

DynamicHealth™

EBSCO Health

Powered by

CINAHL®



Tietoa kaikille terveysalan asiantuntijoille



Lääkärit



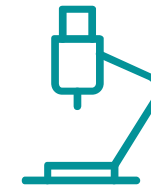
Sairaanhoitajat



Muu
terveydenhuolto



Johto



Tutkijat



Opettajat ja
kouluttajat

Tarvittavassa muodossa



Hoitotyön tuki



Tietokannat



E-kirjat










Lehdet



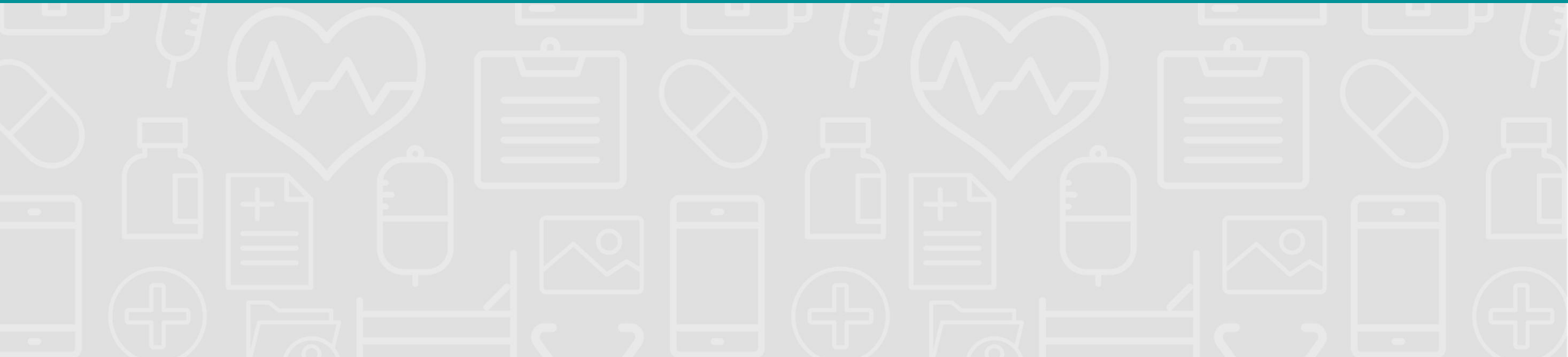
E-lehdet

EBSCO Health - näyttöön perustuva toimitusprosessi

-  1 Parhaan, soveltuvan näytön systemaattinen kartoittaminen
-  2 Parhaan näytön systemaattinen valitseminen
-  3 Valitun näytön systemaattinen arviointi (kriittinen tarkastelu)
-  4 Löydetyn tiedon ja näytön laadun objektiivinen raportointi
-  5 Useiden näyttöraporttien syntetisointi
-  6 Johtopäätösten ja suositusten tekeminen
-  7 Johtopäätösten päivittäminen, kun uutta soveltuvaa, parasta mahdollista näyttöä saadaan



Dynamic Health



EBSCO Health - sairaanhoidon tietoaineistot

CINAHL[®]

Lehtiartikkelit,
tutkimuskirjallisuus

Nursing^{Reference Center™}
Plus

Helposti
hahmotettavaa tietoa
näyttöön perustuvina
tiivistelminä

DynamicHealth[™]

Käytäntöön
sovellettavaa tietoa,
tietotaidon kehittämistä

Aihealueita



Sairaanhoidon taidot



Kulttuurikompetenssi



Ravitsemusterapia
Työterapia
Fysioterapia
Hengitysterapia
Sosiaalityö
Puheterapia



Potilasohjaus

PATIENT SAFETY SKILL

Restraint-Free Environment Design and Implementation

 Guide Checklist

Purpose

Red Flags

Nursing Considerations

Evidence

- Research

Procedure

- Supplies
- Pre-procedure Steps
- Procedure Steps
- Patient/family Education
- Post-procedure Steps
- Documentation

Nursing Outcomes

References

Purpose

The purpose of designing and implementing a restraint-free environment is to create a healthcare setting in which patients are prevented from harming themselves or others and the risks associated with use of restraints are avoided.

Red Flags

- Patients who are confused, weak, dizzy, or uncoordinated should be assessed for adverse effects of medications and/or drug interactions
- If a patient falls, evaluate him/her for obvious injuries, call for help, take vital signs, and assist to bed if conscious. If the patient has arrested, initiate cardiopulmonary resuscitation (CPR) according to facility protocols. Notify the treating clinician of the fall

Tiedon
käyttötarkoitus ja
tärkeät huomiot.

