

THE RESTRAINT DILEMMA: CHALLENGES AND SOLUTIONS

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You don't just slap restraints on someone, just like you don't just marry the first person you meet.

In both scenerios you really need to review the situation and consider all of the options.

Before Applying Restraints	Before Getting Married
Firstly, if restraints are required it is most likely because the patient is agitated. Agitation is such a vague word, encompassing many attributes (restlessness, wandering, aggression, verbally abusive, impulsive...). There needs to be a common definition of agitation among health care providers so that we understand each other.	If you plan on marrying someone, then you must love them. People throw the word 'love' around all of the time – 'I love my car', 'I love the show American Idol'. You and your partner need understand the definition of love. You might feel that it is love, but he might simply feel only lust.

Before Applying Restraints	Before Getting Married
<p>When staff report to each other that the patient is agitated – it is a very vague, broad statement. That can range anywhere from rocking back and forth but still being able to participate in rehab to throwing walkers or IV poles at you when you walk into the room. You need to use a measurement tool in order to quantitatively and qualitatively describe the agitation.</p>	<p>You might say ‘yeah, I want kids’ and he might say ‘yeah, I want kids’ and you think great, we are on the same page. But when you said it you meant 5 kids and he only meant 1. Quantifying helps with communication.</p>
<p>You need to be able to accurately measure the degree of agitation so that you can determine objectively the effectiveness of your interventions. It is not acceptable to say during morning report, ‘oh, he is more/less agitated today’ – because the new staff do not have a reference point to draw from.</p>	<p>You can’t say, ‘well, he’s a lot nicer and better lookin’ than my last boyfriend so I guess I’ll marry him’.</p> <p>You need to evaluate his traits, your relationship, and your mutual goals.</p>

Before Applying Restraints	Before Getting Married
<p>You need to be aware of all the potential causes of agitation (altered labwork, withdrawal, sleep disturbance...) and treat them. Restraints are only a bandaid. They do not fix the problem.</p>	<p>For second time marriages... you can’t just jump into a second marriage without analyzing why the first marriage didn’t work.</p>
<p>You need to be aware of environmental changes that can be utilized to diminish agitation (dim lights, private room....)</p>	<p>Environmental changes...</p> <p>Do we move closer to his work or mine? Who’s décor style do we use to decorate our home – mine or his? Do we spend more time with his family or mine?</p>
<p>You need to be aware of proper communication techniques with the patient, their family and fellow staff.</p>	<p>Many of you have witnessed great examples of how staff have conducted themselves around an agitated patient and many have witnessed blow-outs between staff and patients. The same can be said for communication between partners.</p>

Before Applying Restraints	Before Getting Married
<p>You need to consider chemical restraints as well as physical restraints. Many drugs can be sedating and have a negative effect on rehabilitation. The choice of drug and dosage needs to be followed closely.</p>	<p>Well..... sometimes a little bit of wine is good for a relationship... a lot of it.... Not so good.</p>
<p>If restraints are to be utilized, then a protocol should be followed for application of the restraints, monitoring of the patient while in restraints and continual assessment for when the restraints should be removed.</p>	<p>If one does become engaged, they don't just get married. You apply for a license, maybe do a pre-nup, take a marriage prep course, get joint accounts, do your wills..... It's not just as easy as saying 'I do'.</p>

*** By no means am I trying to imply that being married is like being in restraints!!!!

- So before talking about the application of restraints it is best to start at the beginning and review:**
1. The Definition of Agitation.
 2. Signs and Symptoms of Agitation.
 3. Causes of Agitation.
 4. Measurement of Agitation.
 5. Communication Strategies for Relatives to Employ when with an Agitated Patient.
 6. Environmental Interventions When Dealing with an Agitated Patient.
 7. Interventions When Dealing with an Agitated Patient.
 8. Interventions When Dealing with an Aggressive Patient.
 9. Interventions When Dealing with a Disinhibited Patient, an Impulsive Patient or a Resistant Patient.
 10. Chemical Restraints.

