pre-fillAuto-fillAuto-fillAuto-fill |  |
|  |  | **Patient Identifiers** |  |  |
|  | SSNFINPTNAMEFPTNAMELBIRTHDTSEXRACEETHNICITYCOHORTAGE | Patient SSNFINFirst NameLast NameBirth DateSexRaceEthnicityCohortAge | Pre-fill: no changePre-fill: no changePre-fill: no changePre-fill: no changePre-fill: no changePre-fill: **can change**Pre-fill: no changePre-fill: no changePre-fill: no change*Age: calculation (depends on study timeframe)*  |  |

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| 1 | admdt | Date of admission to inpatient care: | mm/dd/yyyy**Auto-filled: can be modified**

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| <= dcdate and <= pull date |

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| Warning if admdt is > 6 months prior to dcdate |

 | **Auto-filled; can be modified if abstractor determines that the date is incorrect.*** Admission date is the date the patient was actually admitted to acute inpatient care.
* For patients who are admitted to Observation status and subsequently admitted to acute inpatient care, abstract the date that the determination was made to admit to acute inpatient care and the order was written. Do not abstract the date that the patient was admitted to Observation.

**Example:**  Medical record documentation reflects that the patient was admitted to observation on 04-05-2023. On * 04-06-2023 the physician writes an order to admit to acute inpatient effective 04-05-2023. **The Admission Date would be abstracted as 04-06-2023**; the date the determination was made to admit to acute inpatient care and the order was written. If there are multiple inpatient orders, use the order that most accurately reflects the date that the patient was admitted.
* The admission date should not be abstracted from the earliest admission order without regards to substantiating documentation. If documentation suggests that the earliest admission order does not reflect the date the patient was admitted to inpatient care, this date should not be used.

**ONLY ALLOWABLE SOURCES:** Physician orders (priority data source), Face Sheet**Exclusion:** admit to observation, arrival date |
| 2 | psyadmdt | Date of admission to inpatient psychiatric care.  | mm/dd/yyyy

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| >= admdt and<= psydcdt and <=dcdate, and <= pull date |

 | Enter the exact date the patient was admitted to inpatient psychiatric care. In hospitals with an inpatient psychiatric unit, the Psychiatric Admission Date may be different from the original hospital admission date.If the patient was in an acute-care hospital and had multiple admissions to the psychiatric unit during this hospitalization, enter the date of the first admission to the psychiatric unit.**Exclusion:** **admission to observation, arrival date** |
| 3 | psydcdt | Enter the date of discharge from inpatient psychiatric care.  | mm/dd/yyyyAbstractor can enter 99/99/9999

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| > = psyadmdt and <= dcdate and <= pull date |

 | Enter the exact date the patient was discharged from inpatient psychiatric care. If the patient left against medical advice or expired, enter the date of occurrence. If there are multiple admissions to the psychiatric unit during this hospitalization, enter the date of the discharge from the psychiatric unit that corresponds with the admission in psyadmdt.. If the patient has not been discharged from inpatient psychiatric care and is currently still admitted at the time of this review, enter 99/99/9999. |
| 4 | dcdate | Discharge date from hospital. | mm/dd/yyyy**Auto-filled. Can be modified**Abstractor can enter 99/99/9999

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| --- |
| > = admdt and >= psydcdt, and <= pull date |
| If psydcdt = 99/99/9999, dcdate must = 99/99/9999 |

 | **Auto-filled; can be modified.**The computer auto-fills the discharge date from the Office of Analytics and Performance Integration-Performance Measurement (API-PM) pull list. This date can be modified in order to ensure the selected episode of care is reviewed. If the auto-filled date is incorrect, enter the exact date the patient was discharged from acute inpatient care.If the patient has not been discharged from the hospital and is still admitted at the time of this review, enter 99/99/9999.  |
| 5 | psycare | Did the patient receive care in an inpatient psychiatric care setting?1. Yes 2. No | 1**,** \*2**\*If 2, the case is excluded from TJC HBIPS quality measures. Go to end.** | * **In order to answer “1”, there must be documentation in the medical record that the patient was receiving care primarily for a psychiatric diagnosis in an inpatient psychiatric setting, i.e. a psychiatric unit of an acute care hospital.**
* Psychiatric Units that treat dual diagnosis patients (patients with **both** substance use disorders and psychiatric diagnoses) are included in the Hospital Based Inpatient Psychiatric Services (HBIPS) measures.
* **Exclude:**
	+ Chemical Dependency Units that treat patients primarily for substance use disorders and occasionally psychiatric diagnoses.
	+ Patient with a psychiatric diagnosis who received care in an inpatient unit OTHER than a psychiatric unit within an acute-care hospital or free standing psychiatric hospital.