Purpose

Red Flags

Nursing Considerations

Evidence

“Nursing Considerations”
antaa taustatietoa.

Alakohdasta toiseen
navigointia onnistuu
vasemman laidan
sisällysluettelon
avulla.

Nursing Considerations

- Restraints can actually increase the risk of patient injuries (e.g., due to falls) and deaths, and restraints hinder patient rehabilitation because patients are not allowed to move as freely as they desire

A restraint-free environment is designed and implemented because physical, chemical, and environmental restraints have many negative implications and drawbacks. See physical restraints. See chemical restraints. See environmental restraints

The use of restraints is often perceived by healthcare staff and family members of patients as an effective strategy for maintaining patient safety, particularly for patients with cognitive impairment and/or limited mobility. Some staff and family members perceive the potential injury that can result from a fall as a far greater risk than the risk of injury associated with using restraints

- Efforts to minimize the use of restraints can be met with resistance by administration, staff members, and patient families

Members, including physicians, require education on alternatives to alternatives to restraint use

A restraint-free environment should be regularly evaluated and The healthcare team should collaborate in solving problems during disciplinary meetings, and develop strategies to help each patient strain free-environment. See Strategies and Methods for a environment

- Assess patients regularly. See patient assessment
- Hospitalized patients who are restrained are 8 times more likely than nonrestrained patients to die; asphyxiation is the most common cause of restraint-related death⁸
- The reported use of physical restraints in long-term care facilities in the U.S. is

Purpose

Red Flags

Nursing Considerations

Evidence

- Research

Procedure

- Supplies
- Pre-procedure Steps
- Procedure Steps
- Patient/family Education
- Post-procedure
- Documentation

Nursing Outcomes

References

Evidence

RESEARCH

In the early 1990s, the United States Food and Drug Administration (FDA) attributed more than 100 deaths annually to the use of restraints.¹⁰

In a questionnaire-based study of 104 nurses working in skilled nursing facilities (SNFs), 67% of respondents reported having physically restrained older adult residents more than 10 times in the past year.²

The authors of a systematic review analyzed 31 publications and concluded that nurses have mixed attitudes about the use of physical restraints in geriatric care, but there is a need for restraints in clinical practice.⁶

A study of 13 nurses working in critical care units—the hospital unit most likely to be used—found no strong correlation between their attitude about the use of physical restraints, but did find that nurses with more experience were more likely to have learned about the use of restraints in the nursing curriculum.⁹

Researchers in a study published in 2011 described the design and implementation of a “delirium room,” which they described as a restraint-free environment that involves placement of all patients with delirium, maintaining 24-hour nursing observation and management. The researchers stated that the use of a delirium room has reduced the incidence of negative outcomes associated with delirium to rates that are comparable with rates in patients without delirium.⁴

EBSCO Healthin erikoisalaa
ovat näyttöön perustuva hoito
ja tutkimuskirjallisuuden
helppo löytäminen.

- Purpose
- Red Flags
- Nursing Considerations
- Evidence
 - Research

- Procedure
 - Supplies
 - Pre-procedure Steps
 - Procedure Steps
 - Patient/family Education
 - Post-procedure Steps
 - Documentation

- Nursing Outcomes
- References

Procedure	
SUPPLIES	+
PRE-PROCEDURE STEPS	+
PROCEDURE STEPS	+
PATIENT/FAMILY EDUCATION	+
POST-PROCEDURE STEPS	+
DOCUMENTATION	+

Osiot voi laajentaa tai pienentää

Nursing Outcomes

- The patient will be assessed to be safe and comfortable in the healthcare environment
- Any unexpected occurrences (e.g., patient falls or other injury) will be thoroughly and promptly evaluated and effectively treated, and the patient’s plan of care will be adjusted accordingly

References

RESEARCH

1. Agens, J. E. (2010). Chemical and physical restraint use in the older person. British Journal of Medical Practitioners, 3(1), 302-307.
2. Ben Natan, M., Akrish, O., Zaltkina, B., & Noy, R. H. (2010). Physically restraining elder residents of long-term care facilities from a nurses' perspective. International Journal of Nursing Practice, 16(5), 499-507. doi:10.1111/j.1440-172X.2010.01875.x

Purpose
Red Flags
Nursing Considerations
Evidence

- **Research**

Procedure

- Supplies
- Pre-procedure Steps
- Procedure Steps
- Patient/family Education
- Post-procedure Steps
- Documentation

Nursing Outcomes

References

“Procedure Steps” -osio
sisältää ohjeistuksia
askel askeleelta.

