Nebraska Medicine

Education for Pandemic Staff (March, 2020)

Restraints

The criteria for the use of restraints are:

- ✓ Patient's behavior exhibits danger to self and others
- Alternative measures are ineffective.
  - **The decision to use any type of restraint lies with the medical team and the nurse caring for the patient.**

Alternative Measures: As a PCT, you may be asked by the RN to assist with alternative measures which may include: diversion activities, reality orientation, up to bathroom with assistance, call light within reach, camouflage (medical devices), therapeutic communication, bed/chair alarm use, ambulation with assistance, offer food/fluids, warm blankets, etc.

Physical restraints: Any manual method, physical or mechanical device, material or equipment that immobilizes or reduced the ability of the patient to move his or her arms, legs, body or head freely.

- PCTs will need to know how to apply and remove restraints as well as provide basic needs to the patient in physical restraints.

Application: Improper application can result in skin breakdown, loss of circulation, asphyxiation, greater agitation or other related conditions including death.

- Slip knot application with quick release (demonstration in class)
- Never secure any restraint strip to the bedside rails. Secure straps to the portion of the bedframe that mode with the patient to avoid constriction the patient.

Soft restraints:

1. Wrap the limb holder cuff around the patient's wrist [or ankle] so the buckle and connecting strap is on the side opposite of the thumb.
2. Secure the hook and loop fastener. Slide ONE finger (flat) between the cuff and the inside of the patient's wrist to ensure proper fit. The strap must be snug, but not compromise circulation.
3. Feed the wrist strap through the toothless opening of the buckle, and then between the sliding metal bar and the teeth (fig. 4). Insert TWO fingers (flat) under the buckle and pull the strap snug, but not so tight as to restrict circulation (fig. 5).

Locked ("hard") restraints:

1. Only the nurse or security should be applying, locking, or unlocking. Nurse will remain at the bedside with these patients.

Monitoring: In most cases, cares need to be performed on restrained patients every 2 hours. Sometimes, the patient will need every 15 minutes observation by the RN instead.

Cares to provide to these patients:

- Active/passive range of motion
- Change of position
- Hygiene/elimination needs
- Food/fluids intake