Exploring the Change in Knowledge Level of Undergraduate Nursing Students at Robert Morris University in Conjunction with a Foundations of Nursing Practice Course

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Abstract

The purpose of the study was to explore the impact of lecture on the knowledge level of undergraduate nursing students regarding restraint use. The specific aim is to determine if second year nursing students’ knowledge of restraint use and guidelines improves after they take a foundations of nursing practice course. Restraint in long term and acute care settings has grown from simple physical restraints such as wrist and chest straps to include unlabeled use of medication, use of threatening language, the positioning of bedrails and tray tables, and isolation. There are many adverse effects associated with restraint use, including damage to bodily function, psychological damage, and death. In the clinical setting, the most serious mistakes are caused by lack of knowledge. If a clinician is unknowledgeable about a practice, he or she is more likely to cause harm to a patient. This quantitative research study featured non-randomized educational testing and was implemented prior to and following a lecture by the course instructor. The lecture contained the content information in which the students were tested. The study was conducted at Robert Morris University, Moon Township, Pennsylvania, in the Spring 2014 semester. The sample consisted of three groups of undergraduate nursing students who were enrolled in course NURS3015, Foundations of Nursing Practice. The course requirements included that students participate in a two-hour lecture on nursing practice, as well as three hours of lab time per week. The educational tests, “pre-test” and “post-test,” were conducted in the lecture part of the class. A sample of 66 students participated by completing a demographic questionnaire that accompanied the pre-test, listening to the narrated PowerPoint presentation, and completing the post-test. The literature addresses many aspects of restraint use, including guidelines, definitions, types, and alternatives, but gaps were found specifically with student nurse knowledge. Lecture may be one way to increase nursing students’ knowledge of restraint use practice in a clinical setting. The findings indicate a significant difference in pre-test and post-test scores. This demonstrates a positive change in knowledge level of the participants after the lecture and warrants future study in this specific area of nursing education.
Introduction
Restraint in long term and acute care settings has grown from simple physical restraints such as wrist and chest straps to include unlabeled use of medication, use of threatening language, the positioning of bedrails and tray tables, and isolation. There are many adverse effects associated with restraint use, including damage to bodily function, psychological damage, and death. Although there are many risks, restraint use is still a prominent problem, due to several barriers, including fear of aggravating coworkers, fear of injury to all parties involved, and understaffed facilities. Even with the barriers to reducing restraint use, there are several ways to avoid using the various types of restraints: increasing staff, positive conversation with patients, and the use of comfort rooms instead of seclusion or restraint. The purpose of this study is to determine if nursing students’ at Robert Morris University knowledge of restraint use improves after education in a nursing foundations course.

Related Literature and Studies
Even in the progressive society of today, restraints are used to control patients who would otherwise be a nuisance for healthcare professionals. While restraint use has declined in the past few years, from as high as 37% in some facilities two decades ago (Karlsson, Bucht, Eriksson & Sandman, 2001), to as low as 5% currently (Agens 2010), it is still a prevalent problem in many long-term care facilities. As of 2001, 25-43% of elderly patients in the long term care environment had been restrained at least once in their lifetime (Karlsson et al, 2001). There are many aspects of control, including types, indications, effects, barriers, and alternatives to use.

Guidelines for Restraint Use
As most nurses are taught as students, according to JCAHO standards, physical restraints are to be reordered every 24 hours, and must be visualized by a nurse every hour. Likewise, in an emergency situation, a nurse may apply restraint, however a physician’s order must be obtained within an hour. These guidelines were established in the OBRA Act of 1987. CMS mandates require that these guidelines are followed by all nursing homes that accept Medicare and Medicaid as financial reimbursement.

Physical Restraint
Restraint use over the years has grown to encompass not only the well-known lap restraints and wrist straps. Physical restraint can be described as anything restricting a person’s liberty, or keeping them from doing something they want to do (Yan et al, 2009). It has also been described as a device or medication used to restrict a patient’s movement (Agens 2010). There are many types of physical restraints, such as straightjackets, posey vests, 4-5-point body restraints and leg and arm straps (Mohr, Petti & Mohr, 2003). More examples of restraints include side rails, lap sashes, and recliner chairs (Moore & Haralambous, 2007).

