

# Restraint Documentation: An Audit Tool

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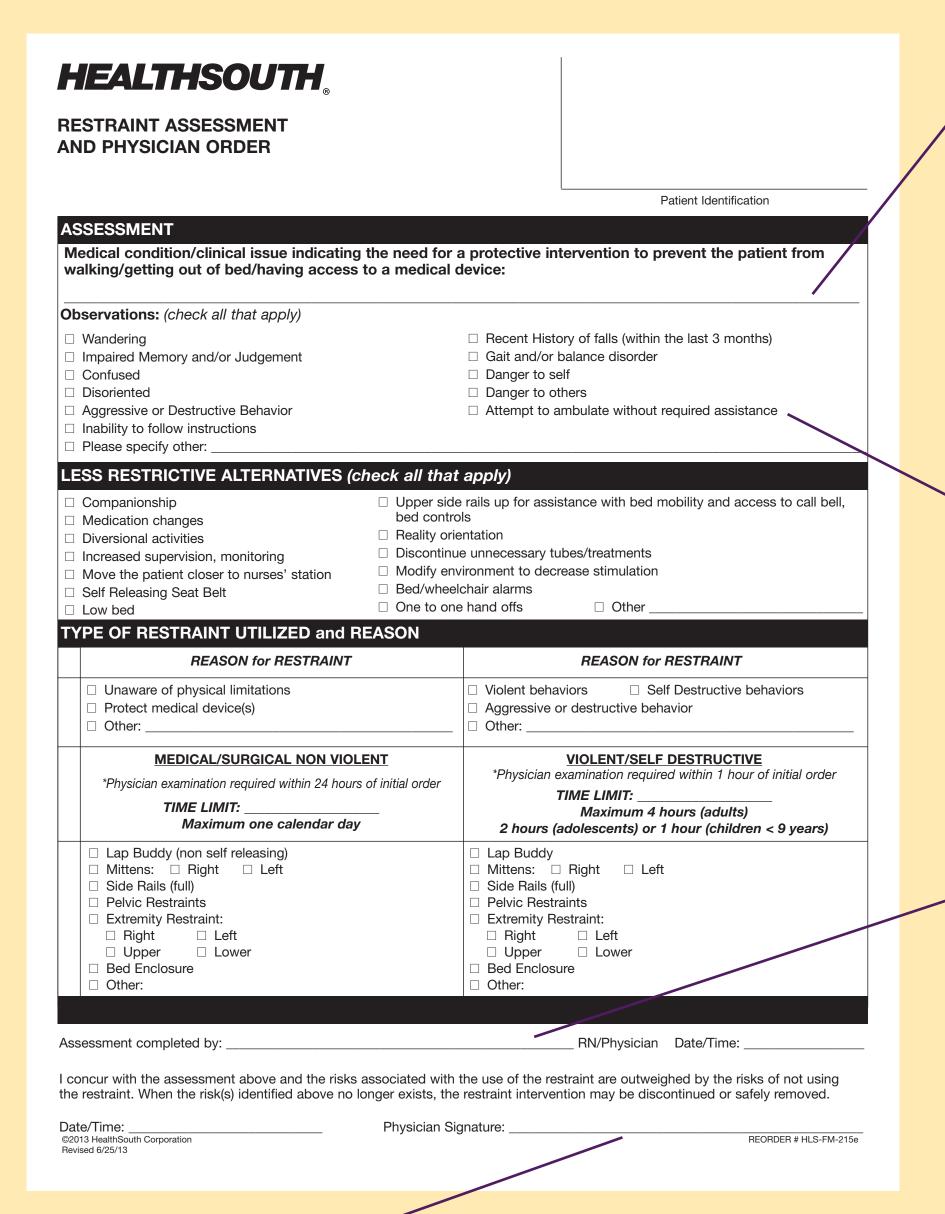


#### Introduction Hospitals

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 listed that justifies why the patient needs the restraint. The behavior cannot just say, "Patient attempting to get out of bed (OOB)," patients have the right to get OOB. It must include why they shouldn't be getting OOB. It should say, "Patient unable to weight bear on left leg, attempts to get OOB 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 RN to identify which of these are appropriate. Any others can also be checked when the RN deems appropriate.

Question #1 An assessment must be done before restraints can be applied. The time that 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 1000 and the restraint not applied until 1800.

**Question #2** After the assessment, the RN has one hour to get a physician order for restraints. If the physician is not present, a telephone order can be obtained. A comparison is done between the time the RN assessed the patient and the time the physician ordered the restraint to assure it was not more than one hour.

## Restraint Flow Sheet

Question #5 The safety section is reviewed to see if the staff has documented the type of restraint, if the restraint is on or off, if the patient's circulation has been evaluated with a pelvic or wrist restraint, and if food/fluid/toileting have been offered. Also reviewed is the patient's response to safety measures. If a patient is in a bed enclosure and the staff checks calm or sleeping all night, then the question arises, "Why is the bed enclosure needed?"

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			Bed Pads   Mattress																						
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#### Weekly Restraint Monitoring Form

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					-						
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	П	П	П		П						
e											
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The need for a restraint must be reassessed and reordered every day. This form is used to review restraint documentation for every day the patient requires the restraint. A "Y" means the documentation was complete and an "N" means it was not completed as required.

#### FRONT

Write in date and number to identify which question the comment is addressin

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June 2014		

**BACK** 

If a question is non-compliant (N), a note is written to explain why it was non compliant, and the name of the nurse is provided for follow up. The nurse manager is given a copy of the form to follow up with the appropriate staff. At the end of the month, a tally with all the results of the entire month is completed and shared with the staff.

