

SHC Restraints Clinical

1. SHC Restraint Seclusion Clinical

1.1 Restraint Seclusion RN



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Restraints/Seclusion: Clinical

1.2 Introduction


Restraints: Introduction

This course reviews key aspects of using and caring for patients in *Restraints and Seclusion*.

Remember:

- The "Check Your Knowledge" questions are NOT scored; go ahead and guess.
- The Post Test is scored and a final score given.
- 90% is needed to pass the *Restraints/Seclusion: Clinical* module.
- **Demonstration of correct use of restraint devices is required** in addition to the completion of this module.


Contact your unit educator for details.



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1.3 Learning Objectives

Restraints: Learning Objectives



When you complete this online course, you will be able to:

- Define the SHC philosophy about the use of restraints and seclusion.
- Identify causes of threatening or harmful behaviors.
- Recognize patient's response to restraint use.
- Identify alternatives to restraints.
- Define the different restraint categories.
- Describe the policies for: orders to start using a restraint, renewal of orders.
- Identify correct patient assessments for different restraint categories.
- Describe correct care of a restrained patient.
- List restraint devices that can be used at SHC.



1.4 CYK: Risk factors

Check Your Knowledge: Risk Factors



True or False:
A **restraint** is defined as *any way of restricting a person's freedom of movement, physical activity or normal access to their body.*

Choose a response:



Warning (Slide Layer)

Check Your Knowledge: Risk Factors



True or False:
A **restraint** is defined as *any way of restricting a person's freedom of movement, physical activity or normal access to their body.*

Choose a response:

True

False




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Please click an answer before clicking Next.

True (Slide Layer)

Check Your Knowledge: Risk Factors




True or False:
A **restraint** is defined as *any way of restricting a person's freedom of movement, physical activity or normal access to their body.*

Choose a response:

True

False


Correct,
A restraint is *any* manual, physical or mechanical device, material, or equipment that *immobilizes or reduces the ability of a patient to move his/her arms, legs, body, or head freely.*



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False (Slide Layer)

Check Your Knowledge: Risk Factors




True or False:
A **restraint** is defined as *any way of restricting a person's freedom of movement, physical activity or normal access to their body.*

Choose a response:

True

False

Incorrect,
A restraint is **any** manual, physical or mechanical device, material, or equipment that *immobilizes or reduces the ability of a patient to move his/her arms, legs, body, or head freely.*



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1.5 SHC Restraint Philosophy

Restraints: SHC Restraint Core Principles

At Stanford Health Care (SHC) patients have the *right to be free* from restraints or seclusion.



Certain conditions warrant the use of restraints or seclusion *for the safety of the patient and others.*

To help make sure we meet the rights and safety of our patients:


- Restraint or seclusion should **only be used to protect the immediate physical safety of the patient, staff or others.**
- Restraint or seclusion are **never** used as a means of *coercion, discipline, convenience or staff retaliation.*
- Restraint and seclusion should **only be used when less restrictive interventions are ineffective.**
- **Use the least restrictive form of restraint or seclusion** that protects the physical safety of the patient, staff, or others.
- **Discontinue restraint or seclusion at the earliest possible time,** regardless of the scheduled expiration of the order.

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1.6 Reasons for restraints seclusion

Restraints: Preventing Problems

Click on the 3 boxes to learn about reasons for restraints and/or seclusion use.



Warning (Slide Layer)

Restraints: Preventing Problems

Click on the 3 boxes to learn about reasons for restraints and/or seclusion use.

 Please click each box before clicking Next.

restraint (Slide Layer)

Restraints: Preventing Problems

Click on the 3 boxes to learn about reasons for restraints and/or seclusion use.

- Non-Violent Restraints**
Restraints are used when necessary to promote healing and prevent significant harm to the patient.
- For example, they may be necessary during treatment of conditions such as post traumatic brain injury, delirium or when behaviors **endanger the patient** or **seriously compromise** the effectiveness of a procedure.
-

[Click box](#) to close



restraint seclude (Slide Layer)

Restraints: Preventing Problems

Click on the 3 boxes to learn about reasons for restraints and/or seclusion use.

- Violent Restraint or seclusion**
*Restraint or seclusion used for the **management of violent or self-destructive behavior** that jeopardizes the immediate physical safety of the patient, a staff member, or others.*
-
-

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seclusion (Slide Layer)

Restraints: Preventing Problems


Click on the 3 boxes to learn about reasons for restraints and/or seclusion use.

