



**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.

11 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)



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	<ul style="list-style-type: none"> • Consider alternatives for nasogastric tubes • Medicate for pain • Supervise confused patients carefully 	
Scratching	<ul style="list-style-type: none"> • Eliminate itch / treat cause • Garden gloves 	Mittens and elbow extenders before limb holders
Wandering	<ul style="list-style-type: none"> • Assess for infection, pain and other sources of discomfort (constipation, cold, elimination needs, fear, etc.) • Determine where the patient is going and why • Provide diversionary activities • Decreased stimuli • Provide reminiscence and validation therapy • Avoid reality testing • Family/friend supervision • Alarms where available • Avoid half doors and restrictive barriers 	Use geri chair with table top before roll belt
Rummaging and scavenging	<ul style="list-style-type: none"> • Busy boxes or aprons • Reminiscent equipment and diversionary activities • Reorientation and reassurance • Family/friend supervision 	Geri chair with table top before roll/lap belt
Combative	<ul style="list-style-type: none"> • Control for visual and auditory stimuli • Music therapy • Structured routine and Consistent personnel • Time outs and rest periods • Contracting, when appropriate • Medication, when appropriate • Family/friend involvement 	Establish effectiveness of two point soft limb holders prior to using four point restraint

RESTRAINT APPLICATION

- Explain the difference between behavioral and non-behavioral restraints
- Discuss and demonstrate the appropriate and safe application techniques when using restraints. *This is a demonstration competency where the scenario should include the components listed below as well as a situation with the use of siderails as a restraint.*

‡ Non-behavioral (previously known as medical/surgical) restraints are used to ensure the physical safety of the non-violent or non-self-destructive patient who is interfering with necessary medical or nursing care. For example, the patient who is pulling at a critical tube, line or dressing, or cannot remember to call for assistance, and is at great risk of falling, may need to be restrained to ensure safety and/or that needed medical care is provided. Typical behaviors that warrant the use of this type of restraint include interfering with lines/tubes/dressings, unsafe exits from bed or chair, and behaviors that place the patient in danger of harm to self or others, such as the confused patient who wanders or insists on leaving against medical advice.

‡ Behavioral restraints, which can be physical or pharmacologic, are used when a patient appears to be in imminent danger to self or others. Behaviors include the patient who is aggressive, violent, or otherwise out of control, requiring immediate physical or pharmacologic interventions to gain control of the behavior.

‡ A medication used solely to manage the patient's behavior or restrict the patient's freedom of movement that is NOT a standard treatment or dosage for the patient's condition (chemical or drugs used as a restraint) requires that the behavioral restraint policy be implemented (continuous observation, assess every 15 minutes; face to face assessment within 1 hour). *A "standard treatment" would include all the following and would not be considered a restraint:*

- ‡ Medications used within the pharmaceutical parameters approved by the FDA and the manufacturer for the indications it is manufactured and labeled to address, including dosage parameters (e.g. haloperidol for treatment of delusions or paranoia in schizophrenic patient)



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- ‡ *Use of the medication follows national practice standards established or recognized by the medical community and/or professional medical association or organization (e.g. haloperidol for hallucinations due to delirium or paranoid behaviors due to dementia)*
- ‡ *Use of the psychotropic medication to treat a patient's documented clinical condition is based on that patient's symptoms, overall clinical situation, and on the physician's knowledge of the patient's expected and actual response to the medication.*
- ‡ NOT CONSIDERED RESTRAINT:
 - ‡ Age or developmentally-appropriate restrictions: crib or crib covers
 - ‡ Forensic restrictions: Handcuffs used by police
 - ‡ Procedural immobilization: straps during surgery or procedure
 - ‡ Medical immobilization: armboard for IV
 - ‡ Protective devices: gurney rails, up to 3 bedrails, chair seat belt. full side rails/pads in immediate post-operative period (reevaluate need when patient wakes up) or when patient actively seizing
 - ‡ Adaptive device: postural support belt to maintain body alignment in patient with hemiparesis

SAFETY considerations:

1. Choose the most appropriate, least restrictive device possible and correct size (as applicable). Sizing for elbow restraints and Velcro belt is critical to ensure effectiveness and patient safety.
 - ‡ Mittens, elbow extenders and wrist restraint for pulling at lines, if alternatives (discontinuing, camouflage or diversionary lines/activities) ineffective
 - Elbow extenders- Vinyl elbow splint (3 sizes); freedom splint (4 sizes)
 - Mittens- one size fits all adults
 - Single strap limb holder quick release –wrist restraints (one size fits all)
 - Tuff cuff – one size fits all adults
 - ‡ Full Side Rails and Roll belt in bed, and Velcro Lap and Torso Support belt in chair [comes in 4 sizes (small to extra large)] for unsafe bed/chair exits, if alternatives to restraint ineffective.
2. Patient needs to be placed in anatomically correct position, with skin and bony prominences assessed. Pad skin and bony prominence under restraint, if applicable.
3. Secure restraint with “quick release” clip or slipknot (never bowtie or double knot) to the moveable portion of bed or chair.
 - Always attach restraint to a part of the bed frame that moves when the head of the bed is raised or lowered
 - Insert one finger under the secured restraint to ensure restraint is not too tight or too loose
 - If patient is in chair, secure ties under the armrests and tie at back of chair; If tied in front, as a reminder not to get up unassisted, and patient able to remove, belt is NOT considered a restraint.
4. Remove each restraint at least every two hours and perform range of motion to affected areas. Assess the patient's skin, circulation and overall condition and attend to basic care needs (offer toileting, fluids, repositioning, etc. (*more details re. every two hour assessment described below*)).
5. When using full side rails to prevent unsafe exits from bed (non-behavioral restraint), the patient must be assessed for the risk of bed entrapment. This can occur in patients who are frail, confused and lack the strength or trunk control to reposition themselves in bed. As such, patients can become trapped in the spaces between mattress and bed frame and between rails. If the patient is found to be at risk of bed entrapment, the nurse must:
 - a. Assess for and eliminate gaps between mattress and the side rails (Use of gap fillers, change bed)



