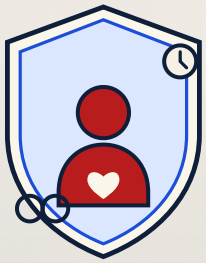
NCLEX • MENTAL HEALTH • SAFETY / LEGAL-ETHICAL

2026 TEST PLAN • HIGH-YIELD

Restraints & Seclusion.

Last-resort safety interventions with strict legal, ethical, and clinical boundaries. Master the **least-restrictive rule**, order time-limits, and the nursing priorities that keep the patient — and your license — safe.

LAST RESORT ONLY | LEAST RESTRICTIVE FIRST | IMMINENT DANGER = TRIGGER | 1:1 OBSERVATION



01 / OVERVIEW

Definition & Why It Matters

DEFINE

- **Restraint** — any manual method, physical/mechanical device, or medication (chemical) that restricts a patient's freedom of movement, physical activity, or normal access to their body.
- **Seclusion** — the involuntary confinement of a patient alone in a locked room from which they are physically prevented from leaving.
- **Rule of Use:** Used ONLY when less-restrictive measures have failed *and* the patient is an **imminent danger** to self or others. Not for staff convenience, punishment, or staffing shortages.

02 / PROCESS

Decision Pathway

PATHO

1. **Verbal de-escalation** — calm tone, low stimuli, offer choices. ALWAYS first.
2. **Environmental measures** — reduce stimuli, redirect, 1:1 presence.
3. **PRN medication** offered voluntarily (oral preferred).
4. **Seclusion** — less restrictive than physical restraint.

03 / INDICATIONS

When to Use (& Never)

S/S

✓ APPROPRIATE

- ✓ Imminent risk of harm to **self**
- ✓ Imminent risk of harm to **others**
- ✓ Severe aggression unresponsive to de-escalation
- ✓ Disruption of essential medical treatment

NEVER

- ✗ Staff convenience / coercion
- ✗ Punishment or retaliation
- ✗ Substitute for adequate staffing
- ✗ **PRN** (as-needed) standing orders

RED FLAG esCALATION: clenched fists, pacing, verbal threats, throwing objects, invading personal space — act on early cues before physical aggression.

5 **RESTRAINTS — LAST RESORT.** Obtain provider order + face-to-face eval within 1 hr.

04 / PRIORITY ACTIONS

Nursing Interventions — ABCs & Safety

DO

ASSESS (Q 15 MIN)
- → Continuous **1:1** observation during violent restraint
- → Circulation, skin integrity, ROM
- → Vital signs per facility protocol
- → Mental status & readiness for release

PROVIDE (Q 2 H)
- → Food & fluids
- → Toileting / hygiene
- → ROM exercises — **one limb at a time**
- → Repositioning for comfort

SAFE APPLICATION
- → **Quick-release** knots only — never square knots
- → Tie to **bed frame**, never side rails
- → Two fingers fit under the restraint
- → Padded, correct-size restraint

DOCUMENT Q 15 MIN
- → Behavior & justification
- → Less-restrictive attempts that failed
- → VS, circulation, hydration, ROM
- → Continued need or release plan

ORDER TIME-LIMITS	< 9 YR	9-17 YR	ADULT ≥18
	1 hr	2 hr	4 hr

05 / CHEMICAL RESTRAINT

Pharmacology

MEDS

Haloperidol
HALDOL · TYPICAL ANTIPSYCHOTIC

MOA: Blocks dopamine (D_2) receptors in the CNS to reduce agitation and psychosis.

Side effects: EPS, NMS (high fever, muscle rigidity, altered mental status), QT prolongation, tardive dyskinesia.

Nursing: Monitor ECG & temp, AIMS assessment, hold if fever or rigidity.

Lorazepam
ATIVAN · BENZODIAZEPINE

MOA: Enhances GABA inhibition → sedation, anxiolysis, anticonvulsant.

Side effects: Respiratory depression, hypotension, over-sedation, paradoxical agitation in elderly.

Nursing: Monitor RR & SpO_2, keep **flumazenil** (reversal) available, fall precautions.

Diphenhydramine
BENADRYL · H_1 ANTIHISTAMINE

MOA: Blocks histamine H_1 & cholinergic receptors → sedation, counters EPS.

Side effects: Anticholinergic — dry mouth, blurred vision, urinary retention, confusion in elderly.

Nursing: Fall precautions; avoid in older adults when possible (Beers list).

CLASSIC EMERGENCY IM COCKTAIL

"B-52" = Benadryl 50 mg + Haldol 5 mg + Ativan 2 mg IM

06 / NCLEX TRAPS

Test Traps ⚠

TRAPS

- **PRN restraint orders are NEVER allowed.** A new order is required for each episode.
- **Verbal de-escalation** is the FIRST priority action — not medication, not restraint.
- **Seclusion < Restraint** on the restrictiveness scale — choose seclusion first if it works.
- Patient retains **civil rights**: visitors, communication, informed consent for treatment.
- **Face-to-face provider eval within 1 hour** of initiation — telephone orders alone are not enough.
- Continuous **1:1 observation** required for violent/self-destructive restraint — not q15 checks alone.

07 / TEACHING

Patient Education

TEACH

EXPLAIN PURPOSE
Use simple, calm language. Reassure this is a safety measure, not punishment.

RELEASE CRITERIA
Clearly state the behaviors required for release (e.g., calm voice, safe posture).

OFFER CHOICES
Restore autonomy where possible — food, position, lighting.

RIGHTS REMINDER
Patient retains right to refuse non-emergency care and to contact family.

DEBRIEFING
After release, debrief patient AND staff — review triggers & coping.

FAMILY INVOLVEMENT
Teach family de-escalation & aftercare; involve in safety planning.

08 / MEMORY

Memory Boosters 🧠

RECALL

"RESTRAIN" — the 8 rules

- **R** Release knots quickly (quick-release only)
- **E** Every 15 min — assess & document
- **S** Skin & circulation checks
- **T** Two fingers fit under the restraint
- **R** Remove ASAP; reassess need
- **A** Always get order + face-to-face eval
- **I** 1:1 continuous observation
- **N** No PRN, No punishment

"1 – 2 – 4" Time Rule

- **1** **1 hr** — children under 9
- **2** **2 hr** — ages 9 to 17
- **4** **4 hr** — adults 18 and older
- ⏱ **1 hr** — max to face-to-face MD eval

B-52 Cocktail

- **B** Benadryl 50 mg
- **5** Haldol 5 mg
- **2** Ativan 2 mg IM

L *"Least restrictive, Longest break, Last resort."*
— The three L's of safe restraint practice.