Chemical Restraint
Another well known type of restraint is chemical restraint. An example of this is the use of antipsychotic drugs to restrain a delirious or demented patient who is combative (Agens, 2010). Whether or not the use of a medication is considered a restraint depends on if that medication is part of a set treatment plan, or is simply used to control the patient’s behavior. Medicines that are used for a normal course of treatment are not considered a restraint, whereas medicines that are used solely for control are (Currier & Allen, 2000). The FDA has currently not approved antipsychotic drugs for this purpose, however they are widely used (Agens 2010). One study documents nurses having reported using a wide variety of sedatives to keep the peace in their geriatric ward (Hantikainen & Kappeli, 2000). This, by definition is chemical restraint.
Currently, the range of chemical restraints not only includes the typical hypnotic-sedative drugs, but also antidepressants, anxiolytics, antipsychotics and mood stabilizers (Braum & Frolik, 2000).

**Atypical Types of Restraint**

The term restraint no longer applies to only physical and chemical restrictions, but can be widened to include verbal violence, provocation, and coercion (Karlsson et al, 2001). One study shows an example of this: nurses used threats of calling the police and having video cameras installed as means of controlling their difficult patients (Hantikainen & Kappeli, 2000). Another example of a psychological tactic used as restraint is seclusion. This involves leaving a patient in a room by themselves (Whaley & Ramirez, 1980). Different types of restraint have different effects on the behavior and overall health of mental health patients. A study on the effects of restraint and coercion recently found that if all possible interventions are attempted, and the patient must be restrained, some forms of restraint are better than others. It was found that involuntary medication was the best choice for restraining difficult or high-risk patients, and that a combination of mechanical restraint and seclusion was the most damaging method of restraint (Georgieva, Mulder & Whittington, 2012).

**Reasons for Restraint Use**

There are many indications for the use of restraints in the health care setting. According to one study, the most common reasons for restraint in long term care facilities were cognitive impairment, inability to complete ADL’s, antipsychotic use, urinary and bowel incontinence, old age, history of falls, and mobility impairment (Karlsson et al, 2001). Another study of geriatric patients cited the four most common reasons for restraint as impaired mobility, mentally challenged patients who wander, physically aggressive, and patients interfering with life support measures (Powell, Mitchell-Pederson, Fingerote & Edmund, 1989). This has not changed much in the past few decades. One study from 1980 showed that the most common reasons for restraint or seclusion were due to issues of violence, out-of-control patients, and risk of injury to other patients or visitors. According to the same study, the most common reasons to take the patient out of restraints were when the patient was “ready,” or when the patient was in control (Whaley & Ramirez, 1980). Another study, from 1997, states that the most common predictors of restraint use in patients were decreased ability to complete ADL’s, advanced age, use of psychotropic medications, history of falls, and mobility problems (Castle, Fogel & Mor, 1997). While the reasons are the same, statutory language today has evolved to keep healthcare facilities from being prosecuted. The most common reason for restraint reported was to prevent therapy disruption (Minnick, Mion, Johnson, Catrambone, & Leipzig, 2007).

**Negative Effects of Restraint Use**

The effects of restraint on patients are extremely serious. One study describes an elderly woman that was physically restrained using wrist straps who harmed herself unnecessarily. In attempting to free herself, she dislocated both of her shoulder joints. Also, being restrained physically increases a patient’s risk of confusion, pressure ulcers, and falls (Agens 2010). Restraint use increases all of these risks along with increased infections, incontinence, cardiac stress, nutritional imbalances, contractures, and a decrease in functional capabilities (Yan, Kwok, Lee & Tang, 2009). Likewise, many restrained patients suffer from dehydration, choking, and circulatory and skin problems (Mohr et al, 2003). One study states that the risk of injury is a worthwhile risk, considering the psychological harm that could result from an elderly patient being restrained unwillingly (Hantikainen & Kappeli, 2000). It falls to the health care providers and the families to determine which is more damaging. Nurses are faced with a difficult ethical
dilemma when they must use restraints. According to one study, nurses must prioritize which of their beliefs is the most important, which can cause turmoil for the nurse involved (Goethals, de Casterle & Gastmans, 2012).

Likewise, while the patients are the most affected, the use of restraints also affects the families and healthcare professionals caring for them. Many nurses report frustration, guilt, and ambivalence when using restraints (Karlsson et al, 2001). The reaction of most family members when faced with a restrained loved one was shock and horror, accompanied by profound sadness (Powell et al, 1989). Another study states that 78% of nurses in one nursing home view restraint as an area of concern (Yan et al, 2009). It was also shown that nurses who had lived with an elderly relative believed that physical restraints made mental disorders such as dementia worse (Yamamoto, Mizuno & Aota, 2012). Clearly, restraint use is not as widely accepted and agreed upon as would be expected.

