



Nursing Best Practice Research Unit
Unité de recherche sur les pratiques exemplaires
en soins infirmiers



Restraint Prevalence Tools

NURSING BEST PRACTICE GUIDELINES

EVALUATION USER GUIDE

November 2006

Disclaimer

The opinions expressed in this publication are those of the authors. Publication does not imply any endorsement of these views by either of the participating partners of the Nursing Best Practice Research Unit, which include members of the University of Ottawa faculty and members of the Registered Nurses' Association of Ontario (RNAO).



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Nursing Best Practice Guidelines Evaluation User Guide

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Printed in Ottawa, Ontario, Canada

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The recommended citation is:

Davies B, Danseco E, Ploeg J, Heslin, K, Stansfield M, Santos J & Edwards, N. (2006). Nursing Best Practice Guideline Evaluation User Guide: Restraint Prevalence Tools. Nursing Best Practice Research Unit, University of Ottawa, Canada. pp. 1-20.

Acknowledgements

This user guide was based on an evaluation project awarded to Barbara Davies and Nancy Edwards with the Registered Nurses' Association of Ontario (RNAO) and funded by the Government of Ontario. The authors are grateful for the support of the Nursing Secretariat of the Ministry of Health and Long-Term Care (MOHLTC), in particular the Chief Nursing Officer, Sue Matthews. The authors would also like to acknowledge the contributions of Tazim Virani and RNAO staff, clinical sites that pilot-tested the evaluation tool, members of the evaluation team and project staff. The authors also thank Dianne Rossy and Marlene Mackey for permission to adapt their tool and the assistance they provided in the revisions to their tool.



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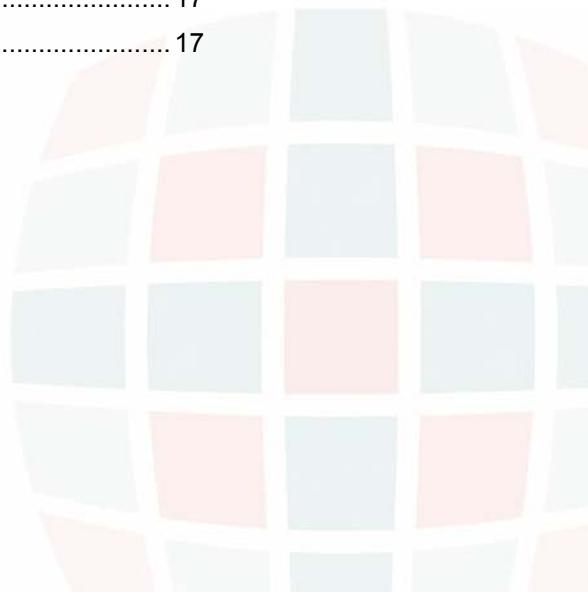
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Development of the Restraint Prevalence Tools

1



Chapter highlights

- > Why evaluation tools for Best Practice Guidelines are necessary
- > Process used for developing the Restraint Prevalence Tools

The Nursing Best Practice Research Unit (NBPRU) was formed in January 2005 as a partnership between the University of Ottawa, School of Nursing and the Registered Nurses' Association of Ontario (RNAO). One of the research unit's objectives is to develop and pilot test tools useful in the evaluation of the implementation of clinical nursing BPGs.

BACKGROUND

Clinical or best practice guidelines (BPGs) summarize the most up-to-date research on various clinical topics. They contain recommendations that are useful in helping healthcare providers practice evidence-informed care and improve patients' health outcomes. The Registered Nurses' Association of Ontario (RNAO), with funding from the Ontario

Ministry of Health and Long-Term Care has developed 30 BPGs to date. Each BPG includes evidence-based practice, education, and organization/policy recommendations. Details about the RNAO Best Practice Guideline Program may be obtained on the RNAO website: www.rnao.org/bestpractices

When BPG recommendations are implemented in a healthcare organization, the evaluation of its impact needs to be linked with changes in nursing practice and improvements in patient outcomes. The measures used to evaluate the BPG implementation need to be valid and reliable so that conclusions about the relationships between the implementation and the outcomes can be established. These measures also need to be feasible, acceptable, and meaningful to healthcare providers and patients. Sound measures are crucial for effective decision-making on the implementation and evaluation of evidence-informed care.

