

## Lab Day: Ticket to Enter

Student Name: Jessica Runde

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1. What is a restraint? Name the three different types of restraints.

**direct application of physical force to a person with or without his or her permission to restrict his or her freedom of movement. This can be human, mechanical or seclusion.**

2. What are some nursing interventions or least restrictive alternatives to using restraints?

**offer toileting every hour, take for a walk, offer to lie down after meal, assist on a walk, weight alarm to bed or wheelchair, offer to do activity, change caregivers, ask about pain level, offer a blanket, give them something to hold.**

3. When can restraints be used? Are there any contraindications?

**Restraints can be used after all means exhausted and patient is of harm/combatative or aggressive to self or others. Restraints can not be used for convenience of staff.**

4. Who can apply restraints? Who is responsible for assessing the patient after they have been restrained?

**Restraints can be applied by a nurse or provider. The nurse provides the assessment after restraints are used.**

5. What should be assessed after a restraint is utilized and how often should an assessment occur?

**Assessment after use of restraints include skin condition, circulation of hands and feet, emotional well-being, readiness to discontinue, and any medical side effects. Assessment by nurse should be done every 1-2 hours but a one on one staff member should be monitoring at all times.**

6. When should the restraint be discontinued?

**As soon as possible**

7. A provider has provided a restraint order for a patient who is at risk of harm to self and others.

A. What information should be on the order?

a. The name of the ordering **physician** or other licensed practitioner permitted by the state and the **facility** to order **restraint** or **seclusion**;

b. The date and time the order was obtained; and

c. The **emergency safety intervention** ordered, including the length of time for which the **physician** or other licensed practitioner permitted by the state and the **facility** to order **restraint** or **seclusion** authorized its use.

8. A 24-hour restraint order has been written on 8/24/23 at 1353 for patient X. The nurse knows a new order will need to be obtained by **8/25/23 at 1353** if it is to be continued.

9. Can a nurse initiate a restraint order in an emergency? What will need to be done if restraint is initiated in an emergency?

**Yes, but the nurse has to notify the provider immediately and the provider has to do an assessment on the patient within one hour.**

10. What is an intentional tort? Are nurses liable for intentional tort or voluntary acts? Videbeck p. 150

**Tort is an act resulting in harm to client. They can be voluntary or involuntary. Nurses are liable for this.**

11. A patient is having a seizure. What are some nursing actions the nurse should implement? Videbeck p. 260. (Name 3-4)

**If a patient is having a seizure, put them on their side, loosen clothing around neck/head, stay by their side, yell for help to call 911 or assistance, provide privacy, move any nearby furniture, if standing, safely lower to ground and to side, maintain airway, reassurance.**

12. T or F: The nurse should stick something in the patient's mouth to prevent the patient from biting his tongue during a seizure. **FALSE**

13. T or F: The nurse should provide a safe environment and remove items from the area to prevent injury. **TRUE**

14. T or F: The nurse should tie a person down to prevent the patient from moving. **FALSE**

15. T or F: The nurse should keep the person in supine position during a seizure. **FALSE**