In addition to bodily damage, physical restraints have many potential psychological effects such as cognitive impairment, depression, fear, regression, and poor self-image (Yan et al, 2009). Some patients became withdrawn and passive, while others became more aggressive under restraint (Powell et al, 1989). Similarly, restraint takes away the independence of patients. For example, a patient who has been sedated unnecessarily is unable to advocate for themselves. They are not able to tell a nurse if they are in pain, if they need to use the restroom, or if they are hungry. Concurrently, restrained patients are unable to get out of harm’s way in case of emergency. This can result in injury from other patients, and hazards such as fire. (Mohr et al, 2003). Likewise, psychotropic drugs, due to their sedative action can cause increased fall risk, memory impairment, hypotension, withdrawal, and agitation. Additionally, even taking a patient off wrongly used psychotropic drugs can be harmful. The doses of many medicines can cause withdrawal symptoms or adverse effects (Braum & Frolik, 2000).

While there are many serious effects of restraint use on patients, the most serious risk is death. Several patients, while restrained using a chest strap slid down in their beds and asphyxiated from the lack of oxygen (Agens, 2010). Another man, a 25 year-old psychiatric patient who was chemically and physically restrained died from positional asphyxia (Morrison & Sadler, 2001). There was also a release of catecholamines, which are hormones released when the body is under stress that prepare a person for a flight or fight response. This release of hormones led to cardiac arrest in addition to the asphyxia. One study lists seven patients who, while being restrained, suffocated. There were three different causes of death involved: mechanical asphyxiation from strangulation, mechanical asphyxia from thoracic compression, and thoracic or abdominal compression with no signs of asphyxia. All seven of the patients had been restrained properly, and over time had either slipped in the restraints or had tried to get out of bed and in doing so, had limited their ability to take air in (Karger, Fracasso & Pfeiffer, 2008). As in the case of the psychiatric patient, catecholamines were released, causing cardiac problems in several of the patients. Another possible cause of death resulting from physical restraint is a thromboembolism. A recent case study documents this exact cause of death. In the study, a patient’s blood clot formed in an extremity while he was physically restrained. Upon being released from his restraints, the blood clot was mobilized and lodged in his lung tissue. Although the restraints were applied properly, and he was monitored according to standard protocol, the thromboembolism resulting from immobilization caused his death (Cecchi, Lazzaro, Catanese, Mandarelli & Ferracuti, 2012).
Positive Effects of Restraint Use

Used therapeutically, psychotropic medications can be extremely helpful in treatment, however, if used simply for discipline or convenience, these medications can have harmful effects (Braum & Frolik, 2000). As most nurses know, restraints can be very useful in preventing interruptions in care and fall related injuries. Common fall related injuries include fractures, concussions, and contusions. Often, the families of patients are willing to restraint a patient to avoid these risks. According to a 2007 study, family members and caretakers of restrained patients understand the emotional and psychological trauma that can be caused, but feel that the risk of injury resulting from a fall or similar situation is potentially more damaging than the trauma caused by restraint use. (Moore & Haralambous, 2007).

Barriers to Reduction of Restraint Use

Even with the long list of risks, restraints are still used frequently in both acute care settings and long-term care settings. There are many other barriers to reducing the use of restraints. These included not only physical barriers, such as risk for injury, environmental clutter and lack of alternative equipment, but also social barriers, such as lack of education and understaffed facilities (Moore & Haaralambous, 2007). A 2000 study found that many nurses would use restraints less; however the risk of not being accepted by colleagues caused them to follow a more popular course of treatment - restraining a patient at risk (Hantikainen & Kappeli, 2000). Likewise, restrained patients were more likely to be viewed as dangerous, difficult, and unsafe by healthcare professionals (Powell et al, 1989).

Alternatives to Restraint

Even with the barriers to reduction, some hospitals and facilities are striving to lessen restraint use. One study describes a facility that set goals to completely eliminate restraints and seclusion. They did this through the creation of comfort rooms, a safe alcove where upset or violent patients could go voluntarily to release frustration or anxiety. This differs from seclusion tactics in that patients have a choice to use the room. Since the formation of the comfort rooms, there has been no seclusion or restraint at that facility (Sivak, 2012).

