Welcome to the Restraints Reduction annual training. Physical restraints should only be used when a patient’s actions interfere with the medical treatment plan or if they are a danger to themselves or others and when no alternative methods have worked. Restraints are a high-risk method for dealing with unsafe behavior and should only be used as a last resort. Before applying patient restraints, always consider alternative interventions. Patients’ rights and safety must always be balanced with the need to limit movement.

In this training, you will learn about alternatives to restraints and how to properly care for patients in restraints.
This course should take approximately 15 minutes to complete. If you have any questions, please contact the appropriate number listed on this screen. Remember, all technical questions should go to the Help Desk at 610-402-8303.

This course does not contain audio narration, please review the notes tab for more course information.
Upon completion of this course, you will be able to:
• Discuss patient care interventions that can serve as alternatives to restraint use,
• Describe interventions necessary when caring for a patient in restraints, and
• Describe findings that should be reported to the patient’s clinical team.
At Lehigh Valley Health Network there are two policies that govern the use of restraints:
• Restraint for Non Self-Destructive Behavior. The information in this policy is used to prevent the patient from interfering in the treatment plan or pulling at tubes due to confusion. An example of a type of restraint under this policy would be 1-3 cloth restraints.
• Restraint and Seclusion for Violent/Self-Destructive Behavior. The information in this policy is used to limit patient behavior that may be harmful or dangerous to themselves or to others. Examples of restraints under this policy include the following:
  • Locked restraints
  • More than 3 cloth restraints
  • Forced Hold
  • Forced Physical Escort
  • Seclusion of the patient

Both policies can be found on the LVHN PolicyTech web site under the Administrative Policy Manual section.
Other types of restraints include the use of more than 3 side rails and wedging the bed against the wall.

The following items are not considered restraints:
- Recliner chairs with trays that can be removed by the patient,
- Lap huggers and bed fellow pillows,
- Arm boards as part of IV therapy, and
- Mitts.
It is easier to deal with patients when we understand why they behave the way they do. By understanding the reasons behind your patient’s actions, you will be able to address the underlying needs of your patient. You will also be able to choose which actions you should take to appropriately deal with your patient and reduce the need for restraints. Factors that affect how a patient reacts to being in the hospital and to physical contact include:

- Age
- Developmental concerns, such as mental retardation
- Gender
- Culture
- History of abuse
- Cognitive impairments or change in mental status
- Medical diagnosis
- Emotional and psychological concerns about being ill, such as:
  - Anxiety about tests
  - Fear of needles
  - Financial concerns
  - Depression
Patients may become upset or restless for many different reasons. If you understand the reasons why your patient is acting a certain way, you will be able to help your patient better.

Click next to learn more about the reasons why patients may become upset or restless.
Consider the emotional needs of your patient. Patients may feel a loss of freedom when they have to follow hospital rules and routines.
If your patient is upset or restless, you should assess your patient’s physical needs. If your patient is hungry or thirsty, provide them with food or water if appropriate. Patients who need to go to the bathroom may need a bedpan or need help getting to the bathroom.
Being in the hospital often feels strange to patients. Hospital sights and sounds may scare or confuse them, or make them feel upset or lonely. When sights and sounds make it hard for patients to get rest, provide a quiet space for them. Spend time with patients who feel alone. Also, offer activities and promote family visits.
Patients on more than one drug may have side effects that affect how they behave.
Patients may become restless or upset due to a medical problem, such as reduced oxygen, abnormal blood work, or pain. If a medical problem is found, it can be treated.

