UC DAVIS HEALTH | Center for Professional Practice of Nursing

Restraint Safety for Therapists and Technologists DAHS-NSCRSTT11

Name:	PPS#:
Unit:	Title:

PERFORMANCE CRITERIA - Unless otherwise specified all skills will be demonstrated in accordance with the appropriate UCDMC Policy and Procedure.

Method of Instruction		Preceptor Verification of Skill: Method of Evaluation	
CP=Clinical Practice	**P**=Policy/ Procedure Review	**N/A**=Not applicable to specific patient care area	**RD**=Return Demonstration
D=Demonstration	**SP**=Study Packet	**O**=Observation (in clinical setting)	**T**=Written Test
E=Education Session	**REF**=Reference Information only-*Not assigned in UCL*	**OT**=Online Test	**V**=Verbal
OM=Online Module			

These skills will be considered complete when all below performance criteria are completed and have been scanned and emailed to: hs-cppn@ucdavis.edu

	Method of Instruction:	Date	Initials of Preceptor	Method of Evaluation:
References: 1. UC Davis Health Policy 4069; Restraints 2. UC Davis Health Policy 4070; Use of Restraints Protocol for Specific Patient Conditions 3. UC Davis Health, Radiology Department Policy 210; Use of Restraints in the Department of Radiology				
Completion of Online Module Restraint Safety for Therapists and Technologists #DAHS-NGNRSTT11	**OM**			
Attach and release a safety clip.	**OM/D**			**RD**
Remove and reapply a mitt to a simulated patient.	**OM/D**			**RD**
Remove and reapply a limb restraint to a simulated patient.	**OM/D**			**RD**
Remove and reapply a belt restraint device to a simulated patient.	**OM/D**			**RD**
Demonstrate how to check for restraint interference with respiration.	**OM/D**			**RD**
Demonstrate how to check for restraint interference with circulation/sensitive/motion.	**OM/D**			**RD**
Demonstrate how to check for restraint damage to skin integrity.	**OM/D**			**RD**
Demonstrate EMR documentation for restraint.	**OM/D**			**RD**

PRECEPTOR SIGNATURE		
Signature and Printed Name of Preceptor or other verified personnel who have initialed on this form:		
Initial:	Print Name:	Signature:

PRECEPTEE STATEMENT AND SIGNATURE:

I have read and understand the appropriate UC Davis Health Policies/Procedures and/or equipment operations manual, I have demonstrated the ability to perform the verified skills as noted

Printed Name	**Signature**	**Date**

Scan and email to: hs-cppn@ucdavis.edu

REVISED JANUARY 2020