The Nursing Best Practice Research Unit (NBPRU) was formed in January 2005 as a partnership between the University of Ottawa, School of Nursing and the Registered Nurses' Association of Ontario (RNAO). One of the research unit's objectives is to develop and pilot test tools useful in the evaluation of the implementation of clinical nursing BPGs. At a symposium held in the spring of 2005, a team of leading researchers, administrators, government funders, and policy researchers identified a gap in the availability of tools for measuring the outcomes of guideline implementation. Hence, the NBPRU has developed evaluation tools to accompany various BPGs. The psychometric properties of these evaluation tools were examined in several studies.

This user guide presents a brief description of evaluation tools designed to measure the frequency, type, and patterns of physical restraint use among patients with delirium, dementia, or depression. A chart audit tool and an observation tool measuring physical restraint were developed (**Appendix A**), to evaluate the implementation of recommendations targeted by

the RNAO Best Practice Guideline on Caregiving Strategies for Older Adults with Delirium, Dementia, and Depression (DDD) (RNAO, 2004). The minimization of physical restraint use in nursing care is a key patient outcome associated with nursing best practice recommendations.

This user guide on the restraint prevalence tools is intended for users who have experience and/or graduate training in basic research and evaluation. Edwards, Danseco, Heslin, Ploeg, Santos, Stansfield and Davies (2006; see **Appendix B**) provide a more in-depth description of the development of the restraint prevalence tools, including the psychometric properties.

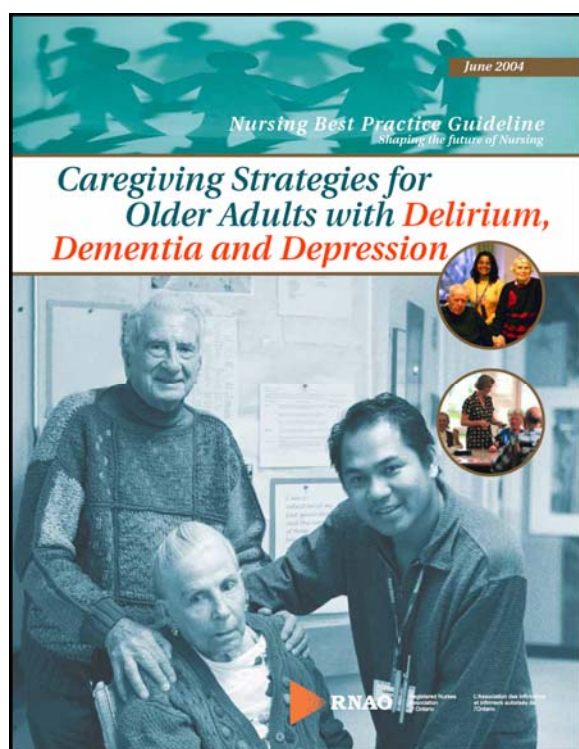
THE RNAO BEST PRACTICE GUIDELINES ON CAREGIVING STRATEGIES FOR OLDER ADULTS WITH DELIRIUM, DEMENTIA AND DEPRESSION

The RNAO Best Practice Guidelines on *Caregiving Strategies for Older Adults with Delirium, Dementia and Depression* is the second in a series of BPGs targeting older adults with delirium, dementia and depression (RNAO, 2004). In 2003, the RNAO developed a BPG on screening for DDD (RNAO, 2003). These two BPGs are intended to be used together for comprehensive nursing care for older adults who are at risk for DDD.

The BPG on Caregiving Strategies outlines various interventions that nurses can utilize such as behavioural strategies, pharmacological interventions, and environmental support or manipulation. Tenets of care underlying these caregiving strategies are also discussed. In addition, there are several recommendations in

the following areas: 1) screening and assessing symptoms of DDD in the context of treatment or caregiving (in contrast to the BPG on screening which focuses on assessment with the aim of obtaining diagnosis); 2) prevention strategies; 3) monitoring and evaluation; 4) documentation; and 5) knowledge components.

Key patient outcomes associated with the implementation of this guideline include improved quality of life, improved functional and cognitive status, reduced length of stay and readmission rates, and less caregiver stress.