**Suggested data sources**: Discharge summary, ED record, physician orders**Exclusion Statement:****Lack of medical record documentation that the patient was receiving psychiatric care in an inpatient psychiatric setting****excludes the case from The Joint Commission (TJC) HBIPS quality measures.**  |
| 6 | resevent | During the period from (computer display psyadmdt through psydcdt, or pull date if psydcdt=99/99/9999), is there documentation of a physical restraint/violent restraint event? 1. Yes 2. No | 1, 2If 2, go to secevent | **A physical restraint event *(Event Type 1)* is use of any manual method or physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body or head freely when it is used as a restriction to manage a patient’s behavior or restrict the patient’s freedom of movement.** **Examples of physical restraint include but are not limited to:*** 2-point restraint
* 4-point restraint
* 5-point restraint
* Body nets
* Mittens to prevent intentional self-harm
* Wrist-to-waist restraints
* Soft wrist restraints
* Manual holds
* Stapling
* Jarvis
* Leather restraints
* Devices that serve multiple purposes such as a Geri

chair or side rails, when they have the effect ofrestricting a patient’s movement and cannot be easilyremoved by the patient, constitute a restraint.**Exclude:*** Devices such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets
* Methods that involve the physical holding of a patient to conduct routine physical examinations or tests
* Methods that protect a patient from falling out of bed
* Methods that permit the patient to participate in activities without the risk of physical harm (does not include a physical escort)

**Cont’d next page** |
|  |  |  |  | **Restraint cont’d*** Restraint uses that are forensic or correctional

restrictions applied and used by outside lawenforcement* Restraint uses that are forensic or correctional restrictions applied and used by designated hospital security personnel to transport the patient to court off the locked unit.

**Suggested data sources:** Licensed independent practitioner (LIP) orders/physician orders, nursing flow sheet, nursing notes, observation sheets, progress notes, psychiatric notes, restraint monitoring form, restraint/seclusion flowsheet, restraint/seclusion notes, scanned notes (Vista Imaging), therapist notes, iView or Results Review in Oracle Cerner |
| 7 | resord | Did the earliest restraint order contain an order name?1. Yes
2. No
 | 1,2If 2, go to restyp1 | **Locate the earliest order for restraint and determine if there was a name for the order.****Examples of Order names:** Restraints/Seclusion Orders, Behavioral Restraints/Seclusion, Restraint/Seclusion for Violent or Self-Destructive Behavior |
| 8 | resordnm | Enter the name of the restraint order.

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 | Text box | **Enter the name of the restraint order.** |
| 9 | restyp1restyp2restyp3restyp4restyp5restyp6restyp7restyp8restyp9restyp10restyp11restyp12restyp13 | **Select the type of restraint that was used.****Select all that apply:**1. 2-point restraint
2. 4-point restraint
3. 5-point restraint
4. Body nets
5. Mittens to prevent intentional self-harm
6. Wrist-to-waist restraints
7. Soft wrist restraints
8. Manual holds
9. Stapling
10. Jarvis
11. Leather restraints
12. Devices that serve multiple purposes such as a Geri chair or side rails, when they have the effect of restricting a patient’s movement and cannot be easily removed by the patient
13. Other
 | 1,2,3,4,5,6,7,8,9,10,11,12,13If restyp13 <> -1, go to resdt  | **Review all notes documenting restraint of the patient and select all that apply.** **If more than one episode or type of restraint occurred during the hospitalization, select all that apply.** |
| 10 | othres | Enter the name of the other type of restraint used.

