AGENCY
CLINICAL EDUCATION

RESTRAINTS ARE:

AMG SPECIALTY HOSPITAL
Healthcare Management for Complex Medical Needs
Feliciana

- Limited in use to clinically appropriate and adequately justified situations.
- Used to prevent risk of injury to the patient or others when less restrictive interventions are not sufficient.
- Used when the potential risks to patients, from failure to apply, outweighs the potential risks of application;
- Never used as punishment, for convenience of staff, or in response to behaviors or circumstances that do not constitute danger or injury to patients or others, e.g. Verbally abusive behavior.
- Initiated and applied only by individuals authorized and qualified to do so, and whose competencies are validated.
- Used in conformity with all prevailing laws, regulations and accreditation standards.

Alternative Interventions:

- **TOILETING**
- Providing glasses/hearing aids
- Offering fluids or snacks
- Maintain frequently used items within reach
- Reorientation to environment
- Adjustments to lighting
- Relocation of patient for better observation
- Family/Sitter to accompany patient
- Assist patient to chair or to ambulate
- Diversional activities
- Patient and/or Family education
- Reposition or conceal medical devices
- Staffing Adjustments
- Clutter-free environment
- Increased frequency of observations
- Decrease stimulation
- Solicit suggestions from family
- Avoid interventions during normal sleep hours
- Visual cues used as a patient reminder
- Pain Management

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ORDERS

- **Medical/Surgical Purposes:**
  - A written order, based upon the examination of the patient by a physician is entered into the patient's medical record within 24 hours of the initiation of the restraint device.
  - The order must be in accordance with a written modification to the patient's plan of care that includes (1) implementing in the least restrictive manner possible; (2) use in accordance with safe and appropriate restraining techniques; and (3) ending use at the earliest possible time.
  - The physician order will not exceed a period of 24 hours.
  - Continued use of the restraint beyond the first 24 hours is authorized by a physician by issuing a new order if the restraint continues to be clinically justified.

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Safe Application and Removal

- Staff involved in the application and removal of restraints will have participated in appropriate training prior to implementation. Education of the staff promotes an environment that encourages alternatives to restraints and the use of least restrictive devices while assuring the safety and efficacy of the restraint devices.
- Restraining devices will be applied and maintained according to the manufacturer's guidelines.
- All staff who have direct patient contact must have ongoing education and training in the proper and safe use of restraint application, techniques and alternative measures for handling behavior, symptoms, and situations that have traditionally been treated through the use of restraints.

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Monitoring

- Patients will be monitored during the use of restraint to determine their well being and assessed for the continuing need for restraints. Patients will have a trial release of restraints every shift as appropriate.
- Monitoring will include assessment of peripheral circulation, sensation, movement, and skin integrity every two hours.
- Patients will be reassessed for the continued need for restraint a minimum of every 2 hours.
- Patients will be offered food/fluid, toileting, and hygiene at least every two hours.
- PROM exercises or position changes will be provided at least every two hours.
- Patients will be assessed for pain at least every two hours.