APPROACH TO SCALE DEVELOPMENT

The development of evaluation measures for the BPG on Delirium, Dementia and Depression (DDD) followed a collaborative process involving representatives from the guideline development panel, implementation sites, and

the guideline evaluation team. This collaborative team identified priority recommendations of the BPG, selected an area for developing an evaluation measure, and reviewed relevant tools identified during a literature review. We called this team the DDD “DREAM” Team (**D**eveloping, **R**eviewing, **E**valuating and **A**nalyzing Measures).

The team identified the need for measures on quality of life, functional status, and physical restraint use. There are several valid and reliable instruments on quality of life and functional status but few on physical restraints. Most instruments found were unique to the institution, used one item, or did not have information on their reliability. Following consultation with clinical experts, the team identified a restraint prevalence tool developed as a quality improvement initiative by the Ottawa Hospital (Rossy & Mackey, 2003). It was used to measure the prevalence of the use of restraints in an acute care hospital. However, no data on its reliability and validity were available at the time of the study. With the advice of an expert panel, and Rossy and Mackey’s permission, we adapted the tool for use with patients in complex continuing care and rehabilitation settings. Table 2 in Edwards et al. (2006) provides details of changes to the original tool.

We asked several experts to review the adapted tool, made the suggested changes, and then pilot-tested the tool in two sites: 1) a hospital with complex continuing care and rehabilitation units which is part of a network of healthcare organizations; and 2) a healthcare facility providing rehabilitation and complex continuing care for over 250 patients. The paper by Edwards et al. (2006) also provides a more detailed description of the design of the study.

Chapter highlights

In this chapter, we describe the following:

- › Restraint Prevalence Observation Tool
- › Restraint Prevalence Chart audit Tool
- › Steps in administering and scoring the tools.

The Restraint Prevalence Observation Tool and Chart Audit Tools provide complementary information and should both be used for accurately measuring the prevalence of restraint use. The appendices provide additional resources for administering the tools in research or quality improvement (e.g., a primer on how to conduct research in healthcare settings, SPSS data entry guidelines, sample SPSS programs for the restraint prevalence tools, and a quick reference guide).

DESCRIPTION OF THE RESTRAINT PREVALENCE TOOLS

The Restraint Prevalence Tools are comprised of two instruments: an observation tool and a chart audit tool. **The observation tool** is used prior to the chart review. The observation tool enables an observer to gather direct information on the presence or absence of a restraint device, the patients' ability to loosen or release the device, and whether the device itself was appropriately used. The physical restraints included are mitts, wheelchair belts, soft waist belts, pelvic supports, limb holders, four-point restraints, and bed rails.

The observation tool includes questions about the patient's activity and whether the patient can release the device or not. These are crucial in determining whether the device can be defined

as a restraint or not. To construct a tool that was valid for the Canadian context, we used the Minimum Data Set (MDS) definition of physical restraint as this is being currently tracked by the Canadian Institute of Health Information (CIHI) (Hirdes, Zimmerman, Hallman, & Soucie, 1998; CIHI, 2002; Centres for Medicare and Medicaid Services, 2005). Table 1 in Edwards et al. (2006) provides the algorithm for deciding whether a device is considered a restraint or not. Briefly, a device is considered a restraint if the patient cannot release the device. Those situations where patients cannot demonstrate whether they can release the device or not (e.g., while the patient is sleeping) are considered "potential" restraints.

The chart audit tool is a retrospective instrument requiring the observer to gather information from a patient health record 12 hours before and 12 hours after a physical restraint was observed in use. Information to be extracted from the health record in the chart audit tool includes: the type of physical and/or chemical restraint devices used, the reasons why a physical restraint device was used, and the types of alternatives and interventions attempted prior to the use of the physical restraint device. Information about patient consent can also be collected here, depending on the patient population and applicable legal requirements.

The observation and chart audit tools were developed to complement each other and should be used in tandem to capture the multi-faceted nature of restraint use. While the observation tool can provide information on whether a patient can release the device, the chart audit tool can supplement that information by providing details on who ordered the physical restraint, reasons for physical restraint use and whether a chemical restraint was used concurrently. Prevalence or frequency estimates of physical restraint use across various units/facilities can also be derived with information obtained through the two tools.