Seclusion

*Seclusion is to be used **only** for the emergency management of violent and/or self-destructive behavior.*

Seclusion is the *involuntary confinement* of a patient in a secure room or area in which the patient is *physically prevented from leaving*.

- The *confinement is based on* an assessed emergent need to limit the patient's environmental access and movement **to protect the patient or others**.
- A patient *physically restrained alone* in an unlocked




Restraints: Preventing Problems

Click on the 3 boxes to learn about reasons for restraints and/or seclusion use.

- The *confinement is based on* an assessed emergent need to limit the patient's environmental access and movement **to protect the patient or others**.
- A patient *physically restrained alone* in an unlocked room **does not** constitute seclusion.
- *Confinement on a locked unit* or ward where the patient is *with others* **does not** constitute seclusion.
- Seclusion is used **only** in **Psychiatry** and in the **Emergency Department**.

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1.7 Assess patient

Restraints: Assess the Patient

You need to anticipate the patient's needs and decide when using restraints is the best option for patient safety.



Make sure the family knows that *restraints are used as a last resort* after the staff has tried other things to keep the patient safe.



- **Assess for conditions or behaviors** that could interfere with medical care or harm self or others.

Review medical history, history of falls and past substance use.

- **Develop a plan** with other healthcare providers to try to anticipate the patients needs.

- **Educate the patient** and, when appropriate, the *family should be told why* the use of restraints is necessary and the criteria for their discontinuation (*stopping their use*).

Encourage the family or significant others to *participate in reducing the need for restraints*.

1.8 Restraint Myths

Restraints: Myths to Using Restraints

Click the pictures to review 3 common myths about using restraints.



Warning (Slide Layer)

Restraints: Myths to Using Restraints

Click the pictures to review 3 common myths about using restraints.




 Please click each image before clicking Next.

1 (Slide Layer)

Restraints: Myths to Using Restraints

Click the pictures to review 3 common myths about using restraints.



Myth # 1:


- *Restraints protect patient's from harm* and prevent falls and injuries.

Fact:

- Restraints increase the risk of injury and the rate of injury.
- Studies have shown that physical restraints are **NOT effective** in reducing falls or injuries.

One study showed that even though patients in restraints *fell less frequently*, their *injuries were more severe* when they did fall.


[Click box](#) to close



2 (Slide Layer)

Restraints: Myths to Using Restraints

Click the pictures to review 3 common myths about using restraints.




Myth #2:

- Restraint use *reduces liability*.

Fact:

- **Liability** can increase if a restraint is **NOT** used correctly.
- Liability does **NOT** decrease if you choose not to use a restraint.
- Liability increases the longer the patient remains in restraints. Regulations are clear *the patient's behavior must cause a safety issue* prior to use of restraints and restraint use *must be limited to shortest amount of time* to prevent injury.


[Click box](#) to close



3 (Slide Layer)

Restraints: Myths to Using Restraints

Click the pictures to review 3 common myths about using restraints.



Myth #3:


- Restraints *calm* an agitated or confused patient.

Fact:

- Patients may become even *more agitated* when restrained against their will.

Their confusion increases because they can not understand what the device is or why the restraint is on.

[Click box](#) to close



1.9 Myths

Restraints: Myths to Using Restraints

Additional myths include:



Myth: *Less staff is needed when a restraint is used*

Fact: *Due to the limit on what patients can do for themselves and increased lengths of stay, more time (and sometime more staff) is needed to give care.*

Myth: *Effective alternatives to restraint do not exist*

Fact: There are many effective alternatives to restraints. A multi-modal approach is usually needed.

The usual reason for using a restraint first when they are not truly needed is that *the staff does not know what else to do.*

- Have family members at the bedside, re-orient the patient to time and place, diversion with TV or radio, etc. are examples of other things that can be used.

- A thorough assessment of the patient is the key to finding and applying a variety of less restrictive options.



1.10 Potential Risks

Restraints: Potential Risks of Restraint Use


Click on the pictures to review what can happen to patients who are restrained.



Warning (Slide Layer)

Restraints: Potential Risks of Restraint Use

Click on the pictures to review what can happen to patients who are restrained.