DEFINITION OF AGITATION

It is surprising that clinicians have yet to agree on definitions of agitation and aggression. A variety of terms are used to refer to agitation and aggression and often the two terms are treated as interchangeable.

A review of the literature revealed little consensus regarding which behaviours and/or cognitive states define agitation.

It is therefore difficult to determine the incidence of agitation following brain injury as each study uses a different definition of agitation.

INCIDENCE OF AGITATION AND TBI

2004	→	Kadyan, Mysiw, Bogner et al. Examined 158 persons with TBI in an inpatient rehabilitation setting; 50% of their sample experienced agitation.
1996	→	Wolf, Gleckman, Cifu and Ginsburg Surveyed 162 skilled nursing facilities in Connecticut and found that agitation was present in 45% of BI patients.
1995	→	Bogner and Corrigan Found 42% of TBI patients admitted to rehab exhibited agitative behaviour.
1994	→	Galski, Palasz, et al. Found of 28 persons with brain injury due to stroke, trauma or anoxia in a rehab facility 39% demonstrated some aggressive behaviours within the first week of admission.
1992	→	Brooke, Questad, Patterson and Bashak Found that in 100 CHI patients within an acute care setting, 11% showed marked aggression and 35% showed restlessness.

Some of the variation in the reports of frequency of posttraumatic agitation may be a result of a lack of consensus of the specific definition of the term.

In 1997 Fugate surveyed psychiatrists to define agitation.

Physical Aggression 90%
Explosive Anger 81%
Increased Psychomotor Activity 75%
Impulsivity 70%
Verbal Aggression 69%
Disorganized Thinking 62%
Perceptual Disturbances (illusions, hallucinations) 56%
Reduced Ability to Maintain Attention 56%
Reduced Ability to Shift Attention to New External Stimuli 50%
Emotional Lability 45%
Rapid, Loud Excessive Talking 44%

The unification of the definition of agitation is highly recommended. The ability to compare or replicate studies depends on a common language describing this condition.

Lombard and Zafonte (2005) suggest the following definition for post-traumatic agitation:

‘A state of aggression during post-traumatic amnesia. This state occurs in the absence of other physical, medical, or psychiatric causes. It can be manifested by intermittent or continuous verbal or physical behaviours and can be identified by a score of ≥ 22 on the Agitated Behaviour Scale.’

(incorporates components that can be objectively measured)

In 1996 Sandel and Mysiw reviewed the literature and published this definition of agitation:

- A subtype of delirium unique to TBI
- The survivor is in a state of PTA
- There are excesses of behaviour that include some combination of aggression, akathisia, disinhibition and/or emotional lability.

Of the above definition Lombard and Zafonte say,

‘Akathisia is described as a constant sense of inner restlessness, which may or may not be manifested in motor activity, ranging from bouncing legs and fidgeting hands to pacing behaviours. It is not limited to brain injury (extrapyramidal side effect from neuroleptics). As akathisia does not require the presence of aggression, it is not synonymous with agitation, although it can be a component of it.’