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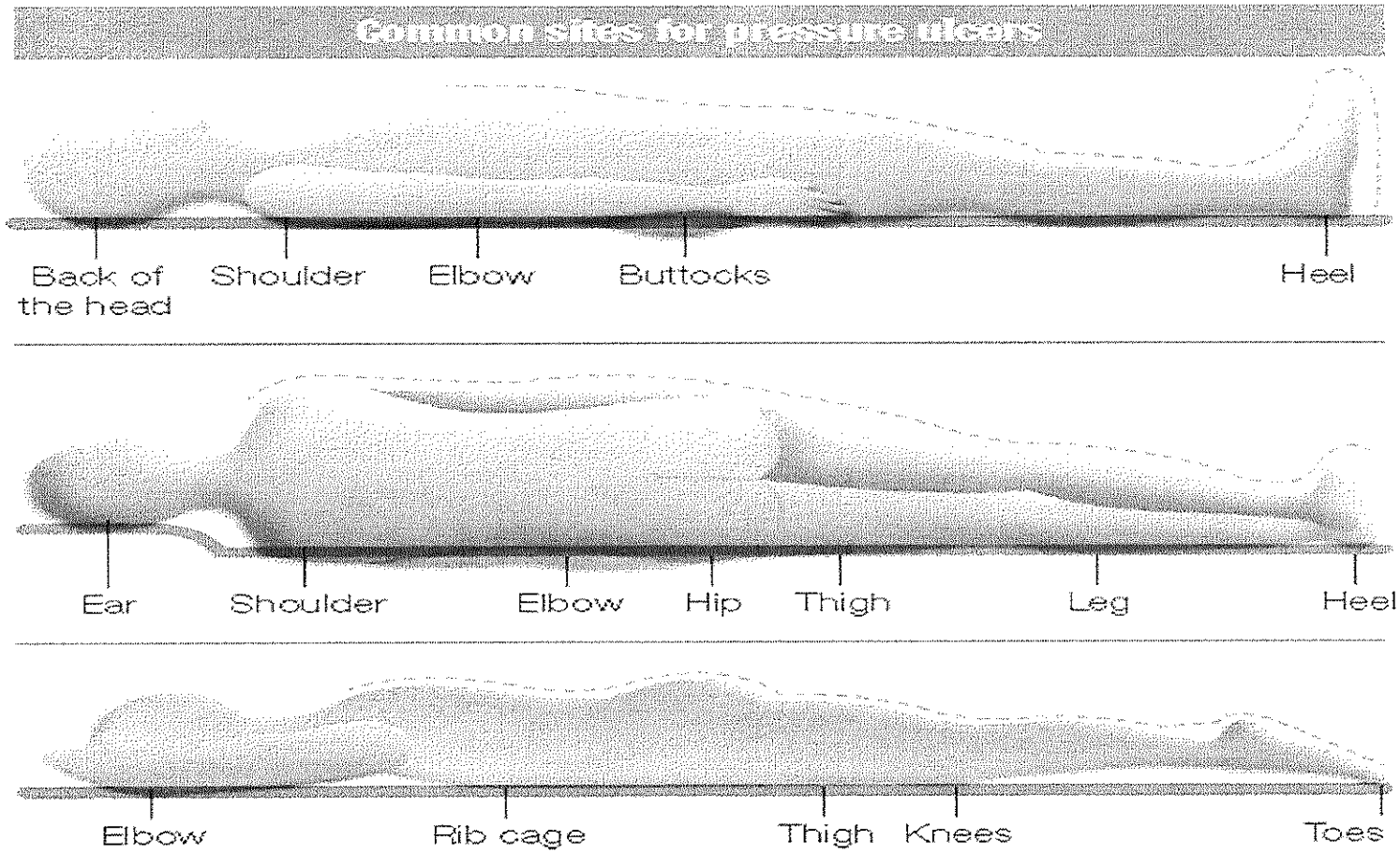
COMMON SITES FOR PRESSURE ULCERS



Partial Thickness vs. Full Thickness

- **PARTIAL THICKNESS**
- Destruction of Epidermis and dermis

- **FULL THICKNESS**
- Destruction of epidermis, dermis, subcutaneous and/or deeper.

Measuring

- **Dimensions:** Always measure length, width, and depth in centimeters.

- **Length:** Longest head-to-toe measurement
- **Width:** Longest hip-to-hip measurement.
- **Depth:** Deepest part of wound.

- Measure open area only.
- Diameter from edge to edge.
- Length x Width x Depth in cm.

Staging

- **STAGE I:**
- Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area.

- **STAGE II:**
- Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.

Staging

- **STAGE III:**
- Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.

- **STAGE IV:**
- Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling.

Descriptions

- **UNSTAGEABLE:**
- Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed.

- **SUSPECTED DEEP TISSUE INJURY:**
- Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.

RRT / CODE BLUE PROCEDURE

- The response team members must respond within 5 minutes to each call/notification that there has been a change in the condition of the patient.
- The response team assists the nurse caring for the patient in assessing and stabilizing the patient's condition and organizing information to be communicated to the patient's physician.