ADMINISTRATION

Restraint Prevalence Observation Tool

The observation tool is administered first, followed by the chart audit. The administration of the observation tool involves the following: 1) review of the tools and items for applicability and feasibility in the organization, 2) training of staff, 3) decisions on timing and frequency of observations, 4) announcement of the study to staff and patients, and 3) conducting the observation itself. On average, observations can take 1 to 5 minutes per patient.

It is highly recommended that a multidisciplinary team or committee be responsible for planning, implementing and analyzing the results of the restraint prevalence tools. This team should be part of an ongoing initiative or program by the healthcare organization where tracking of indicators related to restraint prevalence can be reviewed periodically. Such a committee or team should also be able to make or implement recommendations, based on various indicators or measures of restraint.

The items in the tools should be carefully reviewed to see if there are any that are not applicable to the organization. An inventory of all devices used in the organization to restrain patients or clients should be done, and the tool can be revised accordingly. It may be necessary for staff to be aware of other objects not in the inventory that may be used as restraining devices.

Training of staff conducting the observation can be done in a minimum of two hours. This training will include familiarization with all the restraint devices used in the organization, how to recognize proper and improper application of the

items, how to approach patients and direct care staff during the observation phase, and how to re-apply the restraint.

Restraint Prevalence Chart Audit Tool

The chart audit tool is completed at least 24 hours after the observations are done.

Depending on the convenience for staff, patients' charts can be collected and brought to an office, or chart reviewers can review the charts on the unit/ wards. The charts of patients who were observed having restraining devices can be reviewed first, followed by those with "potential" restraints.

Reviewers note the time of the observation, and look for records pertaining to the restraint, for the 12 hours before and 12 hours after the application of the restraint. On average, a chart audit can be completed in 5 to 15 minutes per patient.

SCORING AND INTERPRETATION

Restraint Prevalence Observation Tool

Two prevalence estimates can be calculated from the information obtained through the observation tool. The first prevalence estimate determines the frequency of **definite restraint** use, while the second prevalence estimate calculates a frequency of **definite and potential** restraint use (referred to as definite+potential restraint use).

The prevalence estimate of definite restraint use is the number of patients with restraints (excluding those who can release the device, and excluding patients where their ability to release the device could not be assessed), divided by the number of patients in the unit. The second prevalence estimate is the number of patients

with restraints (including those patients where their ability to release the device could not be assessed), divided by the number of patients in the unit. The second estimate should technically be a larger number.

To calculate these prevalence estimates, it is important that the denominator be a count of those patients actually on the unit at the time of the observation period. That is, eligible patients not on the unit at the time of observation are not to be included in the frequency estimate calculations.

Other information that can be obtained from the observation tool includes the number and percent of patients with devices (i.e., not just restraints). If observations are done more than once, an average estimate can be calculated. As highlighted in the paper by Edwards et al. (2006), doing several observations is recommended and can give valuable insights as to the times when restraint use is high.

Restraint Prevalence Chart Audit Tool

Prevalence estimates can also be calculated from the data obtained through chart review. For these estimates, any indication that physical restraints were used in the 12 hours before and the 12 hours after the observation period is to be included in the numerator of the calculation. The denominator from the observation phase is used as the denominator for these calculations.

Chart audit data can be used to calculate several different frequency estimates, such as reasons for restraint use, assessment of proper application of restraint device, who ordered the physical restraint and patient consent to restraint. To obtain these estimates, a count of the number of times these items are documented for each eligible patient on each of the observation days

is taken. Information on compliance with legislation with respect to patient consent can also be determined through the chart audit tool.

A frequency estimate of the number of times chart audit items were found in the health records can be computed by adding up the number of observation days across all patients. Thus a patient who is on the ward for all observation days (5 in our study) is counted as

five separate observations. A percentage of observation days for which physical restraint alone or physical and chemical restraint was recorded in the health record can then be estimated.

3

Overview of Psychometric Properties of the Restraint Prevalence Tools

A paper by Edwards, Danseco, Heslin, Ploeg, Santos, Stansfield and Davies (2006; see Appendix B) provide a more in-depth description of the psychometric properties of the Restraint Prevalence Tools.

The Restraint Prevalence Tool has satisfactory content validity as judged by a panel of experts who commented on clarity of wording, instructions and comprehensiveness of topics covered. Edwards et al. (2006) report inter-rater reliability to range from 60% to 100% for the observation tool, and from 80% to 100% for the chart audit. Thus both raters (whether using the observation or chart audit tool) were able to use the tools as they were constructed (able to identify absence or presence of restraint use, likelihood that patient could release restraint, reason restraint device was ordered, etc.).

