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Prospectus: Minimizing the Inappropriate Use of Physical Restraint

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Minimizing the Inappropriate Use of Physical Restraint

Clinical Leadership Theme

The purpose of this project is to minimize the inappropriate use of physical restraint in the acute respiratory unit. This project focuses on the Clinical Nurse Leader (CNL) as an educator and outcomes manager. The CNL, as an educator, uses an evidence-based educational tool to change the behavior and the practice of using the physical restraint. As discussed by King and Gerard (2016), the CNL has the capacity to use an evidence-based principle “to design care... in making clinical decisions and assessing outcomes” (p. 38). As an outcome manager, the CNL has a vital role in the promotion of a safe and ethical environment. The CNL learns how to gauge and measure risks to patient safety and work with the team to plan, implement, and evaluate practice that support safe patient care (King & Gerard, 2016). The CNL will also act as the transformational leader in altering the behavior in providing the utmost, excellent care towards patient safety. Transformational leaders as described by Grossman and Valiga (2013), “are those who can propel a vision, recruit the new generation of nurses, empower followers to work enthusiastically to realize a vision, meet change... and grow from it” (p. 169).

A transformational leader encourages opinion, ideas, and participation from the team. In developing, implementing, and evaluating the project, the stakeholders’ participation is important to the success of the behavior change. The staffs will see unit champions as a model and their influence will provide enthusiasm in the promotion of an excellent, quality patient care. Partnership entails teamwork with all the members being equal and connecting horizontally, rather than through a hierarchical structure, observing accountability and ownership of each member. Every member contributes a distinctive set of talents towards a common goal (Grossman & Valiga, 2013).

Statement of the Problem

Patient safety is the focus of all health care organizations. The Institute of Medicine (IOM) recommends to all healthcare organizations to build an environment in which culture of safety is an optimal goal (Sammer, Lykens, Singh, & Mains, 2010). In constructing an environment of safety, people in the organization need to understand their own values, behavior, and attitudes towards the creation of a culture of safety as well as employing the best evidence-based practices. There are multiple issues concerning patient safety, but one problem that is being left out is the physical restraint use. One of the issues found during the practicum is the inappropriate application of physical restraint. Although multiple departments are noted to have issues regarding the utilization of restraints, the microsystem focus is the acute respiratory unit.

Physical restraint is frequently utilized in health care facilities for a specific intervention, which is “to ensure patients’ safety and to prevent unexpected accidents” such as pulling of endotracheal tubes and/or central lines, falls, and so on (Li & Fawcett, 2014, p. 446). The question is: *Does it really ensure the safety of patients or does it contribute to patients’ injury?* According to a study by HCPro (2015), there is evidence that restraint do not avert harm, but contribute to increasing delirium or a more serious injury, such as pressure injuries or death. Altering the present connotation in the use of restraints will encourage the promotion of a safe environment and revising a policy that is based on the current evidences. A standard guideline has been developed specifically for the appropriate use of the restraint by both the Center for Medicare and Medicaid Services (CMS) and The Joint Commission (TJC). It was developed to provide evidence-based information and policy for the prevention of sentinel events and maximize patient satisfaction (TJC, 2016; CMS, 2016). The use of physical restraint, if all other means failed, will be the last option.

In the department observed in this project, the gathered data shows multiple patient restraints used were inappropriate. A Quality Improvement (QI) data from the beginning of the year until September, was obtained which showed that the Acute Respiratory Unit was one of the lowest performing unit when it comes to observing the four categories of restraint utilization (see Appendix C & F). The categories were formed into: having a current order, using less restrictive measures prior to using restraint, doing 2-hour assessment of patients in restraint, and explanation why restraint was applied. In one month alone, there were five patients who were on restraints, including two patients with cerebral palsy (CP). Three of the patients were on two types of restraint, but only one type was ordered by the physician. One patient was on restraint, but no renewal order was noted. According to Wagner, McDonald, and Castle (2012), the “discriminate or inappropriate use of these devices is widely regarded as suboptimal care” (p. 547). Observational and subjective data through informal interviews, indicate insufficient knowledge of the staffs in initiating, assessing, documenting, and terminating the restraint.

The issue was justified when TJC surveyed the hospital and found that the restraint of the patients does not have any order for consecutive days. The policy and procedure of the hospital’s restraint use is in place, but educating the staff is deemed helpful to understand the policy and its interpretation (See Appendix B). Double checking the policy and procedure regarding the use of any equipment, procedure, and even finding the chain of commands will be helpful in handling issues and concerns appropriately, which prevent errors or any untoward event, especially when physical restraint is involved.

Project Overview

The major aim of the project is to be able to minimize the inappropriate use of a physical restraint from 45% to at least 20% by December 5th. To accomplish the goal, educating the staff

on the proper utilization of the physical restraint as well as the underlying knowledge and attitude of the nurses toward the use of restraint needs to be identified. According to a study, the level of attitude and knowledge of the nurses has a direct and an indirect effect on the care being provided, therefore, behavior and skills of caregivers should be acknowledged and addressed as well (Sujata & Kaur, 2015).

Another factor that is considered attributable to the issue is the insufficient knowledge of the nursing staff regarding physical restraints. The staffs are unaware of what is available to them and a fast turnover of nurses contributes to the problem as well. A study by Stinson (2016) shows that “novice nurses were less likely than expert nurses to have been taught any content about the use of physical restraints in their basic nursing education” than nurses with more clinical experience (p. 24). Assisting the nurses in understanding the proper utilization of the physical restraint, its importance, and guiding the nurses in honing the skills encouraged teamwork, accountability, and confidence in caring for patients needing or in restraint within the microsystem.

The main improvement theme after the microsystem assessment is to increase the knowledge of the nursing staff, as well as the other ancillary personnel in the safe utilization of any restraint and documentation of physical restraint in the electronic health record (EHR). As emphasized by Hofmann and Hahn (2013), health care providers should consider the effects and be diligent on deciding on restraint use and the “decisions should be based on the decision models and evidence” (p. 3022). As we aim to improve the quality and safety of patient care in the acute respiratory unit by decreasing the use of physical restraint, the process begins on admission or transfer and the process ends with the patient being discharged to home or transferred to a Skilled Nursing Facility (SNF). We expect that by working on the process, 100%

compliance will be achieved as mandated by the TJC, a 90% decrease of restraint-related injury, and an 80% of decrease length of hospital stay due to physical restraints. Empowering the staff will improve compliance issue, prevent sentinel events from occurring due to restraint, and prevent financial loss due to restraint-injury related suit or due to inability to discharge or transfer patient in a timely manner.

