

## **Project Title**

Safety Without Restraints in Surgical Intensive Care Unit (SICU) (Sustainability Phase)

## **Project Lead and Members**

Project lead: Yang Xuelian

Project members: Li Qin, Wang Lin, Rasidah, Lee Pei Khim, Jaclyn Chow, Xu Min Ling

## **Organisation(s) Involved**

Tan Tock Seng Hospital

## **Healthcare Family Group(s) Involved in this Project**

Nursing, Allied Health

## **Applicable Specialty or Discipline**

Surgical Intensive Care Unit, Physiotherapy

## **Project Period**

Start date: Aug 2018

Completed date: Mar 2021

## **Aims**

To reduce the inappropriate use of wrist-restrainers for intubated surgical patients in TTSH SICU from 41% to 15% over a sustained period

## **Background**

See poster attached/ below

## **Methods**

See poster attached/ below

## **Results**

See poster attached/ below

## **Lessons Learnt**

See poster attached/ below

## **Conclusion**

See poster attached/ below

## **Additional Information**

Accorded the NHG Quality Day 2022 (Category A: Improving and Sustaining Quality & Safety) Merit Award

## **Project Category**

Care & Process Redesign

Quality Improvement, Lean Methodology, Value Based Care, Safe Care

## **Keywords**

Decision Wheel, Restraint Use

## **Name and Email of Project Contact Person(s)**

Name: Yang Xuelian, Nurse Clinician

Email: [xue\\_lian\\_yang@ttsh.com.sg](mailto:xue_lian_yang@ttsh.com.sg)



# Safety Without Restraints in Surgical Intensive Care Unit (Sustainability Phase)

**Ms Yang Xuelian, Ms Li Qin & Mr Wang Lin**  
**Ward 3B**

## Mission Statement

To reduce the inappropriate\* use of wrist-restraints for intubated surgical patients in TTSH SICU from 41% to 15% over a sustained period  
Inclusion Criteria: Patient who is alert, able obey comments, not confused.

Exclusion Criteria:

- CAM ICU +ve
- RASS > +2 (Patients in Confused & Agitated State)
- Nasal intubation; Intubation grade >3

