Client ID, falls, restraints and emergencies

Two identifiers and the time-out, falls and seizures, restraint rules, START triage, fire and exposures

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1 AT A GLANCE

Two identifiers, never the room number. Meet needs before clients get up alone. Restraints: alternatives first. Fire: rescue first.

Does it count as an identifier?

Detail	Identifier?
Full name; date of birth; hospital ID number	Yes
★ **Room or bed number**	**Never**: clients move
Diagnosis	No: clients can share one

How: At least two identifiers before medications, treatments, blood or specimens. Ask the client to state their name and birth date, then check the wristband. Scanning adds a layer; it doesn't replace them.

Bands, orders and near misses

- ★ **Band missing or wrong:** pause nonurgent care, use your approved two-identifier process, and replace the band. Don't delay emergency care for it.
- Order unclear or unsafe: hold it and clarify with the prescriber. Never change it yourself.
- A near miss is still reported, by incident report, not in the chart.
- An error reached the client: check the client first, then tell the provider.

Before procedures: the Universal Protocol

Core step	What happens
Preprocedure verification	Consent for the right procedure, naming the site and side; client and site identified, with the client stating them; two team members check the images
Site marking, when it applies	By the provider doing the procedure or a privileged team member, with the client taking part; still visible after prep and draping. No mark possible: a special wristband
★ **Time-out**	Immediately before it starts. **Every active team member**, including the scrub person or technician, agrees out loud: client, procedure, site and side, consent

Speak up: Unless clinically necessary, no sedation until consent, marking and identification are done. Anyone who sees a problem speaks up, and the procedure waits until it's resolved.

Fall risk and prevention

- Assess on admission, after a fall or a change in condition or medicines, and as often as policy requires.
- Higher risk: a recent fall, new confusion, frequent toileting, sedating or blood pressure drugs, tubing, dizziness on standing.
- Pain medicines, antipsychotics, anticonvulsants and benzodiazepines are examples. Review each client's own medicines.
- Every client: orient, call light and belongings in reach, bed low and locked, non-slip footwear, night lights, clear floors.
- ★ **Hourly rounding:** pain, toileting, position. Needs are met before the client gets up alone.
- Side rails: a restraint or not depends on whether they restrict that client's voluntary movement, not purpose alone.

Seizure precautions

- Oxygen and suction at the bedside; bed in its lowest position; padded rails if policy says.
- During: if not in bed, ease to the floor. Protect the head. Turn them on their side if you can. Move furniture away, loosen tight clothing, remove glasses.
- ★ **Never put anything in the mouth, and never hold the client down.**
- Time it, and watch the eyes, consciousness, breathing, color and any incontinence.
- ★ **5 minutes or more**, or repeated seizures without recovery between, is status epilepticus: emergency care starts at 5 minutes, sometimes sooner.
- After: on the side so secretions drain; check the airway, vital signs and neuro status.

Is it a restraint?

Device or action	Restraint?
Rails raised so a client can't get out of bed by choice	Yes
★ **A sedative only to keep a client quiet**	Yes: chemical
A tray locked onto a chair; a mitt pinned to the bed	Yes
A cast, dressing or protective helmet	No
Briefly holding still for a routine exam or test	No
A self-release seat belt the client can undo	No

Seclusion: Involuntary confinement alone, kept from leaving. Only for violent or self-destructive behavior that threatens immediate safety.

Restraint rules

- Only for immediate physical safety, never convenience or punishment. Alternatives first; the least restrictive type.
- ★ An order from a licensed practitioner responsible for the client: **never standing, never as needed**.
- Violent behavior: up to 4 hours for adults, 2 hours ages 9 to 17, 1 hour under 9; renewable up to 24 hours, then the practitioner sees the client.
- Seen face to face within an hour by a practitioner, or a trained RN or physician assistant who promptly consults the practitioner.
- ★ **Ends as soon as it's safe**, not when the order runs out.

Educational use only. Not a substitute for clinical judgment, your facility's policy or the provider's orders. Where practice varies, follow facility policy and state law. No patient information.

Client ID, falls, restraints and emergencies

1 AT A GLANCE, CONTINUED

Monitoring and alternatives

- Checks at intervals your policy sets: commonly continuous, or at least every 15 minutes. Release every 1 to 2 hours for movement and a skin check; meet fluids, food and toileting.
- ★ Tie it to the **bed frame, not the side rail**, with a quick-release knot.
- Document the behavior, the restraint, the alternatives tried, time and site, teaching, the response and why it's still needed.
- Alternatives: routine and toileting, pain control, a medicine review, distraction, a supervised area, alarms, a sitter or family.

