Restraints
Course Objectives

This course will review de-escalation, immobilization & restraint interventions, which are based on thorough assessments of the patient and the immediate care environment. For more information, refer to the Restraint Policy.

At the end of this course the learner should be able to:

- Recognize warning signs of the potential for disruptive behavior
- Identify de-escalation techniques to use in order to avoid the use of behavioral restraints
- Describe the criteria for initiation of restraints
- Identify when to notify a physician of restraint use
- Recognize the key aspects of:
  - immobilization
  - medical/surgical restraints
  - behavioral restraints
- Identify policy requirements for:
  - medical immobilization
  - assessment for all types of restraints
  - reassessment for all types of restraints
  - documentation for all types of restraints
- Identify key patient criteria that must be assessed prior to restraint application (medical/surgical restraints and behavioral restraints.)
Remember

- The "Check Your Knowledge" questions are **NOT** scored; go ahead and guess.
- The **Post Test** is scored and a final grade given.

**90% or greater** is needed to pass the *Restraints* module.
Verbally expressing anger and frustration, irritability, excitement, agitation, pacing, and questioning are all behaviors you may see in people who are exhibiting anxiety and could possibly escalate to disruptive behaviors.

Correct, People who are verbally expressing anger and frustration, showing irritability, excitement, agitation, pacing, and questioning are exhibiting anxiety and could possibly escalate to disruptive behaviors.
Disruptive Behavior: Warning Signs

These are behaviors you may see in persons who are exhibiting anxiety and could possibly escalate to disruptive behaviors:

- Verbally expressed anger and frustration
- Irritability, excitement, agitation, pacing, questioning
- Body language such as threatening gestures
- Signs of drug or alcohol use
- Presence of a weapon

Awareness is more than just looking around. You need to be proactive which involves an educated observation and effective response.
De-escalation Techniques: Verbal

Use the following verbal techniques when dealing with a person who is showing signs of increasing anxiety:

- Be supportive by providing information and offering comfort measures (i.e. sleep, bathroom breaks, food, go for a walk)
- Develop trust through open, honest communication
- Use objective and neutral speech/vocabulary
- Identify and offer contacts with whom the individual would like to speak (offer use of telephone.)
De-escalation Techniques: Non-Verbal

Click on each box to find out about different non-verbal ways you can try to de-escalate a person.

- If safe to do so, speak to the person at their own level (i.e. sit down)
- Explore the possibility of an alternative activity: “when you get upset like this, is there something that might help you feel calmer or to help you slow down?”
- Stand slightly sideways versus face-to-face. Be an arms’ length away and keep hands in clear view (not in pocket or behind back.)
- If possible, move a disruptive individual to a designated area for privacy and containment, and re-direct bystanders.
Managing Disruptive Behavior

To deal with disruptive behavior remember: Team, Isolate and Plan

- **TEAM** – Do not enter the room of a disruptive/agitated individual unless you have support/back-up

- **ISOLATE** – If possible, move a disruptive individual to a designated area for privacy and containment. Redirect bystanders to an assigned area to decrease ‘contagion’ reaction

- **PLAN** – Develop and communicate a unit based plan for managing inappropriate and/or disruptive behavior
Restraint Use

Restraints

There are occasions when a patient must be immobilized or restrained to prevent injury or harm to self and/or others.

The Restraint Policy has been developed to provide safe and effective use of restraints while preserving patient dignity and individual rights.
Check Your Knowledge

In an emergency, a patient may be placed in restraints at the initiation of a registered nurse. The physician can be contacted later when possible.

Correct. In an emergency, a patient may be placed in restraints at the initiation of a registered nurse.

The attending physician needs to be informed as soon as possible if a patient requires any type of restraint.
Definition of Restraint

Restraint is bodily physical restriction or use of a mechanical device that limits the patient’s ability to move their arms, legs, head, or body.

Medication is considered a restraint only when it is not the standard treatment or dose for the patient’s condition and the intent is to restrain the patient.

The intent, not the device, determines whether or not the movement restriction is considered restraint.
Restraint Use

Things that are Not Considered a Restraint

The following categories include items not considered restraints:

**Protective Equipment**
Examples include: *(but are not limited to)*

- bed rails
- mesh beds
- tabletop chairs
- high top cribs
- highchairs
- helmets
- mittens that are not pinned or tied down

**Medical Immobilization**
Temporary immobilization as part of treatment. Examples:

- arm board
- papoose
- welcome sleeves/ mittens that are not pinned or tied down

**Adaptive support**
Including: *(but are not limited to)*

- orthopedic appliances
- devices to aid in postural support identified in response to assessed physical needs of an individual

**Forensic**
Use of handcuffs and shackles by law enforcement officers is *considered constraint* rather than restraint and, therefore, does NOT fall within the hospital documentation
Restraint Categories

**Click** on the pictures for an example of each the categories of restraints.

**Medical-surgical**

Medical-surgical restraints are used to prevent incidents related to removal or disturbance of medical or surgical devices or treatment. These restraints may be initiated by a RN when deemed clinically necessary. The physician will be contacted as soon as possible.