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Early Warning System
Staff

- A response triggered by two or more of the following criteria out of limits:
  - Systolic Blood Pressure:
    < 90 mmHg > 200 mmHg
  - Respiratory Rate: < 9
    > 28
  - Heart Rate:
    < 50 > 120
  - Saturation:
    < 90% (on room air or if on O2)
  - Urine Output: < 50 ml
    in 4 hours
  - Conscious Level:
    Acute change in conscious state

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PROCEDURE

- The charge nurse and respiratory therapist or designated nurse will document their response assessment on the Response Team Record.
- The response team nurses and/or therapist will communicate the assessment / patient change in condition using the SBAR format.

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SBAR

- **S =** **Situation**
- **B =** **Background**
- **A =** **Assessment**
- **R =** **Recommendations**

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CODE BLUE

- If the patient codes, the nurse caring for the patient as well as the Rapid response Team members will initiate the code as appropriate.
- Once the code or critical event is over, debriefing will be done by the CCO.

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Debriefing

Will include the following:

- The staff member who called the Response team, if possible, as well as the staff on duty at the time of the code.
- Discussion of what happened.
- How they identified the need for the Rapid Response Team.
- What interventions they made.
- The disposition of the patient.
- Response time of the team.

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Planning a **Transfer/ Lift**

There are many variables to patient transfers that need to be considered prior to the transfer.

- Know the patient's precautions
  - limb range of motion precautions
  - weight bearing precautions
  - Wounds
  - Isolation precautions

ALWAYS CHECK WITH THE NURSE OR CHART TO REVIEW PATIENT'S CONDITION OR PRECAUTIONS.

- **Know the patient's precautions**
- **How many people are required to move the patient? Call for lifting help if needed**
- **Equipment (draw sheet, gait belt, sliding board, etc)**
- **Safety (lock all brakes, use proper body mechanics)**
- **Call Bell (after the transfer, don't forget to give the patient a call bell)**

Rolling/Turning Patients

If the patient can use arms, have them reach toward the rail with the uppermost arm during the roll, or have them use the bedrail to pull themselves. If they are in need of max assistance, it is better to keep the bedrail down, so you are not bending over the rail.

Lay the bed flat

Raise the bed to your waist and lower the bed rails

If the patient can use their legs, keep the leg in the direction of roll straight and bend the other knee placing the foot on the bed

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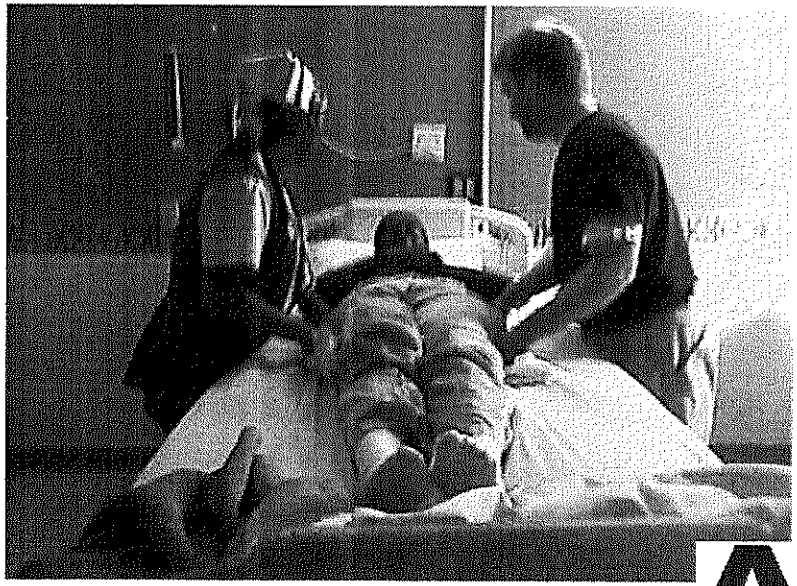
Moving A Supine Patient To The Head Of The Bed

If the patient is unable to move on their own, but has use of arms, they may assist by pulling on the bed rails or trapeze. If they are able to use their leg(s), have them bend their knees placing their feet flat on the bed (not the draw sheet).

Have one caregiver on each side and raise the bed to waist height

Lower the bed rails



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LIFTING

- Roll the draw sheet so your hands are as close to the patient as possible
- Keep your elbows at your sides and take a step toward the head of the bed. DO NOT LIFT the patient or PULL the patient from under the arms. Use the draw sheet to SLIDE them.
- If the patient is large, place the bed in a trendelenberg position before moving the patient. Gravity will help.

