
Lucile Packard Children's Hospital
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Restraints

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Restraint Use

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.)

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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 *Restraint*s module.

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Restraint Use

Check Your Knowledge

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.

True

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.

False

Close window

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Restraint Use

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.

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Restraint Use

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.)

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Restraint Use

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.

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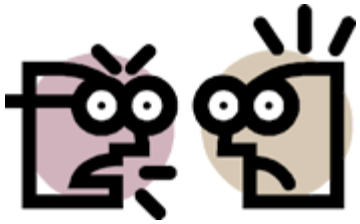
Restraint Use

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

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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.

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Restraint Use

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.

True

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.

False

Close window

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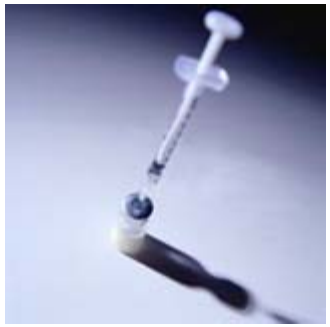
Restraint Use

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.

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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

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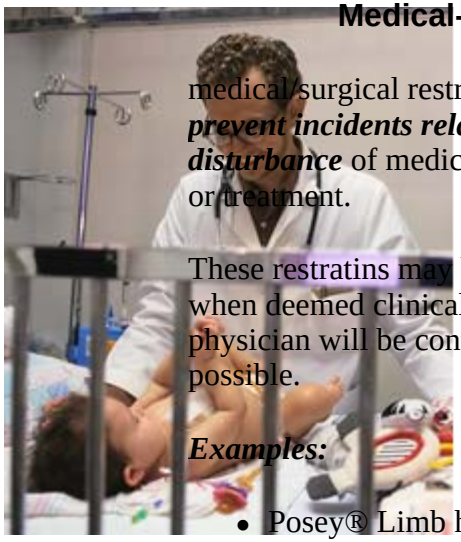
Restraint Categories

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



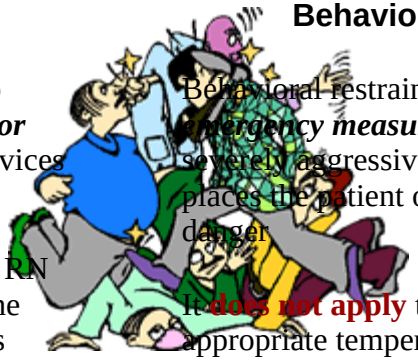
Medical-surgical

medical/surgical restraints are used to ***prevent incidents related to removal or disturbance*** of medical or surgical devices or treatment.

These restratins 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, severely aggressive, destructive behavior places the patient or others in imminent danger.

It **does not apply** to developmentally appropriate temper tantrums in young children.

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.

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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)

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Restraint Use

Restraint Orders

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

Intervention	Medical/Surgical	Behavioral
Initial Orders	An MD or an Allied Health Practitioner (AHP)	**MD Only:** Residents who write behavioral orders must have completed at least 1 year of postgraduate medical training. **Allied Health Practitioner (AHP):** When restraint is required to prevent a patient from injuring himself or others.
Verbal Orders	MD/AHP **must** see patient and write orders *within 24 hours*	MD/AHP **must** see patient and write orders *within 1 hour*
Length of time before re-order	Daily	• Children **<9** renew every **1 hour** • Children ***9-17*** renew every **2 hours**

		• Patients ***18 & older*** renew every **4 hours**

For more information Click to view the restraint policy & restraint order sets for reference

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Restraint Use

Documentation

Documenation for Medical/Surgical Restraints

Every 2 hours	A RN will assess and document: • Comfort /level of distress • Response to restraint • Comfort/level of distress • Body position • Skin integrity • Circulation • Correct application of restraints • Vital signs as appropriate • Readiness for release
Periodically	• Exercise limbs while awake
As Appropriate	• Regularly prescribed medication • Adequate ventilation/heating • Appropriately lighted • Regularly scheduled meals/snacks • Bath at least once daily

Documentation for Behavioral Restraints

Every 15 minutes	• All of above • Patient's response to restraint • Vital signs as appropriate • Readiness for release

	• Behavioral Q 15 minute checks can be done by a RN or nursing assistant

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Restraint Use

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.

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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.

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Restraint Use

Putting on a Restraint

Click to view the manufactures 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:

Fact	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. Check circulation frequently and monitor for skin discoloration.
Safety	For safety: ***Do not*** attach the limb holder in a way that the patient may use his/her teeth to remove the device or inflict self-injury. 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. Always secure strap at a *frame juncture* which will **not** allow the straps to slide in any direction, changing the position of the product.
Safety	After applying a restraint or self-release product; ***always*** put all side rails in the UP position.
Safety	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.

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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.

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Summary

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

Previous Next

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

Previous Next

Question 4 of 10

Documentation for Behavioral Restraints consists of:

Answers

- A. Patient's response to restraint
- B. Vital signs as appropriate

C. Readiness for release
D. Behavioral Q 15 minute checks can be done by a RN or nursing assistant
E. All of the above

Previous Next

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

Previous Next

Question 6 of 10

When a patient dies that is in or was in restraints with in 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

Previous Next

Question 7 of 10

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

Answers

True
False

Previous Next

Question 8 of 10

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

Answers

True
False

Previous Next

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

Previous Next

Question 10 of 10

A patient in behavioral restraints requires a one-to-one sitter.

Answers

True

False

Previous

Close Submit