SHC Restraints Clinical

1. SHC Restraint Seclusion Clinical

1.1 Restraint Seclusion RN



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.



1.3 Learning Objectives



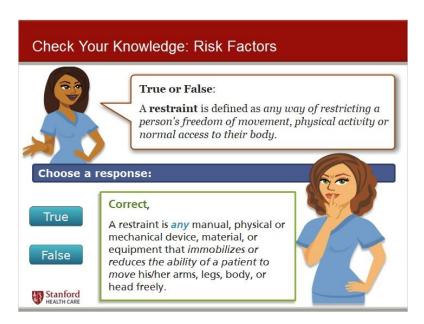
1.4 CYK: Risk factors



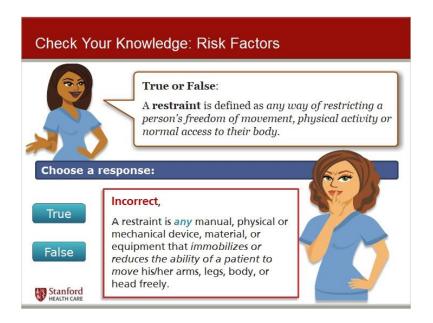
Warning (Slide Layer)



True (Slide Layer)



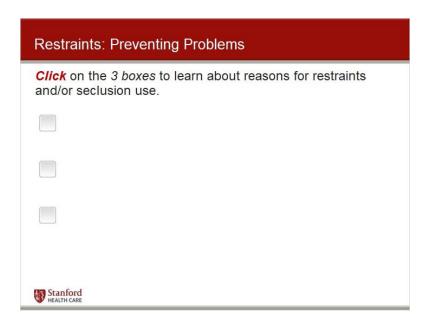
False (Slide Layer)



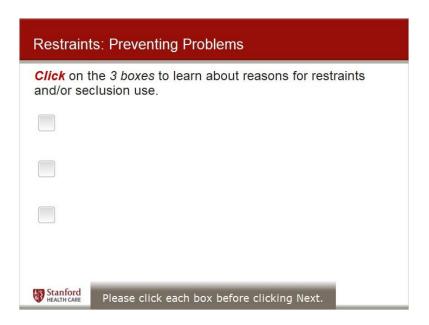
1.5 SHC Restraint Philosophy



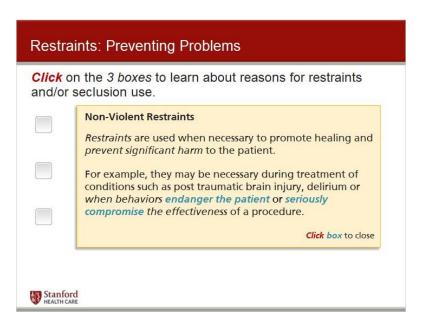
1.6 Reasons for restraints seclusion



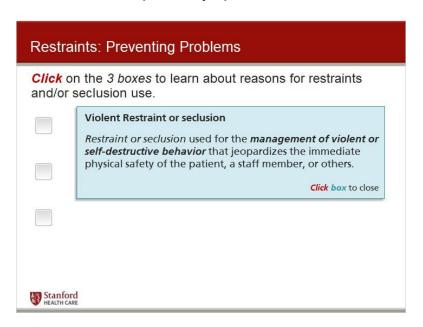
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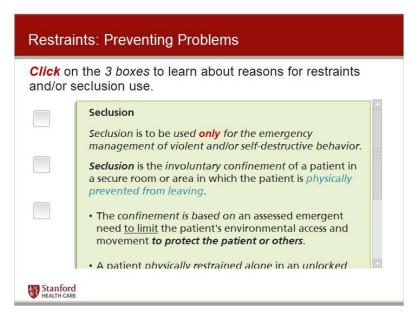
restraint (Slide Layer)

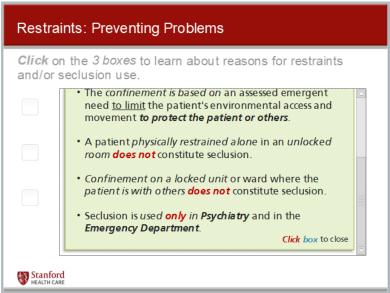


restraint seclude (Slide Layer)



seclusion (Slide Layer)





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

 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.

anticipate the

• Educate the

- **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.

