Assessing and documenting patient restraint incidents

Accurate information can promote restraint-free care.

By Jim Woodard, RN, MBA

Restraining a patient is considered a high-risk intervention by the Centers for Medicare & Medicaid Services, The Joint Commission (TJC), and various state regulatory agencies, so healthcare providers must carefully assess and document the patient's condition.

Assessing the patient's medical condition

Review the patient's medical record for preexisting conditions that can cause behavioral changes—for instance, delirium, intoxication, and adverse drug reactions. If the behavior results from an underlying medical problem, accurate assessment allows timely medical intervention and may reduce the restraint period required or even eliminate the need for restraint.

Assessing the patient's behavior

To establish the patient's behavioral baseline, assess his or her mental status, mood, and behavioral control. This allows clinicians to later determine how the patient is tolerating restraint and helps ensure restraint will be discontinued as soon as clinically indicated.

Medications can be an important part of a restraint intervention. Appropriate use of as-needed medications can shorten the restraint time. Assess the patient's response to medications.

Assessment during the restraint period

A restrained patient is susceptible to injuries caused by restricted breathing, circulatory problems, and mechanical injuries. Once restraints have been applied, take steps to ensure a safe, injury-free outcome. Perform a quick head-to-toe assessment to help identify areas of concern or conditions that require further monitoring.

Being restrained is a traumatic experience for the patient, so continually assess how he or she is dealing with the stress.

Documentation

Accurate documentation of the restraint episode is vital to safe, effective patient care and provides information that can improve the quality of care. Document the reason for restraint and that you explained the reason to the patient and family.

You can use a flowsheet to document assessments. The flowsheet should include the following:

- patient behavior that indicates the continued need for restraints
- patient's mental status, including orientation
- number and type of restraints used and where they're placed
- condition of extremities, including circulation and sensation
- extremity range of motion
- patient's vital signs
- skin care provided
- food, fluid, and toileting offered.

Also, include the education you provide to the patient and family. Remember—the goal is to remove the restraints as soon as possible.

Post-restraint debriefing

When the restraint episode ends, a nurse or other qualified caregiver should debrief the patient. Reviewing the restraint episode with the patient yields important information that can help lead to restraint-free treatment. Information gained from debriefing helps the treatment team design therapeutic interventions that may help prevent the need for restraints. Be sure to document the debriefing.

Toward restraint-free care

Accurate assessment and documentation of restraint episodes provide valuable information to improve treatment processes, ultimately helping nurses create an environment where restraint-free care is possible. •

Visit www.americannursetoday.com/?p=18952 for a list of selected references.

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