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Bed to Bed Transfers

- The empty bed should be slightly lower than the bed the patient is in
- If available, use a sliding board
- The caregivers by the empty bed should climb up onto the bed. They should avoid standing on the floor and bending over to reach the patient
- Make sure to support the head, if the patient does not have head control
- On the given count, move the patient half way. DO NOT attempt to move the patient all the way on the first move
- Climb down off the bed, the caregivers on the other side climb up onto the bed
- On the given count, move the patient the rest of the way
- DO NOT TRY TO LIFT the patient. Instead, slide the patient using the draw sheet

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Supine to Sit

- Lower the bed to lowest position for patient safety
- Have the patient roll to the side of the bed they plan to sit on
- From the side lying position, bring their legs over the edge of the bed by guiding from behind the knees
- Place one hand on the patient's hip bone (now on top) and the other hand under the trunk
- Encourage the patient to prop up on their elbow. Using their hand and elbow work their way into sitting. Apply pressure to the hip and under the trunk to assist.

Sit to Stand

- Have the patient scoot to the edge of the bed or chair
- Then move their feet below or just behind their knees
- With the patient sitting straight, have them lean forward keeping their eyes and head up
- And push into standing using legs and arms.
- If the patient needs assistance, use a gait belt. You should stand in front of the patient blocking one or both knees with your knees. Squat down, do not bend to reach the gait belt. Never assist a patient by pulling under their arms. Do not pull on the patients clothing. Do not allow the patient to place arms around your neck.

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Pivot Transfers

- With the patient in sitting position with the foot closer to the direction of transfer slightly forward, have them lean forward
- The caregiver is directly in front of the patient in a squat with hands on the gait belt, block one or both knees with your knees
- On count of 3, lean back and push with your legs to lift the patient off the chair/bed
- The goal is NOT to stand them, but to get the high enough to clear arm rests and pivot

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Two Person Lift

- One caregiver stands behind the patient and places arms around the patient's trunk
- Second caregiver squats to lift patient's legs
- The patient is moved with the force directed onto the trunk, NOT pulling up under the arms as this may damage the patient's brachial plexus

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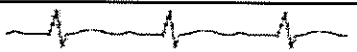
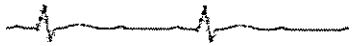
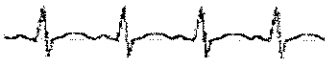
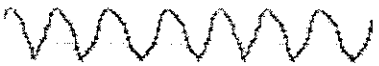
TELEMETRY MONITORING CHEAT SHEET

Rhythm	Description	View
1st Degree Heart Block	Long PR Interval	
2:1 Heart Block	2 P waves per QRS complex	
Asystole	Flatline	
Bradycardia	SR, rate < 60	
Idioventricular (IVR)	No P wave, bizarre QRS, rate 20-40	
Normal Sinus Rhythm (NSR)	Normal P, QRS, T wave formation, rate 60 - 100	
Premature Atrial Contraction (PAC)	Premature P wave, irregular P-P	
Premature Ventricular Contraction (PVC)	Wide QRS, unrelated to P-wave.	
Tachycardia	SR, rate > 100	
Ventricular Fibrillation (V-Fib)	Chaotic waves	
Ventricular Tachycardia (V-Tac)	Bizarre, wide QRS, no P-wave. Rate >100 (Resembles teeth)	

End Of Life - EOL

- The hospital provides for the cultural, emotional, spiritual and psychosocial needs of the dying patient and his family with attention to the individual/family's values and beliefs.
- Care at the end of life may include, but not be limited to, treatment for primary and secondary symptoms as medically appropriate, pain management, and psychosocial support as needed.
- Organ donation will follow the LOPA guidelines.