Procedure

SUPPLIES



PRE-PROCEDURE STEPS



PROCEDURE STEPS



1. Initiate assessment of patient risk of self-injury or injury to others
2. Serially assess patient risk at regular intervals
3. Monitor physical and mental status, medications received, and fall risk
4. Assess for increased risk of wandering, risk of violent behavior, and triggers for problem behavior
5. Instruct nursing assistants to monitor for and report certain patient behaviors, including confusion, attempts to get out of bed unassisted, pulling at tubes, and combativeness
6. Assist the patient with the use of eyeglasses, hearing aids, and other sensory aids and devices, as appropriate; verify that devices are turned on and functioning when the patient is awake
7. Assign the patient to the same caregivers whenever possible for continuity of care
8. Provide companionship for the patient whenever possible
9. Encourage family members and friends to stay with the patient
10. Use volunteers for sitting with the patient if a volunteer companion program is available in the facility
11. Place the patient in a room that is accessible to caregivers and as close to the



The printable version of this checklist contains a form to allow you to record evaluator and examinee names and signatures, date and pass/fail status.

“Checklist” välilehdelä löytyy tarkistuslista mm. alaisen tai opiskelijan taitojen arvioimiseen...

Standard Pre-Procedure Steps

1. Review the facility/unit protocol for use of strategies other than restraints to maintain patient safety, if one is available
2. Review the treating clinician's order for activity and ambulation for the patient
3. Determine if the patient/family requires special considerations regarding communication. Make arrangements to meet these needs if they are present
4. Use professional certified medical interpreters, either in person or via phone, when language barriers exist
5. Orient the patient and family members to the healthcare environment, as appropriate, and introduce any staff members who will assist you. If necessary, point out staff identification badges and assist the patient in reading each staff member's name

...tai
muistettavat
kohdat
toimenpidettä
tai potilaan
kohtaamista
varten.

5. Orient the patient and family members to the healthcare environment, as appropriate, and introduce any staff members who will assist you. If necessary, point out staff identification badges and assist the patient in reading each staff member's name
6. Review the patient's medical history/medical record
7. Verify completion of facility informed consent, if necessary
8. Check the orders and care plan
9. Review the manufacturer's instructions for all supplies to be used, and verify that they are in good working order
10. Maintain level of infection precautions, as appropriate
11. Provide privacy for the patient
12. Identify the patient
13. Introduce yourself
14. Explain the procedure
15. Perform hand hygiene according to facility protocol, and don personal protective equipment (PPE), as appropriate
16. Assess general health status, including pain level and provide prescribed analgesic, if necessary, before proceeding
17. Recruit other staff members to assist as necessary

Procedure Steps

1. Initiate assessment of patient risk of self-injury or injury to others
2. Serially assess patient risk at regular intervals
3. Monitor physical and mental status, medications received, and fall risk
4. Assess for increased risk of wandering, risk of violent behavior, and triggers for problem behavior
5. Instruct nursing assistants to monitor for and report certain patient behaviors, including confusion,



Tiedon muokattavuus oman organisaation tarpeisiin

- Aineistoa voidaan muokata omiin tarpeisiin
 - piilottamalla sisältöä, joka ei ole tarpeellista tai soveltuvaa.
 - lisäämällä muistiinpanoja.
 - lisäämällä omia ohjeita.

Home

Nursing

Skills

Patient Instruction Skills

PATIENT SAFETY SKILLS

Eye Care for

“Hide Content” –napista
admin voi piilottaa osioita,
jotka eivät ole tarpeellisia
oman organisaation
käyttäjille.

 Hide Content Guide Checklist Videos Images EMAIL

Purpose

Red Flags

Nursing Considerations

Evidence

- Research

Procedure

- Supplies
- Pre-procedure Steps
- Procedure Steps
- Patient/Family Education

 PRINT

IN THIS GUIDE

VIDEOS

ALL (2) >

Purpose

The purpose of eye care is provided for comatose patient is to clean and moisturize the comatose patient's eyes, while avoiding eye irritation and infection. Without protective eye care the patient can develop exposure keratopathy, which can result in permanent damage to the cornea (e.g., corneal scarring).