Please click each image before clicking Next.

injury (Slide Layer)

Restraints: Potential Risks of Restraint Use

Click on the pictures to review what can happen to patients who are restrained.



Injury and potential death

Injuries like dislocations and nerve damage can occur if restraints are applied improperly or if patient is struggling to get out of restraints.


Death can happen from strangulation or asphyxiation (*lack of oxygen*) when trying **to get out of** the restraint.

[Click box](#) to close

cardiopulm (Slide Layer)

Restraints: Potential Risks of Restraint Use

Click on the pictures to review what can happen to patients who are restrained.



Cardiopulmonary issues


- *decreased lung expansion* and *ciliary movement*
- patient's can have an *increased resting heart rate* from the stress and anxiety that restraints can cause

[Click box to close](#)

skin (Slide Layer)

Restraints: Potential Risks of Restraint Use

Click on the pictures to review what can happen to patients who are restrained.



Skin and musculoskeletal issues

- *increased pressure on skin*
- *potential for shearing and friction injuries* from patients pulling or fighting with physical restraints
- muscle weakness
- contractures

[Click box to close](#)

GI GU (Slide Layer)

Restraints: Potential Risks of Restraint Use

Click on the pictures to review what can happen to patients who are restrained.



GI and GU issues


- *constipation, dehydration, diminished appetite* from the patient being less mobile when restraints are used
- increased risk of *urinary track infection* and *loss of continence*

[Click box to close](#)

psych (Slide Layer)

Restraints: Potential Risks of Restraint Use

Click on the pictures to review what can happen to patients who are restrained.



Psychological

Patients can become:

- *anxious*
- *withdrawn*
- *depressed*
- *other reactions* to the restraint

[Click box to close](#)

1.11 Increased Restraint Risks

Restraints: Increased Risks

Factors that can increase risk of restraint-related death include:



- **History of smoking** - respiratory function may be decreased.
- **Physical limitations** that prevent correct use of restraints.
- **Patients in supine position** - can lead to aspiration.
- **Patients in a prone (face down on stomach) position** - it can lead to suffocation.
 - ✓ Restraining patients in a prone position is **not** allowed.
- Restrained patient in a **room that is not easily and frequently watched** by staff.



1.12 Patient's Responses to Restraints

Restraints: Patients and Restraints

Patient's responses to restraints included:



- **Not understanding what they had done** to make the staff use a restraint.
- Feeling like they were **being punished** or unfairly treated.
- Feeling that the **staff did not spend enough time listening** to them.
- Feeling **angry and unhappy** with the hospital after they were released.

Patient's stated that being secluded was:

- the **single most traumatic part** of their inpatient stay.
- **left them with negative feelings about their entire hospital stay** no matter how positive their feelings about the staff.



1.13 Alternatives to restraints

Restraints: Alternatives to Using Restraints

Click on the pictures to review actions you can take, instead of using Restraints, for patients who may cause harm.





Warning (Slide Layer)

Restraints: Alternatives to Using Restraints

Click on the pictures to review actions you can take, instead of using Restraints, for patients who may cause harm.






 Please click each image before clicking Next.

1 (Slide Layer)

Restraints: Alternatives to Using Restraints


Click on the pictures to review actions you can take, instead of using Restraints, for patients who may cause harm.



When dealing with *agitation* in cognitively impaired patients (*Dementia and Delirium*) you should:

- *Explain procedures before touching* an impaired person.
- Have family *bring familiar personal items* to the hospital.
- *Reduce noise, light and other noxious (harmful) stimuli.*

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2 (Slide Layer)

Restraints: Alternatives to Using Restraints

Click on the pictures to review actions you can take, instead of using Restraints, for patients who may cause harm.



When dealing with wandering:

- *Use sensors* or alarm systems.
- *Provide for physical needs: toileting, thirst, pain, etc.*
- Put the patient in *room near nursing station.*
- Put *personal items close to the patient* and in easy reach.


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3 (Slide Layer)

Restraints: Alternatives to Using Restraints


Click on the pictures to review actions you can take, instead of using Restraints, for patients who may cause harm.



To deal with aggressive behavior: [Click box](#) to close

- Try to **de-escalate** or *talk the person down*.
- Use **active listening skills** so the person knows you are paying attention.
- Speak in a **soft voice** and in **short sentences**.
- **Avoid giving orders**.
- **Keep some distance** from the person because closeness can be misinterpreted as a threat.