End Of Life

Patient Family Issues

- **Emotional support**
- **Communication**
- **Continuity**
- **Pain and symptom management**
- **Respect**
- **Support of patient decision making**

Factors Affecting EOL

- Incomplete information
- Unrealistic expectations
- Unresolved family issues
- Uncontrolled pain
- Uncontrolled symptom management

Communication

- Honesty
- Listening
- Silence
- Being there
- Being open

- **CAREGIVER SUPPORT**
- Acknowledge the caregiver's efforts
- Assess the caregiver's health
- Teach the basics of care
- Medication teaching and scheduling
- Explore how others can help

Managing Pain

- Understand the principles of pain control at the end of life
- Acute or escalating pain
- Is this a medical emergency?
- Breakthrough pain
- "Addiction"

APPROACHING DEATH

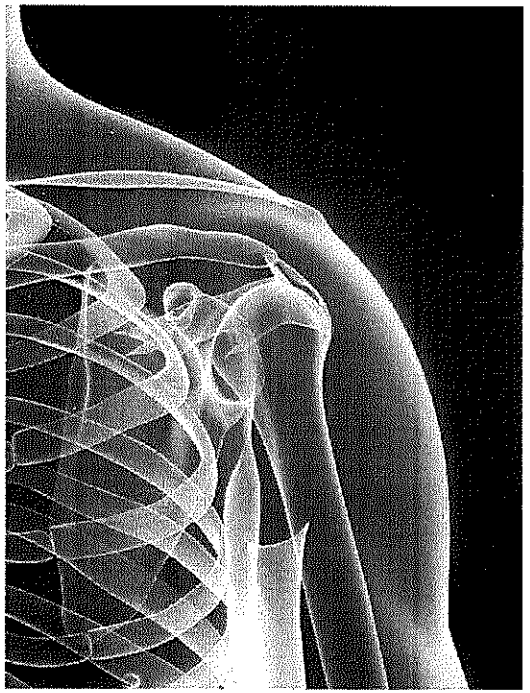
- Profound weakness
- Decreased LOC
- Cognitive failure
- Change in pain status
- Social withdrawal
- Disinterest in fluids

After Death

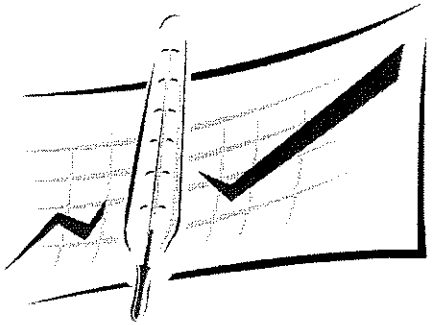
- Make the body look as natural as possible, (remove lines, lay bed flat, patient on back, arms at side, place a pillow under head, close eyelids, close mouth, wash soiled areas, etc.)
- Make the environment clean, (remove all equipment and supplies from bedside).
- Allow the family to stay with the patient to say goodbye. Comfort them and let them grieve.
- ***KEY POINT:*** *Document in medical record until patient leaves the hospital or enters the morgue.*

PAIN Assessment

- Consider the following during the pain assessment:
  - Site of pain
  - Duration of pain
  - Intensity of pain
  - Quality of pain
  - Location of Pain
  - Type of pain
  - Pain onset
  - Pain duration
  - Alleviating and aggravating factors
  - Other symptoms
  - Relief measures

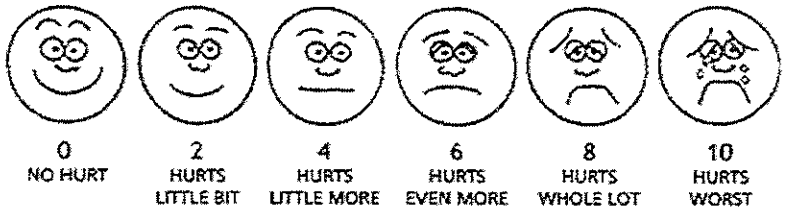


Assessment



- For patients, who are unable to rate their pain by using numbers or are otherwise unable to communicate

Wong-Baker FACES Pain Rating Scale



From Wong D.L., Hockenberry-Eaton M., Wilson D., Winkelstein M.L., Schwartz P.: Wong's Essentials of Pediatric Nursing, ed. 6, St. Louis, 2001, p. 1301. Copyrighted by Mosby, Inc. Reprinted by permission.

Both scales are 0-10 equivalent

Pain Management

- Documentation of pain assessment, treatment and evaluation of treatment effectiveness is initiated upon admission and documented in the patient's medical record
  - Initial Nursing Assessment
  - Daily Nursing Assessment