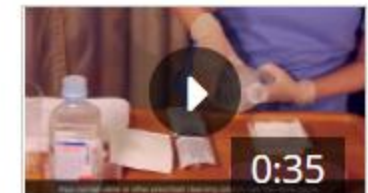


Figure 1.
Cleansing the
Eyelids

PATIENT SAFETY SKILL

Eye Care for a Comatose Patient

The content is **currently hidden** from Springfield Hospital users

[Unhide Content](#)[Guide](#)[Checklist](#)[Videos](#)[Images](#)[EMAIL](#)**Purpose****Red Flags****Nursing Considerations****Evidence**

- Research

Procedure

- Supplies
- Pre-procedure Steps

Purpose

The purpose of eye care is provided for comatose patient is to clean and moisturize the comatose patient's eyes, while avoiding eye irritation and infection. Without protective eye care the patient can develop exposure keratopathy, which can result in permanent

[PRINT](#)**IN THIS GUIDE****VIDEOS**[ALL \(2\) >](#)

Figure 1.
Cleansing the

Admin näkee aina,
mitkä osiot on
piilotettu.

Springfield Hospital

The administrative tools below help you manage customizations for this location.

Hidden Content

Kaikki piilotetut aiheet löytyvät yhdestä paikasta.

CONTENT	DATE	ADMIN	
<div>NURSING SKILLS</div> <div>Accidental Drop Prevention for Newborns</div>	Aug 25 2017	T Robinson	Unhide
<div>NURSING SKILLS</div> <div>Eye Care for a Comatose Patient</div>	Aug 30 2017	P Darcy	Unhide

NURSING SKILLS

Bed Rail Restraints In Older Adults

HIDE CONTENT

ADD NOTE

Guide

Checklist

Videos



EMAIL

Purpose

Red Flags

Procedure

- Supplies
- Pre-Procedure Steps
- Procedure Steps
- Patient/Family Education
- Post-Procedure Steps
- Documentation

Nursing Considerations

Evidence

- Research
- Guidelines

Nursing Outcomes

References

Purpose

Raising all bed rails is a physical restraint if it restricts the patient's movement or reduces the patient's ability to move his or her arms, legs, body, or head freely. The use of bed rails is intended to reduce risk for falls and subsequent injury, and to prevent the patient from getting out of bed when medically contraindicated.

Red Flags

- Bed rails are associated with an increased risk for falls and mortality
- Use of bed rails is risky, especially if the patient is elderly or disoriented
- Bed rail restraints can only be used under the orders of a treating clinician and according to unit or healthcare facility protocol
- 1:1 staffing can be necessary even during restraint use depending on the patient's condition and mental status

Organisaatiokohtaisia
muistiinpanoja voidaan
lisätä mihin tahansa.

GUIDE

ALL (1) >



0:32

VIDEO 1
Bed Rail
Restraints In
Older Adults

IMAGES

ALL (1) >



IMAGE 1
Bed With Full Bed
Rails Raised

NURSING SKILLS

Bed Rail Restraints In Older Adults

 HIDE CONTENT

A Note From Your Workplace

 DELETE  EDIT

Published on May 14 2018 by BCAdmin: In step 65 when evaluating pain, Westside Hospital should use the Abbey Pain Scale to assess pain in their their restrained nonverbal patients. All other sites will continue to use Wong-Baker Scale.

 Guide☒ Checklist Videos Images About EMAIL

Purpose

Red Flags

Procedure

- Supplies
- Pre-Procedure Steps
- Procedure Steps
- Patient/Family Education
- Post-Procedure Steps
- Documentation

Nursing Considerations

Evidence

- Research
- Guidelines

Purpose

Raising all bed rails (2 full bed rails or 4 side rails) is considered a physical restraint if it prevents a patient from voluntarily getting out of bed or reduces the patient's ability to move his or her arms, legs, body, or head freely. The use of bed rails is intended to reduce risk for falls and subsequent injury, and to prevent the patient from getting out of bed when medically contraindicated.

Red Flags

- Bed rails are associated with an increased risk for falls and mortality
- Use of bed rails is risky , especially if the patient is elderly or disoriented

 PRINT

IN THIS GUIDE

VIDEOS

ALL (1) >



VIDEO 1
Bed Rail
Restraints In
Older Adults

IMAGES

ALL (1) >



Kaikki oman organisaation
käyttäjät näkevät lisätyn
muistiinpanon.