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- b. Increase the frequency of observation (every 30 minutes), asking family members to stagger visits to promote more family at bedside to monitor, and move patient closer to the nurses station for better visualization
- c. Safety education to patient and family

- Explain how often to observe and assess the patient in non behavioral/behavioral restraints**
Restraint Application Summary

Element of Care:	Restraint Application to Ensure the Physical Safety of the Non-Violent or Non-Self-Destructive Patient	Restraint Application for Behavioral Management
Emergency Application by RN permitted	Yes	Yes
Physician Order#	Telephone order obtained ASAP not to exceed 12 hours of application	Verbal or telephone order obtained ASAP not to exceed 1 hour of initiation of restraint
Physician Assessment*	Face-to-face within 24 hours of application. However, if reason for restraint represents significant or unanticipated change of condition, the physician must be notified immediately and the patient assessed as soon as possible.	Face-to-face within 1 hour of initiation of the restraint; If performed by trained RN, MUST consult with physician ASAP after assessment
Duration of Initial Order	Maximum time limit: 24 hours	Maximum time limit of: 4 hours for adults (18 years or older) 2 hours for Children 9-17 yrs. 1 hour for Children under 9 yrs.
Renewal/Reassessment	Once each calendar day	Same as above
Visualization / Observation frequency	As indicated by patient condition and type of restraint. Must be observed at least every hour	Continuous observation with recording of observation every 15 minutes.
Needs Assessment @/ Monitoring frequency	At least every 2 hours.	At least every 15 minutes.
Release from Restraints	At least every 2 hours.	At least every 2 hours.
Patient Education	Includes rationale, purpose, risks and benefits of restraint needs to be documented	Inform family in accordance with patient wishes

If order obtained by on call/after hours non-treating physician, the ordering physician or RN must consult with the treating physician (who has primary responsibility for patient care/management) ASAP.

* The 1-hour face-to-face medical and behavioral evaluation will include:

- a. A description of the patient's behavior and the intervention used
- b. Alternatives or other less restrictive interventions attempted (as applicable);
- c. The patient's condition or symptom(s) that warranted the use of the restraint or seclusion; and
- d. The patient's response to the intervention(s) used, including the rationale for continued use of the intervention.

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- **List at least two areas that need to be assessed and documented after the application of restraint**
 - ✦ The patient's physical and emotional well-being
 - ✦ Comfort and care needs, including hygiene, elimination, hydration, nutrition
 - ✦ The appropriateness of restraint application and removal and reapplication
 - ✦ Assessment of the need for continuing or discontinuing restraint. **Trial releases are encouraged, but if the patient needs the restraint reapplied within the time frame of the current order, a NEW order still needs to be obtained.**
 - ✦ Restraint devices are released every 2 hours. The patient's skin, circulation, and condition of limbs are assessed, and released limbs receive Range of Motion (ROM) exercise. The patient is also assessed for the possibility of discontinuation of the restraint and basic care needs attended to.

- **Identify who, when and what needs to be documented in the "face to face" assessment of the patient in restraint.**
 - Behavioral Restraint: requires a face-to-face medical and behavioral assessment by the physician or a specially trained registered nurse (restraint champion) within one hour of the initiation of restraint that includes:
 - A description of the patient's behavior and the intervention used;
 - Alternatives or other less restrictive interventions attempted (as applicable);
 - The patient's condition or symptom(s) that warranted the use of the restraint or seclusion; and
 - The patient's response to the intervention(s) used, including the rationale for continued use of the intervention.
 - If the one hour assessment performed by the "trained" RN, the physician needs to be consulted ASAP
 - Non-behavioral Restraint: requires a face-to-face medical and behavioral assessment by the physician within 24 hours of the application of restraint.

- **Describe at least two adverse signs/symptoms of physical and/or psychological distress due to the use of restraints and how to respond.**
 - ✦ Circulatory compromise, numbness, difficulty-moving extremities, color change to white, cool to touch, decrease pulses, skin reddened or abrasions.
 - ✦ Escalating of behavior with restraints, such as thrashing, screaming, signs of terror, or hallucinations.
 - ✦ Positional asphyxia or respiratory distress

The RN needs to be notified at the first sign of distress with a full assessment performed and physician notified.