Rationale

The eagerness to promote an environment of safety for the patients, their families, and the health care providers as well as promoting compliance, led me to dig deep into the issue. This also promotes advocacy, being a voice for those patients who are unable to express their concerns and their rights due to disability or medical condition.

Determining the barriers and needs that prevent the inappropriate use of physical restraint by a series of data collection through observation, chart audit, and informal questionnaires were compiled. During data gathering and analysis, there were five patients in restraints. As mentioned above, three of them have two types of restraint, a soft wrist restraint and a bilateral mitten. During the process of checking the physician orders, only one type of restraint was ordered and documented. Another patient was in restraint, but order was not renewed by the physician in the computerized physician order (CPO). This data already shows patient safety issues. Huckshorn, LeBel, and Jacobs (2014) discussed that the use of seclusion and restraint in many healthcare settings was the most concerning practice that still occurs up to this modern day. There were 80% of physical restraint that was used inappropriately and patients with cerebral palsy (CP) were included in one unit alone. Although constraint-induced therapy was used in certain CP patients, the restraint in this instance were not for therapy, but the nurses assumed that contraptions will be pulled out by the patient.

With the advancement of medical devices and modern technology, physical restraint was still a growing issue. It was emphasized that the “use of physical restraints in the hospitals continues to be a major practice problem” (Ludwick, Meehan, Zeller, & O’Toole, 2008, p. 81). The need to address the problem immediately encompass a thorough evaluation and annual competencies toward a much safer, injury-free, and a compliant microsystem.

A microsystem analysis has been performed to distinguish the demographics and needs of the acute respiratory unit. The acute respiratory unit can cater 28 to 38 patients with respiratory issues which often need constant breathing treatments, oxygen therapy, as well as assistance with their activities of daily living (ADLs). The patients are very fragile, sick, and unable to move independently due to their breathing concern. Most the patients come from home, the rest comes from skilled nursing facilities, board & care, assisted living facilities, and sometimes downgraded from ICUs. The nurses to patients’ ratio is 1:4, with an unencumbered charge nurse. Due to the staffing issue, most of the time, the charge nurse has patients of her own, which makes it difficult to oversee the staffs, patients, and the unit. It prevents her from concentrating on her team of nurses and the needs of the unit. There is a secretary to answer the telephone and act as a messenger if some specimen needs to be sent to the laboratory. An assigned case manager, social worker, and care coordinator will be available if their help and expertise is needed. Multiple physicians make rounds every day to examine their patients and inform the nurses of the plan. Therapists, such as physical therapy, occupational therapy, speech therapy, and very seldom respiratory therapy personnel will be present when required by the physicians and circumstances.

Informal conversation was considered in data collection as this prevents bias and nurses can give their most honest opinion regarding the topic and its sensitivities. Some nurses

admitted that they have not read nor seen the policy. As mentioned above, reviewing the policy and showing where to find it was a good idea in meeting compliance and empowering the staff. Encouraging questions, if some information was not clear would be beneficial to the nurses as well and prevent assumptions.

From the data collected, the main reasons nurses use physical restraints are: the intervention will prevent dislodging tubing or the removal of intravenous access, as well as prevent falls. It was discussed by Saarnio and Isola (2010) in Barton-Gooden, Dawkins, and Bennett's (2015) article, that "nurses underestimate the physical and psychological impact of restraints on clients and believe that good alternatives... are unavailable" to them (p. 75). Analyzing this, it gives us information that the root cause of the issue is lack or insufficient knowledge of the staffs in the use or handling of physical restraints. The American Nurses Association (ANA) position statement on the Reduction of Patient Restraint and Seclusion in Health Care Settings (American Nurses Association, 2012) emphasized that due to insufficient personnel, proper monitoring will be inadequate, thus, there is a potential risk of violating patients' rights, which might cause patient injury while on a physical restraint.

Analyzing the information gathered, there are multiple strengths and opportunities that we can identify. Though weaknesses are noticed, the advantages would still be greater than not empowering the health care providers (see Appendix A). With this in hand, the projected cost of the project will be minimal, because reeducating the staffs by giving handouts and leaving information of the go-to person for any questions will only take a few minutes and not spending an extra hour which will cost about \$35 to \$60 per hour per nurses. The benefit of knowing the appropriate use of the physical restraint is vast and it will encourage compliance, competency, and confidence in delivering care. If the physical restraint is continuously used inappropriately;

it will eventually harm the patient. When patients are injured due to restraint, an event reporting needs to be completed. The level of injury obtained needs to be specified, such as abrasion, pressure injury, or even death. When these injuries developed, additional expenditure will be assessed. If pressure injury developed, per the Agency of Healthcare Research and Quality (AHRQ), the “cost of individual patient care ranges from \$20,900 to 151,700 per pressure” injury (2016). A lawsuit may happen as well, if found guilty of neglect or causes death due to restraint, this will again add to the unexpected expenditures of the organization. The sentinel events associated with restraint use are preventable and appropriate action should be supported. In addition, sentinel events will no longer reimbursable from the federal government and any serious injury due to restraint may require lengthy hospitalization. It was estimated that the cost of one episode of restraint use will range from around \$300 to \$400, “depending on the number of containing methods used (e.g., physical, mechanical, or medication” (Substance Abuse and Mental Health Services Administration, 2011, p. 8).

Methodology

The main objective of the project is to minimize the inappropriate use of physical restraint in the acute respiratory unit through effective education and empowerment. The approaches that will assist in the success of the project is based on the Lewin’s Change theory. There are three stages of change: *unfreezing*, *moving*, and *freezing* (Grossman & Valiga, 2013). This theory of change is appropriate because it addresses the urgency of the change in the provision of patient safety and compliance. Some of the nursing staff admitted that they do not have sufficient knowledge in the application of physical restraint. Some stated that the physical restraint use were not discussed thoroughly during their nursing school. There are nurses that have not read the protocol or policy, nor know where to find the policy. Acceptance of the

stakeholders is vital in the accomplishment of the objective of the project, as this encourage commitment. The moving phase is the implementation of the project through staff education and in-service training. This will empower the staff and encourage competency of the subject. Being competent is vital in the delivery of safe patient care. Patients and families feel secure and safe if the nurses and other caregivers are competent and knowledgeable while providing care for their loved ones. The last stage is the freezing, wherein the change is evaluated and encouraged to stay in the microsystem, then eventually be embraced in the macrosystem. To measure if the goal is reached, a Performance Improvement (PI) through data collection, analysis, and identification of opportunities to reduce and eventually eliminate the use of restraint will be compiled to find an evidence-based practices or strategies that is effective compared to the current approaches being utilized.