WESTSIDE HOSPITAL

The administrative tools below help you manage customizations for this location.

[Hidden Content](#)[Workplace Notes](#)[Workplace Skills](#)

Skills may be authored by administrators and will appear as Workplace Skills within Dynamic Health for users at a specific location.

Admin voi myös
lisätä omia osioita!

[ADD NEW SKILL](#)

TITLE	DATE	LAST MODIFIED BY	STATUS	
External Female Catheters - Appl...	Apr 26 2018	kathyjensen1	PUBLISHED	Edit Delete

[Home](#)[Nursing Skills](#)[Allied Health Skills](#)[Transcultural Care Skills](#)[Patient Instruction Skills](#)[Your Workplace Skills](#)[Workplace Skills >](#)

Add/Edit Skill

Fill out all **required fields** (*) and then Save & Publish.

Title *

[100 characters remaining]

Short Description *

This is shown when the skill appears in search results and on the 'Your Workplace Skills' page.

[130 characters remaining]

Purpose *

Red Flags

Add each item

+

Procedure

Any Pre-Procedure, Procedure, and Post-Procedure Steps will be used to populate this skill's checklist.

Täyttämällä nämä kentät
voidaan luoda paikallinen
ohjeistus "Workplace Skill".

SUPPLIES

Add each item



PRE-PROCEDURE STEPS

Add each item



PROCEDURE STEPS *

Add each item



POST-PROCEDURE STEPS

Add each item



PATIENT/FAMILY EDUCATION

DOCUMENTATION

Additional Notes

SAVE & PUBLISH

Cancel

“Save & Publish” tallentaa tietueen kaikkien oman organisaation käyttäjien nähtäväksi ja löytyy myös haussa.

WESTSIDE HOSPITAL

The administrative tools below help you manage customizations for this location.

Kaikki paikalliset ohjeistukset löytyvät yhdestä paikasta otsikon "Workplace Skills" alta, jossa admin voi lisätä ja poistaa niitä.

[Workplace Skills](#)

appear as Workplace Skills within Dynamic Health for

[ADD NEW SKILL](#)

LAST MODIFIED BY

STATUS

kathyjensen1

PUBLISHED

[Edit](#)[Delete](#)

Videot ja kuvat

- Tuhansia videoita ja kuvia
- 3D- ja 2D-animaatioita
- Tekstitettyjä videoita
- Piirroksia ja valokuvia



Tukea visuaaliselle oppijalle.

Home Nursing Skills Allied Health Skills Trans

Results for "Bed Rail Restraint Application for Older

All

Videos

Images

NARROW RESULTS

SKILL TYPE

Nursing Skills (9)

1-9 of 9 Skills

CLINICAL NURSING

Restraint-Free
Implementati

Designing and imple
involves using strate
do not involve the u

PROCEDURE

CLINICAL NURSING SKILL

Winged-Needle Catheter for
Peripheral Intravenous (PIV)
Catheter Insertion

VIDEOS

ALL (11) >



Figure 3. Inserting a
Winged Needle Catheter

IMAGES

ALL (18) >



ALL (11) >



Figure 3. Inserting a
Winged Needle Catheter

ALL (18) >



Evidence-based training and support for nurses and allied health professionals

bed



GO TO

Bed bug bites

Bedaquiline

Nail **bed** injury - emergency management

SEARCH FOR

bed

bed alarms

bed and bedding

bed bugs

Enhanced search
functionality improves
accuracy by
understanding
users' intent

“Älykäs” hakusanan
ehdotus auttaa haun
tekemisessä

Assessment

Vital Signs

All Categories

ALLIED HEALTH SKILLS

This is the description of an allied health skill. Explore >

an attempt to minimize the
newborn's risk for accidental falls.