You can address these problems by:
• Talking to caregivers. Ask the clinical staff what you can do to help.
• Involving the patient. The family may be able to tell you about past medical problems and what will calm the patient.
• Checking the patient often. Keep an eye on restless patients. Let other caregivers know what upsets or calms the patient.
• Reporting what you observe. Tell the patient’s physician or other caregivers if you notice the patient is restless or upset.
• Repositioning the patient. Patients with pain or discomfort, or other medical problems may need to be placed in other positions.
If your patients can’t follow or understand directions, it may be difficult to prevent them from removing medical equipment or tubes. You can solve this problem by doing any of the following:

- Allow family to visit. Patients often feel safer when family members are with them.
- Spend time with the patient. This may calm the patient and they may forget about the tubes.
- Cover the tubes or equipment so that blinking lights do not confuse or scare the patient.
How you communicate with your patient can also influence your patient’s behavior. Do not argue with your patient. You need to recognize the fact that the patient’s feelings are real to him or her. Explain procedures to the patient before starting. The patient will be more calm if they understand what is happening to them.
Restraints should only be used as a last resort. Alternative methods should be attempted before placing a patient in restraints. Alternatives to restraints include:

- Attempting to de-escalate patient behavior
- Reassessing the patient’s medications
- Keeping the bed in the lowest position
- Using diversionary activities for patients
- Checking patients frequently
- Toileting patients every 2-3 hours to prevent incontinence
- Using bed or chair alarms
- Ensuring that the patient’s physical and emotional needs are met
- Problem solving
- Reducing stimulation
- Providing positive reinforcement
- Involving family members
Patients who roam around the hospital:
• May not be at risk for getting hurt,
• Often feel steady on their feet,
• Can follow commands, and
• Are usually always moving.
What can you do to help patients who wander? Instead of using restraints, use the following methods to help the wandering patient:

- **Follow a regular schedule.** This provides order and safety, and helps the patient feel more secure.
- **Use simple commands to redirect patients back to their rooms.**
- **Call the patient by his name, look directly at him when you talk.**
- **Gain the patient's trust.**
- **Set limits.**
- **Give patients different things to do, so they don’t become bored.** Offer TV, radio, and books.
An order for restraint for non self-destructive behavior must be obtained as soon as possible after application. If continued use of restraints is needed, an order must be obtained every 24 hours. The order for restraints must include the clinical justification for the application of the restraint, the type of restraint that is used, and the criteria for discontinuation of restraint.
An order for restraint and seclusion for violent/self-destructive behavior must be obtained as soon as possible (no more than one hour) after application. If continued use of restraints is needed, an order must be obtained appropriate to the time limits of the existing order. The order for restraints must include the clinical justification for the application of the restraint, the type of restraint that is used, and the criteria for discontinuation of restraint. Anyone in violent restraints MUST BE on arm's length observation.
If restraints are removed while family is visiting or as a trialing off, and must be reapplied this constitutes a new restraint episode and a new order must be obtained.
When non-violent restraints or violent/seclusion are initiated, you must document in Epic:
- The type of restraint being used,
- The reason the restraint is necessary,
- The alternatives attempted,
- The criteria for release from restraints,
- The care provided.
When violent/self destructive restraints or seclusion are initiated, you must document in Epic:
- The type of restraint being used,
- The reason the restraint is necessary,
- The alternatives attempted,
- The criteria for release from restraints,
- The care provided.
Let’s see how much you have learned so far.

You are responsible for caring for three patients: Mr. Jones, Mrs. Smith, and Mr. Todd. Select each patient’s file, then decide the actions that should be taken to care for each patient.
Many methods have been tried to keep Mr. Jones from pulling out his tubes, but none have worked. He is being placed in restraint. Should you tell the family why Mr. Jones is being restrained and what needs to be done for the restraints to be removed?
Good job. If Mr. Jones’ family knows why he is restrained, they may feel less worried and afraid. If his family helps him deal with this problem, he may spend less time in restraints.
I'm sorry, you did not select the best response. If Mr. Jones’ family knows why he is restrained, they may feel less worried and afraid. If his family helps him deal with this problem, he may spend less time in restraints.
Mrs. Smith takes a lot of medications since her stroke. Today, she became so upset that she almost pulled out her IV. What should you do?

• Ignore how she is acting, or
• Report Mrs. Smith’s actions to her clinical team
Good job. You should report Mrs. Smith’s actions to her clinical team. They will need to assess Mrs. Smith’s actions to decide what to do next. You should not ignore how Mrs. Smith is acting. You’ll need to keep a close eye on her to make sure she remains safe.
I'm sorry, you did not select the best response. You should report Mrs. Smith's actions to her clinical team. They will need to assess Mrs. Smith's actions to decide what to do next. You should not ignore how Mrs. Smith is acting. You'll need to keep a close eye on her to make sure she remains safe.
Mr. Todd just learned that he may not be able to go home today. At dinner he would not eat. Then he threw his tray on the floor. What should you do?