In planning the educational tool for the healthcare providers, a PowerPoint presentation and leaflets will be provided. The topics included in the presentation are: definition of restraints, types of restraint being utilized in the hospital, the views and attitude of health care providers and its effect on the use of restraint, the behavior of patients needing or in restraint, the mandate of the CMS and TJC, the evidence-based practices gathered, and the proper documentation of pre- and post-restraint. It will also include reviewing the protocol and distributing a copy of the policy. As discussed by Barton-Gooden et al., (2015), the views, attitude, and the interpretation of the nurses and doctors contribute to the establishment of the best practice guidelines.

At the implementation period, there are anticipated issues, such as resistance from staff and the priority of the Education department may be different from what is perceived. The higher up will be consulted and presented the plan for them to reconsider the appropriateness of the topic, especially strengthening the patient safety campaign of the organization. Empowering

the staff through education creates a sense of accountability and responsibility, as well as confidence in providing care to the patients and families.

Data Source/ Literature Review

The microsystem of the study is the acute respiratory unit which accommodates 28 to 38 inpatient beds. The patients are adult with respiratory issues and multiple co-morbidities. Most of the patients need breathing treatment, BiPaP, VapoTherm, or pulmonary drainage and percussion treatment as well as other treatments that pertains to the respiratory aspect. The patients are from home, Skilled Nursing Facility (SNF), assisted living, and Board and Care. Due to their acute respiratory issues, patients usually need assistance with activities of daily living (ADL) to function, such as toileting, feeding, and grooming. Any strenuous activities will make them short of breath. There are times that delirium occur due to unknown cause, which makes the patient confuse and combative resulting to the utilization of restraint by the nurses. A delirium is an “acute brain failure that causes impairment of attention and other cognitive functions” (Hessler, Bronner, Etgen, Gotzler, Forstl, Poppert, Sandr, & Bickel; 2015; p. 360). Currently, expansion is being done to accommodate more patients in the acute respiratory unit.

To find supporting evidence for this change project, a PICO search was conducted. Do nurses (population) education and in-service about restraint (intervention) be beneficial than no education at all (comparison) in minimizing the use of physical restraint (outcome) in the acute respiratory unit? The relevant articles reviewed in developing this essay include the following databases: CINAHL, Medline, Ovid, and Google Scholar. The key words used in the search included were: *physical restraint, patient safety, and seclusion*. The articles selected were restricted to English and intended to find literature in the acute care inpatient settings, but all health care settings were also embraced. The timeframe for the enquiry was the previous five

years (2011-2016), however this timeframe did not generate adequate data and so the range was boosted to eight-year span (2008-2016).

Multiple factors contribute to the use of restraint. According to Kong and Evans (2012), several themes resulting to why health care providers uses physical restraints; “being too busy, lack of resources, beliefs and concerns, lack of education, differences and inconsistencies, and relationship issues” (p. 176). It is important to identify the reasons nurses turned to using the restraint. The identification of the barriers in reducing the use of restraint is crucial in the success of the project and the provision of a safe environment.

Study shows that serious injuries can result from the use of restraint that are largely preventable. Per Butterworth (2015), “never events should be underpinned by up-to-date guidance and there is no guidance on the content of restraint training programs or on the competencies and experience of trainers” (p. 30). The author emphasizes that proper skills-set and education largely influence the decision to use restraint and its proper application and documentation. This answers the compliance issue observed.

Cole (2014) emphasized that the goal for both the TJC and the CMS “is to protect patient’s right” while ensuring patient safety and eradicating the inappropriate use of restraint or seclusion (p. 372). The author discussed about using the Iowa model of evidence-based practice to guide her project in the reduction of restraint use in the Emergency Department that can be applied in the acute setting as well. Strategies that significantly useful in the decrease use of restraint is included and would be helpful in the planning of the PowerPoint presentation of the project.

In understanding the perception of the health care provider and the decision to use restraint, the proper assessment and documentation will encourage to identify if the use of

restraint was justified or not. According to Woodard (2015), having an accurate information about the sequence of events promotes a restraint-free care which will be helpful in the provision of improving treatment process which will ultimately help the “nurses create an environment where restraint-free care is possible” (p. 32).

Assessing the nurses’ views and attitude as well as their knowledge in the utilization of physical restraint is tremendously vital in the promotion of positive patient outcome. A study has been conducted and discussed the association between nursing educational preparation in relation to patient outcomes, how much knowledge they know about the subject, their skills, and their confidence in delivering care. This encourages thorough assessment of the level of understanding the nurses on the use of restraint, thus closing the gap of lack of knowledge in the proper use of restraint (Liao, Sun, Yu, & Li, 2016).

Evidence-based practices improve patient care. The campaign in the prevention of sentinel events, especially in the use of restraint, support compliance and patient safety (Kirk, McGlinsey, Beckett, Rudd, & Arbour, (2015). Understanding the contributing factor in the development of sentinel events will lead to finding the best evidence-based resolution and practices which improve patient outcomes as well. This literature is vital in guiding the project in gathering the evidence-based practices supporting the development of the project.

Timeline

The project began in mid-September 2016 with microsystem assessment as the first step. During the assessment, a review of the policy will be initiated to provide a clear understanding and/or if there are missing practices that needs to be addressed (See Appendix B). Stakeholders meeting will be conducted once a month for three months to encourage brainstorming and to see the progress of the project. Pre-implementation and post-implementation data collection will be

gathered and adjustment of time, if needed, will be considered to accommodate any challenges. The challenge foreseen was the waiting time for the Education department and the QI office to respond. Receiving feedback from the appropriate channels will determine the timeliness of the implementation. If the project will push through as planned, it will end on the first week of December (see Appendix D).

Expected Results

The plan on minimizing the physical restraint use is timely, as the hospital is campaigning on boosting patient safety. During the microsystem assessment, the inappropriate use of physical restraint was determined, encouraging to further assess the issue. The nurses in the acute respiratory unit expressed lacking insufficient knowledge and/or no knowledge at all in the proper utilization of restraint. Multiple relevant issues were noted during the microsystem assessment (see Appendix E). With the project implementation, the problem will be addressed and the health care providers will be able to gain more knowledge in the application, assessment, termination, and documentation of restraint. This will address the issue of compliance and patient safety by utilizing the best evidence-based practices. A more competent, compliant, and safety conscious health care providers are expected which will encourage boosting the performance level of the microsystem.