Another study discusses ways to reduce the use of coercion as a restraint. The methods for attaining this included reproaching an uncooperative patient at a later time, changing personnel, allowing patients to wander under supervision, limiting choices by conscious language use and redirecting negative conversations into positive ones. The study found that these methods have the potential to help eradicate restraint and coercion use, however they require an increase in staff, and willingness of all staff to cooperate (Gjerberg, Hem, Forde & Pederson, 2013). An increase in state and federal mandates can decrease the use of physical restraint. According to the article, increasing the minimum quality of standards increases the quality of care in nursing homes. (Bowblis & Lucas, 2012)

“Gap in the Literature”

While there are many aspects of restraint use in the clinical setting that have been researched and explained, there is very little research about restraint use as it is understood by nursing students in the academic setting.

Statement of the Problem

According to the Institutes of Medicine, medical errors are the third leading cause of death in the United States (Kohn, Corrigan & Donaldson, 2000). In the clinical setting, the most serious mistakes are caused by ignorance. If a clinician is unknowledgeable about a practice,
they are more likely to cause harm to a patient. Therefore, by increasing the knowledge of nurses at an early level, medical errors due to ignorance of restraint use guidelines can be prevented. For the function of this research, this concept will be applied to knowledge of restraint use. The purpose of this research is to show that second year nursing students’ knowledge of restraint use and guidelines greatly improves after they take a nursing foundations course.

Methods
Setting and Sample
The study was conducted as part of a required thesis for completion of the Honors Program curriculum at Robert Morris University. Robert Morris University is located in Moon Township, Pennsylvania and offers both undergraduate and graduate nursing programs. This study was conducted in the Spring 2014 semester, and focuses on the sophomore level nursing students. These students are required to take NURS3015, Foundations of Nursing Practice during their spring semester. The class consists of three hours of lab class per week, as well as three hours of didactic lecture. The study took place during a regularly scheduled lecture for the class, so all students had an equal opportunity to participate in the study. In order to accommodate the large number of students enrolled in the class, there are three sections offered. All three sections were included in the study, and were administered the same consent form, tests, and PowerPoint presentation.

Design
Once the students were explained the procedure, they were issued a consent form which was signed both by the professor of the class and the student (See Appendix C). The students were then asked to complete a test with eight questions about restraint use. This test also had survey questions related to the demographics of the group (See Appendix A). After all the students had completed the test, they were presented with class material on restraint use, guidelines, adverse effects, and alternatives (See Appendix D). This information was presented in a PowerPoint by the professor. Next, the students were asked to complete another eight question test. This test contained the same questions as the first test, but did not contain the same demographic survey (See Appendix B). In order to match the students’ pre and post tests, each pre-test was numbered prior to its distribution. The students were asked to remember this number, and to write it on their post-test. This allowed the students to remain anonymous, but the data to be accurately analyzed. Although seventy-two tests were administered, only sixty-six were analyzed. Some of the students forgot to complete both pages of the tests, which would have given them an inaccurate test score. Thus, these tests were not included in the study.

Demographics
The sample population consisted of students enrolled in the NURS3015, Foundations of Nursing Practice course in the Spring 2014 semester. According to a demographic survey (See Appendix A), administered with the pre-test, the students were 18.2% males and 71.2% females, and 10.6% of those surveyed did not respond. Most of the students reported their age to be between the ages of 19 and 21, with only nine of the 66 students falling outside of this range. 87.9% of the students reported their grade level as sophomore, 1.5% of the students described themselves as non-traditional, and 10.6% of the students refused to complete the survey. Additionally, the students were asked to report if they had experience in the healthcare setting prior to enrolling in the course; 25.8% reported having had experience, 51.5% reported having had no prior experience, and 22.7% did not respond to the question.
Results

After analysis of a paired $t$-Test, the P-value was determined to be $1.99 \times 10^{-17}$. In the context of the test, this value was compared to an alpha value of 0.01. In comparing these values, it is noted that the p-value is less than alpha, which demonstrates the results to be statistically significant. As presented in Table 1, there was also a positive change in both the mean and standard of the pre-test and post-test scores. This reinforces the findings of increased performance on the post-test compared to the pre-test.

Table 1

Results of Paired Sample $t$-Test on Pre-Test and Post-Test Scores

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>P-Value</th>
<th>$\alpha$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Test</td>
<td>3.261538</td>
<td>1.057</td>
<td>1.99E-17</td>
<td>0.01</td>
</tr>
<tr>
<td>Post-Test</td>
<td>5.353846</td>
<td>1.268959</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 2 demonstrates the change in descriptive statistics between the pre-test and post-test. As depicted, the minimum, median, and maximum scores for the post-test were greater than those of the pre-test.

