Reducing Physical restraint use on the ACE service: a QI intiative

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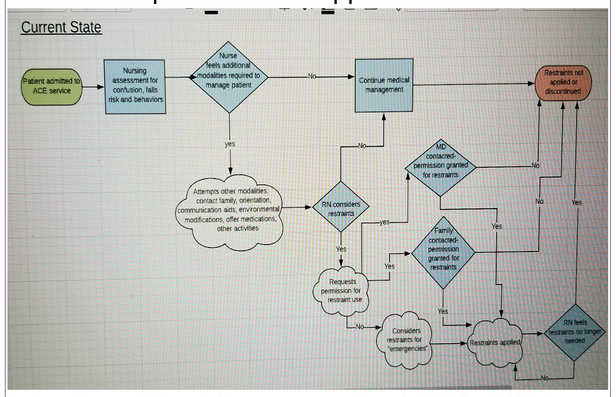
AIM Statement: By December 2022, decrease the median of patient-restraint days on the ACE service by 50 %.

PROBLEM DEFINITION

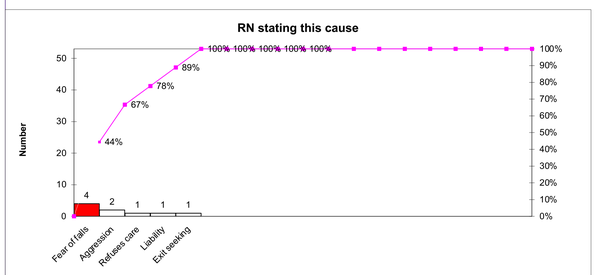
Clinical guidelines and Ontario legislation stipulate that physical restraints are supposed to be used as a last resort only. Despite this, physical restraints are used commonly in hospitalized seniors. Over a 2-week period the median rate of physical restraint use was 17 patient-restraint days.

ROOT CAUSE ANALYSIS

Process map for restraint application:



Interviewed front line nurses (and MRPs/NPs):
Most common causes for restraint application:
1) Fear of the patient falling
Other factors (fear of):
Patient wandering off unit, aggression/agitation, patient interference with medical treatments



Misperceptions about physical restraints and their harms promote their use. Educational interventions, policy changes, MRP awareness, providing alternatives to restraints may result in less restraint use

IMPLEMENTATION

Planned PDSA cycles:
1) Modify restraint policy (with mandatory staff education); inclusion of MRP in decision making around restraints
2) Survey to assess staff knowledge and needs around restraint use
3) Short educational videos provided to nursing staff (pre and post knowledge surveys)
4) Educational sessions to MRPs and residents
5) Consider active consultative models if above ineffective

MEASUREMENT & RESULTS

Baseline Restraint use (Patient restraint days)

After PDSA implementation, measure knowledge change (surveys) as process measure; neuroleptic use and falls (as balancing measures)

SUSTAINABILITY

1. Process owner- Manager of ACE unit
2. New standard: new restraint policy
3. Monitoring plan- ongoing concurrent data collection to highlight performance and emphasize need to reduce restraints