Nursing Relevance

Patient safety is an overall goal of any health care organization. The process improvement project is vital in ensuring that the provision of safety is being observed when physical restraint is being utilized. Minimizing the inappropriate use of physical restraint as much as possible, will warrant a safer environment to the patients, whether they are confused elderly patients or developmentally challenged individuals. By addressing the patient safety

through minimal use of physical restraint, this project focuses on the compliance of the organization as well. Proper assessment, sufficient knowledge, competent skills-set, and attitude of the health care providers influence the restraint use as well as the proper documentation. Evidence-based practices will assist in the development and the provision of excellent patient care, which will eventually affect the patient satisfaction and the nurses' satisfaction in providing the utmost care they can offer.

Empowering the staff and other health care providers with the necessary tool in providing a safe environment for all patients, families, and health care providers encourages compliance, confidence, and improvement of patient outcome. The strategy will help visualize the project and it can be implemented all over the hospital, even throughout the network of sister hospitals.

Summary Report

The aim of the project was to minimize the inappropriate use of physical restraint from 45% to about 20% in the acute respiratory unit, which caters to about 28 to 38 patients with acute respiratory issues, in the promotion of the patient safety and improving patient outcomes. In the beginning of the project, it was noted that the acute respiratory unit was one of the lowest performing units when it comes to the proper utilization of physical restraint. As what argued by HCPro.com (2015), using a physical restraint does not reduce harm, but contributes to the delirium of the patient and sometimes cause other serious condition such as the development of pressure injuries, fall, and even death.

The patients' population ranges from young adult to elderly. Most of the patients had co-morbidities, making it difficult to intervene in a simple manner, but in a multidisciplinary approach. There was some discrepancy regarding reported types of restraint and the actual restraint use, hence the First Line Supervisor (FLS) was notified about the incongruity. The

finding was noted during the survey period and the primary RN was informed immediately followed by a one on one teaching. Educating the nurses in a positive, ethical, and professional manner facilitates “effective strategies for clinical decision-making in health care” enabling nurses perform their duties in a safe and patient-centered care (English, 2016, p. e1).

During the implementation of the project, multiple challenges were met. One of the trials was the limitation on budget and the lack of time that would allow me to gather the staff with the stakeholders to officially present the project. It was impossible to meet all the staff to formally introduce the aim, the plan, and the implementation strategy of the project due to budget constraint. At that time, the only way perceived feasible was a one on one teaching and in-service as well as distributing handouts with the contact number and email address in case they have questions. It was a laborious process, but an improvement was seen just after a few weeks of implementation. One example was the removal of physical restraint in a timely manner which prevented delays in the transfer of the patient to the next level of care. Proper assessment and documentation was performed which enable the case management and other interdisciplinary team to do their part in providing the necessary care and planning.

A baseline data was obtained by handing out questionnaires (Appendix G). There were only 16 participants’ questionnaires received pre- and post- teaching and in-service (Appendix H). Prior to the intervention, a few nurses were confident in using physical restraint and most of the staff just browses on the policy and procedure, meaning they have not read the whole policy. Most of the nurses were unaware of other options that they can use in place of restraint or they were not aware of the least restrictive strategies that they can utilize. Post intervention, the nurses show an increased in knowledge in using the physical restraint appropriately. Effective education creates a bridge in filling the gap in patient care in need or in physical restraint. As

explained by Sujata and Kaur (2015), improving the training and skills in the use of restraint as well as reflecting on oneself, promotes increased knowledge, critical thinking, and improve skills in the practice and the application of physical restraint. The education and in-service also touches on the ethical and legal aspect of patient care which improves organization's compliance. This was justified when a surveyor for the State Department arrived unannounced and found no issue with regards to physical restraint utilization.

In evaluating the outcome of the project a post intervention survey was performed and the result was stunning (Appendix H). The data shows the effectiveness of the teaching and the importance of acquiring the knowledge in providing a safe patient care and environment. The evaluation will not end until the end of the year, but a follow up survey will help maintain the momentum and will encourage the nurses to be more conscientious in utilizing the physical restraint. Continuous feedback would be obtained from the nursing staff and other health care provider to learn of any suggestions that can possibly be applied in minimizing the inappropriate use of physical restraint. As mentioned before, annual skills competency would be helpful in meeting the staff compliance and preserving the knowledge.

The materials used during the implementation were handouts, PowerPoint presentation about physical restraint, the review of the organization's policy, and questionnaires as stated above. I am planning to send the PowerPoint presentation to the Education Department to consider in including the teaching in the hospital's annual competency and skills online teaching. Taking this step will encourage the sustainability of the project, not only in the microsystem, but in the macrosystem as well.

To attain the sustainability of the project, finding the champions in the microsystem is the key in keeping the strategies alive. The champions include the FLS and two staff from each

shift. They are the motivator and the navigators of the team that influence and promote the best practice in physical restraint use towards “reducing restraint use by supporting ongoing monitoring and quality improvement projects” (Springer, 2015, p. 27). Reducing the inappropriate use of restraint congruently connects to the mission and vision of the organization in the promotion of patient safety as well as the promotion of justice and advocacy to those who are unable to voice out their concerns. Now, the benefits of the CNL project is being perceived by the staff, but in a slow pace due to unavoidable circumstances, such as budget and time constraints. The awareness of the staff towards the project and its benefits in the microsystem encourages the sustainability of the project and the possibility of being implemented in another microsystem.

The experience and knowledge inculcated in me during my CNL internship was challenging and satisfying. In my heart and mind, I know and believe that this will enhance my skills, knowledge, and prepare me for the near future in becoming an effective CNL, who will touch the lives of so many people and making a difference in their lives. Creating a safe environment for all aligns with the values, mission, and vision of the organization in the improvement and maintenance of quality patient care. Being a faith-based hospital, this project encourages justice and stewardship, protecting the very people in the community that encourages each nurse, doctors, and other health care providers to perform their best and be an advocate, thus, providing an excellent quality care to all patients in all walks of life.

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Appendix A

SWOT Analysis



Appendix B

Policy and Protocol of Restraint

I. POLICY

- A. The patient has the right to be free from restraints of any form that are not medically necessary. Consistent with our mission and values, St. Joseph's Medical Center will work to actively decrease the use of restraint. When restraint is necessary, such activity will be undertaken in a manner that protects the patient's health and safety and preserve the patient's dignity, rights, and well-being. The use of restraint will be used as a last resort and will be used only after alternative interventions have been determined to be ineffective.
- B. The decision to use restraint will be driven by a comprehensive individual assessment that concludes that for a specific patient at a specific time, the lack of restraint poses a greater risk to the individual's health and well-being than the use of restraint.
- C. The hospital will report to California Department of Health Services any death that occurs while a patient is restrained or in seclusion per section (L) of attached.
- D. Policy is complete only with attached Dignity Health Corporate Policy Attachment A.