- **Describe the criteria that would indicate restraints are no longer needed.**
 - ✦ The patient must be continually assessed with every interaction for readiness for discontinuation for the restraint device. The absence of the behavior that triggered the application of restraint, or the patient's needs can be met with less restrictive methods should initiate a full assessment of whether the restraint can be discontinued. The patient may appear calm, less agitated, more coherent, less thrashing, able to rest; and speaking clearly, and vital signs returned to parameters that are within normal limits. In the patient in behavioral restraint, the behavior that placed the patient or others has abated and the patient is no longer a threat to self or others
 - ✦ Trial release, especially when family members are at the bedside or when the patient is sleeping or calm, is encouraged. However, a trial release is interpreted by a regulatory agency as a PRN restraint (which is never warranted). If the behavior returns, a new order for restraint must be obtained.



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Identify which patient's in restraint need to be reported by hospital to outside agencies (CA Department of Public Health or Centers for Medicare/Medicaid Services).

Report to Nurse Manager: Report to nurse manager: all patients in behavioral restraint >12hrs., or any death in restraint.

External Reporting Requirements

Reporting Requirements	CDPH Report	CMS	Comments
Death of a patient while in restraints or seclusion.		Y	CMS report required even if death is not associated with restraints or seclusion.
Death associated with the use of restraints or bed rails.	Y	Y	MedWatch Report to FDA is also required within 10 working days.
Death that occurs within 24 hours after the patient has been removed from restraint or seclusion.		Y	CMS report required even if death is not associated with restraints or seclusion.
Death that occurs with one week after restraint or seclusion where it is reasonable to assume that the use of the restraint or placement in seclusion contributed <i>directly or indirectly</i> to the patient's death.	Possibly	Y	Death <i>directly</i> associated with the use of restraints or bedrails may be reportable to CDPH in addition to CMS.
Serious disability associated with the use of restraints.	Y		MedWatch Report to restraint manufacturer within 10 working days also required.



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Restraint Management Written Competency Test

1. Common staff/patient behaviors, events and environment factors that may trigger circumstances that require the use of a restraint might include:
 - a. Staff not taking time to explain steps to patient
 - b. Patient refusing food and fluids
 - c. Patient not talking
 - d. Patient wandering into other patient's rooms\
 - e. Patient hitting staff
 - f. Staff talking too fast to be understood
 1. a, b, d
 2. a, d, e, f
 3. a, d, e
 4. b, c, d

2. Triggers that can accelerate behavior leading to restraints include:
 - a. Fatigue
 - b. Change of environment or routine
 - c. Excessive noise
 - d. All of the above

3. Relevant clinical and social information that places the patient at greater physical or psychosocial risk during restraint might include
 - a. History of child abuse
 - b. Phobia of being tied down
 - c. History of post traumatic stress disorder
 - d. All of the above

4. Non-physical interventions indicated for problematic behaviors prior to using restraints include (at least 3 each):
 - a. Pulling at indwelling urinary catheter: _____
 - _____
 - b. Constant attempts to get OOB: _____
 - _____
 - c. Wandering: _____
 - _____

5. List the appropriate type of restraint beginning with the least restrictive to the most restrictive for each behavior (considering non-physical interventions NOT entirely successful):
 - a. Pulling at ET tube (ICU only): _____
 - b. Pulling at indwelling catheter: _____
 - c. Constant attempts to get OOB: _____
 - d. Wandering: _____

6. Review of physician orders for behavioral restraints must be specific to time and renewal by age. The following are true or false (max time limit prior to new order)

a. Age ≥ 18 yrs. – 4 hrs	True	False
b. Age 9 – 17yrs. – 4 hrs	True	False
c. < 9 yrs – 2 hr	True	False



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7. Signs of physical and psychological distress may include, but are not limited to:

- a. Circulatory compromise
- b. Numbness
- c. Respiratory distress
- d. Escalating behavior of screaming
- e. All of the above

8. Assessment of patient behaviors indicates that restraints are no longer necessary as the patient is much more calm, no longer trying to get out of bed, and able to recall simple instructions to stay in bed. The roll belt is released for the entire shift. However, during the PM shift the patient became more restless and confused and was unable to maintain weight bearing restrictions as she keeps trying to get out of bed. The roommate is complaining that the bed alarm is keeping her awake as it is alarming at least every hour. The restraint can be reapplied as the physician order is still current (less than 24 hours old).

- a. True
- b. False

9. Which of the following are true concerning restraint use?

- a. Non-physical alternatives to restraint should be trialed first
- b. Use the least restrictive restraint
- c. Discontinue the restraint as soon as possible
- d. All of the above

10. An order for a restraint must include:

- a. Reason for
- b. Type of restraint
- c. Time limit guidelines
- d. All of the above

I have reviewed the above competency checklist and understand that I am accountable and responsible for these items

Signature of Employee: _____

Remediation Plan: None Follow-up with Nursing Manager Other