- Tell him he can go without dinner
- Ask that he be restrained
- Ask him why he is upset

Click on your answer.
Good job. You should speak directly to Mr. Todd and ask him why he is upset. Provide support by spending more time with him.

You can also talk with his family. They may be able to help him come to terms with his concerns.

You should not tell him he can go without dinner. If he has emotional concerns he may need your support.

And you should not ask that he be restrained because, if he feels out of control, restraining him may only scare or upset him further.
I'm sorry, you did not select the best response. You should speak directly to Mr. Todd and ask him why he is upset. Provide support by spending more time with him.

You can also talk with his family. They may be able to help him come to terms with his concerns.

You should not tell him he can go without dinner. If he has emotional concerns he may need your support.

And you should not ask that he be restrained, because if he feels out of control, restraining him may only scare or upset him further.
Restraints may be discontinued based on an assessment by either an RN or Licensed Independent Practitioner. For the patient to have the restraints removed, the patient must show an absence of the behavior that caused the need for restraints. Once the patient’s restraints are discontinued, the order in the computer must be discontinued immediately.
If the patient is restrained, staff must:
• Document the behavior that required the restraints
• Document alternative measures attempted
• Document care given to the patient, such as offering fluids, range of motion, toileting, etc.
• Obtain a physician order within the time frame specified in the restraint policy. A physician order is obtained within one hour of application.
Providing Quality Care

Check patients with non-self-destructive restraints at least every 2 hours:
• Offer fluids every 2 hours if appropriate
• Offer toileting every 2 hours
• Remove the restraint every 2 hours and provide exercise and skin care

Other patient care needs:
• Emotional needs
• Physical needs
• Dignity and well-being

When patients are restrained, their comfort and safety needs must be met. Check patients with non-self-destructive restraints at least every 2 hours (Form: NSG 224 or appropriate electronic documentation per policy) and provide for their comfort.
• Offer fluids every 2 hours if appropriate and with meals,
• Offer toileting every 2 hours, and
• Remove the restraint every 2 hours and provide exercise and skin care.

When caring for a patient in restraints, you should also take into consideration these other patient care needs:
• Emotional needs,
• Physical needs, and
• Dignity and well-being.
Check patients with restraint and seclusion for Violent or Self-Destructive Behavior every 15 minutes. The monitoring (Form NSG 223 or appropriate electronic documentation per policy) must include the patient’s behavior, the type of restraint that is being used, what interventions are being used to help the patient gain control of their behavior, and if the interventions are successful.

A patient in violent self-destructive restraints must have someone in attendance at all times to observe the patient and assure safety.

When caring for a patient in restraint and seclusion for violent or self-destructive behavior, you should also take into consideration these other patient care needs:

- Offer fluids
- Offer toileting every 2 hours
- Remove the restraint every 2 hours and provide exercise and skin care.
When a patient is restrained, immediately notify an RN of signs of distress or any changes in the patient’s condition, such as:

- Difficulty breathing or complaints of shortness of breath
- Change in color of the restrained extremity
- Change in temperature of the restrained extremity
- Decrease in level of consciousness
- Change in patient vital signs, such as
  - Increased heart rate
  - Increased or decreased respiratory rate
  - Elevated blood pressure
Physical restraints should only be used when patients are a danger to themselves or others and when no other method will work. When patients are physically restrained, we must protect their rights and well-being.

- Patients have a right to take part in their own care
- Cover restraints. They may attract attention and are a threat to the patient's privacy.
- Have the patient wear clothing. It helps ensure that the patient's comfort and privacy needs are met.
Thank you for participating in the Restraints Reduction module. You should now be able to:

- Discuss patient care interventions that can serve as alternatives to restraint use
- Describe interventions necessary when caring for a patient in restraints
- Describe findings that should be reported to the patient’s clinical team.