Agreement between recorded definite restraint use obtained through the observation and chart audit tools ranged from .25 to .95 for both sites combined.

The observation tool's acceptability by end-users was good as indicated by the fact that very few items had missing data points. The acceptability of the chart audit tool, however, was poorer due to the high percentage of missing data. Missing data is not reported for

those items adapted from the observation tool. Both observers noted that obtaining data for the chart audit was difficult due to the lack of documentation on this type of information within the health record itself.

Finally, the observation and chart audit tools can be used in healthcare settings with complex continuing care and rehabilitation services, in addition to the acute care setting for the original tool developed by Rossy and Mackey (2003). The tools are feasible and can provide useful information for minimizing restraints.

Summary

The minimization of physical restraints is a key outcome associated with the implementation of recommendations by the RNAO Best Practice Guideline on Caregiving Strategies for Older Adults with Delirium, Dementia, and Depression (DDD) (RNAO, 2004). A chart audit tool and an observation tool measuring physical restraint were developed to assist in the evaluation of this BPG. A tool designed by Rossy and Mackey (2003) for acute care settings was adapted for use in estimating the prevalence of restraints among patients receiving rehabilitation services and in complex continuing care.

This user guide provides an overview of the restraint prevalence tools, including information on how to administer, score and interpret the observation and chart audit tools, as reported in Edwards, et al. (2006) and in Davies, et al. (2005). The measurement of the prevalence of restraint is fairly complex, requiring staff training on various devices, restraint use, and conducting observations of restraint use. Several methods may be necessary to capture accurate information on the prevalence of restraints in a healthcare organization, such as using different measurement times and different techniques (observation and chart review). Preliminary results show that the restraint prevalence tools described here provide feasible, meaningful and reliable information.

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Appendix

LIST OF APPENDICES

Appendix A Restraint Prevalence Tools

Appendix B Reprint of Journal Article (print copy only)

Appendix C Resources

Appendix D Quick Reference Guide

Appendix A: Restraint Prevalence Tools

Physical Restraint Prevalence Study – Part 1 Observation Tool - *Data Collection Form*

Observer:

Unit:

Total # of Patients on Unit Census:

Start Time for Observation:

Date of Observation:

End Time for Observation:

	Code D: Type of Physical Restraint (May choose more than one)	Code F: Current activity (May chose more than one)
0.	None	Sleeping / resting in bed
1.	Lap belts	In therapy / treatments
2.	Trunk restraint	In group activities
3.	Limb restraint	In personal activities
4.	Full bed rails	Eating
5.	Other types of bed rails	Outdoors
6.	Chair that prevents rising	Moving in wheelchair
7.	Elevated wheelchair foot pedals	Leave of Absence
8.	Other: Specify in comments*	Other: Specify in comments*

Patient Room & Bed #	Patient ID # (If not on unit census)	Time of Observation	Length of Observation (Min.)	Current Activities (Indicate type (s) from Code F) 0 1 2 3 4 5 6 7 8	Potential Physical Restraint in Use (Indicate type (s) from Code D) 0 1 2 3 4 5 6 7 8	Patient able to release/loosen restraint			Assess restraint used for proper application		
						Yes	No	Unable to Assess	Yes	No	Unable to Assess
				0 1 2 3 4 5 6 7 8	0 1 2 3 4 5 6 7 8						
				0 1 2 3 4 5 6 7 8	0 1 2 3 4 5 6 7 8						
				0 1 2 3 4 5 6 7 8	0 1 2 3 4 5 6 7 8						
				0 1 2 3 4 5 6 7 8	0 1 2 3 4 5 6 7 8						
				0 1 2 3 4 5 6 7 8	0 1 2 3 4 5 6 7 8						
				0 1 2 3 4 5 6 7 8	0 1 2 3 4 5 6 7 8						
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				0 1 2 3 4 5 6 7 8	0 1 2 3 4 5 6 7 8						
				0 1 2 3 4 5 6 7 8	0 1 2 3 4 5 6 7 8						

Comments:

Instructions:

1. **Print unit census and attach to the data collection forms.**
2. Complete the data collection tool: Identify unit & site, day, date & time of observation.
3. Indicate the # of patients from the unit census at time of “sweep”.
4. Each line represents one patient. Use as many sheets as required.
5. Complete the required sections on the data collection tool for **all inpatients**.

