Restraint Documentation: An Audit Tool
HealthSouth Harmarville Rehabilitation Hospital
Bonita Gormly, BSN, RN, CRRN

Introduction
Hospitals today utilize many different measures to decrease or eliminate the use of restraints. However, when these methods prove to be ineffective and patients are at risk for injuring themselves or others, restraints may be clinically appropriate. The Joint Commission and CMS have many requirements for the application of restraints, and hospitals must ensure they follow these guidelines.

Documentation is one area that MUST be in compliance. This information presents an audit tool that can help assure that proper documentation is contained in the medical record. This tool includes: physician orders, restraint assessment, identified behaviors requiring restraint usage, alternatives to restraint attempted or considered, timeliness of documentation, type of restraint, completion of restraint flow sheet, behavior documentation to justify restraint usage, and updating of the plan of care.

Restraint Assessment and Physician Order

Question #3 A behavior must be noted that justifies why the restraint needs the restraint. The behavior cannot just say “Patient attempting to get out of bed (OBED)”. Patients have the right to get OFF. A better option would be to write “left leg attempts to get OFF without assistance unable to follow safety instructions.”

Question #4 Our Department of Health believes that the only two reasons a patient should ever be restrained is if they are a danger to self or danger to others. So, we require the RNs to identify which of these are appropriate. Any other reasons are also checked when the RN deems appropriate.

Question #5 An assessment must be done before restraints can be applied. The time the RN does the assessment is compared to the time the restraint was applied as documented on the flow sheet. There cannot be an assessment done at 10:00 and the restraint not applied until 12:00.

Restraint Flow Sheet

Question #6 The safety section is reviewed to see if the staff have documented the type and usage of the restraint. If the restraint is in or out, if the patient’s circulation has been evaluated with a pulse or wrist restraint, and if foot/foot/wrist/ankle/neck band(s) been offered. Also reviewed is if the patient has any medications or devices in place. The patient is asked if is a bed encasement and the staff checks the reason. At this time, the question arises, “Why is the bed encasement needed?”

Weekly Restraint Monitoring Form

The need for a restraint must be reassessed and recorded every 2 hours (adolescents) or 1 hour (children < 9 years). The form is used to review restraint documentation. If during the 2-hour review period the restraint is no longer required, the restraint is to be removed. A “Y” means the documentation was complete and an “N” means it was not completed as required.

Daily Progress Notes

Question #8 When a patient is in a restraint, there must be documentation at least once per shift, identifying the behavior for which the restraint is being utilized. If there is no behavior identified and the form is completed, “Why is this patient in a restraint?”

Plan of Care and Plan of Care Update

Question #7 The restraint must be addressed on the Plan of Care immediately following the assessment and application. Then, once a week, the status of the restraint must be updated on the Plan of Care.