

Lab Day: Ticket to Enter

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1. What is a restraint? Name the three different types of restraints. (pg. 145-146)

A restraint is any method, chemical or physical, that restricts the freedom of movement of an individual for the purpose of managing their behavior.

- a. A human restraint happens when staff members physically control the client and move them to a seclusion room.
- b. A mechanical restraint is devices, like ankle and wrist restraints that are fastened to the bed frame to curtail the client's physical aggression like hitting, kicking, and hair pulling.
- c. Chemical restraints are medication used to restrict the client's movement or interaction with their environment.

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

Check on the patient frequently, encourage family members to visit to provide comfort and supervision, provide a toileting schedule for the patient, and offer food and drinks. As well, manage pain, reposition, reorient confused patients using therapeutic communication, offer diversions like activities or watching television, reduce noise, and provide good lighting.

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

Restraints should be used as a last resort and applied to protect the patient from themselves, staff, and others from physical harm. A doctor's order is required for restraints to be used. Restraints are contraindicated when they are used for staff convenience and as a form of punishment.

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

Restraints are applied by nurses and physicians. The nurse and doctor is responsible for assessing the patient after they have been restrained.

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

A nurse must monitor and document the client's skin condition, blood circulation in hands and feet, emotional well-being, and readiness to discontinue seclusion or restraint. A nurse should assess these every one to two hours and keep close supervision of the client.

6. When should the restraint be discontinued?

A restraint should be discontinued when the patient stops making threats to himself, staff, and others, and the patient can control their behavior.

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?

The order should have the date and time the order was issued, the type of restraint used, the duration of the order, and the circumstances to why the restraint is being used.

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 _____ if it is to be continued.

Answer: 8/25/23 at 13:53

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, a nurse can initiate a restraint order in an emergency. But, the nurse must notify the provider and get the order within an hour.

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

Videbeck p. 148

An intentional tort is a civil wrong that happens when someone intentionally causes harm to another person or their property. For example, assault, battery, and false imprisonment. Yes, nurses are liable for intentional torts or voluntary acts that result in harm to the client.

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

- a. Lowering the patient to the floor and cushioning their head.
- b. Clearing the area of hazards that can hurt the patient during the seizure.
- c. Maintain an open airway for the patient.
- d. Loosen tight clothing on the patient.

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.

Answer: False

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

Answer: True

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

Answer: False

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

Answer: False