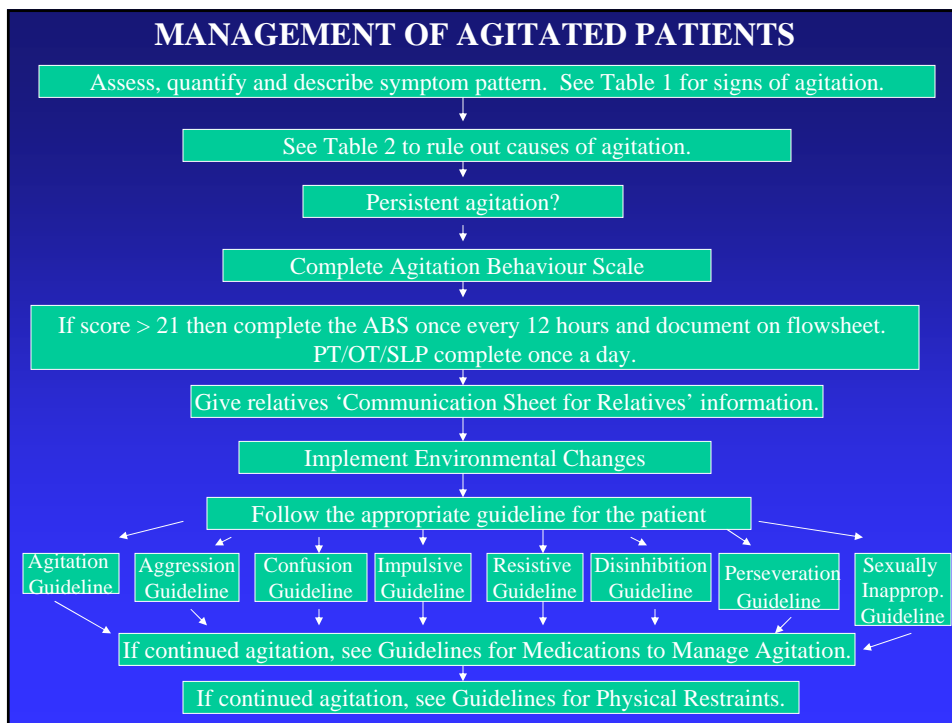


Table 1:

SIGNS AND SYMPTOMS OF AGITATION

- Increased talkativeness
- Pacing or wandering
- Rapid eye movements
- Abusive verbal behaviour (cursing, verbal attacks, ↓ impulse control, yelling, threats)
- Irritability
- Pulling at tubings or dressings
- Trying to get out of bed
- Attentional problems, disorientation
- Restlessness
- Uncooperative
- Strikes, attacks others
- Rapid, loud or excessive talking
- Taking off clothes
- Does not rest or sleep
- Refuses food or drink
- Increased respiration

Table 2: CAUSES OF AGITATION

Electrolyte and Acid Base Disorder	→	Hyponatremia/Hyponatremia Acidosis/Alkalosis
Infection	→	Fever ↑ WBC Septic Shock Bacterial, fungal or viral infection
Pain	→	Incisional pain Headache Contractual pain
Discomfort	→	Need for repositioning Need for urination Feeling of constipation
Sleep Hygiene	→	Sleep disturbances can be deleterious effects.

Organ Failure	→	Hypoxia Hypercarbia Hypotension Uremia Hyperammonemia
Toxic	→	Intoxication Withdrawl Anticonvulsants Corticosteriods Opiates
Nutritional	→	Inconsistent water and food intake, leading to hunger pangs, hypoglycemia, and dehydration Low B12, Folate, Thiamine
Endocrine	→	Hypothyroidism Hypercorticism Hyperparathyroidism Hypopituitarism

Pain is a well recognized cause of agitation. Persons with TBI have many potential pain generators:

- musculoskeletal injuries
- spasticity
- heterotopic bone
- iatrogenic causes, such as lines, trachs, G tubes...

The inability to voice pain complaints may lead to frustration and agitation. Regular monitoring of pain control, either by patient reports or by observation of behaviours is an essential component of agitation management. However, as opioids can be sedating, they should be used judiciously in this population.

STUDY BY FUGATE, 1997: SURVEYED PATTERNS OF MEASURING AGITATION.

157 psychiatrists with a special interest in head injury called.

N = 129 (82% response rate)

RESULTS:

% Who use no scale 81 %

% Who use Agitated Behaviour Scale 6 %

% who use Aggression Scale 3 %

Other 10%

MONITORING AGITATION

When determining a treatment plan for an agitated patient, it is necessary to have a measurement tool to determine objectively the effectiveness of treatment. In 1989, Corrigan described an instrument named the Agitated Behaviour Scale.

