Restraint use in DCCM

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Function	Clinical Practice
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Department(s) affected	Department of Critical Care Medicine (DCCM)
Applicable for which patients, clients or residents?	Adult DCCM patients
Applicable for which staff members?	DCCM clinicians
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1. Purpose of policy

This policy guides the safe use of restraint with critically ill patients to ensure Department of Critical Care Medicine / HDU staff practice within legislative framework of applied restraint. To ensure that DCCM/ HDU staff are safe while caring for non-compliant patients because of physiological dysfunction.

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2. Scope

All staff caring for patients who may require to be restrained while receiving intensive therapies within DCCM/HDU.

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3. Definition

Restraint: is the implementation of any forcible control that limits the actions of the consumer in circumstances in which the consumer is at risk of injury and /or of injuring other person. Intentionally removes a consumer's normal rights to freedom

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4. Indications for use, training, safety and assessment

Indications for use of restraint

- The decision to restrain a patient in DCCM/HDU is the joint responsibility of the Nurse assigned to the patient and/or Intensivist on duty.
- Restraint in DCCM/ HDU is for patients with behaviour that is combative, confused, disorientated or violent. This behaviour is a result of physiological dysfunction of a range of systems, or from pharmacological therapies.
- Restraint is required to keep the patient safe while intensive therapies are administered.

Staff Training

- Patients are assessed **three times a day by an Intensivist** on the ward rounds.
- Registrar cover is rostered over a 24 hour period within the department.
- Medical staff document key treatment concepts on the 'Plan of the day'
- Nursing staff assess and document the patient's risk of falling, violent behaviour, disorientation and self-harm at the **commencement of each shift** on the DCCM Initial Shift Assessment form/ care plan CR4771, HDU Initial Shift Assessment form/ care plan CR2474 and includes the documenting of restraint interventions for safe practice and family teaching.
- This assessment is undertaken in relation to the disease process and physiological abnormalities. Ongoing half hourly monitoring and documentation of -assessment is completed on the 24 hour chart CR5710 e.g. of skin integrity of the limbs where restraints are applied .
- Incidence of restraint use is also documented on DCCM Nursing History Form CR3605 and in clinical notes for monitoring purposes.

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5. Restraint methods

a. Key considerations

- At all times the **safety, dignity and autonomy** of the patient is a prime consideration. However, at no time should staff and other patients have their safety compromised
- If the situation /environment becomes **unsafe, emergency assistance** (i.e. "Now Call" must be activated as soon as possible however if the patient is too aggressive for intervention a Code Orange must be called
- Appropriate and timely communication with the patient, family/Whanau must occur. Documented on the initial assessment / care plan CR4771 and Nursing History form CR3605
- Communication with the family must ensure that they understand the need for intervention and that they have received all the information that they require
- If valuables/taonga/ items of cultural, religious significance are removed during restraint for the safety of the patient, this must be done as per ADHB valuables policy.

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b. Mattress on the floor

Patients may be assessed for placement on their mattress on the floor to allow maximum freedom for restless disorientated behaviour without the risk of falling.
For this to be an option, the patient requires to be able to support his/her own airway and breathing.

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c. Padded Bedrails

These are applied to the bed of any restless patients who are at risk of hurting themselves through restless behaviour. They may also be used in conjunction with other measures.

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d. Wrist Restraint

The decision to apply restraint is the responsibility of the RN caring for the patient.
'Gordon' wrist restraints are to be applied to patients who are at risk of pulling out vital invasive lines.
Only the approved wrist restraints are to be applied to patients. These must be applied and tied in the correct way without impeding circulation to the hand along with correct and comfortable limb alignment.

When wrist restraints are used the following documenting must occur:

- Date and time applied and withdrawn on 24 hour chart.
- Family was informed of restraint application.

Any other factors associated with the decision making or any negative outcomes from the use of restraint e.g. skin tear.

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e. Nurse constant

This staff allocation category is prescribed by the medical staff on the DCCM/ HDU detailed Order Sheet when vascular lines or airway removal is life threatening to the patient (patient may have a grossly swollen airway or line limitation). This category means that the patient is never to be without a nurse in direct attendance.

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f. Four point restraint

To be applied to patients who are demonstrating violent behaviour towards others (kicking).
On assessment document clinical risk, date, time, when families were informed of the need for restraint and when restraint was withdrawn. A Risk Monitor pro and Restraint Monitoring Form must be completed along with the other DCCM restraint documentation forms. Audit: POST INCIDENT REVIEW Form /DD3097FOLLOWING RESTRAINT form on intranet.
The completed Post Incident Review forms to be used by the local restraint coordinator for review of practices and discussion at service quality group level, copy to be sent to the Quality Manager.