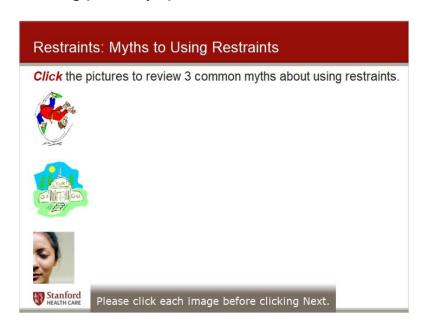








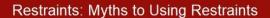
Warning (Slide Layer)



1 (Slide Layer)



2 (Slide Layer)



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.







1.9 Myths

Restraints: Myths to Using Restraints

Additional myths include:



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

- 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.



else to do.

1.10 Potentail Risks

Restraints: Potential Risks of Restraint Use

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







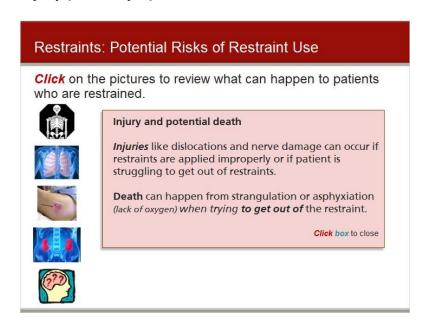




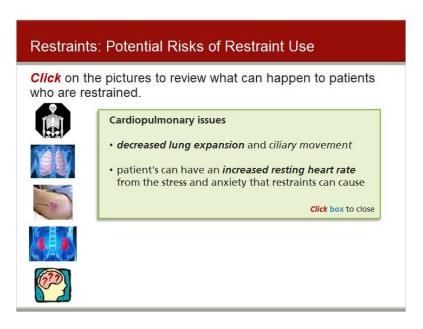
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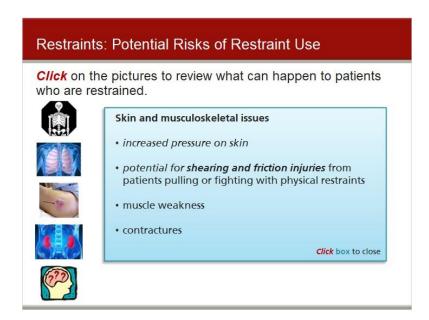
injury (Slide Layer)



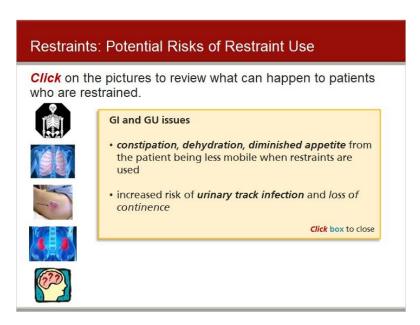
cardiopulm (Slide Layer)



skin (Slide Layer)



GI GU (Slide Layer)



psych (Slide Layer)



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











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)



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.

Click box to close





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.

Click box to close



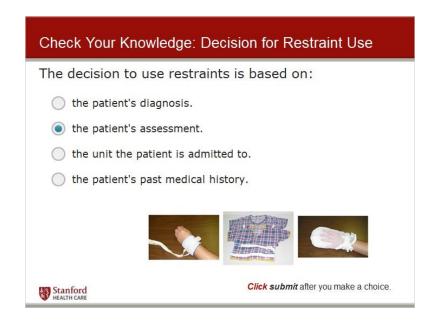


3 (Slide Layer)



1.14 CYK: Decision for restraint Use

(Multiple Choice, 0 points, 1 attempt permitted)



Correct	Choice	
	the patient's diagnosis.	
Х	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:

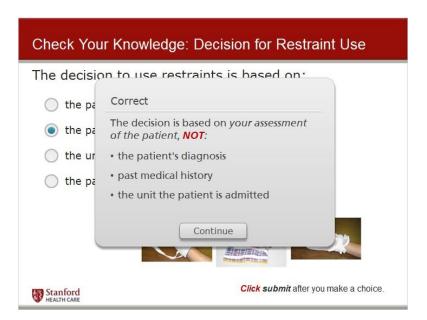
The decision is based on your assessment of the patient, NOT:

the patient's diagnosis

past medical history

the unit the patient is admitted

Correct (Slide Layer)



Incorrect (Slide Layer)



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.