*Examples:*
- Posey® Limb holders with quick release buckle
- Posey® synthetic leather limb holders

**Behavioral Restraints**

Behavioral restraints are used only as an emergency measure when unanticipated, aggressive, destructive behavior places the patient or others in imminent danger. Behavioral restraints should only be used when behavioral strategies, such as de-escalation techniques, have failed to calm the patient and to safely manage the patient situation.
Restraint Use

Behavioral Restraint

The decision to use restraint may be made by the nurse alone if an immediate consultation with a physician can not occur.

A physician/AHP must evaluates the patient and write an order for behavioral restraints within 1 hour of starting the use of the restraints.

Patients need to be in 1-to-1 visual observation (visual contact) while behavioral restraints are used.

Deciding to use, putting the behavioral restraints on and removal of behavioral restraints occurs either:

- By trained clinical staff
- By Security personnel when directed by the appropriate clinical staff

The initial assessment of a patient at risk for self-harm or harm to others should also include:

- Techniques, tools, and/or methods the patient finds helpful to control his/her behavior. (Example: Individualize Behavior Plan)
Restraint Orders

The following is order information for *Behavioral* and *Medical/Surgical* restraints.

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Medical/Surgical</th>
<th>Behavioral</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Initial Orders</strong></td>
<td>An MD or an Allied Health Practitioner (AHP)</td>
<td><strong>MD Only:</strong> Residents who write behavioral orders must have completed at least 1 year of postgraduate medical training. <strong>Allied Health Practitioner (AHP):</strong> When restraint is required to prevent a patient from injuring himself or others.</td>
</tr>
<tr>
<td><strong>Verbal Orders</strong></td>
<td>MD/AHP <em>must</em> see patient and write orders <em>within 24 hours</em></td>
<td>MD/AHP <em>must</em> see patient and write orders <em>within 1 hour</em></td>
</tr>
</tbody>
</table>
| **Length of time before re-order** | Daily | • Children <9 *renew every 1 hour*  
• Children 9-17 *renew every 2 hours* |
For more information [Click to view](http://authordev.healthstream.com/content/stanford_medical/lpch%20restraint_rn/RNreview_90.htm) the restraint policy & restraint order sets for reference.
Documentation

**Documentation for Medical/Surgical Restraints**

<table>
<thead>
<tr>
<th>Every 2 hours</th>
<th>A RN will assess and document:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Comfort /level of distress</td>
</tr>
<tr>
<td></td>
<td>• Response to restraint</td>
</tr>
<tr>
<td></td>
<td>• Comfort/level of distress</td>
</tr>
<tr>
<td></td>
<td>• Body position</td>
</tr>
<tr>
<td></td>
<td>• Skin integrity</td>
</tr>
<tr>
<td></td>
<td>• Circulation</td>
</tr>
<tr>
<td></td>
<td>• Correct application of restraints</td>
</tr>
<tr>
<td></td>
<td>• Vital signs as appropriate</td>
</tr>
<tr>
<td></td>
<td>• Readiness for release</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Periodically</th>
<th>Exercise limbs while awake</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>As Appropriate</th>
<th>Regularly prescribed medication</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Adequate ventilation/heating</td>
</tr>
<tr>
<td></td>
<td>Appropriately lighted</td>
</tr>
<tr>
<td></td>
<td>Regularly scheduled meals/snacks</td>
</tr>
<tr>
<td></td>
<td>Bath at least once daily</td>
</tr>
</tbody>
</table>

**Documentation for Behavioral Restraints**

<table>
<thead>
<tr>
<th>Every 15 minutes</th>
<th>All of above</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Patient’s response to restraint</td>
</tr>
<tr>
<td></td>
<td>Vital signs as appropriate</td>
</tr>
<tr>
<td></td>
<td>Readiness for release</td>
</tr>
</tbody>
</table>

http://authordev.healthstream.com/content/stanford_medical/lpch%20restraint_rn/RNreview_95.htm
• Behavioral Q 15 minute checks can be done by a RN or nursing assistant
Documentation of Restraints

Document initial and ongoing patient assessments, alternatives attempted, and care in a timely and appropriate manner for all restraints.

Click on each box to find out specific things you need to document when using restraints.

- A description of the patient’s behavior and the interventions used, alternatives or other less restrictive interventions as applicable.
- Patient’s condition or symptoms that was the cause for using the restraints.
- Patient’s response to interventions and reason for continued use of intervention.
- Document all applicable assessments at appropriate intervals.
- Document the one hour face to face medical evaluation for behavioral restraints.
Release of Restraints

The nurse reassesses and documents the need for continued use of a restraint.

When the reason and need for the restraint is gone, the restraint is removed.

- Example: ET tube is removed

Medical/Surgical restraints may be released when a nurse or parent is present.