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g. Sedation

Sedation is prescribed by the Intensivist to allow intensive therapies to be administered safely.
Medical staff will assess and review sedation regularly (8 hourly) or more frequently.

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h. Code Orange

When a patient's behaviour poses an immediate risk to the safety of self or others, and cannot be managed by other proved methods, a Code Orange may need to be called.

If Code Orange is called for a patient this is documented in the patient's clinical record – present situation and outcome, and an event notification form completed. A Risk Monitor Pro must also be completed and the post audit document be completed.

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6. Documentation and evaluation

Documentation Requirements

The **Restraint Classification Tool** provides guidelines on when an event notification form must be completed.

Evaluation and Review

- DCCM follow-up program collects information on patient's memories of restraint for audit purposes
- Restraint use is reviewed at the monthly DCCM Nursing Focus Group.

Six monthly audits of restraint usage must be sent to the Restraint Reduction Group by the restraint coordinator. DCCM documentation audits are completed three monthly capturing restraint documentation on the Initial Shift Assessment Form, Nursing Care Plan, Patient History and Nursing Documentation Form, 24-hour chart and Clinical notes. The number of patients restrained in DCCM/ HDU is captured from the 24-hour chart documentation.

Reviewed by Restraint coordinator for DCCM LIV

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7. Restraint classification tool

Type of Restraint Used	Usage	Application	Monitoring	DOCUMENTATION
Mattress on the floor	For patients who can protect their own airway and gas exchange and are very restless	Head injured patients rousing from unconsciousness or patients delirious from other pathophysiology	• Ability to migrate off the mattress • Privacy • Escalating distress	Level of restless Physiological changes Restraint form
Padded bedrails	Prevent pt from injury from bed rails and risk of fall	Ensuring safe environment for the patient and preventing injury	• Check appropriateness • if pt is confused and at risk of climbing out of bed • Ensure rails secure	Level of restless and physiological changes Initial Shift assessment/ Nursing Care Plan
Nurse constant	Prescribed by medical staff to ensure that a critical care nurse is always with the patient	For patients whose invasive therapies are absolutely life threatening if removed (e.g. swollen airway)	• Monitor adequacy of sedation therapy • Wrist or four point restraint	• Responsiveness • Application of restraint • Family informed
Four point restraint	Responsibility of bed side nurse to prevent staff injury	For violent patients with deranged pathophysiology who use their legs as weapons against health professionals	• Observe and document behaviour • Physiological changes • Sedation	Document on Initial Shift Assessment/ Nursing Care Plan CR4771, Clinical Record, Risk Monitor Pro Nursing History Form CR3605 Restraint Monitoring Form Restraint Post Evaluation Form
Wrist Restraint	To retain invasive therapies	Patients who have the potential to remove invasive intensive therapies	• Correct application • Skin integrity	Document on Initial Shift Assessment / Nursing Care Plan CR4771 , Clinical Record and Nursing History Form

				CR3605 24 hour chart
Sedation	Prescription by intensivist	Patients with deranged pathophysiology that requires control while therapy is administered	• Sedation level • Physiological changes	Physiological signs and responses
Code Orange	For out of control physical behaviour where staff are at risk	For patients or families	• Risk • Escalation • De-escalation • Resolution	Document in clinical record Restraint Monitoring Form, Risk Monitor Pro Restraint Post Evaluation

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8. Legislation

- NZ Bill of Rights
- Code of Health and Disability Services
- Consumer Rights (1996)
- Mental Health (compulsory Assessment and Treatment) Act 1992 and Amendment Act 1999
- Crimes Act 1961

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9. Associated Auckland DHB documents

Board Policy Manual

- Bicultural Policy
- Behaviours of Concern (BoC) - Patient Observation
- Informed Consent
- Restraint Minimisation & Safe Practice
- Valuables, Property & Taonga

NZ Standard

- 8141:2001 Restraint Minimisation and Safe Practice

DCCM

- DCCM Nursing Documentation

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10. Disclaimer

No guideline can cover all variations required for specific circumstances. It is the responsibility of the health care practitioners using this ADHB guideline to adapt it for safe use within their own institution, recognise the need for specialist help, and call for it without delay, when an individual patient falls outside of the boundaries of this guideline.

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11. Corrections and amendments

The next scheduled review of this document is as per the document classification table (page 1). However, if the reader notices any errors or believes that the document should be reviewed ***before*** the scheduled date, they should contact the owner or the Clinical Policy Advisor without delay.

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