

Quality Improvement Activity : Restraints for a combative patient

A 19-year-old patient was admitted to the hospital with manic episodes and delirium. The patient's mother called EMS when she noticed the patient acting strange. Upon further inspection of the patient's room, the mother realized the patient was experiencing methamphetamine-induced mania and delirium. She was unable to control the patient so she called EMS. Upon admission, the triage nurse is told by EMS that restraints were put on the patient by the trainee for her safety and the safety of the EMS team. The ED nurse begins her assessment of the patient and notices that she is experiencing bradypnea. She checks her oxygen saturation and it is reading 80%. The patient's heart rate is below 60 and she has cyanosis around her mouth. The patient then goes into cardiac arrest, a code blue is called. The ED nurse tries to move the patient to place a board underneath her to begin high-quality CPR, when she notices the patient's jacket restraint is constricting the patient's neck. She immediately pulls out her scissors and cuts away the restraints. By this time it is too late, the patient does not make it.

Describe the scenario. In what way did the patient care or environment lack? Is this a common occurrence?

In the scenario above, a patient is admitted with restraints to the emergency department via EMS. The patient's mother reported altered LOC and aggression by the patient, so she called EMS to have the patient admitted. EMS reported to the scene, restrained the patient, and traveled over an hour to get her to the ED. All this while the patient was put into a restraint by an EMT in training. The trainee lacked training in using restraints, thus causing the death of the patient. The Joint Commission requires patients to be monitored during restraint use. Vital signs and neuro status must be assessed to prevent harm to patients during restraint use. Death or injury is a common occurrence in the health field when restraints are used, proper education and training must be completed to be able to safely use restraints on patients.

What circumstances led to the occurrence?

The circumstances that directly led to this occurrence was the certified EMT not verifying that the trainee had applied the restraints correctly. Also not checking the status of the patient on the drive to the hospital.

In what way could you measure the frequency of the occurrence? (interview nurses, examine charts, patient surveys, observation, etc)

The frequency of the occurrence of death/injury from use of restraints is constantly being reviewed by The Joint Commission and hospital leaders within the health care setting. Due to the increase in death/injury of patients in restraints, hospitals use evidence based practice to prevent injuries and educate how to properly use restraints. One way that they are measuring how often death/ injury is occurring is by reviewing patients charts and medical history if they are harmed or death occurs while they are in restraints.

What evidence-based ideas do you have for implementing interventions to address the problem?

Specialized training in de-escalation techniques should be required to try to avoid restraints all together. Training on the application of restraints is needed to safely apply restraints without causing harm to patients. Healthcare workers must be trained to monitor patients vital signs and asses for skin breakdown while they have restraints on. The Joint Commission already requires that a order for restraints be renewed and reevaluated every 24 hours to prevent injury/ death of patients. Staff should be trained in identifying when a restraint is no longer needed and can be discontinued.

How will you measure the efficacy of the interventions?

Measuring the efficacy of these interventions can be accomplished by reviewing weekly reports of any occurrences of death/injury by restraint use. An increase or decrease in death/injury can be compared to previous occurrences. This will help healthcare members identify whether we are progressing in the knowledge and safety of restraint use.

