



**Patient Care Services
Clinical Education**

**RN/ LVN/ NA Skills Checklist:
Restraint Management Competency Study Packet**

It is the policy of Kaiser Permanente that restraint:

1. will never be used unless medically necessary, and only if needed to improve the patient's and/or other person's safety.
2. will not be used until nonphysical interventions (alternatives to restraint) are utilized and deemed ineffective prior
3. must be the least restrictive possible for the shortest period of time
4. do not cause unnecessary physical discomfort, harm or pain, and is easily removable in an emergency.
5. will never be used for any other purpose, such as coercion, discipline, convenience, or retaliation by staff.
6. is not used based on an individual's history or solely on a history of dangerous behavior.
7. when used, the nurse needs to ensure that patient's rights, dignity and well-being are protected.

The purpose of this packet is to provide all staff who interact with restrained patients the assessment and management techniques needed to provide the highest standard of care while ensuring patient and staff safety.



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II Discuss at least three common staff/patient behaviors, events and environmental factors that may trigger circumstances that require the use of a restraint.

<i>Staff Behaviors</i>	Rushing, not taking time to explain steps to patient, not listening, need to be in charge, non-compromising, high stress level, talking too fast to be understood, appears to not care or angry; Staff not recognizing that patient is unable to hear or has unattended needs (pain, need to void, etc.), speaking foreign language in patient's presence.
<i>Patient Behaviors</i>	<p><u>Psychiatric conditions:</u> e.g. Psychosis, schizophrenia, mania, anxiety and depression. These patients may experience hallucinations and delusions and have difficulty processing information.</p> <p>Patients who are developmentally delayed or mentally retarded may be unable to follow directions which can compromise patient safety.</p> <p><u>Medical Conditions:</u></p> <ul style="list-style-type: none"> • Delirium (acute confusional state) causes short term memory loss and deficits in attention. Commonly associated with behaviors such a picking at tubes and drains, and hallucinations that make it difficult for the patient to respond appropriately. • Dementing illnesses are commonly associated with difficult behaviors e.g. paranoia, wandering, resistiveness to needed medical or nursing care; Short term memory loss and language deficits, that are the hallmark signs of dementia, make it difficult for the patient to follow directions regarding use of call light which increase risk for falls. <p>Aggressive or violent behaviors e.g. hitting, punching, throwing, presenting as a danger to self or others, whether due to psychiatric, medical or other conditions (stress).</p>
<i>Events and environmental factor</i>	<p><u>Physiologic Stressors:</u> Fatigue, Sleep deprivation, Pain/discomfort, Unmet elimination needs (retention, incontinence, constipation), too hot or cold,</p> <p><u>Environmental:</u> Noise, heat, circumstances that would lead someone to feel unsafe or in danger (real or imagined) can escalate anxiety;</p> <p>Change of environment, routine or caregiver, overwhelming or misleading stimuli, excessive demands placed on patient can trigger disruptive behaviors in patients with dementia</p>

III Identify the appropriate assessment parameters required prior to placing a patient in restraint Every episode of restraint must be triggered by an individualized assessment, and never based on history. The choice of safe, effective and least restrictive methods of restraint is determined by the assessment of a registered nurse, in collaboration with the physician and other healthcare team members, based upon the patient's needs and the behavior exhibited by the patient. Assessment includes:

- A description of the patient's behavior, condition, or symptom that warranted the use of the restraint. Behaviors that typically necessitate the use of restraint include:
 - unsafe exits from bed/chair in the patient at high risk of falling,
 - interfering with needed medical therapies (attempts to dislodge lines, tubes, dressings),
 - danger to self or others. Besides the violent, combative patient, this also includes that the cognitively-impaired patient who wanders or desires to leave the hospital against medical advice.
- Alternatives to restraint and/or less restrictive interventions attempted (See Table I)
- Behavioral restraint: Relevant clinical and social information that places the patient at greater physical or psychosocial risk during restraint. For example preexisting medical conditions, physical disabilities

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and limitations, ethnicity or gender issues, developmental considerations, and previous chemical or substance, physical, sexual or elder abuse can place the patient at higher risk of adversely responding to restraint. Knowing this history can keep the patient and staff out of harm's way and determine a more appropriate method of addressing patient behaviors. If needed, elicit this background information from family or significant others.

Identify at least three non-physical interventions that need to be considered prior to placing patient in restraints (See table 1 for risk-specific non-physical alternatives to restraint)

For ALL patients, regardless of behavior, it is critical for nursing staff to communicate therapeutically, using good communication techniques, active listening skills, and appropriate body language.

- Be sure the patient can see and hear you (use glasses, hearing aid or hearing amplifier as needed). Get his/her attention, establish and maintain eye contact (but do not appear threatening), call the patient by name, and introduce yourself (as needed). Assess and meet the patient's needs before expecting your needs to be met. The patient who is in pain, needs to go to the bathroom, etc. will be less likely to respond to your needs, and behaviors may escalate, if personal needs are not met first.
- Be aware of body language and communicate caring. Do not appear rushed, impatient, angry, or bored. Get down to the patient's level, and be aware of the need for personal space and how you position yourself. Hovering over a person or getting too close can be intimidating; Trapping yourself in a room with an aggressive person blocking the door can be dangerous.
- Observe the patient closely for signs of increased anxiety, stress, especially body language.

List three types of restraints, identifying which is the least restrictive for a particular behavior

TABLE 1

Behavior Exhibited	Suggested Alternative Interventions	Less Restrictive Devices
Fall Risk	<ul style="list-style-type: none"> • Routinely meet basic care needs <ul style="list-style-type: none"> ○ Routine toileting rounds ○ Establish and maintain supervised ambulation schedule ○ Aggressively address pain and comfort needs ▪ Increase Observation <ul style="list-style-type: none"> ○ Room close to and/or sit patient within view of nurses station ○ Family supervision ○ Hourly safety rounds ▪ Maintain Safe environment and devices <ul style="list-style-type: none"> ○ Devices: Bed-chair exit alarms, Specialty Low bed, Daytime recliners ○ Beds low and locked at all times (when staff not in attendance) ○ Adequate lighting ○ Grab rails and raised toilet seats ○ Eliminate hazards, clear a path to the bathroom ○ Provide glasses, hearing aid, purse, etc., and keep all necessary items including call bell within reach at all times ○ Use skid free slippers or shoes ○ Patient/family safety education ▪ Regularly review medications and eliminate as possible high risk medication e.g. sedative-hypnotic, tranquilizers, and anticholinergic medications. 	Wedge cushion Lap Buddy Geri chair with table top Self-releasing belt Side rails Most restrictive: Roll Belt, Vest (not used in medurg/ICU)
Pulling tubes, lines or dressings	<ul style="list-style-type: none"> • Remove unnecessary tubes/lines as soon as possible • Hide or camouflage tubing; <ul style="list-style-type: none"> ○ Skin sleeve or cuffed gowns to hide IV lines ○ Position indwelling catheter tubing between legs and secure bag to foot of bed; Secure Foley catheter to abdomen (males), or to leg with tape or Wear briefs/pants over Foley catheters ○ Hide or camouflage dressings and Overdress wounds ○ Abdominal binder to hide gastrostomy tube • Provide alternative tubing or diversionary activities to keep patient occupied 	Mittens and elbow extenders before limb holders (most restrictive)