Table 2

Descriptive Statistics of Test Scores

Table 3 demonstrates the distribution of differences between the paired pre and post-tests. The differences of all participants (n=66) were analyzed and found to have a left-skewed bell shaped curve, with most students’ scores increasing by 2-3 points.
Conclusions

Several findings point to the conclusion that the students’ knowledge as a group increased with the presentation of the lecture. This one-time measurement provides preliminary data that shows student’s knowledge of restraint use increased with lecture. While the results are statistically significant, they have not yet been applied in the clinical setting. It is unclear at this point if the students will retain the information at a later date. It is also unclear if the information will be applied to clinical scenarios appropriately. The findings of this study provide concrete data that the students’ knowledge level increased during the course, as was demonstrated by statistical analysis.

Scope and Limitations of the Study

This study was limited by the small population size (n=66). Since the classes being studied contain a small number of students, and the demographics of the students are similar, it is difficult to generalize the findings to a larger student nurse population. Another limitation to this study was the frequency of the tests. Since the study was only conducted during one semester, and was not repeated, there is no additional data to compare. Had the research been conducted among consecutive semesters, or repeated in second-degree students as well as traditional undergraduate students, the findings would be more easily translated to a larger population. Another limitation of the study was the format of the validity tools, or the pre and post-tests. The tests consisted of multiple choice questions. While these types of questions are able to be graded objectively, and reflect knowledge of the subject at hand, they are not a widely accepted validity tool. One potential issue with this is that students could have guessed on answers, or eliminated certain responses to get the correct answer, which would not reflect appropriate knowledge level. The final limitation of this study is the lack of supportive literature. As discussed, there is significant research on restraint use, effects, guidelines, and alternatives. However, research on student nurse knowledge level is very difficult to find, and this type of research related to restraint use is virtually absent.
Implications for Further Research and Practice

This study demonstrated statistical significance that using lecture to present information to students increased knowledge level. In the case of restraint use, providing information on the topic in a didactic setting will improve clinical outcomes for both the student nurses and their patients. In demonstrating an understanding of the theory behind restraint guidelines, the students are able to accurately differentiate safe practices in the clinical setting. Likewise, students are able to correctly assess and care for a patient requiring restraints more completely when they have a previous knowledge of best practice. Additionally, discussion of restraint use exposes students to the ethics of the nursing profession. For many nursing students, the topic of ethics has not been incorporated at the sophomore level, so analyzing restraint use stimulates critical thinking and allows them to care for the patient as a whole being. Nursing educators should continue to explore this topic, as it will ultimately have a positive effect on nursing interventions and outcomes.
References


Appendix A
Sample Pre-Test

Gender: Male Female
Age: ______
Class Level: Freshman Sophomore Junior Senior Non-Traditional
Previous Experience in Healthcare Setting: Yes No

1. The nurse has determined that a confused older adult client who keeps pulling out the intravenous line and indwelling catheter is in need of soft wrist restraints. Which of the following should the nurse include in this client’s plan of care?
A. Obtain a p.r.n. restraint order
B. Assess the placement of the wrist restraints, skin, and circulation every hour and document
C. Place the client in a supine position after applying the restraints and secure the wrist restraints to the side rails when the client is in bed
D. Remove the restraints once every four hours to perform activities of daily living

2. The nurse assesses a cyanotic appearance and cool temperature in the hand of a client wearing a wrist restraint. The client complains of numbness and tingling in the hand. What should the nurse do first?
A. Remove the restraint and call the physician
B. reapply the restraint in a different area of the wrist
C. Leave the restraint in place and notify the physician
D. Loosen the restraint and exercise the limb

3. A nurse applies restraints to a client who is combative. The nurse informs the physician and knows that the physician must see the client within what time frame for evaluation?
A. 1 Hour
B. 4 Hours
C. 12 Hours
D. 24 Hours

4. A client is admitted with a diagnosis of dementia. He attempts several times to pull out his nasogastric tube. An order for cloth wrist restraints is received by the nurse. Which of the following actions by the nurse is MOST appropriate?
A. Attach the ties of the restraints to the bed frame.
B. Perform range of motion to the restrained extremities once a shift.
C. Remove the restraints when the client is up in a wheelchair.
D. Explain the need for restraints only to the family because the client is confused.