The “in-person assessment within 1 hour rule” applies even if the behavioral restraint is stopped and removed within 1 hour.
## Putting on a Restraint

[Click to view](#) the manufacturer's instructions on restraint placement. You will need to see your unit educator to review correct placement and removal of Posey® devices.

The following are key safety facts about **POSEY® LIMB HOLDERS** device use:

<table>
<thead>
<tr>
<th>Fact</th>
<th>If the limb holder device is applied too tightly, circulation will be impaired; If too loose, the patient may be able to slip his/her limb from the device.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Check circulation frequently and monitor for skin discoloration.</td>
</tr>
<tr>
<td>Safety</td>
<td>For safety: <strong>Do not</strong> attach the limb holder in a way that the patient may use his/her teeth to remove the device or inflict self-injury.</td>
</tr>
<tr>
<td></td>
<td>An additional body restraint (fifth point) may be required to prevent the patient from moving the line/wound/tube site to within access of his/her hands.</td>
</tr>
<tr>
<td></td>
<td>Always secure strap at a frame juncture which will <strong>not</strong> allow the straps to slide in any direction, changing the position of the product.</td>
</tr>
<tr>
<td>Safety</td>
<td>After applying a restraint or self-release product; <strong>always</strong> put all side rails in the UP position.</td>
</tr>
<tr>
<td>Safety</td>
<td>Always use quick-releasing ties that do not slip/loosen or buckles, to secure straps - they allow easy release in the event of accident or fire.</td>
</tr>
</tbody>
</table>
When a Patient Dies

The hospital is responsible for reporting to CMS (Center for Medicaid and Medicare Services) each death:

- That occurs while the patient is in restraint or in seclusion at the hospital
- That occurs within 24 hours after the patient has been removed from restraint or seclusion
- Known to the hospital that occurs within one week after restraint or seclusion where it is reasonable to assume that use of restraint or placement in seclusion contributed directly or indirectly to a patient’s death

Report all deaths to the Nursing Supervisor

- Indicate whether the patient has been in restraint or seclusion
- Indicate whether the patient had been in restraint or seclusion within the past 24 hours

The Nursing Supervisor will report to Risk Management whether the patient met any of these requirements for reporting to the CMS.
Let's review

- Restraints are *only applied* when they have been deemed a clinical necessity and when alternative, less restrictive measures have been unsuccessful or cannot be employed without jeopardizing patient safety or care.

- Patients in restraints will be monitored for safety during restraint use and qualified staff will attend to their needs.

- Qualified staff will also provide ongoing needs assessments and appropriate interventions for these patients.
Post Test

Examination Summary

- This examination contains 10 question(s).
- You must answer 90% correctly or 9 out of 10 question(s) in order to pass this examination.
- Use Next/Previous rather than the scroll bar.
- Do NOT click the X on the upper right-hand corner of the window.
- Please answer all questions below, then click the SUBMIT button at the bottom of the page to have your examination scored.
- This assessment is not timed.

Question 1 of 10
De-escalation techniques should be used prior to using restraints.

Answers
- True
- False

Next

Question 2 of 10
How long after behavioral restraints are applied is a physician assessment and order required?

Answers
- A. 4 hours
- B. 2 hours
- C. 1 hour
- d. 12 hours

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Question 3 of 10
What verbal techniques can be used when dealing with a person who is showing signs of increasing anxiety?

Answers
- A. Be supportive by providing information and offering comfort measures (i.e. sleep, bathroom breaks, food, go for a walk)
- B. Develop trust through open, honest communication
- C. Use objective and neutral speech/vocabulary
- D. Identify and offer contacts with whom the individual would like to speak (offer use of telephone)
- E. All of the above

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Question 4 of 10
Documentation for Behavioral Restraints consists of:

Answers
- A. Patient’s response to restraint
- B. Vital signs as appropriate
Question 5 of 10
Which one of the following is considered a restraint?

**Answers**
- A. Bed rail
- B. Arm board
- C. Use of handcuffs and shackles by law enforcement officers
- D. No-No’s tied to the bed

Question 6 of 10
When a patient dies that is in or was in restraints within the past 24 hours, what do you do?

**Answers**
- A. Call the Nursing Supervisor who facilitates the required reporting
- B. No one, nothing needs to happen
- C. Call the family
- D. Call Security

Question 7 of 10
Medical/Surgical restraints may be released when a nurse is present.

**Answers**
- True
- False

Question 8 of 10
The device determines whether or not the movement restriction is considered restraint.

**Answers**
- True
- False

Question 9 of 10
What does a nurse assess and document every 2 hours for a patient in a medical/surgical restraint?

**Answers**
- A. Comfort /level of distress, Response to restraint, Body position, Skin integrity, Circulation, Correct application of restraints, Vital signs as appropriate, Readiness for release
B. Vital signs with B/P, Comfort / level of distress, Response to restraint, Correct application of restraints
C. Body position, Skin integrity, Circulation, Correct application of restraints and Exercise limbs while asleep

**Question 10 of 10**
A patient in behavioral restraints requires a one-to-one sitter.

**Answers**
- True
- False

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