Use supportive side stance. Avoid approaching from behind; an arching 45-degree angle of approach is safer and least threatening.






1.14 CYK: Decision for restraint Use

(Multiple Choice, 0 points, 1 attempt permitted)


Check Your Knowledge: Decision for Restraint Use

The decision to use restraints is based on:

- the patient's diagnosis.
- the patient's assessment.
- the unit the patient is admitted to.
- the patient's past medical history.



[Click submit](#) after you make a choice.



Correct	Choice
	the patient's diagnosis.
X	the patient's assessment.
	the unit the patient is admitted to.
	the patient's past medical history.

Feedback when correct:

The decision is based on your assessment of the patient, NOT:

the patient's diagnosis

past medical history

the unit the patient is admitted

Feedback when incorrect:

The decision is based on your assessment of the patient, NOT:

the patient's diagnosis

past medical history

the unit the patient is admitted

Correct (Slide Layer)

Check Your Knowledge: Decision for Restraint Use

The decision to use restraints is based on:

- the patient's diagnosis
- the patient's assessment
- the unit the patient is admitted to
- the patient's past medical history

Correct

The decision is based on *your assessment of the patient*, **NOT**:

- the patient's diagnosis
- past medical history
- the unit the patient is admitted

Continue

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Click **submit** after you make a choice.

Incorrect (Slide Layer)

Check Your Knowledge: Decision for Restraint Use

The decision to use restraints is based on:

- the patient's diagnosis
- the patient's assessment
- the unit the patient is admitted to
- the patient's past medical history

Incorrect

The decision is based on *your assessment of the patient*, **NOT**:

- the patient's diagnosis
- past medical history
- the unit the patient is admitted

Continue

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Click **submit** after you make a choice.

1.15 Category of Restraints

Restraints: Restraint Categories

The *intent* of the restraint determines the category.



Each restraint category has different standards for orders, assessment, monitoring and care.

Categories include:

- **Non-violent:** Restraints *used when necessary to promote healing and prevent significant harm* to the patient.

For example, they may be *necessary during treatment* of conditions such as post traumatic brain injury or *when behaviors endanger the patient* or seriously compromise the effectiveness of a procedure.

- **Violent:** Restraint or seclusion *used for the management of violent or self-destructive behavior* that jeopardizes the immediate physical safety of the patient, a staff member, or others.



1.16 Standards for restraint use

Restraints: Standards for Restraint Use


Click on the images for an example of each standard for restraint use.



Warning (Slide Layer)

Restraints: Standards for Restraint Use

Click on the images for an example of each standard for restraint use.



 Please click each image before clicking Next.

non-violent (Slide Layer)

Restraints: Standards for Restraint Use

Click on the images for an example of each standard for restraint use.



Non-violent Standard

Mrs S. has Alzheimer's disease and is admitted for sepsis.

Shortly after an IV is started, *she pulls out the line and climbs out of bed.*

The staff puts on a non-violent restraint *after less restrictive actions* are attempted and are **not** successful.

Standard: The non-violent restraint is being used to *prevent treatment interruption.*



Click box to close



violent (Slide Layer)

Restraints: Standards for Restraint Use

Click on the images for an example of each standard for restraint use.



Violent Standard

Mr. L becomes *increasingly aggressive* and throws a chair and other objects at a staff member.


His behavior *presents a danger to others*.

Staff tries to calm Mr. L without success, and have to use violent restraints.

Standard: The violent restraint is used to control dangerous and/or aggressive behavior.

There is **NO** medical or surgical care being interrupted.

[Click box to close](#)



1.17 Standards do not apply

Restraints: Times When Standards Do Not Apply

The following situations and devices are **NOT** considered restraints:



(Scroll down to see all content)

- When *orthopedic prescribed devices* are used.
- When surgical dressings or bandages are placed.
- When protective helmets, or other methods that involve the **physical holding** of a patient for:
 - the purpose of conducting routine physical examinations or tests.
 - to permit the patient to participate in activities without the risk of physical harm.
- *Side rails on a gurney* are **not** restraints since the



Restraints: Times When Standards Do Not Apply

The following situations and devices are **NOT** considered restraints:



purpose is to prevent patient from falling, or if used on a hospital bed to protect a patient with frequent seizures

NOTE: The use of **all side rails up with the intention to prevent a patient from exiting a hospital bed IS** considered a restraint.