5. The nurse receives a change-of-shift report for a 76-year-old client who had a total hip replacement. The client is not oriented to time, place, or person and is attempting to get out of bed and pull out an I.V. line that's supplying hydration and antibiotics. The client has a vest restraint and bilateral soft wrist restraints. Which action by the nurse would be appropriate?
Select all that apply:
A. Assess and document the behavior that requires continued use of restraints.
B. Tie the restraints in quick-release knots.
C. Tie the restraints to the side rails of the bed.
D. Ask the client if he needs to go to the bathroom and provide range-of-motion exercises every 2 hours.
E. Position the vest restraints so that the straps are crossed in the back.

6. Which of the following are appropriate alternatives to restraint use? (Select all that apply)
A. Low beds
B. Putting all 4 side rails up
C. Using a bed alarm
D. Using patient sitters
E. Using sedative medications

7. Emergency restraints or seclusion may be implemented without a physician’s order under which of the following conditions?
A. When a written order will be obtained from the primary physician within 24 hours
B. Never
C. If a voluntary client wants to leave against medical advice
D. When a minor child is out of control

8. Which of the following is true about side rail restraint use?
A. They are not commonly used as a restraint
B. The patient does not need to be able to exit the bed
C. All four side rails up is considered a restraint
D. The bed should be kept in a high position
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Appendix C

Sample Consent Form
Robert Morris University

**Title of Project:** Exploring the Change in Knowledge Level of Undergraduate Nursing Students at Robert Morris University in Conjunction with a Nursing Foundations Course

**Principal Investigator:** Anne Kandray
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  330-774-0144

**Advisor:** Dr. Janene Szpak
School of Nursing and Health Sciences
(412) 397-5246; szpak@rmu.edu

1. **Purpose of the Study:** The purpose of this study is to measure if nursing students’ at Robert Morris University knowledge of restraint use increases after education in a nursing foundations course.

2. **Procedures to be followed:** You will be asked to answer questions on a quiz. Then, the lecture will be presented. After the lecture, you will be asked to answer questions on another quiz.

3. **Statement of Confidentiality:** Your participation in this research is confidential. In the event of a publication or presentation resulting from the research, no personally identifiable information will be shared. On the quizzes, you will be assigned a number. This will not be traceable to any student, but will be used solely to match the pre and post tests.

4. **Right to Ask Questions:** Please contact Anne Kandray at (330) 774-0144 with questions or concerns about this study.

5. **Right to Ask Questions Regarding Human Subject Research:** Please contact the Robert Morris University Institutional Review Board at (412) 397-6227 or irb@rmu.edu

6. **Voluntary Participation:** Your decision to be in this research is voluntary. You can stop at any time. You do not have to answer any questions you do not want to answer.

You must be 18 years of age or older to take part in this research study. If you agree to take part in this research study and the information outlined above, please sign your name and indicate the date below.

______________________________________________  ____________________
Participant Signature  Date

______________________________________________  ____________________
Person Obtaining Consent  Date

Appendix D
Information Presented to Class on Restraint Use

- Restraints
- Device that limits movement or immobilizes patient
- Physical- Mechanical – device
- Chemical- antianxiety meds and sedatives
- Serious complications –
  - pressure ulcers
  - respiratory distress
  - circulatory issues
  - incontinence
  - death
- Restraints  p. 384-386
- Physician ordered – after assessment
  - Type and location of restraint, duration, circumstances (NOT prn)
- Clinically justified – patient or staff safety
- See agency policies – usually 24 hours
- Seek Alternatives
  - Nurse rounds – toilet, food, drinks
  - Involve family/sitters
  - Diversions - camouflage
  - Low beds, floor mats, bed alarms
  - Restraint Alternatives
- More frequent observations
- Involve family
- Frequent reorientation and rounding
- Familiar belongings
- Busy activities
- Food/beverages
- Comfort care
- Evaluate meds/health condition
- Restraint Alternatives
- Side rails
- Most commonly used physical restraint
- Can have top 2 up, all 4 is a restraint
- Patient needs to be able to exit
- If patient is sedated – up for protection to prevent falls – not restraint
- Bed in low position
- What can be delegated?
- Hourly rounds
- Placing restraints – not assessments
- Notifying nurse if changes
- Provision of ROM, nutrition, hygiene, skin care, and toileting