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 | Text box | **Enter the other type of restraint used.** |

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| 111213 | resdtrestartmresendtmrestotmin | For each restraint event during the psychiatric hospitalization, enter the date the restraint event occurred and enter the time the restraints were initiated and discontinued. **May enter multiple events.**

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| Restraint Event Datemm/dd/yyyy

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| >= psyadmdt and <= psydcdt, or <= pull date if psydcdt = 99/99/9999 |

 | Restraint Event Start TimeUMTAbstractor may enter 99:99

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| No restraint events can overlap with each other or with seclusion events. |

 | Restraint Event End TimeUMTAbstractor may enter 99:99

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| If valid times are entered, resendtm -restartm must be > 0 and <= 1440 minutes |

 | **If restartm and resendtm are valid, software will calculate total minutes for each event**

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| --- |
| Must be > 0 and <= 1440 minutes |

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 | **This information is abstracted for each day on which a restraint event (*Event Type 1*) occurs during the patient’s psychiatric hospitalization. A patient may have multiple events during the psychiatric hospitalization.*** When an event (*Event Type*) begins and ends on different dates (crosses midnight) this is considered two (2) separate events; therefore, both dates must be documented in order to determine the total amount of time associated with each *Event Date*.
* **Restraint Event start and end time must be entered as hour and minute (UMT).**
	+ For **start times** that include “seconds,” remove the seconds and record the time as is (e.g., 15:00:35 would be entered as 15:00).
	+ For **end times** that include “seconds,” round up to the next full minute (e.g., 15:00:35 would be entered as 15:01).
* If a patient is in *Event Type* 1 (physical restraint(s)) and then changed to *Event Type* 2 (seclusion), the time for *Event Type* 1 (physical restraint(s)) STOPS. The initiation of *Event Type* 2 (seclusion) stops the time for *Event Type* 1 (physical restraint(s)).
* If a patient is in *Event Type 1* (physical restraint(s)) and *Event Type 2* (seclusion) at the same time, the time should be counted as *Minutes of Physical Restraint*. **Time in physical restraints supersedes time in seclusion.**

Enter 99:99 when either the start or stop time of *Event Type* 1 (physical restraint) event is missing or unable to be determined from the medical record.**Suggested data sources:** Licensed independent practitioner (LIP) orders/physician orders, nursing flow sheet, nursing notes, observation sheets, , progress notes, psychiatric notes, **Cont’d next page****Restraint event cont’d**restraint/seclusion flowsheet, restraint/seclusion notes, seclusion monitoring form, scanned notes (Vista Imaging), therapist notes, iView or Results Review in Oracle Cerner |

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| **If any restotmin > 240 minutes, go to resrenord; else go to secevent** |
| 14 | resrenord | For each restraint event that lasted more than 4 hours, was the restraint order renewed every 4 hours by a physician/APN/PA?1. Yes
2. No
 | 1, 2 | **Per Joint Commission standards, orders for restraint must be renewed every 4 hours.** Look in orders to verify appropriate renewal orders are present every 4 hours. |

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| 15 | secevent | During the period from (computer display psyadmdt through psydcdt, or pull date if psydcdt=99/99/9999), is there documentation of a seclusion event?1. Yes
2. No
 | 1, 2**If 2, go to end** | * **A seclusion event *(Event Type 2)* is the involuntary confinement of a patient alone in a room or an area where the patient is physically prevented from leaving.**
* **The seclusion event may be documented as “seclusion,” but should ideally include more descriptive information such as that found in the examples below:**
* Manually or electronically locked doors
* One-way doors
* The presence of staff proximal to the room preventing exit or the threat of consequences if the patient leaves the room
* Documentation that 1:1 is for the purpose of seclusion (e.g. if seclusion room is already occupied.)
* **Exclude:**
	+ Time-out
	+ Quarantine due to infectious disease
	+ 1:1
* If there are seclusion event(s) that DO NOT occur on the same date and time as restraint event(s), select yes.
* NOTE: If a seclusion event(s) occur on the same date and time as a restraint event(s), the time will be counted as *Minutes of Physical Restraint* (Restraint Date and Time question) because time in physical restraints supersedes time in seclusion.