Take caution and discuss with physician/LIP when *applying all side rails* for the purpose of *fall prevention*.

- *Medical protective devices* such as the temporary use of halter type or soft chest restraint **for postural support**



1.18 CYK: Decision for restraint Use

(Multiple Choice, 0 points, 1 attempt permitted)

Check Your Knowledge: Decision for Restraint Use

Which item below is **NOT** a type of restraint?

- 4 point Leather like device.
- 4 side rails on a bed up.
- hand mitts.
- a bed sheet.



Click submit after you make a choice.

Correct	Choice	Feedback
	4 point Leather like device.	4 Point Leather like devices are restraints used at SHC. A sheet or other bed linen are NOT restraints devices and should not be used to keep a patient in bed or a chair.
	4 side rails on a bed up.	4 side rails up are considered a restraint unless the patient gives permission, or as excluded per policy. A sheet or other bed linen are NOT restraints devices and should not be used to keep a patient in bed or a chair.
	hand mitts.	Mitts are restraint devices used at SHC. A sheet or other bed linen are NOT restraints devices and should not be used to keep a patient in bed or a chair.
X	a bed sheet.	A sheet or other bed linen are NOT restraints devices and should not be used to keep a patient in bed or a chair.

a bed sheet. (Slide Layer)

Check Your Knowledge: Decision for Restraint Use


Which item below is **NOT** a type of restraint?

- 4 point
- 4 sided
- hand mitts
- a bed sheet

Correct

A **sheet or other bed linen** are **NOT** restraints devices and should **not** be used to keep a patient in bed or a chair.

Continue



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Click **submit** after you make a choice.

hand mitts. (Slide Layer)

Check Your Knowledge: Decision for Restraint Use

Which item below is **NOT** a type of restraint?


- 4 point
- 4 sided
- hand mitts
- a bed sheet

Incorrect

Mitts are restraint devices used at SHC.

A **sheet or other bed linen** are **NOT** restraints devices and should **not** be used to keep a patient in bed or a chair.

Continue



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Click **submit** after you make a choice.

4 side rails on a bed up. (Slide Layer)

Check Your Knowledge: Decision for Restraint Use

Which item below is **NOT** a type of restraint?

- 4 point
- 4 side rails up
- hand held
- a bed sheet

Incorrect

4 side rails up **are considered a restraint unless** the patient gives permission, or as excluded per policy.

A **sheet or other bed linen** are **NOT restraints devices** and should **not be used** to keep a patient in bed or a chair.

Continue

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Click **submit** after you make a choice.

4 point Leather like device. (Slide Layer)

Check Your Knowledge: Decision for Restraint Use

Which item below is **NOT** a type of restraint?

- 4 point
- 4 side rails up
- hand held
- a bed sheet

Incorrect

4 Point Leather like devices are restraints used at SHC.

A **sheet or other bed linen** are **NOT restraints devices** and should **not be used** to keep a patient in bed or a chair.

Continue

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Click **submit** after you make a choice.

1.19 Types of restraints

Restraints: Types of Restraints

Types of restraints used at SHC include but are not limited to:



- **Soft wrist** or **ankle** restraints
- **Vest**
- **Leather-like** wrist or ankle restraints
- **4 side rails up** *except as excluded per policy*
- **Mitts**
- Use of a “**net bed**” that *prevents the patient from freely exiting the bed.*

Note: The restraints listed *can be used for both non-violent or violent purposes.*

1.20 Physical chemical restraints

Restraints: Physical and Chemical Restraints



Click each of the pictures to learn more about physical and chemical restraint use.




Warning (Slide Layer)

Restraints: Physical and Chemical Restraints

Click each of the pictures to learn more about physical and chemical restraint use.





 Please click each image before clicking Next.

physical (Slide Layer)

Restraints: Physical and Chemical Restraints


Click each of the pictures to learn more about physical and chemical restraint use.



Physical Restraints

- **Sheets are NOT a restraint:** Anything that restricts movement by definition is a restraint including sheet if used for that purpose. Because sheets are difficult to quickly released and inconsistently secured, they are not an approved form of restraint device.
- **Dispose of restraints:** restraints are for *single patient use* and may **NOT** be sent home with the patient or family.
- **Clean leather-like restraints:** these devices are **NOT** disposable, and therefore need to be *cleaned between patients* with a disinfectant.