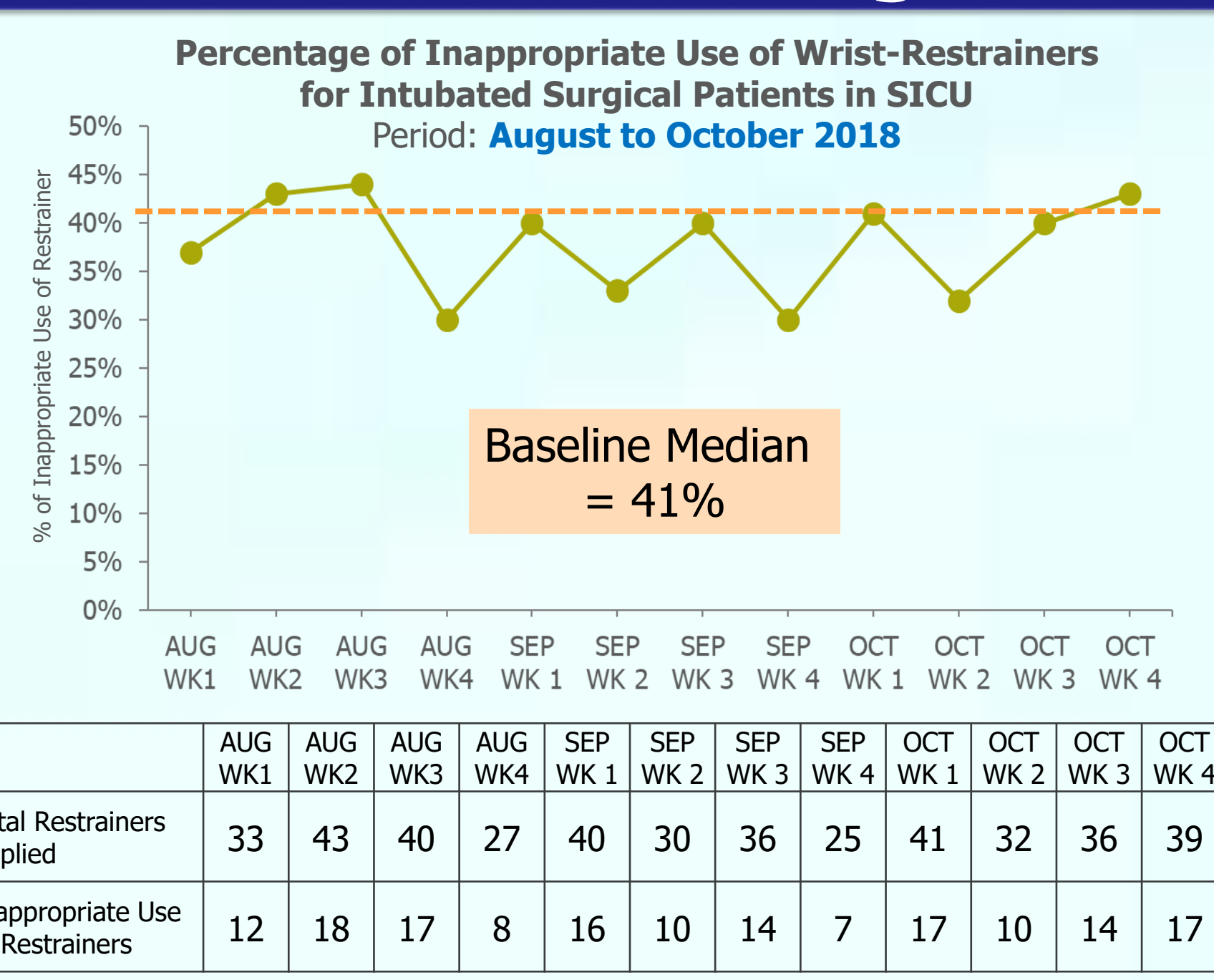
## Team Members

	Name	Designation	Department
<b>Team Leader</b>	Yang Xuelian	Nurse Clinician	Previous: SICU Current: Ward 6D
<b>Team Members</b>	Li Qin	Senior Nurse Clinician	SICU
	Wang Lin	Assistant Nurse Clinician	Previous: SICU Current: Ward 6A
	Rasidah	Senior Staff Nurse	SICU
	Lee Pei Khim	Senior Staff Nurse	SICU
	Jaelyn Chow	Physiotherapist	Physiotherapy
	Xu Min Ling	Assistant Nurse Clinician	SICU

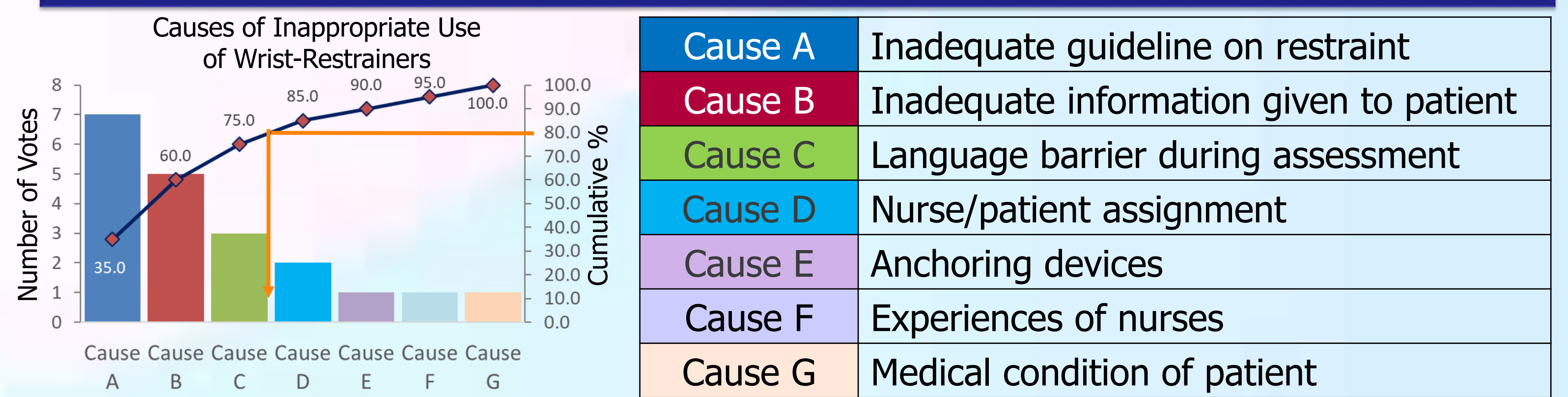
**Sponsors:** Dr Nelson Chua & Ms Tay Meow Hoon