- Developed to assess nature and extent of agitation in acute phase.
- Allows for objective feedback about the course of agitation.
- Serial assessments provides tool to assess efficacy of intervention.
- Designed to rate agitation from coma – clearing of PTA
- Ratings can be completed by various professionals.

Studies showed reliability and validity with: Nursing staff
Physical therapists
Occupational therapists

Validated in a population of severe TBI survivors on an inpatient acute TBI rehabilitation service.

Internal consistency high → Cronbach's alpha 0.83 to 0.92

Inter-rater reliability high.

→ correlation coefficient total score of .91

→ coefficients for the factor scores were

.87 for disinhibition

.89 for aggression

.86 for lability

Content validity has been demonstrated

Concurrent validity of the ABS has been established.

The scale has been shown to be predictive of change in cognitive status, thus establishing its predictive validity.

The ABS is useful for comparing the same individual from shift to shift, therapy to therapy, and/or day to day.

AGITATED BEHAVIOUR SCALE

At the end of the observation period indicate if the behaviour described in each item was present and, if so, to what degree: slight, moderate or extreme. The following numerical values are criteria for your ratings.

1 = absent: the behaviour is not present.

2 = present to a slight degree: the behaviour is present but does not prevent the conduct of other, contextually appropriate behaviour (can be redirected easily, or the behaviour does not disrupt appropriate behaviour)

3 = present to a moderate degree: the individual needs to be redirected from an agitated to an appropriate behaviour, but benefits from cueing.

4 = present to an extreme degree: the individual is not able to engage in appropriate behaviour due to the interference of the agitated behaviour, even when redirection is provided.

1. ___ Short attention span, easy distractibility, inability to concentrate.
2. ___ Impulsive, impatient, low tolerance for pain or frustration.
3. ___ Uncooperative, resistant to care, demanding.
4. ___ Violent and/or threatening violence toward people or property.
5. ___ Explosive and/or unpredictable anger.
6. ___ Rocking, rubbing, moaning or other self-stimulating behaviour.
7. ___ Pulling at tubes, restraints, etc.
8. ___ Wandering from treatment areas.
9. ___ Restlessness, pacing, excessive movement.
10. ___ Repetitive behaviours, motor and/or verbal.
11. ___ Rapid, loud or excessive talking.
12. ___ Sudden changes of mood.
13. ___ Easily initiated or excessive crying and/or laughter.
14. ___ Self-abusiveness, physical and/or verbal.

Total Score

- Scores range between 14 and 56
- Scores below 21 → normal
- Scores between 22 – 28 → mild agitation
- Scores between 29 – 35 → moderate agitation
- Scores between 35 – 54 → severe agitation

- When a patient appears agitated a nurse or other health profession does the ABS.
- If score > 21 then a stamp is put in the doctors orders to perform ABS q shift.
- The individual scores and the final score are recorded on a flow sheet.
- It is completed every shift by the RN and by OT/PT/SLP.
- Staff follow daily trends and implement appropriate interventions.
- Once the score < 21 for 3 times, the ABS is discontinued.

COMMUNICATION SHEET FOR RELATIVES

1. Give short, simple bits of information, short instructions, short questions. Use repetition if necessary.
2. Speak to your relative as one adult to another.
3. Keep the pace slow.
4. Be calm and speak softly.
5. Try to tell your relative information rather than asking a lot of questions.
6. Repeat instructions several times.
7. Maintain eye contact and use nonverbal signals: point, touch, or hand them something; demonstrate what you want done.
8. Reinforce orientation information. If you leave the room and return, start again.

9. You don't need to give a lot of details about the injury, but it is usually more reassuring to know what happened than imagine something worse.
10. Watch for signs that your relative has misinterpreted an event or statement.
11. Keep some distance between you. Avoid moving towards him/her suddenly.
12. Don't take it personally if he/she swears at you.
13. Give verbal or visual feedback about performance.
14. Use a calendar to assist comprehension. Use concrete objects to help communicate information.
15. Encourage choices between 2 alternatives, so that initiative and independence are encouraged.
16. Avoid 3 way conversations, this may be too overwhelming.