[Click box](#) to close.



chemical (Slide Layer)

Restraints: Physical and Chemical Restraints


Click each of the pictures to learn more about physical and chemical restraint use.



Chemical Restraints

- *Chemical Restraint* is a medication **used to manage** the patient's behavior **or restrict** the patient's behavior or freedom of movement and **is not a standard treatment or dosage** for the patient's condition.
- Medications used to restrain the patient **for staff convenience** or as **patient discipline** are **NOT permitted**.
- Medications that are **used as part of a patient's standard medical or psychiatric treatment** are **not** considered a chemical restraint.


[Click box](#) to close.



1.21 Orders - non-violent


Restraints: Initial Non-Violent Restraint Orders

The use of non-violent restraints must have a physician / LIP order as soon as safely possible.



Within 24 hours of starting the use of the non-violent restraint, the patient **must** be examined by the **physician/LIP** and a **written order** entered into the medical record.

- You **must** get a physician / LIP order **any time** you are applying non-violent restraints.
- ✓ If a physician/LIP is unavailable, **a RN who has successfully demonstrated competence** in assessment for restraint **may apply the restraints**, **but a verbal or written order must be obtained as soon as safely possible** after the application of the restraint.
- ✓ If the **change in behavior** is due to a change in the patient's condition, the physician/LIP **must be notified immediately**.
- ✓ The attending physician will be **notified within 24 hours** if the attending **did not write the order for restraint**.



1.22 Orders-violent

Restraints: Initial Violent Restraint Orders

A doctor must visit a violent patient within 1 hr of violent restraints being used. (Scroll down to view all content)




Initial orders for violent restraints

- When a restraint, seclusion, or chemical restraint is used to manage violent or self-destructive behaviors, a *physician or other LIP* **must** see the patient *face-to-face* **with in 1-hour** after starting the intervention, **even if** the behavior stops or intervention is discontinued.
- A telephone or telemedicine methodology **does not replace** the *need for a face-to-face assessment*.
- A registered nurse **may initiate** (start) **restraint** or seclusion in advance of the MD order.
- **Within the first hour** the MD/LIP will evaluate the




Restraints: Initial Violent Restraint Orders

A doctor must visit a violent patient within 1 hr of violent restraints being used. (Scroll down to view all content)



- A registered nurse **may initiate** (start) **restraint** or seclusion in advance of the MD order.
- **Within the first hour** the MD/LIP will *evaluate the patient's physical psychological and behavioral status* and assess the following:
 1. the patient's immediate situation
 2. the patient's reaction to the intervention
 3. the patient's medical and behavioral condition
 4. the **need to continue or stop** the restraint or seclusion



1.23 Order Renewal

Restraints: Restraint Order Renewal

Click on the 2 boxes to learn about what is required to renew violent and non-violent restraints orders.



Warning (Slide Layer)

Restraints: Restraint Order Renewal

Click on the 2 boxes to learn about what is required to renew violent and non-violent restraints orders.


 Please click each box before clicking Next.

restraint (Slide Layer)


Restraints: Restraint Order Renewal

Click on the 2 boxes to learn about what is required to renew violent and non-violent restraints orders.

Renewal Orders for Non-Violent restraint use

- Restraints are *time-limited* to **no more than 24 hours** from the original order. 
- The physician/LIP **must** do a **face-to-face examination** of the patient and renew the order at least once *each 24 hour period* from when the order was initiated (*started*) that the restraint is required.

Click box to close



restraint seclude (Slide Layer)


Restraints: Restraint Order Renewal

Click on the 2 boxes to learn about what is required to renew violent and non-violent restraints orders.

Renewal Orders for Violent restraint use

The *initial and all subsequent restraint orders* shall **expire** in:

- **4 hours** for patients *18 years of age and older*
- **2 hour** for patients from *9 to 17 years*
- **1 hour or less** for patients *8 years of age or younger*.

Face-to-face examination of the patient is to be done by physician/LIP before writing a new order. 

Click box to close

1.24 Nonviolent monitoring

Restraints: Non-Violent Restraint Monitoring

For patient with non-violent restraints, assessment, care and monitoring requirements include the following to be done **every 2 hours**:



Note: the assessments and care given needs to be **charted every 2 hours**.