**Suggested data sources:** Licensed independent practitioner (LIP) orders/physician orders, nursing flow sheet, nursing notes, observation sheets, , progress notes, psychiatric notes, restraint/seclusion flowsheet, restraint/seclusion notes, seclusion monitoring form, scanned notes (VistA Imaging), therapist notes, iView or Results Review in Oracle Cerner |
| 16 | secord | Did the earliest seclusion order contain an order name?1. Yes
2. No
 | 1,2If 2, go to secdt | **Locate the earliest order for seclusion and determine if there was a name for the order.****Examples of Order names:** Restraints/Seclusion Orders, Behavioral Restraints/Seclusion, Restraint/Seclusion for Violent or Self-Destructive Behavior |
| 17 | secordnm | Enter the name of the seclusion order.

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 | Text box | **Enter the name of the seclusion order.** |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 181920 | secdtsecstartmsecendtmsetotmin | For each seclusion event during the psychiatric hospitalization, enter the date the seclusion event occurred and enter the time the seclusion event was initiated and discontinued. **May enter multiple events.**

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **Seclusion Event Date****mm/dd/yyyy**

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| >= psyadmdt and <= psydcdt, or <= pull date if psydcdt = 99/99/9999  |

 | **Seclusion Event Start Time****UMT****Abstractor may enter 99:99**

|  |
| --- |
| No seclusion events can overlap with each other or with restraint events. |

 | **Seclusion****Event End Time** **UMT****Abstractor may enter 99:99**

|  |
| --- |
| If valid times are entered, secendtm -secstartm must be > 0 and <= 1440 minutes |

 | **If secstartm and secendtm are valid, software will calculate total minutes for each event**

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| --- |
| Must be > 0 and <= 1440 minutes |

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 | **This information is abstracted for each day on which a seclusion event (*Event Type 2*) occurs during the patient’s psychiatric hospitalization. A patient may have multiple events during the psychiatric hospitalization.*** When an event (*Event Type*) begins and ends on different dates (crosses midnight) this is considered two (2) separate events; therefore, both dates must be documented in order to determine the total amount of time associated with each *Event Date*.
* **Seclusion Event start and end time must be entered as hour and minute (UMT).**
	+ For **start times** that include “seconds,” remove the seconds and record the time as is (e.g., 15:00:35 would be entered as 15:00).
	+ For **end times** that include “seconds,” round up to the next full minute (e.g., 15:00:35 would be entered as 15:01).
* If a patient is in *Event Type* 2 (seclusion) and then changed to *Event Type* 1 (physical restraint(s)), the time for *Event Type* 2 (seclusion) STOPS. The initiation of Event Type 1(physical restraint(s)) stops the time for *Event Type 2* (seclusion).
* If a patient is in *Event Type 1* (physical restraint(s)) and *Event Type 2* (seclusion) at the same time, the time should be counted as *Minutes of Physical Restraint*. **Time in physical restraints supersedes time in seclusion.**
* Enter 99:99 when either the start or stop time of *Event Type* 2 (seclusion) event is missing or unable to be determined from the medical record.

**Suggested data sources:** Licensed independent practitioner (LIP) orders/physician orders, nursing flow sheet, nursing notes, observation sheets, progress notes, psychiatric notes, **Cont’d next page****Seclusion event cont’d**restraint/seclusion flowsheet, restraint/seclusion notes, seclusion monitoring form, scanned notes (VistA Imaging), therapist notes, iView or Results Review in Oracle Cerner |
| **If any setotmin > 240 minutes, go to secrenord; else go to end** |
| 21 | secrenord | For each seclusion event that lasted more than 4 hours, was the seclusion order renewed every 4 hours by a physician/APN/PA?1. Yes
2. No
 | 1, 2 | **Per Joint Commission standards, orders for seclusion must be renewed every 4 hours.** Look in orders to verify appropriate renewal orders are present every 4 hours. |