## Evidence for a Problem Worth Solving

- In Africa, Langley, Schmollgruber & Egan (2011) reported in their qualitative study that 48.9% of the ICU patients were restrained.
- Kooi et al. (2015) in their study conducted in Netherlands also found out that 23% of the patients are restrained.
- Martin & Mathisen (2005) in their bilcultural study discovered that restraints used in the United States is 39 out of 109 patients (36%), however **0 restrainter use in Norway.**



## Pareto Chart

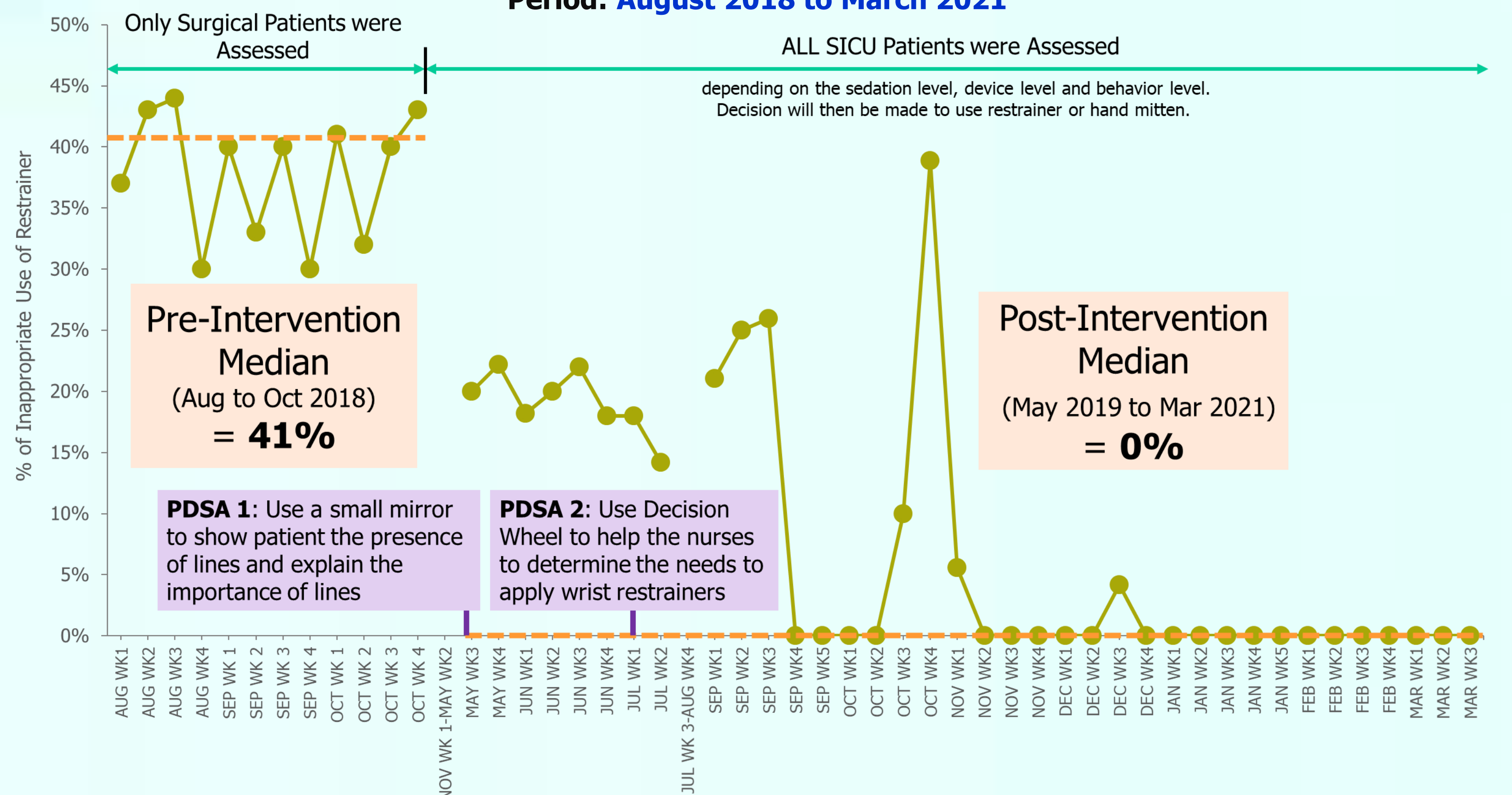