- **Safety:** check that restraints put on correctly and the patient has correct body alignment.
- **Physical status:** check skin, circulation, signs of injury.
- **Care/Comfort:** offer food, fluids, toileting, hygiene, ROM or repositioning, and emotional support.
- **Assessments:** LOC, mental status, behaviors, and *if restraints are still needed*.
- **Vital Signs:** as per patient's condition .

Note: attempts should be made to **identify the possible underlying cause(s)** of the behavior and to alleviate them.

1.25 Violent monitoring

Restraints: Violent Restraint Use

For patient needing violent restraints, assessment, care and monitoring requirements include the following to be done:



If the patient is *sleeping* you **must** do a *visual check of respirations*.



Every 15 minutes:

- **Safety:** make sure there is correct application of restraints and body alignment.
- **Physical status:** check circulation and signs of injury.
- **Assessments:** Level of Consciousness (LOC), mental status, behaviors, and if the restraints are still needed.

Every hour:

- Do vital signs
- Offer food and fluids
- Offer toileting and hygiene
- ROM or repositioning
- Offer emotional support

Note: attempts should be made to **identify the possible underlying cause(s)** of the behavior and to alleviate them.

1.26 Pt assistance to stop behavior

Restraints: Violent Restraint- Care and Monitoring

Most patients need to be given assistance (*help*) to meet the criteria to discontinue(*stop*) the use of violent restraints.



The RN **must** educate the patient on:

- ✓ reasons for restraint use.
- ✓ care while in restraints.
- ✓ criteria for discontinuation.

For example, let the patient know that

"For the restraints to be removed, you will need to stop threatening the nurses and physicians."

Patients in *violent* restraint **must** have continuous **one-to-one** monitoring (*sitter*).



1.27 CYK- New order for restraint

Check Your Knowledge: Patient Screening



You need to get **new order** to re-start *Non-violent restraint* if the restraint is removed from a patient before the time frame of the order expires and the behavior returns.

Choose a response:

True

False



Warning (Slide Layer)

Check Your Knowledge: Patient Screening




You need to get **new order** to re-start *Non-violent restraint* if the restraint is removed from a patient before the time frame of the order expires and the behavior returns.

Choose a response:

True


False



Stanford HEALTH CARE Please click an answer before clicking Next.

false (Slide Layer)

Check Your Knowledge: Patient Screening




You need to get **new order** to re-start *Non-violent restraint* if the restraint is removed from a patient before the time frame of the order expires and the behavior returns.

Choose a response:

True

False


Incorrect,
If a *Non-violent restraint* is removed from a patient a **new restraint order** must be placed.
Restraints **cannot be removed and reapplied on a PRN basis** or for purpose of a trial release.



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true (Slide Layer)

Check Your Knowledge: Patient Screening




You need to get **new order** to re-start *Non-violent restraint* if the restraint is removed from a patient before the time frame of the order expires and the behavior returns.

Choose a response:

True

False

Correct,
If a *Non-violent restraint* is removed from a patient a **new restraint order** must be placed.
Restraints *cannot be removed and reapplied* on a **PRN basis** or for purpose of a trial release.



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1.28 Stopping non-violent restraints

Restraints: Stopping and Restarting Restraint Use

Click each of the pictures to learn more about stopping and restarting *non-violent* restraints.



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Warning (Slide Layer)

Restraints: Stopping and Restarting Restraint Use

Click each of the pictures to learn more about stopping and restarting *non-violent* restraints.



 Please click each image before clicking Next.

stopping (Slide Layer)

Restraints: Stopping and Restarting Restraint Use

Click each of the pictures to learn more about stopping and restarting *non-violent* restraints.



Stopping Non-Violent Restraint Use
(Scroll down to view all content)

- The **time-limited order** does **not** require applying the restraint *for the entire period*.
- The need for restraint should be frequently evaluated and **ended at the earliest possible time** based on the assessment of the patient's condition.
- *Examples of criteria for discontinuance (stopping)* would include the **absence of behaviors/conditions** that created the need for the restraint.



Restraints: Stopping and Restarting Restraint Use

Click each of the pictures to learn more about stopping and restarting *non-violent* restraints.



that created the need for the restraint.