Attachment A
Use of Restraints

Scope

This policy applies to all acute healthcare locations inclusive of acute care, psychiatric care as specified within the content of the policy and to all hospital patients, regardless of age, who are restrained or secluded.

Policy

Restraint or seclusion shall only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and shall be discontinued at the earliest possible time.

When restraint or seclusion is necessary, such activity shall be undertaken in a manner that protects the patient's health and safety and preserves his or her dignity, rights, and well-being.

Restraint or seclusion shall not be utilized for staff convenience, coercion, punishment, or initiated based solely on a patient's prior history and/or behavior.

All patient deaths occurring while restrained or within 24 hours of restraint removal shall be reported to the CMS Regional Office within the next CMS business day following the death.

Definitions

- A. Restraint

1. Any mutual method, 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 or
 2. A drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.
 3. Exclusions
The following are, by definition, not considered to be restraints and are specifically excluded from this policy:
 - a. Standard practices that include limitation of mobility or temporary immobilization during medical, dental, diagnostic procedures and related post-procedure care processes (for example surgical positioning, intravenous arm boards, radiotherapy procedures, protection of surgical and treatment sites in pediatric patients) when such practice is considered an inherent part of the procedure.
 - b. Adaptive support in response to assessed patient need (for example postural support, orthopedic appliances, tabletop chairs).
 - c. Mechanical support used to achieve proper body position, balance or alignment so as to allow greater freedom of mobility than would be possible without the use of such support.
 - d. Helmets
 - e. Holding an infant, toddler or preschool child to comfort the patient.
 - f. Patients restrained by law enforcement of other legal authorities.
 - g. The use of side rails to assist a patient with safety, unless the use is such that the side rails prevent patient mobility (such as all four side rails up).
 - h. Medication (including PRN) used as a standard part of a patient's treatment plan provided the following criteria is met:
 - i. The medication is used within the pharmaceutical parameters approved by the Food and Drug Administration (FDA) and the manufacturer for the indications it is manufactured and labeled to address, including listed dosage parameters.
 - ii. The use of the medication follows national practice standards established or recognized by the medical community and/or professional medical association or organization.
 - iii. The use of the medication to treat a specific patient's clinical condition is based on that patient's symptoms, overall clinical situation, and on the physician's or other licensed independent practitioner's (LIP) knowledge of that patient's expected and actual response to the medication.
- B. LIP (Licensed Independent Practitioner)
1. Any individual permitted by State law to order restraints and/or patients independently, within the scope of the individual's license and consistent with the individually granted clinical privileges.
 2. This includes the authority of a physician to delegate this task to a physician assistants (PA) and advanced practice nurses (APN), to the extent recognized under State law or regulatory mechanism and when the PA or APN has been granted privileges pursuant to the Hospital's standardized procedures.
- C. Seclusion (Not Used at St. Joseph's Medical Center)

1. The involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving.
2. Seclusion may only be used for the management of violent or self-destructive behavior.
3. Placing patients in a voluntary time out in an unlocked room in which the patient is free to leave when he or she chooses does not constitute seclusion.

General Provisions

A. Limitations and Criteria for Use of Restraint and Seclusion

The use of restraint or seclusion is limited to those situations for which there is adequate and appropriate clinical justification.

1. The use of restraint or seclusion is based on the assessed needs of the patient.
2. Seclusion or restraint use may occur only after less restrictive alternatives have been considered and/or attempted as appropriate. Less restrictive alternatives may include, but are not necessarily limited to:
 - a. Re-orientation
 - b. De-escalation
 - c. Limit setting
 - d. Increased observation and monitoring
 - e. Use of a personal assistant
 - f. Change in the patient's physical environment
 - g. Review and modifications of medication regimens
3. The least restrictive, safe and effective method of restraints is to be used. The type or technique of restraint used must be the least restrictive intervention that will be effective to protect the patient, a staff member, or others from harm.
4. The physician, LIP, and registered nurse (RN) will take risk factors into account when assessing the need for, selecting the type of and determining the patient care needs relative to restraint or seclusion. Such risk factors may include, but are not necessarily limited to the following:
 - a. Patients with cognitive impairment may have a greater likelihood for attempting to self-remove restraints. Thus, the risk of injury to this patient/resident population is higher.
 - b. Patients with physical limitations may not have the ability to sense or alert staff of untoward effects of restraint, or communicate needs while restraint.
 - c. Restraining geriatric patients in vest restraint in split side-rail beds may place the patient at a higher risk of injury or death. Use of vest restraints without unifying a split side-rail bed should be avoided, if possible. Restraints are not used on children at SJMC.
 - d. Depending on the age, restraint of a pediatric patient may place the individual at a higher risk of injury for reasons similar to those found in the cognitively impaired or physically limited adult population.
 - e. Patients who have been sexually abused or who may have experienced a prior trauma use of restraint may be a higher risk of psychological harm.
5. Restraint use must be in accordance with a written modification to the patient's plan of care; and implemented in accordance with safe and appropriate restraint techniques

- as outlines in this policy and in accordance with state and federal law, and Joint Commission's accreditation standards.
6. If used, restraints or seclusion shall be discontinued at the earliest possible time when there is no longer adequate and appropriate justification for continued use.
- B. General Requirements for Ordering of Restraint or Seclusion
1. The use of restraint or seclusion must be in accordance with the order of a physician or other LIP who is responsible for the care of the patient.
 2. The patient's treating physician must be notified as soon as possible (without time delay) of the restraint or seclusion was ordered by a different physician.
 3. Restraint or seclusion orders may not be written as standing orders or on an as needed bases (PRN).
 4. Seclusion (not used at SJMC) may only be ordered for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member or others.
 5. Each order for restraint must contain, at a minimum, the following information:
 - a. The name of the patient being restrained.
 - b. The date and time the order was given
 - c. The date and time the restraint were initiated (if they were initiated prior to the order being given).
 - d. The name of the MD or other LIP ordering the restraint.
 - e. The type of restraint to be applied.
 - f. The time limit (duration) of the restraint.
 6. If there is to be any variation from this policy for monitoring of the patient and/or release from restraint, then the rationale for such variation must be contained in the order.
 7. In an emergency, the least restrictive, yet effective restraint or seclusion may be initiated by authorized and qualified staff, without a prior order from the patient's doctor or other LIP, based on an appropriate assessment of the patient. In this case, the patient's doctor or another LIP must be contacted immediately (without time delay) for an order.
 8. Any telephone order must be countersigned, dated, and timed by the patient's doctor or a covering physician on the next visit and no later than 24 hours after the order was given.
 9. The hospital may develop protocols that guide staff in the use and management of restraints or seclusion. However, a protocol cannot serve as a substitute for obtaining a physician or other LIP order before initiating each episode of restraint use or seclusion.
 10. When implementing a protocol that includes the use of an intervention that meets the definition of a restraint or seclusion, a separate order must be obtained for the restraint or seclusion. In addition, the patient's medical record must include documentation of an individualized patient assessment indicating that the patient's symptoms and diagnosis meet use-triggering criteria listed in the protocol.
- C. Additional Requirement for the Ordering of Medical Restraint
1. The use of restraint must be clinically indicated to meet the medical needs of a patient who is not violent or self-destructive.

