



Service Priorities and Programmes
Electronic Presentations

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Restraint Reduction Program

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Introduction

Neurosurgical patient usually have problem on mobility associated with cognitive impairment. They always have behavior(s) which will disrupt life supporting device(s), with risk of fall and risk of missing maintain In order to maintain patient's safety, nurse used to consider physical restraint as an effective intervention. However, physical restraint brings negative psychological impact and sometimes was a conflict on patient' safety.

Objectives

To reduce restraint rate and maintain patient's safety in surgical department.

Methodology

A workgroup was formed in surgical department, with regular meeting held to review the practice. Data was collected from ward staff about their concern, comment and suggestion. Latest surveillance data related to physical restraint was shared to alert ward staff. The program was implemented from April 2012. Existing practice was reviewed and adjusted. Guideline for physical restraint was reminded to ward staff. An "Enhance Safety Observation" area was set up in each ward for close observation of patients. Alternatives were introduced to all ward staff. Supply of alternatives was increased, e.g. the supply of low bed and alarm pads were increased, installation of the anti-warning system. In order to enhance communication, a communication board was designed to indicate patient physical status, mobility level, ADL level and safety measure(s) required. Besides, signage to alert for fall risk also designed to put on patient's head of bed and wheelchair. A label was designed for effective documentation in integrated progress sheet. Besides, a "Assessment and Observation Chart for Patient with Physical Restraint for (Extended Care)" form was adopted. The "Morse Scale" was kept on to be used as fall assessment tool in surgical department. Nursing staff have to make sure they are familiar with the assessment and carry out appropriate intervention based on the result of assessment. The "Morse Scale" assessment was carried out on admission, bi-weekly and anytime when patient changed condition. The monitoring on high risk/ potential risk was also enhanced. There was ongoing monitoring every shift and cross shift by ward in-charge. There was also review during doctor round, and weekly nursing round. The nursing round

was also seen as a senior support for the implementation of the program. Education, information and instruction related to physical restraint were provided to all ward staff so that to enhance their concept, knowledge about restraint. All ward staff should be have a concept that physical restraint must be the last resort when all alternatives were tried. On-going clinical supervision also offered as a support to establish staff confidence and competence on assessment and decision making on using alternatives or physical restraint.

Result

According to KPI restraint rate in surgical department was decreased after the program commenced from April to December 2012: Average restraint rate from Jan 2012 to Mar 2012 was 12.9% Average restraint rate from April 2012 to Dec 2012 was 1.08% Staff became competence on using alternatives for maintaining patient's safety.