



Safety Matters: An Initiative to Improve Temporary Restraint Practices in the Emergency Department

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Background

- The emergency department (ED) is a unique practice setting that services a diverse patient population.
- High patient volumes seen in the emergency department place both patient and staff safety at risk.
- Patients that pose an immediate danger to themselves or others may require temporary restraint.
- Standardization in nursing care through knowledge of adequate monitoring and documentation can ensure a safe environment for patients who require restraint.¹
- Registered nurses are legally “accountable for ensuring their documentation of client care is accurate, timely and complete” as well as for their patient’s safety and wellbeing while in restraints.²
- ED nurses require formal education to be able to determine proper reasoning for restraint use, correct application, management and documentation.
- Decisions about restraint use are difficult, complex and ethically laden and this is why staff education is crucial for ongoing improvements and reduced risk associated with restraint use.^{3,4}

Objectives



1. Knowledge Enhancement

Create an education session for TWH emergency RNs to inform them of UHN Policy, Ontario Law and Best Practice Guidelines for application and monitoring of patients in restraints.

2. Improved Application, Monitoring & Documentation Practices

Create a new tool to improve current restraint application, documentation and monitoring practices as required by UHN policy.

3. Improved Patient & Staff Safety

By educating nurses, and providing them with the skills and tools necessary to make sound decisions and provide the safest care possible.

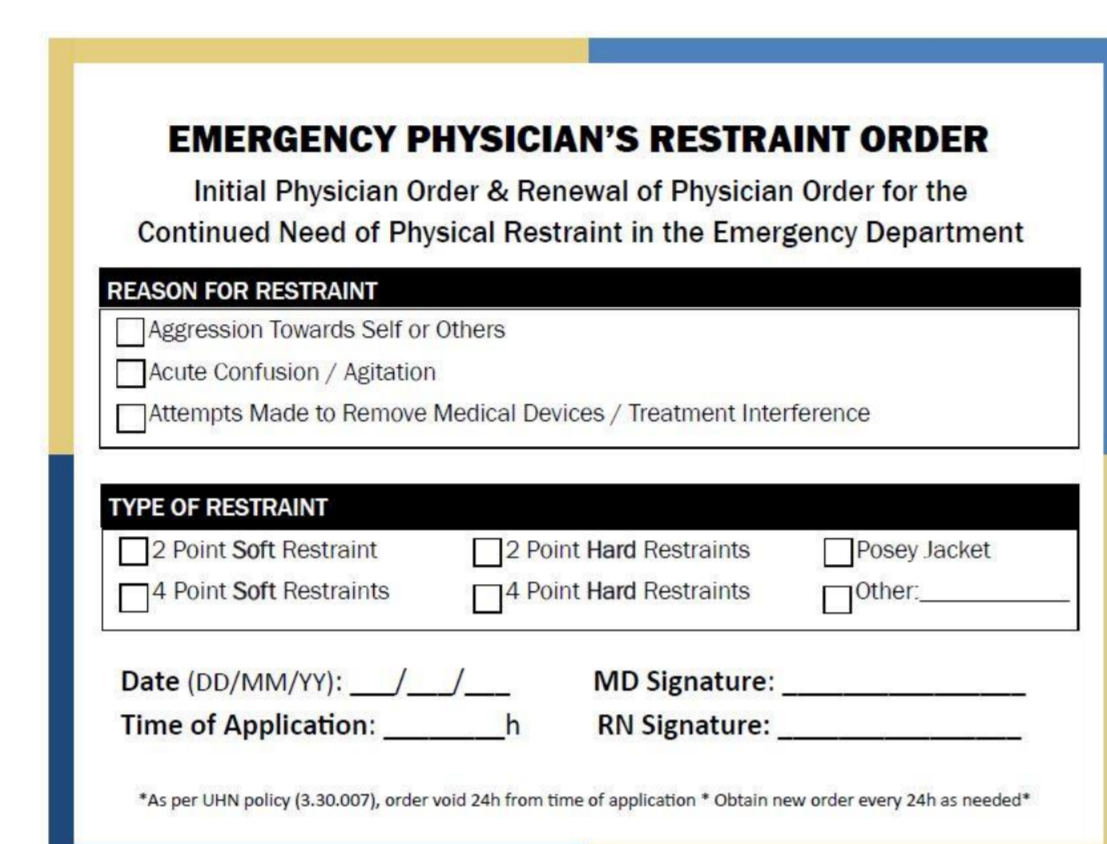
Needs Assessment

48 full time and 7 part-time RNs were surveyed to determine their learning needs (total=55):