Once all data collections are complete, please tally for unit:
Restraint prevalence for the unit:

$$\% \text{ Physical Restraint Use} = \frac{\text{Total \# Patients with Physical Restraints}}{\text{Total \# of Patients on Unit (Census)}} \quad \% = \underline{\hspace{2cm}}$$

Restraint Prevalence Study – Part 2: Chart Audit Tool

Date: _____ Data Collector: _____

I. Chart Review for All In-Patients where restraint use observed & random selection of 25% where not observed						
Patient ID Code						
Age						
M/F – indicate						
Start Time for Chart Review						
End Time for Chart Review						
	Obs 1	Obs 2	Obs 3	Obs 4	Obs 5	
Date of Observation						
Time of Observation						
Unit where observed						
Patient room number where observed						
Service (Code A)						
Diagnosis *use ICD-10 or NRS alpha-numeric code(s)						
Is the Daily Physical Restraint Record used?						
Restraint type (Chemical, Physical, or Both) Indicate in column						
Reason for restraint use (Code B)						
Alternatives/ Interventions attempted (Code C)						
Current activity (Code F)						
Patient Consented to the use of restraint noted (yes/no) (includes substitute decision-maker consent & notification of family) *patients admitted under MHA exempted						
II. Chart Review for Patients with Physical Restraint						
Physical restraint ordered by RN? (Yes/ No)						
Order specific to device (yes/no)						
Date & time of application of restraint (yes/no)						
Type of physical restraint (Code D)						
Patient observed q1h (yes/no)						
Removed/ loosened x 10 minutes q2 hrs & cares given (yes-indicated or/ no-not indicated)						
Assess restraint used for proper application (yes / no / unable to assess)						
New order q24 hours (yes or no-not indicated)						
III. Chart Review for Patients with Chemical Restraint						
Chemical restraint order (yes/no)?						
Type of chemical restraint (Code E)						
Re-evaluated at 24 hr intervals (yes/no)						

Comments:

Instructions:

1. Complete the data collection tool: Identify date & time period, unit & room number of observation. (This corresponds with the observation periods from Part 1 of the Prevalence Study.)
2. Each data collection sheet represents 1 patient for up to 5 observation periods.
3. Complete the required sections on the chart audit data collection tool for **all in-patients where restraint use was observed and a random selection of 25% of inpatients where restraint use was not observed in Part 1 of the study.**
4. Check for documentation on the use of physical restraint or administration of a chemical restraint 12 hours prior and 12 hours after each observation.

Once all data collection is complete, please tally for unit:

Restraint prevalence for unit:

$$\% \text{ Physical Restraint Use} = \frac{\text{Total \# of Patients with Physical Restraints}}{\text{Total \# of Patients on Unit (Census)}} \quad \% =$$

$$\% \text{ Chemical Restraint Use} = \frac{\text{Total \# of Patients with Chemical Restraints}}{\text{Total \# of Patients on Unit (Census)}} \quad \% =$$

Total # of Patients on Unit (Census)

Acknowledgement: This tool was adapted from a tool originally titled “Restraint Prevalence Study – November 2003”) developed by the Ottawa Hospital team of Dianne Rossy & Marlene Mackey. Permission has been granted to the University of Ottawa to use and modify the tool for the Evaluation of the 4th Cycle RNAO Best Practice Guideline: Caregiving Strategies for Older Adults with Delirium, Dementia and Depression

Appendix B: Reprint of Journal Article by Edwards et al. (2006)

Note: Only print copies are available in this user guide.

Edwards N, Danseco E, Heslin K, Ploeg J, Santos J, Stansfield M, Davies B (2006).
Development and Testing of Instruments to Assess Physical Restraint Use. *Worldviews on
Evidence-Based Nursing*, 3(2), 73-85.

Appendix E: Resources

For information on the Registered Nurses' Association of Ontario (RNAO) Best Practice Guidelines Project, consult the website of the RNAO. The nursing BPGs can be downloaded for free. Hard copies are available for purchase.