<u>For example</u>, 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

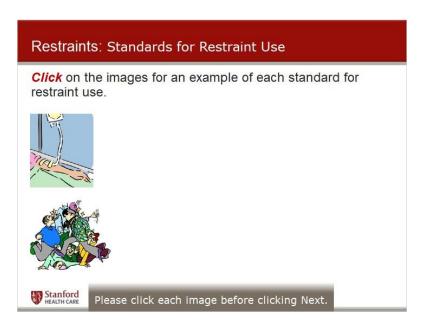
Click on the images for an example of each standard for restraint use.



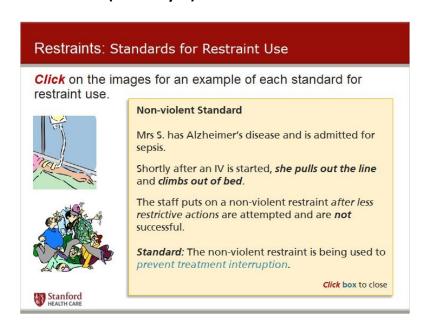




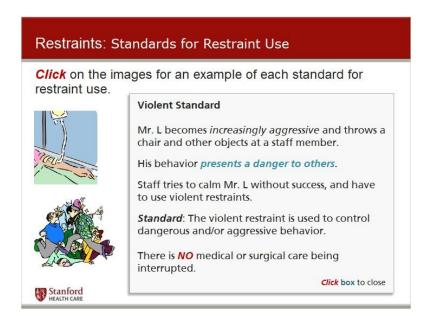
Warning (Slide Layer)



non-violent (Slide Layer)



violent (Slide Layer)



1.17 Standards do not apply





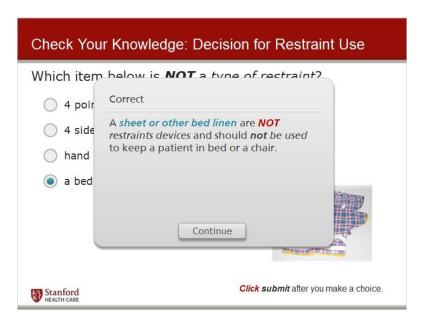
1.18 CYK: Decision for restraint Use

(Multiple Choice, 0 points, 1 attempt permitted)

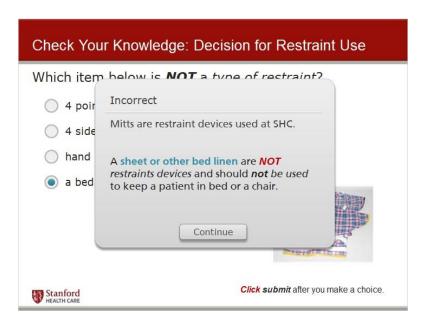


Correct	Choice	Feedback
	4 point Leather like	4 Point Leather like devices are restraints used at SHC.
	device.	A sheet or other bed linen are NOT restraints devices and should not be used to keep a patient in bed or a chair.
	4 side rails on a bed up.	4 side rails up are considered a restraint unless 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.
Х	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.

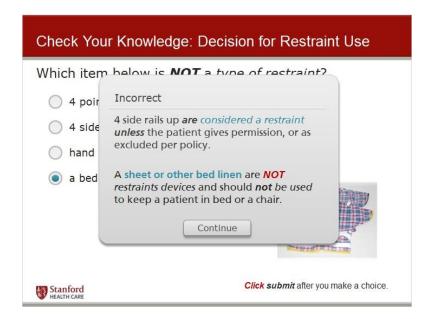
a bed sheet. (Slide Layer)



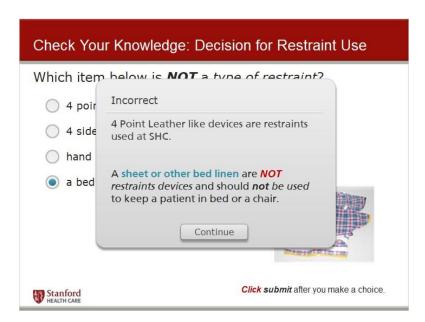
hand mitts. (Slide Layer)



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



4 point Leather like device. (Slide Layer)



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)



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.





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 restraint 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.



