"Refrain from Restrains", Free Me from Strains!!!

Author: Jitsy James (SN), Miki Varghese (SN), Sanju Jose (SN)

INTRODUCTION

Restraints must never be used as a substitute for good nursing care or staff convenience. Restrained patients require more care and increased documentation.

PROBLEM

All cardiac surgical patients received in CTICU post operatively were on mechanical and chemical restrain, throughout 2014, there was high usage of physical restraints to all patient in CTICU.

CRITERIA FOR RESTRAINT

- Physician order required.
- Assessment of patient to determine the clinical needs.
- Patient interfering with treatment.

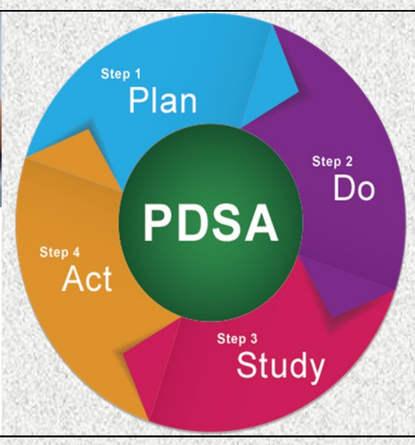
AIM

Reduce mechanical restraint for cardiac surgery patients to 50% by May 2015 and achieve zero percentage by Oct 2015.

IMPROVEMENT STRATEGY

PDSA model for improvement was used for the project

- By educating the staff.
- Continuously evaluating the use of restraints.
- Limit the use of restraints.
- Presence of relatives and reassurance of patient was emphasized.



Failure Mode and Effect Analysis (FMEA)

Selected Topic 2015: "Use of Physical Restraints"

FMEA is a tool to conduct proactive risk assessment study

Objectives:

I. Limit restraint use to adequately justified situation
II. Plan actions to reduce harm from restraint.
III. To monitor and track improvement in restraint us over time.

Priorities:

Step 2 Physician Order				0		
a. No order for restraints	1	1	8	8	328	1st
b. Relay of information on initial assessment	8	8	5	320		
Step 5: Review in 24 hours				0		
a. Patient remain on restrain longer than necessary	7	1	5	35	107	2nd
b. Restrain not ordered every 24 hours	6	2	6	72		

Action:

Priority One

1. Doctor's order should be done before initiating restraint to patient.
2. Restraint order should include reason for use, type of restraint to be used, date and time of order.
3. Staff education regarding restraint and seclusion.
4. Patient/Family involvement in decision for restraint.
5. Only in emergency situation, competent nurse can initiate the restraint. Physician should be immediately informed.
6. PRN orders are not acceptable for restraint

Priority Two

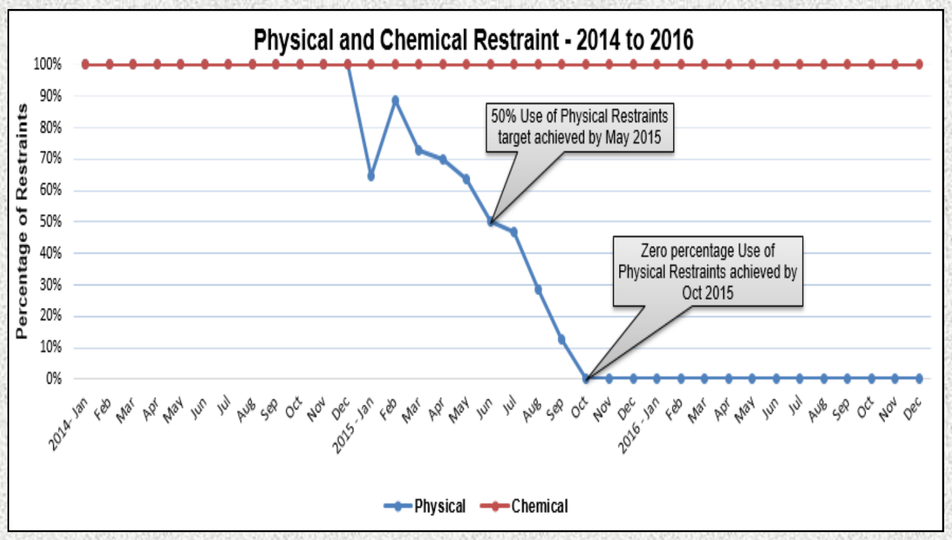
1. Re-educate staff on policy for restraint.
2. Ensure the doctor's order for restraint is written within the past 24 hours.
3. Before repeating order for restraint, physician should do reassessment for the patient to determine if he is still in need for restraint.
4. Every-four-hour reassessment for the need for continued restraint by nurses.
5. Once the nurse found no need for restraint during reassessment, must inform the physician immediately to get order to discontinue restraint (not to wait 24 cycle).
6. Include restraint in handing over

INTERVENTION

- Developed a task force.
- Evaluated the impact of reducing restraint.
- Developed weaning and sedation protocol.
- Involvement of patient and the family was done on the decision of restraint application.
- When there was a need to continue restraints proper reassessment was done by the physician.
- Staff education was given on :
  - Restraints policy
  - Meticulous use of restraints
  - Sedation assessment and Ramsay scale
  - No PRN orders to accept for restraint.
- Taking doctors order for restraints that included the reason, type of restraint, date and time.
- Reassessment of restraint continuation was done every 4 hours.
- During Multidisciplinary rounds assessment on need of restraints and removal of restraints was discussed and accordingly care was delivered to the patient.
- Ongoing explanation of procedures to patients whenever needed.
- Use of distraction or diversional activities.
- Continuous monitoring done by using a monitoring tool.

RESULTS

The graph trend below shows the data of Restraint use from the year 2014 to 2016, which depicts high usage of restraints in the year 2014, which decreased to 50% by the mid of 2015 and achieved zero percent of physical restraint by end of 2015 and remained same in 2016. The data of chemical restraint remains consistent to 100%. We have successfully achieved our zero percent target of reduction in use of physical restraints.



ACKNOWLEDGEMENT

Prof. McKenna, CEO -HH
Mr. Paul Mavin, Executive Director -HH
Mr. Ian Stewart McDonald, EDON -HH
Ms. Fadia Ali, AED Quality -HH

TASK FORCE MEMBERS

Dr. Poonam Gupta, COACH
Dr. Abdul Rasheed A. Pattath, Consultant
Ms. Catherine Marshall, DON
Ms. Shiny Shiju, HN
Ms. Jitsy James, SN
Ms. Miki Varghese, SN
Ms. Sanju Jose, SN

With the help and co– operation of multidisciplinary team effort, CTICU achieved Star of excellence award this year for ***"Multidisciplinary Teamwork — An Innovative Culture"*** *and* ***Merit award for "e-Mobility Program"*** *which embarks a great milestone towards excellence.*

FUTURE PLAN

- Continue education and monitoring.
- To maintain zero percent physical restraint.
- Continue sedation vacation while using chemical restraint.
- To implement weaning and sedation protocol.

CONCLUSION

Restraint generally means some method of restricting another's freedom of movement. Is using restraint good or bad? It depends on what it is being used for, when it is being used for, for whom, who is using it, for how long, and under what conditions.

Reference: - www.ihi.org