ENVIRONMENTAL CHANGES

1. Provide a quiet, calm environment.
2. Establish a reality orientation center in the room:
3. Keep noise and activity to a minimum to reduce stimuli that are competing for attention. Try not to have more than 1 person speaking at once.
4. If the behaviour escalates, shut the curtains and doors. Have extra people leave.
5. Try to keep some of the same routines each day to decrease confusion.
6. Limit the number of visitors to 1 or 2 at a time.
7. Dim the lights.
8. Shut off the television to reduce stimuli.
9. If the patient is agitated, he/she may need to be moved to a semi-private or private room.

MANAGEMENT OF THE AGITATED PATIENT

1. Treatment sessions should be flexible.
2. Treatment environment should minimize extraneous stimulation.
3. Be aware of built up tension, stopping the external stimulation before agitation becomes combative.
4. Redirect the patient's attention to less stimulating or frustrating activities until agitation is reduced and a more demanding task can be resumed.
5. Do not attempt to discuss agitation logically or elicit guilt for the behaviour.
6. Provide encouragement and emotional support to decrease their feelings of insecurity and discomfort and to enhance cooperation.
7. Do not leave the patient unsupervised during agitation.

8. Maintain consistency in personnel who interact with patient to promote familiarity.
9. Permit moving about or verbalization during periods of increased agitation.
10. Maintain your own calm and controlled behaviour.
11. Your voice should be soft in volume and low in tone.
12. Limit the number of visitors to 1 – 2 at a time.
13. Shut off the television/radio to reduce stimuli.
14. Draw the curtains in the room.
15. Dim the lights.
16. Move the patient to a private or semi-private room.

17. Observe which interventions calm the patient and incorporate these interventions into the plan of care. ie. If music calms the patient, utilize this when the patient is agitated.
18. Redirect the patient's attention away from the source of agitation.
19. Avoid sudden changes and surprises.
20. If attempts to change the behaviour fail, leave the room for a cooling off period provided the patient is adequately protected from injury.
21. Increase the patient's physical activity with activities such as pacing the hall. This diverts energy.
22. If the patient was agitated, at a time when the patient is calm, talk to him about the inappropriate behaviour and remind him behaviour can be controlled. The patient can be taught to recognize the loss of control and how to intervene with measures such as walking, turning on quiet music or going to a quiet area.

23. Praise all efforts at self-control.
24. If possible, remove IV's, NG's, foleys...
25. Protectors or binders should be considered when clinically feasible.
26. 50% of TBI patients described difficulty sleeping. Careful monitoring of sleep cycles and quality of sleep is necessary. Chart number of hours slept. If the sleep cycle is disrupted and environmental interventions (such as reducing caffeine intake and minimizing naps during the day) are ineffective, Trazodone should be considered. Also monitor druges and drug interactions for side-effects involving sleep disturbance.

MANAGEMENT OF THE AGGRESSIVE PATIENT

1. Demonstrate calm and controlled behaviour.
2. Your voice should be soft in volume and low in tone.
3. Never attempt to deal with a physically aggressive person alone. Extra members who assist should respond in a quick and calm manner with one person taking charge.
4. When approaching a patient do not confront him face to face; approach from the side. Respect personal space. Keep your arms and hands open and below the waist. Avoid cornering the patient (and avoid being cornered).
5. Talk with the patient about any topic; however, vary content of the talk in order to hold their attention. Do not ask them why they are upset as this may agitate them further.

6. Do not make promises that cannot reasonable be kept.
7. Assist/help deal with fears.
8. Reinforce positive aspects of self (previous coping).
9. Explain what is being done and offer reassurance honestly.
10. Encourage venting of feelings rather than acting them out.
11. Consistently limit setting for inappropriate behaviour – provide external controls – quiet room, remove from environment.
12. If verbal aggression, let the patient vent anger and expend energy through physical outlets with staff support.
13. Be consistent.
14. Avoid power struggles.