92.73% of RNs said they felt “*somewhat familiar*” or “*not familiar at all*” with UHN restraint policy.

76.36% of RNs said they were “*unsure*” or “*disagreed*” when asked if they were knowledgeable of the restraint documentation requirements outlined in UHN policy.

Innovation



1. Creation of a 1-hour educational PowerPoint presentation on restraints:

- Discusses UHN policy regarding restraint application, monitoring and documentation practices.
- Ontario Law, the history of restraints and the Patient Restraints Minimization Act.

2. Creation of a physician’s order sticker for the initiation of restraints:

- A chart audit found that **50%** of charts had no written order (by the MD) or a verbal order (by the RN) for restraints when they had been applied.
- Sticker designed and implemented to correct this documentation issue.
- The new sticker includes the **reason for restraint** and the **type of restraint applied**, both of which are required by UHN policy.

3. Creation of resource binders for ED staff:

- Restraint application instructions for all Posey® products used in the ED.
- All UHN policies related to restraint use e.g.) Patient Restraints Minimization.
- Copies of information sheets for patients and families on restraint use and safety.

Results

1. Education

- Researchers in Taiwan determined that an educational in-service on restraints greatly improved nurses knowledge and skills regarding restraint use. Their findings highlighted the need for in-service education in the acute care setting.⁵
- An increase in nurse’s knowledge of restraints was hypothesized following the dissemination of formalized education.
- Due to a lack of resources available to release staff to attend education sessions, the education program was only delivered to a very small number of ED staff during the fellowship timeline. Future dates for education have been arranged.
- Education will be given via the departments mandatory Professional Development days as well as new hire orientation.

2. Order Sticker

- New order sticker for restraints implemented in the ED on February 17th, 2016.
- 90% of full-time ED RNs received 1 on 1 sticker education.
- Since implementation of the order sticker, **77.78%** of charts have had either the sticker or a written order.
- This is compared to earlier audits that showed MD orders for restraints only **50%** and **33%** of the time.
- Qualitative feedback from staff has been very positive:

“Simple and straight forward, but a great tool for nurses”.

