

Lab Day: Ticket to Enter

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Date: 08/24/2025

1. What is a restraint? Name the three different types of restraints.
 - A restraint is the direct application of physical force to a person without their consent to restrict freedom or movement.
 - Three types of restraints: physical, chemical, and environmental (seclusion).

2. What are some nursing interventions or least restrictive alternatives to using restraints?
 - Keeping the call light within reach, improving lighting, reducing noise, rounding more often if needed to check in on the client, and even bed or chair alarms can be least restrictive alternatives to using restraints.

3. When can restraints be used? Are there any contraindications?
 - Restraints can be used with a physician's order, with time limits included for the client's age, after using the less restrictive measures first, when the client is at risk of harming themselves or others, or when the least alternative options do not apply to the client or situation.
 - Contradictions could be if the restraint is just used for the staff's convenience or patient discipline, severe trauma where restraints could worsen the injury, suicidal or patients on seizure protocols.

4. Who can apply restraints? Who is responsible for assessing the patient after they have been restrained?
 - RNs and sometimes LPNs, under the supervision of the RN, can apply restraints after a provider orders one.
 - The RN is responsible for assessing the patient after they have been restrained, and the provider who ordered the restraint must reevaluate them.

5. What should be assessed after a restraint is utilized and how often should an assessment occur?
 - Per facility protocol, the client should be assessed in terms of safety, toileting, vital signs, pain, food and fluid, and circulation. This assessment should occur immediately after the restraints are applied and should occur every 15 minutes for behavioral and at least every 2 hours for non-behavioral.

6. When should the restraint be discontinued?

The restraint should be discontinued when the issue that caused the client to be restrained is resolved, when the client is no longer at risk of harming themselves or others, the client has been treated, less restrictive alternatives can be used, or when the assessment is being done, if they are not needed.

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?

- Precipitating events and behavior prior
- Type of restraint and reason for it
- Alternative actions taken to avoid restraints
- Time and date the restraint began
- Duration time for the restraint
- Document all completed assessments
- Signature

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, the nurse can initiate a restraint in an emergency; they must notify the provider immediately after.

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

- Intentional torts result in harm to the client. Things like assault, battery, and false imprisonment.
- Yes, nurses can be liable for intentional tort or voluntary acts.

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

- Ensure safety: remove objects that could cause injury and are nearby
- Protect the airway: position the patient on their side if possible
- Observe and document: note start time, duration, and type of movements made
- Post-seizure assessment: check vitals, assess for injuries

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.

- F

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

- T

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

- F

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

- F

The student will be tested off on multiple skills on their skills day. It is the student's responsibility to review these skills in their Taylor's skills book. Additional information regarding the mental health environmental safety assessment (which is the situational assessment) can be found in Edvance 360. Open lab time is available if the student would like to practice these skills before skills day.