15. After acting out, re-establish communication for therapeutic rapport.
16. Acknowledge the patient's distress and establish your role and intent to be an ally. Never minimize the seriousness of the situation by joking or making light of the events.
17. Preface communication with the person's name; hearing one's name is an attention getter. Point out specific events in the environment to focus the patient's attention.
18. Give directions for behaviour. Don't expect an emotionally charged person to make complex decisions and adaptive responses. Use specific statements to tell them what to do.
19. Avoid arguing or defending. These increase emotional levels and escalate the situation.
20. Use a softer than normal tone of voice to de-escalate the situation.
21. Avoid threatening body language.
22. Encourage thought. Ask 'how' or 'when' to get the details of his anger.

MANAGEMENT OF THE CONFUSED PATIENT

Confusion results from the inability of patients to recall minute-to-minute, hour-to-hour, or day-to-day events in their life. As a result, they are unable to understand their current situation in light of what has or will occur. Associated problems in diminished attention, new learning and orientation are prevalent. The primary approach is to increase the external structure for the individual, particularly in regards to place, time, and activities.

1. Every patient should have a calendar in their room, a schedule of daily activities posted in the room and on their person (eg. on arm of wheelchair), as well as a list of ADL steps posted in their room.
2. At the beginning of each treatment session, review the therapist's name, day, date, room and hospital. Utilize calendars, clocks, name tags and building signage to re-enforce this information.
3. Maximize consistency within the treatment sessions and between sessions. Establish routines and minimize clutter.
4. Before each activity, explain what is expected, at the patient's level of understanding, to increase awareness.
5. At the end of each session use the patient's schedule to elicit from him or her the next activity in which he/she will engage.

MANAGEMENT OF THE IMPULSIVE PATIENT

Impulsivity is generally a tendency to act without thinking.

1. Review the steps before allowing the patient to start.
2. The patient verbally rehearses outloud the steps needed to complete a task.

MANAGEMENT OF THE RESISTIVE PATIENT

Resistance to treatment may result from agitation and the patient's inability to control his/her situation in any other manner. Active resistance is different from either apathy or lack of awareness of deficits (see below).

1. Do not give a resistant patient a yes/no alternative to participate in a task. Provide them with two or more alternatives from which to pick.
2. Provide positive feedback on good performances, directing the patient's attention away from errors or mistakes.
3. Maintain your own calm and do not re-enforce the negativism by paying additional attention to it.
4. Break tasks down into smaller steps so that they are within the patient's capabilities and do not feel overwhelming.
5. Resistance may have to be 'waited out', don't re-enforce the refusal to participate with shortened therapy sessions.
6. Decrease the complexity of a task or change to an activity that a person is better at to avoid escalation to agitation.

MANAGEMENT OF A PATIENT WITH DISINHIBITION

Disinhibition is an ability to stop oneself from acting on one's thoughts.

1. Initially focus on simple situation that may be easiest for patients to manage.
2. Identify the issue as one of "self-control" and use this as the key word for cueing the patient when they need to be maintaining their emotional control.
3. When delaying gratification is the issue start with short increments between the behaviour and the reward, lengthening the increment as the patient improves.

MANAGEMENT OF THE PERSEVERATIVE PATIENT

Perseveration is a patient's reflective repetition of certain behaviour, either actions or verbalizations. Some patients persevere on a consistent theme, while others repeat external stimuli or their own responses that immediately preceded.

1. When a patient perseverates on a situation/stimulus, subtly divert attention to other cues (pleasant topics, future events) associated with more appropriate behaviour.
2. Control the interaction by providing a highly structured environment and constant cueing to the task at hand.
3. Redirect the patient from the perseverative behaviour to the task at hand.
4. Do not attempt to use logic to discuss away a repetitive theme.