## Implementation

Root Cause	Intervention	Implementation Date
<b>Cause B:</b> Inadequate information given to patient	<b>PDSA 1:</b> Use a small mirror to show patient the presence of lines and explain the importance of lines	20 May 2019
<b>Cause A:</b> Inadequate guideline on restraint	<b>PDSA 2:</b> Use Decision Wheel to help the nurses to determine the needs to apply wrist-restraints	1 July 2019

## Results

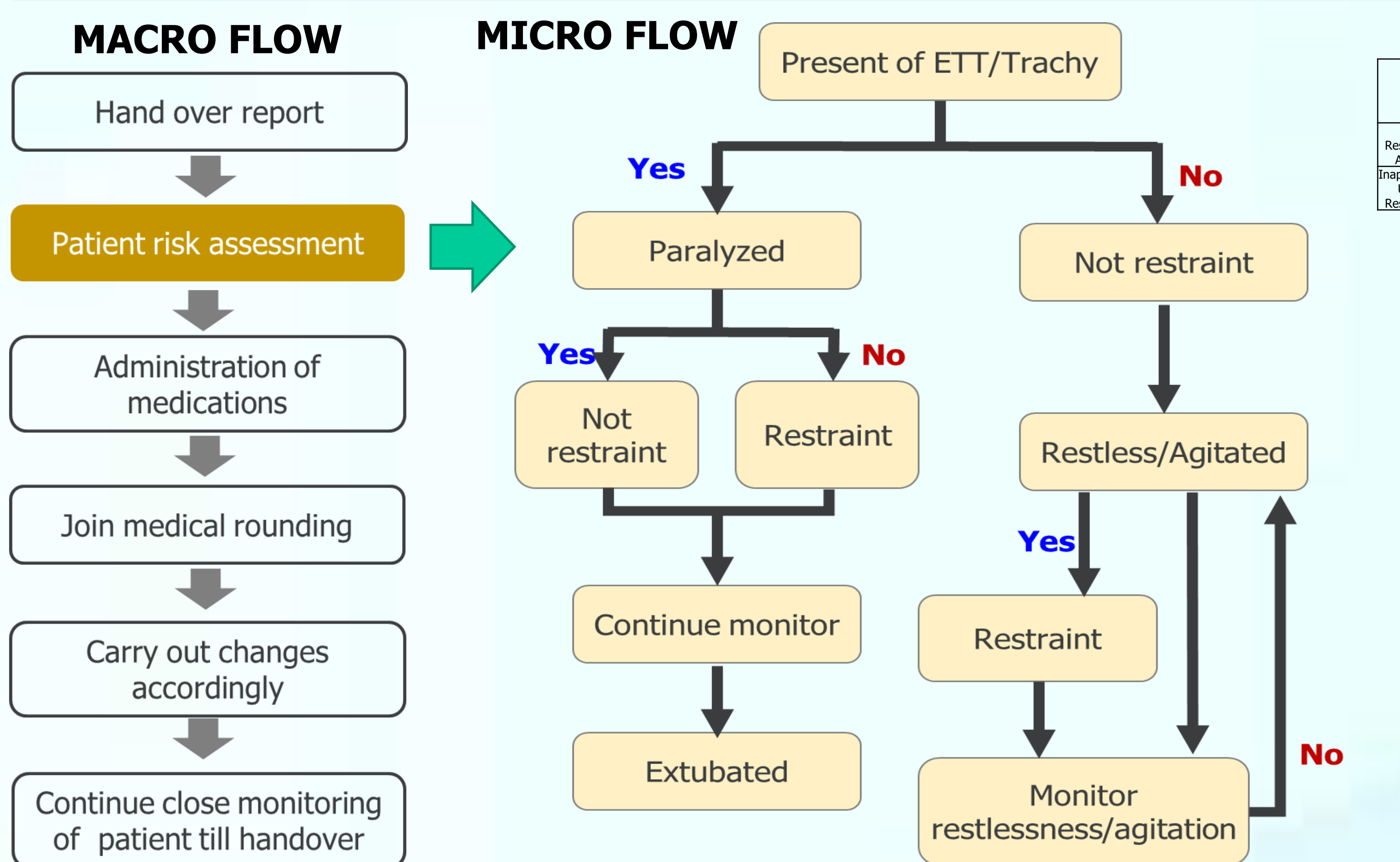
**Percentage of Inappropriate Use of Wrist-Restraints for Intubated Patients in SICU**  
Period: August 2018 to March 2021