2. The initial order for medical restraint must be episode specific, time limited and shall not exceed 24 hours.
 3. Renewal orders shall be based on and examination of the patient by the patient's doctor or another LIP and obtained at least once each calendar day.
- D. Additional Requirement for Ordering restraint for a Violent or Self-destructive Patient
1. Each order for restraint used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member or others may only be ordered/renewed in accordance with the following limits for up to a total of 24 hours. Restraint are not used on children at SJMC:
 - a. Four (4) hours for adults age 18 and older
 - b. Two (2) hours for children and adolescents ages 9 to 17
 - c. One (1) hour for patients under 9.
 2. After 24 hours, a physician or other LIP who is responsible for the care of the patient must see and assess the patient before writing a new order.
 3. See section, Additional Assessment Requirements for Violent or Self-destructive patients, for further reassessment requirements when restraints are used for violent or self-destructive patients.
- E. Application and Removal of Restraint
1. The type of restraint used shall be consistent with the type of restraint ordered.
 2. Restraint devices are applied/removed in accordance with manufacturer's instructions and used in a manner consistent with their intended purpose.
 3. Restraint devices are applied and removed in a manner that preserves the dignity, comfort, and well-being of the patient.
 4. Restraints will be secured to the bed frame if being used while the patient is in bed. Restraints are never tied to the mattress or side rails. Knots shall be tied so that they may be released quickly in the event of an emergency.
 5. Restraint devices are to be applied/removed only by staff authorized, trained, and with demonstrated competency to do so.
- F. Education of the Patient and/or Family
- The reasons for the use of restraint or seclusion (as appropriate) are provided to the patient and/or family in understandable terms and include, but are not limited to:
1. An explanation as to the clinical justification for restraint or seclusion.
 2. An explanation of the purpose and use of the restraint or seclusion.
 3. The criteria by which restraint or seclusion will be terminated.
 4. An explanation as to the monitoring and care that will be provided to the patient/resident.
 5. Other information necessary to assure the safety and comfort, dignity, preservation of rights, and well-being of the patient.
- G. Monitoring the Patient in Restraint or Seclusion
1. The frequency, nature, and extent of monitoring and evaluation are dependent on the needs and health status of the individual patient.
 2. At a minimum, patients in restraints must be evaluated and monitored as follows:
 - a. At least every two hours for all patients in medical restraint
 - b. At least every 15 minutes for patients in restraint for violent or self-destructive behavior.

3. Appropriately qualified staff, as defined in this policy, will monitor/evaluate the following:
 - a. The physical and emotional well-being of the patient
 - b. Vital signs
 - c. Circulation
 - d. Any hydration, hygiene, elimination, range of motion, or comfort needs the patient may have.
 - e. Skin integrity
 - f. Level of distress and agitation
 - g. Mental status
 - h. Cognitive functioning
 - i. That the patient's rights, dignity, and safety are maintained
 - j. Whether less restrictive measures are possible.
 - k. Changes in the patient's behavior or clinical condition required to initiate the removal of restraints
 - l. Whether the restraint has been appropriately applied, removed, or reapplied.
- H. Additional Assessment/Monitoring Requirements for Violent or Self-destructive patients (AKA Behavioral) Patient will be placed in an intensive care unit
 1. The patient must be seen face-to-face within one (1) hour after the initiation of restraints when restraints is used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member or other.
 2. The one-hour face-to-face evaluation includes both a physical and behavioral assessment of the patient. The practitioner who conducts this evaluation must be able to complete both a physical and behavioral assessment of the patient in accordance with the State law, his or her scope of practice, and organization policy.
 3. The purpose of the face-to-face evaluation is to assess:
 - a. The patient's immediate situation;
 - b. The patient's reaction to the intervention;
 - c. The patient's medical and behavioral condition; and
 - d. The need to continue or terminate the restraint.
 4. If the face-to-face evaluation is conducted by a specially trained RN or PA, the RN or PA must consult the attending physician or other LIP who is responsible for the care of the patient as soon as possible (without time delay) after completing the evaluation. Such consultation should occur before the end of the RN or PA shift.
 5. Prior to renewing a restraint or seclusion order for violent or self-destructive behavior, the patient's physical and psychological status is reassessed during a face-to-face evaluation to determine if restraint or seclusion should be continued.
- I. Termination of Restraint or Seclusion
 1. Restraint or seclusion will be determined at the earliest possible time regardless of the rime length of the order.
 2. If restraint is discontinued prior to the expiration of the original order, a new order must be obtained prior to reinitiating the use of restraint.
 3. If a patient is released from restraint and later exhibits behavior than can be handled through the use of restraint, a new order is required.

4. A temporary release that occurs for the purpose of caring for a patient's needs (for Example, toileting, feeding, and range of motion) is not considered a termination of restraint and a new order is not required to resume restraint.

J. Documentation

For each episode of restraints, the patient's medical record should contain at least the following documentation:

1. The complete order for restraint or seclusion.
2. A description of the patient's condition or symptom(s) that warranted the use of the restraint or seclusion.
3. Alternatives or other less restrictive interventions attempted or considered.
4. A description of the restraints that were used.
5. The one-hour face-to-face medical and behavioral evaluation if restraint or seclusion is used to manage violent or self-destructive behavior.
6. The patient's response to the intervention(s) used, including the rationale for continued use of the intervention.
7. Modification of the plan of care to include the use of restraint or seclusion.
8. Documentation of each assessment (at least every two hours for medical restraints and at least every 15 minutes if the restraints are used for violent or self-destructive behavior).
9. Documentation of the periodic re0assessment (frequency depends on the age of the patient) of the need for restraints applied for violent or self-destructive behavior.