MANAGEMENT OF SEXUALLY INAPPROPRIATE BEHAVIOUR

1. It is important to provide the patient feedback on the inappropriateness of such behaviour and not to reward its presence with negative attention.
2. An emotional response from staff, such as anger or embarrassment, can serve to reinforce this behaviour and should be avoided.
3. Ignoring the behaviour or passing it off with a humorous comment also may reinforce its presence and does not provide the patient with adequate information to understand that the behaviour is inappropriate.
4. The best approach is an immediate, unemotional, straight forward, expression of the inappropriateness of the behaviour. Be certain that the patient knows what behaviour is being referred to.
5. When a patient is demonstrating inappropriate behaviour, it's occurrence should be discussed in panel so that all staff can be consistent in the feedback provided to the patient.

CHEMICAL RESTRAINTS

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Fleminger, S., Greenwood, R.J., & Oliver, DL. (2006). Pharmacological Management for Agitation and Aggression in People with Acquired Brain Injury. *The Cochrane Database of Systematic Reviews*. Vol. 1.

Levy, M., Berson, A., Cook, T., et al. (2005). Treatment of Agitation Following Traumatic Brain Injury: A Review of the Literature. *NeuroRehabilitation* 20, 279 – 306.

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ISSUES WITH CHEMICAL RESTRAINTS

1. When medication has been effective in moderating severe behaviour, staff are often reluctant to reduce or withdraw the medication for fear of a return to dangerous or disruptive levels of responding. The patient may be kept on the drug well beyond the time needed.
2. Most medications have the potential to affect the level of alertness, cognition and initiation of a patient, which may have deleterious effects on rehab.
3. Individuals with an ABI are typically more sensitive to medications and their side effects (such as depression, mania, insomnia, paranoia).
4. Some research has shown that certain medications, such as Haldol, can actually interfere with the healing process after an ABI.

Restraint Use Assessment/Alternatives

(Prior to applying physical restraints, complete this form so that alternatives to restraint were ruled out as being ineffective in ensuring the patient's safety)

Patient Assessment/Indication For Use (Check all that apply):

	Indications for Use		Indications for Use
	Wandering		Risk of/recent falls
	Unable to follow directions		Pulling at tubes, drains, etc.
	Unsteady gait		Other:

Alternative Methods Used/Triaed (Check all that apply):

	Lights on		Diversional activities
	Reorient		Room near station
	2 – 4 siderails up		Physical Therapy
	Sitter present		Alarm bracelets
	Occupational Therapy		Tubing disguised
	Mitts (unsecured)		One to one interaction
	Medications		Relaxation methods
	Verbal re-direction		Other:

PROTOCOL FOR PHYSICAL RESTRAINTS

1. Choose the least restrictive safety device.
2. Notify and involve attending physician in decision to initiate protocol.
3. Complete the Patient/Family Education on Restraint Use form.
4. Monitor: check for proper placement at least q1 hour and more frequently if restless; release restraint and check circulation, sensation, skin integrity, at least q 2 hours; toilet, offer fluids q 2 hours while awake.
5. At least once a shift the RN must assess patient to consider appropriateness of a trial at decreasing use of a safety restraint while providing close monitoring.
6. Need for progression from least restrictive to more restrictive safety restraint or for decreasing the use of restraint as patient improves is determined by RN or MD.
7. If patient remains agitated, consider constant care attendant to sit with patient.
8. Give the constant care attendant 'Guidelines for Caring for an Agitated Patient'.
9. Determine if the patient has automobile and/or private insurance to help pay for constant care or a private room.

Patient/Family Education on Restraint Use

Date: _____

_____ Informed patient/family about concern for patient safety

_____ Discussed alternative strategies that may be utilized to minimize safety risks

_____ Discussed risks of restraint use and non-use

_____ Informed patient and family that staff are open to any feedback or suggestions regarding restraint use

_____ Patient and/or family/responsible party acknowledged understanding of restraint use

With whom did you review this checklist? Patient _____

Family/name(s) _____

Responsible Party/name(s) _____

Comments: _____

Nurse's Signature _____