Providence HEALTH CARE

Provincial Health Services Authority
Province-wide solutions. Better health.

☐ Holy Family Hospital
☐ Mount Saint Joseph Hospital
☐ St. Paul's Hospital

RESTRAINT USE: NURSING RECORD

Assessment and Evaluation Guidelines:

1. **Q15 minutes until stable** (patients in seclusion or in 4-limb restraints must remain on Q15 minute assessments for the duration of their seclusion or restraint), ***then*;**
2. **Q30 minutes x 1 hour**, ***then;***
3. **Q60 minutes until the restraints are discontinued** (or the restraints are identified by the team as an agreed-upon component of the patient's continuing care)
4. **Q60 minutes Vital Signs until stable** (or as ordered). **Document Vital Signs on clinical record**

LEGEND ✓ = Satisfactory
✱ = Unsatisfactory (entry in relevant nursing record e.g. Progress Note)
S = Supine or **P** = Prone (positioning determined by clinical judgement & patient condition)

Date:									
Time:									
Behaviours Observed ➢ Enter code number									
Interventions/ Alternatives Attempted ➢ Enter code number									
Restraint Type ➢ Enter code number									
Positioning									
Respiratory Status									
Limb Circulation									
Skin Condition Under Restraint									
Q1H and PRN PHYSICAL NEEDS ASSESSMENT									
➢ Repositioned (*e.g. turned)*									
➢ Toileted									
➢ Food/Fluid Offered									
➢ Pain/Symptom Management									
Restraints Discontinued									
RN / RPN / LPN Initials									

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ASSESSMENT PARAMETERS

Please enter <u>all</u> that apply on the Restraint Initiation and/or Restraint Use Nursing Records

BEHAVIOURS OBSERVED (Codes)

1. Agitation
2. Aggression
3. Combative
4. Pulling out tubes
5. Level of consciousness
   - 5.1 Alert
   - 5.2 Responsive to voice
   - 5.3 Responsive to pain
   - 5.4 Non-responsive to pain stimulus
6. Mental status
   - 6.1 Disoriented
   - 6.2 Hallucinating
7. Memory deficit
8. Impaired mobility
9. Falling
10. Movement disorder
11. Participating in other activities
12. Calm and settled
13. Sleeping
14. Other _____

_____

_____

INTERVENTIONS / ALTERNATIVES ATTEMPTED (Codes)

1. Establishing Rapport
- 1.1 Eye contact
- 1.2 Friendly tone
- 1.3 Calm manner
- 1.4 Approach slowly
- 1.5 Explain procedures
- 1.6 Listen to non-verbal/verbal communication
- 1.7 Maintain consistent care plan
- 1.8 Provide communication aids
- 1.9 Involve family members, as appropriate

2. Nursing Interventions
- 2.1 Regular toileting
- 2.2 Pain control
- 2.3 Food and intake
- 2.4 Eliminate unnecessary tube/lines
- 2.5 Administration of psychoactive medications
- 2.6 Review of prescribed medications
- 2.7 Consider constant/close care
- 2.8 Diversionary activities
- 2.9 Involve OT/PT

3. Environmental Interventions
- 3.1 Adjust stimuli (lighting, noise, proximity to nursing station, number of contacts, roommate selection)
- 3.2 Consider using a private room

NON-RESTRAINT ALTERNATIVES (Codes)

4. Non-restraint product alternatives
- 4.1 Pinel self-release waist belt
- 4.2 Self-release wheelchair belts
- 4.3 Bed and chair alarms
- 4.4 Exit alarms
- 4.5 Floor mats
- 4.6 Non-skid socks
- 4.7 Hip protectors (O.T. consult required)
- 4.8 Helmet (O.T. consult required)
- 4.9 One, two or three split side rails

RESTRAINT TYPE (Codes)

1. Wheelchair belts
2. Waist restraint
3. Limb restraint
4. Mitts
5. Arm splint
6. Secure room
7. Four side rails, (must be used with bed alarm, waist or limb restraint)

PHYSICAL ASSESSMENT

Positioning
✓ Side-lying is preferred for limb restraints, but supine or prone may be used, dependent on clinical judgement & patient condition

Respiratory Status
✓ Ensure breathing is not compromised

Limb Circulation
✓ Ensure that the hand/foot is not discoloured, edematous, cold, or painful

Skin Condition Under Restraint
✓ Ensure that the skin under the restraint is intact and that there is no chafing or skin breakdown