Fire and hazardous materials

- ★ **RACE:** Rescue, Activate the alarm, Confine (close doors), Extinguish or evacuate. Rescue comes first.
- PASS: Pull the pin, Aim low at the base, Squeeze, Sweep side to side.
- Unfamiliar chemical spill: read its safety data sheet first.
- Biohazard waste: closable, leak-proof, labeled containers. Sharps containers are replaced before they overfill.

START triage

Color	Means	Who
Green	Minor	Can walk: the walking wounded
Yellow	Delayed	Serious, but stable enough to wait several hours
★ **Red**	Immediate	Breathing over 30 a minute, no radial pulse or slow capillary refill, or can't follow simple commands
Black	Expectant	Unlikely to survive with the care available: comfort care

Goal: The most good for the most people. Triage is repeated as condition changes: a yellow can become red.

Exposures

Agent	What to do
Inhaled anthrax; botulism	Standard precautions
Smallpox	Airborne and contact, until every scab has crusted and fallen off
Pneumonic plague	Droplet, until 48 hours of effective antibiotics
Carbon monoxide	Pulse oximetry can look normal. Remove from the source; high-flow oxygen by mask
Radiation	Time, distance, shielding. Clothing off removes up to 90%

2 PRIORITY AND SAFETY CALLS

★ Consent says left knee, the mark is on the right: **speak up, and the procedure waits** until the team resolves it. Don't fix the mark yourself.

★ Client on the floor: **stay, call for help, and assess for injury before moving them**. Then notify the provider, document, and complete an incident report.

Frayed cord on a pump that still works: replace it, take it out of service, label it, and report it.

Confused client pulling at his IV: bring in a sitter or family and give his hands something to do, before asking for a restraint order.

★ Smoke and flames in a wastebasket: **get the client out of the room first**.

3 EXAM ANCHORS

1. ID traps: the room number, a yes-or-no name question, trusting a scan or a surgeon over a mismatch.
2. In a seizure, protect, time and observe. Never restrain, and nothing in the mouth.
3. Restraint traps: an as-needed order, tying to the side rail, a sedative to keep a client quiet, and keeping it on until the order ends.
4. START: green walks, yellow waits, red needs help now, black is expectant.
5. Disaster traps: fighting a fire before rescuing, discharging a client on a vasopressor drip, and decontaminating before treating a blocked airway.

4 SELF-QUIZ

1. Use at least _____ identifiers before medications or treatments.
2. Seizure activity of _____ minutes or more is status epilepticus.
3. Restraint orders are never standing orders, and never _____.
4. Tie a restraint to the bed _____, not the side rail.
5. Release a restraint every 1 to _____ hours for movement and a skin check.
6. In START, a breathing rate over _____ a minute means immediate care.
7. PASS: pull the pin, aim _____, squeeze, sweep.

ANSWER KEY 1. two · 2. 5 · 3. as needed · 4. frame · 5. 2 · 6. 30 · 7. low

5 SOURCES

1. The Joint Commission, National Performance Goals: right patient. jointcommission.org/en-us/standards/national-performanc…
2. Open RN, Nursing Fundamentals 2e, 5.6 Preventing Falls. wtcs.pressbooks.pub/nursingfundamentals/chapter/5-6-pre…
3. 42 CFR 482.13, Patient's rights: restraint or seclusion. ecfr.gov/current/title-42/chapter-IV/subchap…
4. Open RN, Nursing Fundamentals 2e, 5.7 Restraints. wtcs.pressbooks.pub/nursingfundamentals/chapter/5-7-res…
5. HHS REMM, START Adult Triage Algorithm. remm.hhs.gov/startalgotext.htm
6. CDC/HICPAC, Isolation Precautions Guideline, Appendix A. cdc.gov/infection-control/hcp/isolation-pre…

Built from RN PocketPal course lessons: Client identification and error prevention (c02-l03); Preventing falls and injuries (c02-l04); Restraints and their alternatives (c02-l05); Emergency preparedness and hazardous materials (c02-l07). Every line on this sheet comes from those lesson scripts.

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