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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-toface 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 avaluate the



Restraints: Initial Violent Restraint Orders

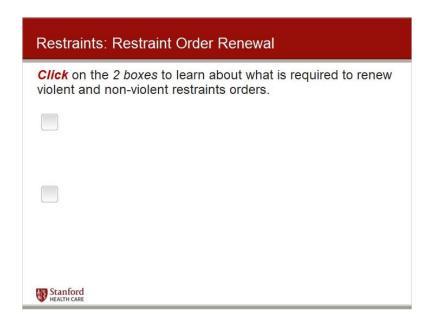
A doctor must visit a violent patient within 1 hr of violent restraints being used. (Scroll down to view all content



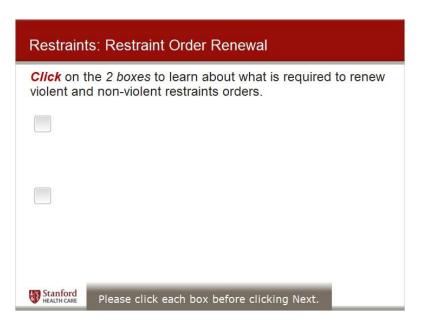
- A registered nurse may initiate (start) restraint or seclusion in advance of the MD order.
- Within the first hour the MD/LIP will evaluate the patient's physical psychological and behavioral status and assess the following:
 - 1. the patient's immediate situation
 - 2. the patient's reaction to the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



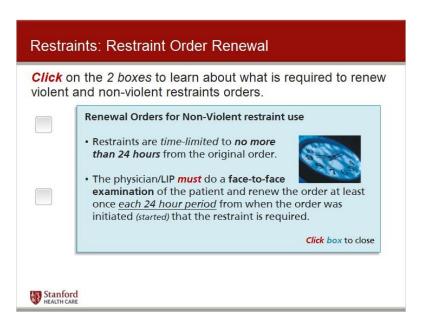
1.23 Order Renewal



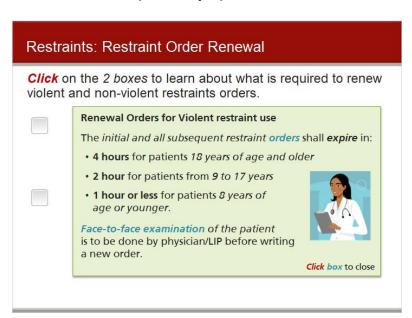
Warning (Slide Layer)



restraint (Slide Layer)



restraint seclude (Slide Layer)



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.

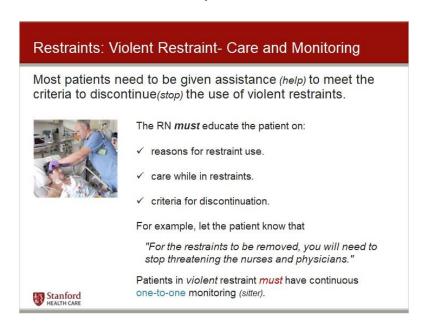
Every hour:

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

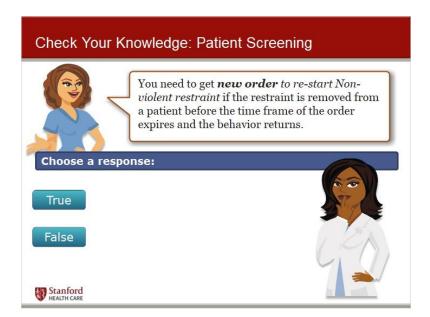


Note: attempts should be made to *identify the possible underlying cause(s)* of the behavior and to alleviate them.