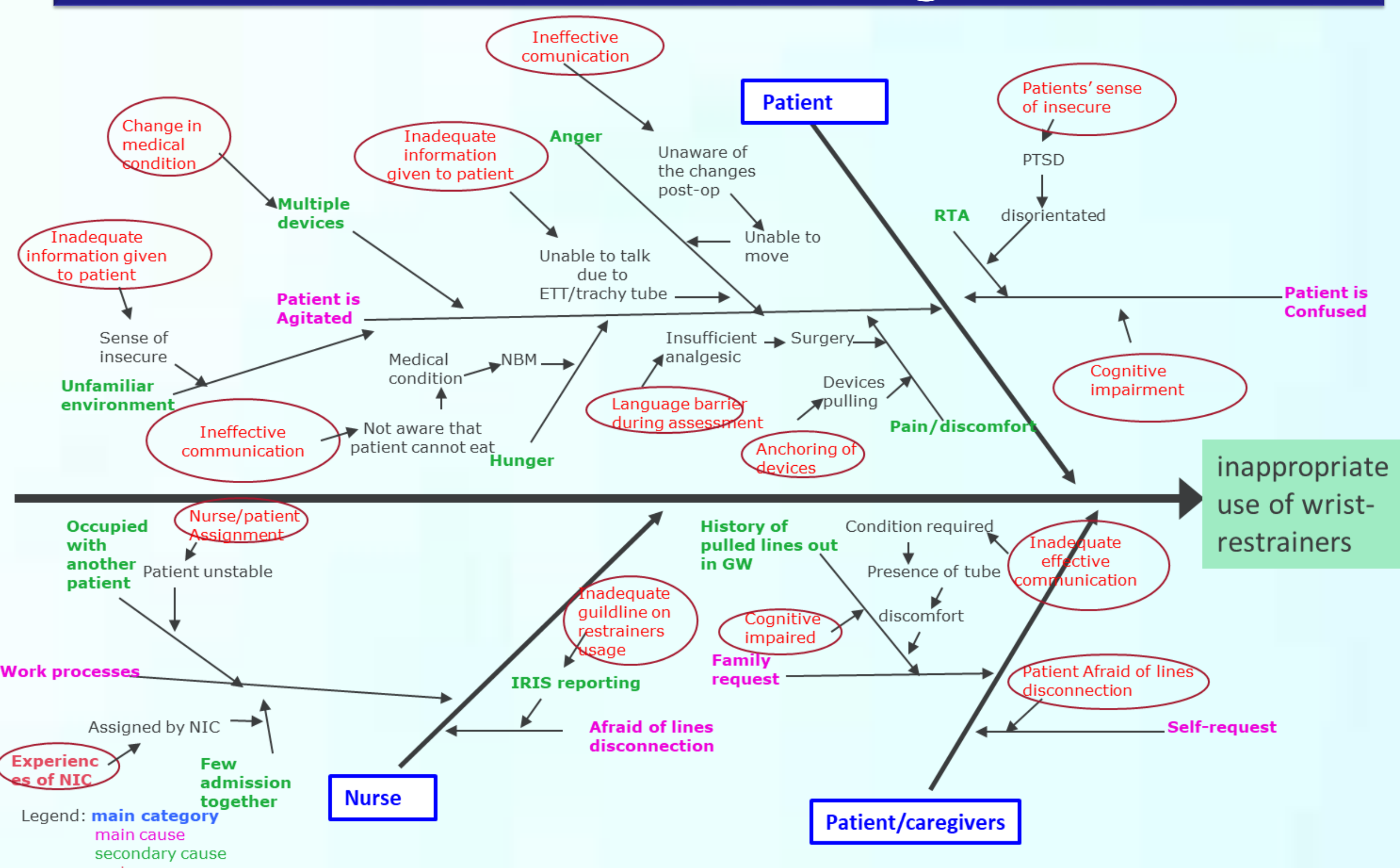
Year	2018				2019				2020				2021																																				
	Aug	Sept	Oct	Nov	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Oct	Nov	Dec	Jan																																	
Total Restraints Applied	33	43	40	27	40	30	36	25	41	32	36	39	17	19	17	18	19	14	16	13	19	24	27	15	9	3	6	10	18	18	16	18	19	15	21	24	18	18	19	7	21	8	10	18	16	17	23	16	27
Inappropriate Use of Restraints	12	18	17	8	16	10	14	7	17	10	14	17	3	4	3	4	4	6	7	0	0	0	0	0	1	7	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0					