K. Training and Competency of Staff

1. Staff that are involved with applying restraints and/or providing for patients in restraint, or with assessing and monitoring competency in the application of restraints, monitoring, assessment, and providing care for a patient in restraint prior to doing so.
2. Staff shall complete restraint training during orientation and subsequently on a periodic basis consistent with hospital policy.
3. Staff shall have education, training, and demonstrated knowledge based on the specific needs of the patient population served in at least the following;
 - a. Techniques to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of a restraint.
 - b. Use of nonphysical intervention skills.
 - c. Choosing the least restrictive intervention based on an individualized assessment of the patient's medical, or behavioral status or condition.
 - d. Safe application and use of all types of restraint used in the hospital, including training in how to recognize and respond to signs of physical and psychological distress (for example, positional asphyxia).
 - e. Clinical identification of specific behavioral changes that indicate that restraint is no longer necessary.
 - f. Monitoring the physical and psychological well-being of the patient who is restrained, including but not limited to, respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by the hospital policy associated with the one-hour face-to-face evaluation.
 - g. Use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic recertification.

4. All contract agency personnel with direct patient care responsibilities will have documented training related to the hospital's restraint and seclusion policies.
 5. Individuals providing staff training must be qualified as evidenced by education, training, and experience in techniques used to address patient's behaviors.
 6. Successful completion of training and demonstration of competency will be documented in staff personnel records.
 7. At a minimum, physicians and other LIPs authorized to order restraint or seclusion by hospital policy in accordance with State law will receive orientation to the hospital policy(s) addressing the use of restraint and seclusion during new physician orientation and/or other times as specified by the hospital.
- L. Reporting of Deaths and Serious Disability of Patients in Restraint or Seclusion
1. Reports shall be telephoned to the CMS Regional Office no later than the close of business on the next CMS business day following knowledge of the patient's death in the following instances. The date and time the report was made will be documented in the patient's medical record.
 - a. Every single death (expected and unexpected) that occurs while a patient is in restraint or seclusion.
 - b. Every single death (expected and unexpected) that occurs within 24 hours after the patient has been removed from restraint or seclusion.
 - c. Each death known to the hospital that occurs within one (1) week after restraint or seclusion where it is reasonable to assume that the use of restraint or seclusion contributed directly or indirectly to the patient's death. "Reasonable to assume" includes, but is not limited to, deaths related to restrictions of movement for prolonged periods of time, or death related to chest compression, restriction of breathing or asphyxiation.
 2. Reports shall also be filed with other regulatory or accreditation agencies as required by state and federal law or hospital policy.

Reducing the Use of Restraint through Performance Improvement

- A. The organization will make all reasonable efforts to reduce the use of restraint. To accomplish this, a performance improvement process will be utilized.
- B. This process may include, but is not limited to:
 - a. Collection of data on the incidence and reason(s) for restraint use in care settings where such use occurs.
 - b. Aggregation and analysis of the data to determine if patterns, trends or cluster of restraint use are evident and to understand why restraints are used.
 - c. Identification and evaluation of opportunities to reduce the use of restraints and to promote the use of alternative strategies as well as to reduce the risks associated with restraint use.
 - d. Development, implementation, and evaluation of actions taken to address opportunities identified.

References:

TJC Standards, Title 22, 72319 and 72527; OBRA 483.13

CMS Conditions of Participation, Patient's Rights 482.13

Health & Safety Code Section 1279

Revisions to Medicare Conditions of Participation, 42 C.F.R. 482.13

Appendix C

Log Restraint

**St. Joseph's Medical Center
Inpatient Restraint Log**

**PLEASE MAKE SURE EACH SECTION IS FULLY COMPLETED
BEFORE SENDING DAILY TO QUALITY SERVICES
ONE LOG PER PATIENT PER DAY
(PLEASE SEND IN INTEROFFICE MAIL, DO NOT FAX)**

Today's Date: / / No Restraints For Today

Unit:
 RICU 4E 4W ONCT 3N SNF 2W 2N 2E CICU SICU Pav ICU 3E 4N

MR #:
 Last Name:

Gender: Male Female Age: Room #: -

Original Restraint Date: / / Original Restraint Time: :

Original Restraint Day of Week: Sun Mon Tues Wed Thurs Fri Sat Original Restraint Shift: Day Evening Night

Last Name of Nurse Restraining: (Original) RN or LVN: RN LVN

Type of Restraints:
 Wrist Vest Mitten Soma Bed Other: _____


Less Restrictive Measures Taken: (Medication, Snacks, Bed Alarm, Active Listening, etc.)
 Yes No