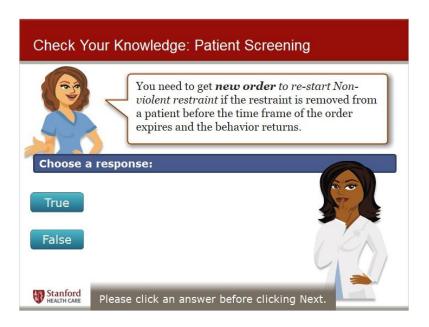
1.26 Pt assistance to stop behavior



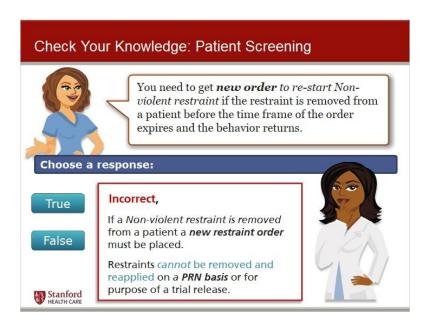
1.27 CYK- New order for restraint



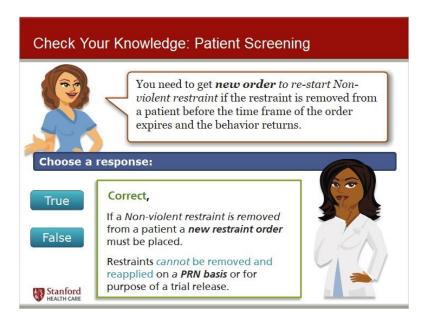
Warning (Slide Layer)



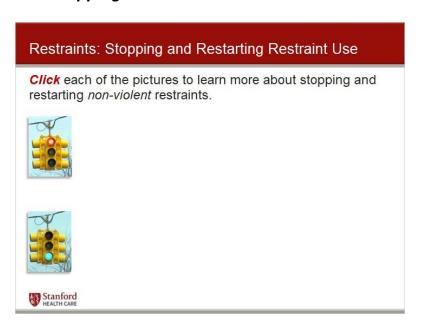
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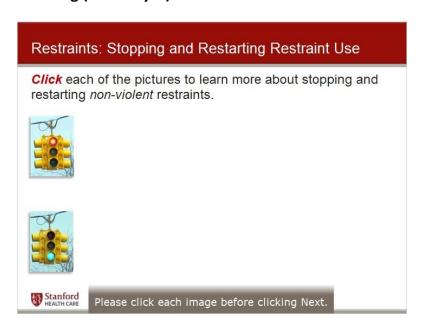
true (Slide Layer)



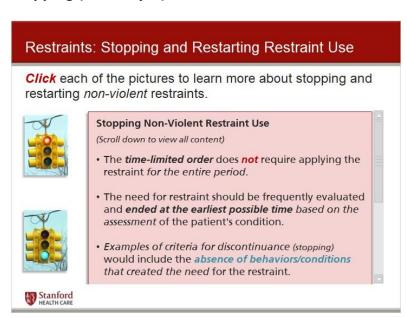
1.28 Stopping non-violent restraints

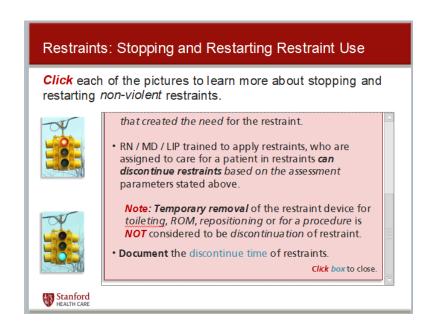


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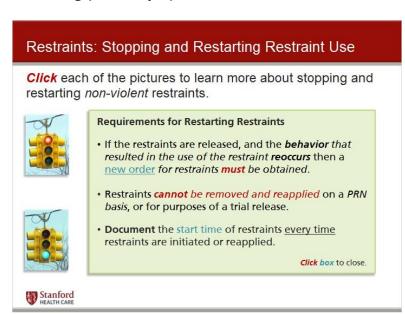


stopping (Slide Layer)





restarting (Slide Layer)



1.29 Stopping violent restraints



Warning (Slide Layer)



stopping (Slide Layer)



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.





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.



• Document the discontinue time of restraints.





restarting (Slide Layer)

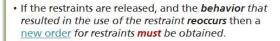
Restraints: Stopping and Restarting Restraint Use

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.







Click box to close.





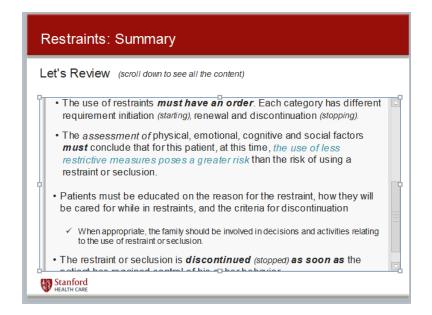
1.30 course summary

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.





1.31 Congratulations!