Since April 2021 onwards, the interventions have been incorporated as part of Ward 3B daily workflow. Compliance to all interventions was ensured with regular briefing and roll calls. Sampling audits will be carried out to see if interventions are ongoing and results sustained. PDSA cycles will kick in to make refinement to the existing intervention when necessary.

## Flow Chart of Process



## Cause and Effect Diagram



## Cost Savings

	Pre-Intervention (Aug to Oct 2018)	Post-Intervention (Jan to Mar 2021)
Average No. of Restraints Applied (Per Week)	35	17
Median % of Inappropriate Use of Restraints	41%	0%
No. of Inappropriate Restraints Used	14	0
Restraint Cost + Nursing Manhour Cost	$(14 \times \$35) + (14 \times \$0.97 \times 6) = \$571.48$	\$0
Potential Cost Avoidance of inappropriate use of Restraints (Per Week)		$571.48 - 0 = \$571.48$
Potential Cost Avoidance of inappropriate use of Restraints (Per Month)		$571.48 \times 4 = \$2,041.48$
Potential Cost Avoidance of inappropriate use of Restraints (in 1 Year)		$441.48 \times 12 = \$23,601.48$

**Note:** Each pair of restrainter cost = \$35; Number of minutes required to apply restraints to patient by nurse = 6 mins; Weighted Ave Cost per min for Senior Staff Nurse = \$0.97

## Lessons Learnt

1. Assessing the need for restraints, multiple approach will enhance nurses' decision making process.
2. Appropriate interventions are required to improve patient outcomes
3. ICU nurses must keep vital therapies intact while maintaining human dignity

## Strategies to Sustain

1. To educate patients at pre-operation phase (to tell in advance - show video that patients will have tube in their mouth etc.)
2. Involve relatives during their visitation period, to encourage them to interact with patient, like holding hands, off restraints if they are around.
3. Explore more alternatives instead of physical restraint, like simple activities to occupy patients' mind.
4. Nurses to change mindset