Explanation Given: (To Family or Patient)
 Yes No

Current Order:
 Yes No










Q2 Hour Assessments Done:
 Yes No

Submitted by: _____

32293 

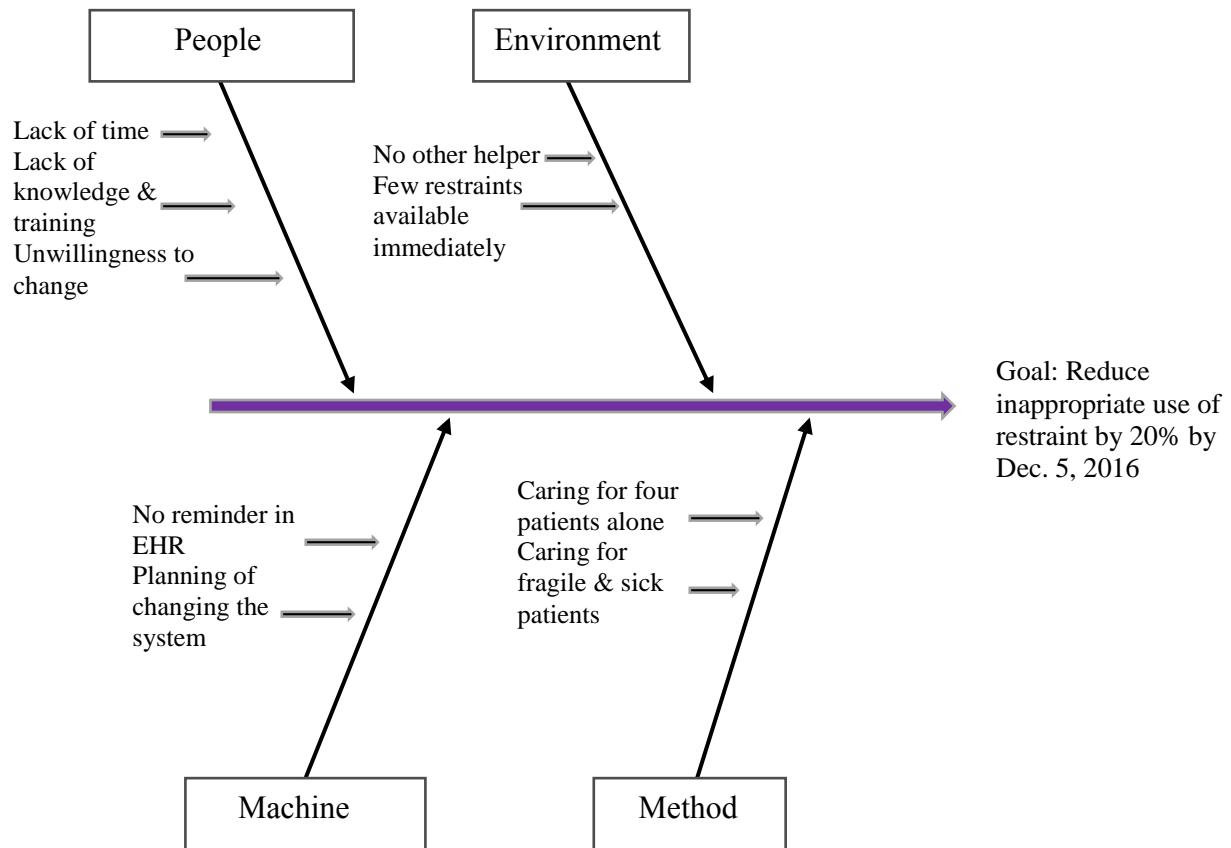
Appendix D

Timeline (Gantt Chart)

	September	October	November	December
Microsystem Assessment				
Restraint Policy Review				
Stakeholders Meeting				
Pre-implementation Data Collection				
Trends Assessment				
Stakeholders Rounding				
Post-implementation Data Collection				

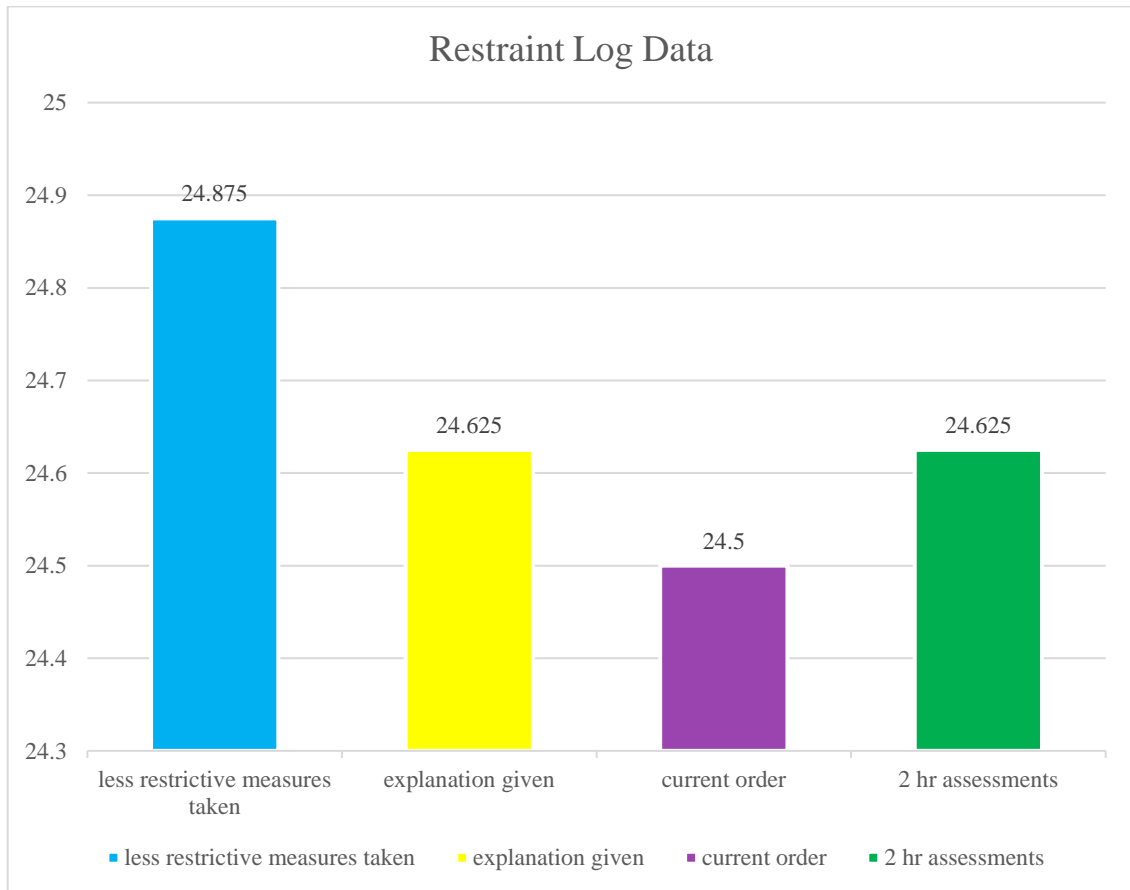
Appendix E

Fishbone Diagram (RCA)



Appendix F

Log Restraint Result (as of September)



Appendix G

Pre- and post- questionnaires

Pre-intervention:

Please circle the number that corresponds to your answer with 1 being lowest and 5 being highest.

1. How confident are you in using physical restraint?

1 2 3 4 5

2. Have you read the policy and procedure in applying restraint?

1 2 3 4 5

3. Do you use restraint for patient safety?

1 2 3 4 5

4. Do you use restraint for your own convenience?

1 2 3 4 5

5. Are you aware of other options that you can use in placed of restraint?

1 2 3 4 5

Thank you for participating!

Post intervention:

Please circle the number that corresponds to your answer with 1 being lowest and 5 being the highest.

1. How confident are you now in using physical restraint appropriately?

1 2 3 4 5

2. Is the teaching method helpful to you and your practice?

1 2 3 4 5

3. Is the content of the teaching empowering to you in the delivery of patient care?

1 2 3 4 5

4. Is the teaching helpful in maintaining a safe environment for the patients, families, and care providers?

1 2 3 4 5

5. Do you think it is possible not to use physical restraint in the future?

1 2 3 4 5

Thank you for participating!

Appendix H

Results of Questionnaires