- RN / MD / LIP trained to apply restraints, who are assigned to care for a patient in restraints **can discontinue restraints** based on the assessment parameters stated above.



Note: *Temporary removal* of the restraint device for toileting, ROM, repositioning or for a procedure is **NOT** considered to be *discontinuation* of restraint.

- Document the discontinue time of restraints.

[Click box](#) to close.



restarting (Slide Layer)

Restraints: Stopping and Restarting Restraint Use

Click each of the pictures to learn more about stopping and restarting *non-violent* restraints.



Requirements for Restarting Restraints

- If the restraints are released, and the **behavior** that resulted in the use of the restraint **reoccurs** then a new order for restraints **must** be obtained.
- Restraints **cannot be removed and reapplied** on a *PRN* basis, or for purposes of a trial release.
- Document the start time of restraints every time restraints are initiated or reapplied.

[Click box](#) to close.



1.29 Stopping violent restraints

Restraints: Stopping and Restarting Restraint Use

Click each of the pictures to learn more about stopping and restarting *violent* restraints.






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Warning (Slide Layer)

Restraints: Stopping and Restarting Restraint Use

Click each of the pictures to learn more about stopping and restarting *violent* restraints.



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Please click each image before clicking Next.

stopping (Slide Layer)

Restraints: Stopping and Restarting Restraint Use

Click each of the pictures to learn more about stopping and restarting *violent* restraints.



Stopping Violent Restraint Use

(Scroll down to view all content)



The restraint or seclusion is discontinued (*stopped*) as soon as the patient is:

- **Able to cooperate** with, or not interfering with the medical/surgical treatment or site.
- **Able to contract successfully for release** and **no longer exhibits the behavior** that created the start/need for restraint or seclusion.
- **No longer a danger** to self or others.

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Restraints: Stopping and Restarting Restraint Use

Click each of the pictures to learn more about stopping and restarting *violent* restraints.




The RN / MD / LIP trained to apply restraints, who are assigned to care for a patient in restraints, **can discontinue restraints** based on the assessment parameters stated above.

Note: **Temporary removal** of the restraint device for toileting, ROM, repositioning or for a procedure is **NOT** considered to be *discontinuation* of restraint.

- Document the **discontinue time** of restraints.



Click box to close.

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restarting (Slide Layer)

Restraints: Stopping and Restarting Restraint Use

Click each of the pictures to learn more about stopping and restarting *violent* restraints.




Requirements for Restarting Restraints

The patient's behavior will be assessed for possible early discontinuation of restraint use.

- If the restraints are released, and the **behavior that resulted in the use of the restraint reoccurs** then a [new order](#) for restraints **must** be obtained.
- Restraints **cannot be removed and reapplied** on a *PRN* basis, or for purposes of a trial release.
- **Document** the [start time](#) of restraints **every time** restraints are initiated or reapplied.

[Click box](#) to close.

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1.30 course summary

Restraints: Summary

Let's Review *(scroll down to see all the content)*

- Patients have the right to be free of restraints and seclusion.
- *Restraints and seclusion* pose risks to a person's physical and psychological health and **should only be used** when there is *imminent risk of injury to the patient, staff or others*, and *alternatives* have been tried or considered and are **not** effective.
- The **intent not the type** of restraint used, determines the restraint category.
- There **must be a clinically appropriate and adequately justified reason** for using restraints or seclusion.
- Restraints may **not** be used as a means of *coercion, discipline, convenience or retaliation* by staff.

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Restraints: Summary

Let's Review *(scroll down to see all the content)*

- The use of restraints **must have an order**. Each category has different requirement initiation (*starting*), renewal and discontinuation (*stopping*).
- The *assessment* of physical, emotional, cognitive and social factors **must** conclude that for this patient, at this time, *the use of less restrictive measures poses a greater risk* than the risk of using a restraint or seclusion.
- Patients must be educated on the reason for the restraint, how they will be cared for while in restraints, and the criteria for discontinuation
 - ✓ When appropriate, the family should be involved in decisions and activities relating to the use of restraint or seclusion.
- The restraint or seclusion is **discontinued** (*stopped*) **as soon as** the patient has regained control of his or her behavior.



1.31 Congratulations!

Congratulations!

Congratulations, you have now completed the training.

You can click the "Review" button below to review this course, or click the "Exit" button on the upper right of this window to exit the course and take the post test.

REVIEW

