Mosby's Nursing Video Skills

Procedural Guideline for Applying Physical Restraints

1. Gather the necessary equipment and supplies.
2. Perform hand hygiene.
3. Provide for the patient's privacy.
4. Use a calm approach and introduce yourself to the patient, including both name and title or role.
5. Verify health care provider orders. Determine if signed consent is necessary.
6. Identify the patient using two identifiers, such as the patient's name and birth date or the patient's name and account number, according to agency policy.
7. Explain to the patient and family the purpose of the restraint.
8. Adjust the bed to the proper height, and lower the rail closest to you. Be sure that the patient is comfortable and in the correct anatomical position.
9. Inspect the area to which the restraint will be applied. Note any tubes or devices. Assess the patient's skin integrity, sensation, circulation and range of motion.
10. Pad the patient's skin and bony prominences that will be covered by the restraint as necessary.
11. Apply the proper size restraint, and follow the manufacturer's instructions.
    A. Belt restraint: Help the patient into a sitting position. Apply the belt over the patient's clothes, hospital gown, or pajamas. Smooth out wrinkles or creases in the patient's clothing. Be sure to place the restraint at the waist, not the chest or the abdomen. Bring the ties through the slots in the belt. Avoid applying the belt too tightly. Help the patient lie down if he or she is in bed. Ask the patient to take a deep breath to ensure there is no restriction to breathing. Attach the restraint securely to a stationary part of the bed frame.
    B. Extremity (ankle or wrist) restraint: Commercially available limb restraints are made of sheepskin or foam padding. Wrap the limb restraint around the patient's wrist or ankle, with the soft part toward the patient's skin, and secure it snugly, but not tightly, by using the Velcro straps. Check to make sure the restraint is not too tight by inserting two fingers under the secured restraint. Secure the strap through the D-ring. Use a quick release tie to secure the restraint to the stationary part of the bed frame.
    C. Mitten restraint: A thumbless mitten device is used to restrain a patient's hands. Place the patient's hand in the mitten, making sure that the Velcro strap(s) are around the patient's wrist, and not the forearm. Check to see that 2 fingers slide easily beneath the restraint.
    D. Elbow restraint: This device is a rigid, padded, fabric splint that immobilizes the elbow joint. It can be removed by the patient. This will help the patient stop picking at an IV line. Place restraint around the patient's arm so the elbow joint rests against the padded area. Keeping the elbow rigid, secure splint with Velcro straps. Check fit of restraint. Hook clip to upper end of sleeve of patient's gown.
12. Reminder: Attach the restraint straps to the stationary part of the bed frame. Be sure the straps are secure. **Do not attach the straps to the side rails.** Restraints can be attached to the frame of a chair or a wheelchair as long as the ties are out of the patient's reach.
13. Secure the restraints with a quick-release tie, a buckle, or an adjustable seat belt–like locking device. **Do not tie the straps of the restraint into a knot.**
14. Double-check to make sure you can insert two fingers under any secured restraint.

15. Remove the restraints at least every 2 hours or according to your agency’s policy, and assess the patient each time. Assess the proper placement of the restraint, including the patient’s skin integrity, pulses, temperature, color, and sensation of the restrained body part. If the patient is violent or noncompliant, remove one restraint at a time, and/or have other staff assist you as you remove the restraints.
16. To ensure the patient's safety, secure the call light or intercom system within reach and lock the wheels on the patient’s bed or chair. Keep the bed in the lowest position, and raise the appropriate number of side rails.
17. Help the patient into a comfortable position, and place toiletries and personal items within reach.
18. Dispose of used supplies and equipment. Leave the patient's room tidy.
19. Remove and dispose of gloves, if used. Perform hand hygiene.
20. Document and report the patient’s response and expected or unexpected outcomes. Document the type of restraint, time applied and reason for restraint according to agency policy.