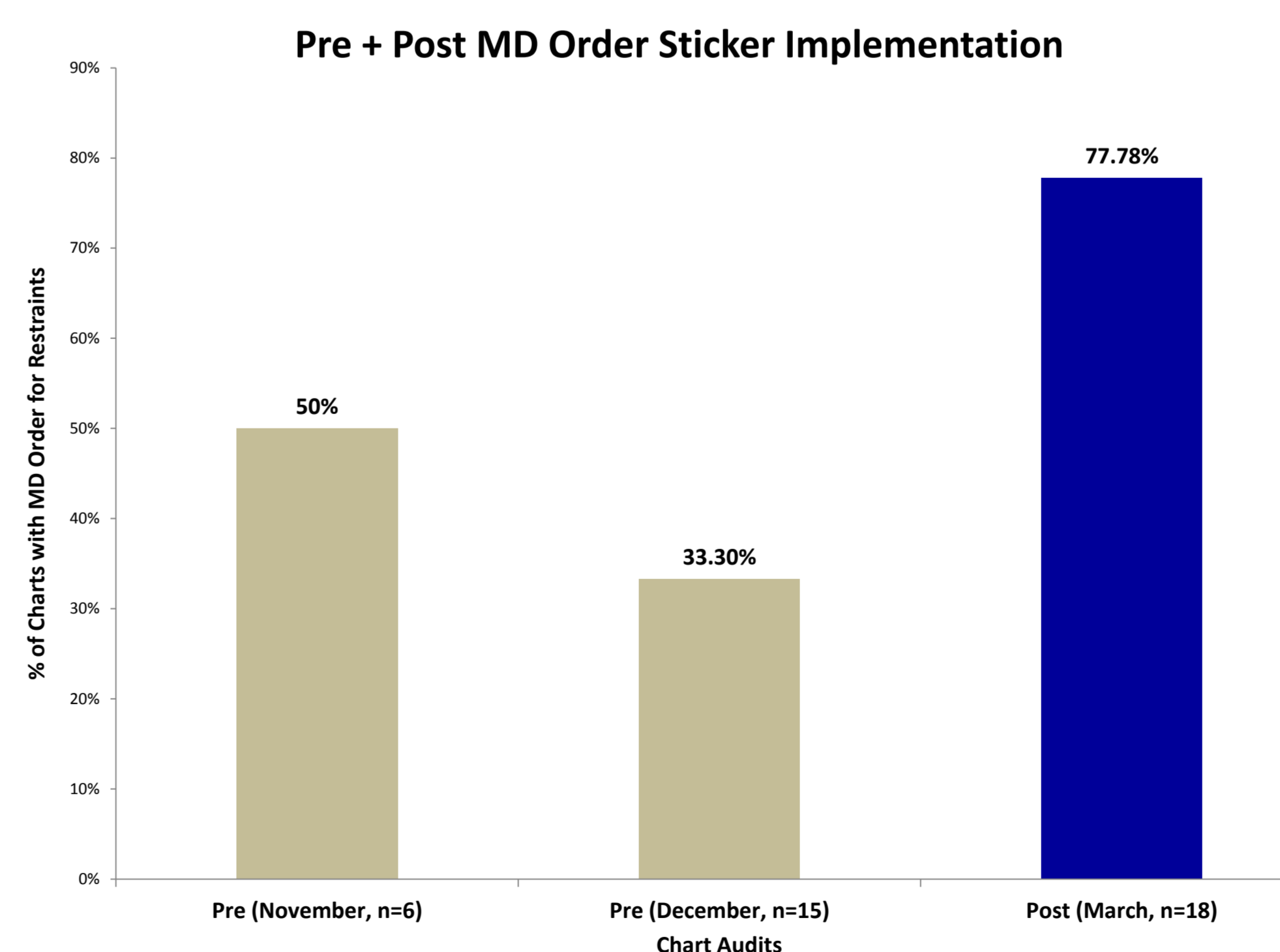
“Restraints are commonly used in our everyday practice. This sticker will be a great reminder for all staff”.

3. Resources

- New area in ED designated to house all restraint resources.
- Signage posted for restraints laundry bins, frequency of monitoring required and restraints algorithm.

4. Overall

- Increased awareness of restraint safety in the department.
- Permanent markings made on stretchers to indicate best area for easy restraint attachment.
- Improved practices for initiating, documenting and applying restraints.



Project Impact

- Education will inform current ED RN staff as well as new hires orienting to the department on the necessary documentation and monitoring required by UHN policy.
- It will inform RNs of the Posey® products approved by UHN and will describe when their use is appropriate.
- The new restraint order sticker will aid in correct documentation and a safer work environment.
- Overall, this project aims to improve current practices regarding restraint use and enhance both patient and staff safety.

Sustainability

- Ongoing Staff Education** – New hire orientation, Professional Development days & annual Posey® in-service training.
- Ongoing Communication**- Via ED newsletter and weekly email series as well as staff feedback via focus groups & unit council.
- Leveraging Existing Roles**- Ward Clerks: restocking monitoring records, PCAs: restraint laundry inventory.
- Continued Audits**– Monitor restraint orders sticker use & proper application.

Next Steps

- Roll out formal education starting with the mandatory Professional Development days in May & June.
- Repeat chart audits at 6 & 12 months for new sticker.
- Collecting ongoing feedback from staff to make any necessary changes to aid sustainability.

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