Wound Cleaning and Irrigation

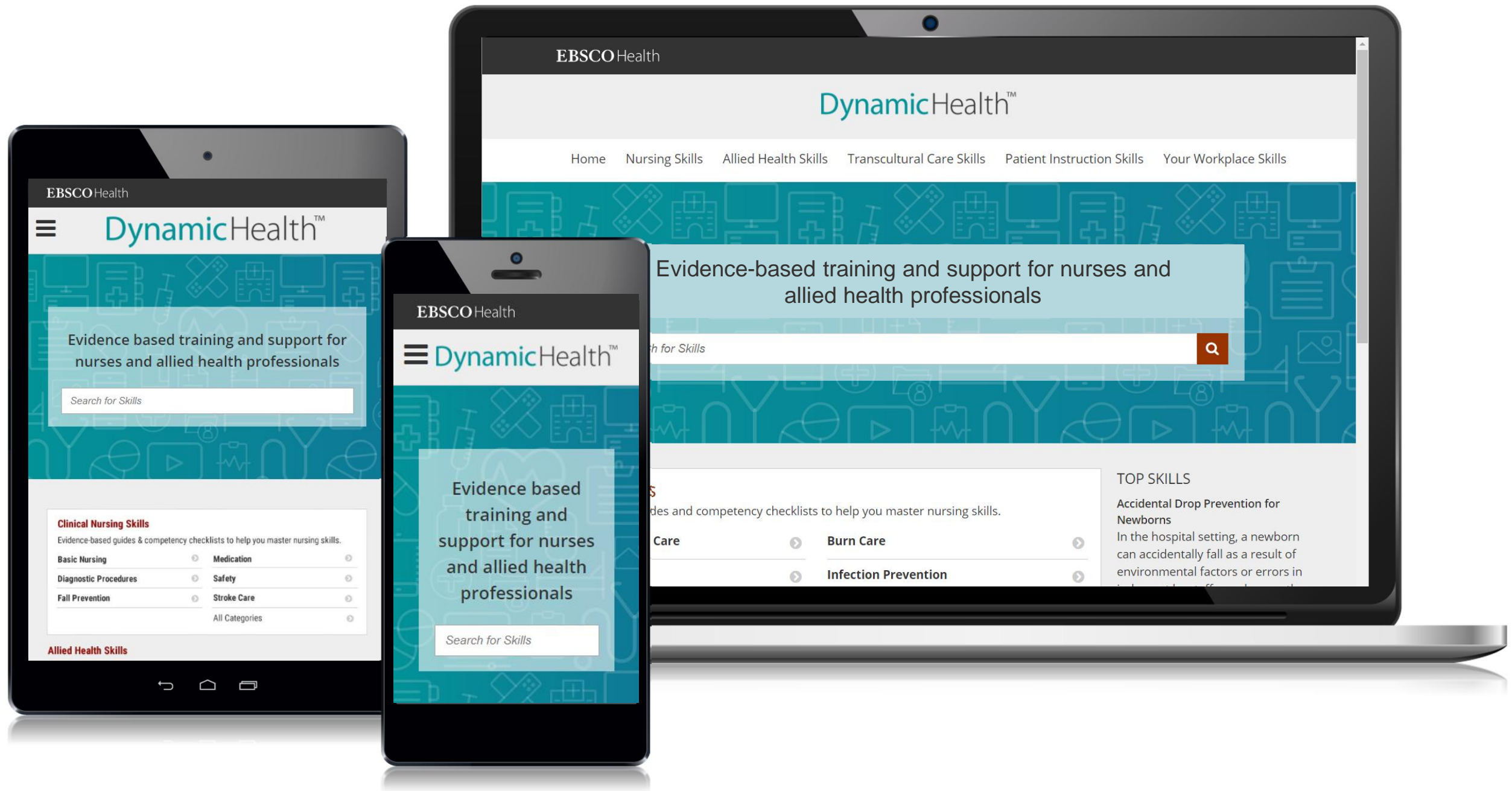
Integrointi

- Voidaan integroida potilastietojärjestelmään
- Voidaan integroida oppimisalustoille

Mobiilikäyttö

- Skaalautuu mobiililaitteille





EBSCO Health

Med vänliga hälsningar| Med vennlig hilsen| Med venlig hilsen| Ystävällisin terveisin
Bestu kveðjur| Parimate soovidega| Inussiarnersumik Inuulluaqqusillunga

Pohjoismaiden EBSCO Health –tiimi: Ert Nordiska EBSCO Health Team:



Chris Holmkvist, Account Executive

Tel: +44 (0)208 447 4114 | **Email:** cholmkvist@ebSCO.com



Veera Mujunen, Regional Sales Manager

Tel.: +358 40 754 7503 | **Email:** vmujunen@ebSCO.com

Muharrem Yilmaz, Implementation Manager

Tel: + 47 406 58 082 | **Email:** myilmaz@ebSCO.com