#### Daily Progress Notes

Question #6 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 documented, then the question arises, "Why is this patient in a restraint?"

TE:		
	i	Patient Identification
ime	Narrative Comments/Add	litional Information/Signature
		FIM Definitions
Help	per: Independence	Helper: Modified Dependence
	le Independence (Timely, Safely) I Independence (Device)	5 Supervision (Subject = 100%)  4 Minimal Assistance (Subject = 75% or more)  3 Moderate Assistance (Subject = 50% or more)  3 Moderate Assistance (Subject = 50% or more)  4 Minimal Assistance (Subject = 25% or 2 helpers required)  5 Comparison (Subject = 25% or more)  6 Activity does not occur, use this only at admission

#### Plan of Care and Plan of Care Update

**Question #7** The restraint must be addressed in 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.

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<b>EALTHSOUTH</b> , interdisciplinary Plan of Care
pairment:
Amputation 🗆 Brain Injury 🗆 Burns 🗆 Congenital deformity 🗆 Fracture of Femur 🗀 Major Multiple Trauma 🗀 Neurologic
Osteoarthritis 🗆 Rheumatoid Arthritis 🗆 Spinal Cord Injury 🗆 Stroke 🗀 Systemic Vasculidities 🗆 Other (specify)

rment:					
		genital deformity □ Fracture of Fer pinal Cord Injury □ Stroke □ Syste			ultiple Trauma □ Neurological Disorder □ Joint Replacement
orbid Conditions:	u tillitio 🗆 O	pinar cora injary - circito - cycle	Jillio Vacca	ilaitic	20 Cition (opcomy)
	, Disease □	Congestive Heart Failure □ Coror	any Arteny	Dica	ase □ Depression □ Dementia □ GERD □ Glaucoma
					☐ Type II Diabetes ☐ Other (specify)
nt/Caregiver Goals:	TI USTEUM		уре г Біаве	,103	1 Type II Diabetes - Other (Specify)
it/Caregiver Goals:					
Safety Concerns	Initiate	Interventions/Treatment Plan	Discontinued		Long Term Goals
Problems	Initial/date		initial/date	✓	By discharge:
Fall Risk Score(from DA Morse Scale)		Standard Fall Precautions to include:			Patient will be able to communicate □ basic □ complex needs to staff & caregivers
Bed Entrapment Risk	1				Patient/caregiver will demonstrate knowledge regarding safety
ack of Safety Awareness	]				precautions
mpulsivity					Patient/caregiver will demonstrate knowledge/resolution of home
isual Impairment	_	High Risk Fall Precautions to include:			safety issues
Auditory Impairment	1				Patient/caregiver will demonstrate compliance with infection control/
Elopement Risk					prevention precautions
solation		Restraints per physician order			
s: List	1	Monitor elimination needs,			
		circulation, food and hydration q 2 hours			
		Re-assess need for continued			
		restraint every 24 hours			
		Bed entrapment prevention			
		side rail pads on while in bed			
		Elopement Prevention			
		Precautions			
	Deticut/E	poils Cafab - Education			
	Patient/Fai	mily Safety Education			
		Fall Prevention Use of Call Light			
		Swallowing Precaution Safety			
	-	Home Safety			
		Medication Storage Safety			-
		Spine Precautions			
		Hip Precautions			-
		PPE & Hand Hygiene			
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will be able to communicate $\square$ basic $\square$ complex	∠ Pt will be able to communicate □ basic □ complex	Pt will be able to communicate □ basic □ complex						
staff/caregivers % of the time	needs to staff/caregivers % of the time	needs to staff/caregivers % of the time						
/caregiver will demonstrate knowledge	Pt/caregiver will demonstrate compliance	Pt/caregiver will demonstrate competence in identifying						
g safety precautions	regarding safety precautions	safety issues and discuss strategies to resolve them						
/caregiver will communicate possible home	Pt/caregiver will demonstrate knowledge of home	Pt/caregiver will discuss strategies to resolve home						
sues related to impairment	safety issues related to impairment	safety issues						
atus Update / Discharge Date	Status Update / Discharge Date	Status Update / Discharge Date						
Modified Morse Scale	Modified Morse Scale	Modified Morse Scale						
of Falls Y=25	History of Falls Y=25	History of Falls Y=25						
ry Diagnosis Y=15	Secondary Diagnosis Y=15	Secondary Diagnosis Y=15						
mbulatory Aid (Device = 15; Furniture=30)	Use of Ambulatory Aid (Device = 15; Furniture=30)	Use of Ambulatory Aid (Device = 15; Furniture=30)						
h Risk Fall Med Y=20	IV or High Risk Fall Med Y=20	IV or High Risk Fall Med Y=20						
Gait (Weak=10; Impaired=20)	Impaired Gait (Weak=10; Impaired=20)	Impaired Gait (Weak=10; Impaired=20)						
tatus Y=15	Mental Status Y=15 TOTAL	Mental Status Y=15 TOTAL						
TOTAL	TOTAL	TOTAL						
Scale/Fall Risk Change	☐ Morse Scale/Fall Risk Change	☐ Morse Scale/Fall Risk Change						
ate fall precautions in place? Y or N (explain)	☐ Adequate fall precautions in place? Y or N (explain)	☐ Adequate fall precautions in place? Y or N (explain)						
ints in use	□ Restraints in use	☐ Restraints in use						
	Type:	Type:						
ued Need? Y or N	Continued Need? Y or N	Continued Need? Y or N						
ntrapment safety pads in place	☐ Bed entrapment safety pads in place	☐ Bed entrapment safety pads in place						
	☐ Other:	☐ Other:						

Short Term Goals/Status Updates

Short Term Goals Week 2 Short Term Goals Week 3