<http://www.rnao.org/bestpractices>

For further information on developing, implementing and evaluating nursing practice guidelines, consult the RNAO "**Toolkit: Implementation of clinical practice guidelines.**" The RNAO Toolkit can also be downloaded for free and hard copies are available for purchase through the RNAO website.

For further information on evaluation of nursing best practice guidelines and other evaluation tools, contact the Nursing Best Practice Research Unit. Other monographs include measures on organizational innovation characteristics, organizational stability, organizational culture for change, organizational support for BPG implementation, education and supportive processes, and perceived worth of the BPG, and interviewing nurses and administrators.

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Appendix D: Quick Reference Guide

Name	Restraint Prevalence Tools: Observation and Chart Audit
Purpose	To obtain prevalence estimates for physical restraint use, through observation and through chart audits
Description	<p>The observation tool requires an observer to identify if certain devices are being used for all patients within a unit, patients' current activity, patients' ability to release the device, and whether the device is properly applied.</p> <p>The chart audit tool reviews documentation for restraints 12 hours before and 12 hours after the observation period. Information includes applicable patient consent, use of chemical restraints, and reasons for restraint use.</p>
Type of data	Real time observation (facility/ unit sweep); Retrospective chart review
Estimated time to collect data	1 to 5 minutes per patient for the observation; 5 to 15 minutes per chart
Training requirements	<p>Familiarity with the use and proper application of restraints and protective devices, legislation requirements concerning physical and chemical restraints, policies and initiatives on minimization of restraints, documentation requirements in the particular healthcare organization.</p> <p>Since this evaluation measure is to be used in conjunction with the RNAO BPG on <i>Caregiving Strategies for Older Adults with Delirium, Dementia and Depression</i>, some training on the BPG is recommended.</p>
Cost	Free electronic copies. Hard copies of the user guide can be purchased.
Summary of Procedures	<ol style="list-style-type: none">1. Train staff on the types of devices, proper application, how to approach patients and staff for observation, and legislation requirements.2. If several persons are conducting the observations and chart reviews, assess level of agreement and continue training until 95 to 100% agreement is reached.3. Determine inclusion and exclusion criteria. Determine observation times, and if these are unannounced.4. Conduct the observations.5. Obtain charts for the audit after at least 12-24 hours after the observation period.6. Review the charts for the required information.7. Obtain prevalence estimates from the observation tool and from the chart audit tool.8. Repeat observation and chart audits, as planned or needed, for monitoring or evaluating prevalence of restraint use.
Scoring & Interpretation	<p><u>Definite restraint</u>: Numerator is number of patients with device, excluding those who can release the device and excluding those whose ability to release the device could not be assessed. Denominator is total number of patients observed.</p>

Name **Restraint Prevalence Tools: Observation and Chart Audit**

Definite+potential restraint: Numerator is number of patients with device, excluding those who can release the device but including those whose ability to release the device could not be assessed. Denominator is total number of patients observed.

Citation Davies B, Danseco E, Ploeg J, Heslin, K, Stansfield M, Santos J & Edwards, N. (2006). Nursing Best Practice Guideline Evaluation User Guide: Restraint Prevalence Tools. Nursing Best Practice Research Unit, University of Ottawa, Canada. pp. 1-20.

Contact **If you plan to use this tool, please contact:**

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We would like to hear from you about this user guide or the Restraint Prevalence Tools.

1. We plan to use the following tools in our organization:

- Observation Tool only
- Chart Audit Tool only
- Both of the tools

2. The approximate number of patients where we will use this tool(s): _____

3. Health sector/ type of organization:

- Long-term care
- Complex continuing care
- Rehabilitation
- Acute care hospital
- Community services
- Home care
- Public health
- Hospice/ palliative care
- Mental health/ substance abuse/ addictions
- Other: (please specify): _____

Please take a few moments to write and tell us about your experiences, suggestions, questions or ideas:

Name (optional) _____
Where can we contact you?
(email or telephone) _____

Fax this form to: Nursing Best Practice Research Unit
ATTN: Dr. Evangeline Danseco
(613) 562-5892


Or email to: edanseco@mail.health.uottawa.ca or
bdavies@uottawa.ca

Nursing Best Practice Guidelines Evaluation User Guide

Restraint Prevalence Tools



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