



INODAYA Hospitals - Kakinada

Documentation code:

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Policy on Use and Care of patients On Restraints

Prepared Date: 05/09/2023

Reference: COP.16.f.NABH Standards – 5th Edition

Issue date: 05/09/2023

Issue no:2

Review NO:01

Review Date: 04/09/2024

1.0 POLICY:

Restraint measures for patients shall be used only if required and shall be justified. Proper care and monitoring shall be done for patient under restraint.

2.0 PURPOSE:

To provide guidelines regarding appropriate restraint use for the medical well-being of non-violent medical-surgical patients and unanticipated severely aggressive or destructive behaviour that places the patient(s) or others in imminent danger.

3.0 DEFINITION:

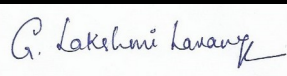
Restraint includes any action, word or deed that is used for the purpose or intent of restricting the free movement or decision-making abilities of another person. As such it may constitute an imposition on a person's rights and dignity and should only be used:

1. As a measure of last resort and
2. For the purpose of promoting and maintaining a person's health and wellbeing, or, in the short term, the health and well being of others.

The intent of restricting the movement or behavior of a person is the key factor that differentiates restraint from other forms of care or medical treatment.

Restraint can be:

- Physical
- Chemical

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4.0 ABBREVIATIONS:

IPD Inpatient Department

5.0 SCOPE:

1. The uses of restraint are primarily to protect the patient and others against injury because of –
 - (a) patient's emotional or behavioral disorder or
 - (b) Any other reason that threatens the patient's safety. The restrain may be physical or chemical- the policy applies to both.
2. Restraint use within the hospital is limited to situations with adequate, appropriate clinical justifications. Restraint may be considered appropriate in the following conditions:-
 - a. When the patient's condition or behavior indicates an immediate & ongoing high risk of self harm (either deliberate or unintentional)
 - b. When patient's behavior poses immediate & ongoing serious risk to others
 - c. When he/she seriously compromises the therapeutic environment e.g. by damaging the property
 - d. When it is necessary to give essential clinical treatment to the individual who is refusing the treatment
 - e. When there is legal support to carry out the prescribed treatment against the person's will.

6.0 RESPONSIBILITY:

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Medical consultant, nursing staff

7.0 DISTRIBUTION:

IPD, ICU

8.0 PROCESS DETAILS:

8.1 DESCRIPTION OF THE PROCESS:

Following protocols shall be followed, for restraining a patient

PROTOCOLS:

1. Orders for restraint intervention are appropriate **only after alternative measures have failed** and safety issues demand an immediate physical response. Such alternative measures may include but not limited to: behavioral intervention, distraction, verbal de-escalation, communication using non-threatening body language/tone of voice, more frequent observation, environmental change (quiet surroundings), room change, comfort measures, obtaining family/relative/attendant support, orientation to his/her surroundings, treatment change, verbal calming techniques, obtaining a psychiatric consult.
2. This policy does NOT apply to the regular clinical procedures such as plaster cast, surgical positioning, radiotherapy, protection of surgical and treatment sites in pediatric patients.

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3. The use of restraint shall not be based on an individual's restraint history or solely on a history of dangerous behavior. Restraints will only be used for as long as necessary to help a patient regain control of his behavior.

Each episode of restraining shall be recorded with

- a. The reason of restraining
- b. Alternative measures tried (may be other than mentioned above)

Authority

- The authority to restrain is reserved with the treating consultant.
- However, in an emergency situation when there is an imminent risk of a patient harming himself/herself or others, including staff, nonphysical interventions are not viable, safety issues require an immediate physical response and a physician is not readily available to conduct an assessment and write restraint orders. – The nurse (based upon an appropriate assessment of the patient) may initiate use of physical restrain. In such case, the nurse shall intimate the treating doctor after the restrain episode and shall get the record/patient file signed by him for the event afterwards.
- The nurse shall never use the chemical restrain (sedation) without proper orders of the treating physician. In case of emergency, the verbal orders from the doctor shall be deemed acceptable, and must be ratified by the consultant at the earliest possible time.
- Use of restraints shall be implemented only on written instructions from the physician after a thorough assessment of the patient and the patients' requirements

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in line with the policy of the institution. Consent for restraint must be taken by the doctor.

- It shall be instituted only after all alternative measures have been considered and exhausted.
- Use of physical or chemical restraints shall be discontinued after 24 hours; patient shall be reassessed for further continuation.
- Patient care needs to be attended every hour or more often and documented; this helps in preventing nerve damage, incontinence, pressure sores, loss of muscle tone, depression, contorted position etc.
- The care-provider can order the use of restraints when he identifies a situation where action is necessary to prevent serious bodily harm to self or to others and routinely in intra-hospital and inter-hospital transportation and in emergency situations and the treating physician may be intimidated verbally.
- All restraint implementation shall be adequately documented and authenticated by the nurse under written order of the treating physician.
- The time of cessation of restraints must be documented by the nurse on the restraint form.

Consent

Consent of the family shall be taken for restraining the patient except the situations where the delay in restrain due to any reason can prove to be a threat to the patient's and /or

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others' safety, the restrain shall be used on patient without any written consent. In such cases, the condition itself may be considered as general consent of the family.

Procedure:

Patient restraint shall be employed to ensure patient and provider safety and to facilitate thorough examination and care of any individual exhibiting an altered level of consciousness. Restraints are of two types: Physical restraints and chemical restraints.

Physical restraints:

Physical Restraints: Physical or mechanical restraints are protective devices employed to prevent a patient from harming self or others, to immobilize a part, to restrict activity and to promote a feeling of security in a patient who needs control.

Chemical Restraints:

Chemical restraints are drugs, which serve the same purpose as physical restraints.

Monitoring

The patient's diagnosis, treatment, and health status dictates whether continual assessment, monitoring, and revaluation are required or if the patient can be monitored and reassessed at regular intervals.

1. Monitoring is accomplished by via observation, interaction with the patient, or by direct patient examination.

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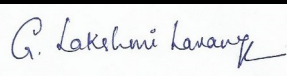
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2. The nurse shall periodically assess the patient. The physician on his clinical judgment shall decide the frequency for this.

5 Clinician:

- The Physician shall conduct a clinical assessment for the use of physical or chemical restraint, wherein the physician substantiates through documentation in the medical record, the reason for the patient being placed in restraint, in order to prevent harm to self or others.
- The physician shall also explain to the patient's family and friends the need for the restraint.
- The chemical restraint is used to temporarily calm the patient.
- The duration of the restraint order is for a 24-hour period and if further restraint is required, a new Physical Restraint Form is to be filled for every 24- hour period.
- The physician shall explain all steps of the intervention to the patient's family as soon as possible after the intervention and at appropriate intervals thereafter, including:
 - Patient's specific behavior causing initiation of restraint
 - The required care and attention that shall be provided while the patient is on restraint.

Nursing Staff:

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- A nurse shall obtain appropriate assistance from other hospital personnel while restraining a patient.
- The nursing staff shall assist the physician in safety administering the restraint. In the absence of the physician, the nursing staff can initiate restraints in the safe interest of the patient but shall obtain approval from the treating physician in emergency situations – verbally and shall ensure appropriate documentation.
- The nursing staff shall ensure that proper care; observation, documentation and reporting procedure are completed.
- The nursing staff shall ensure the removal of potentially dangerous objects from the immediate vicinity or reach of the patient which could be used by the patient to harm self or other or be used to disengage from the restraint applied.
- Patients' under restraint shall be continually monitored by the nursing staff every hour.
- The nurse shall check for consciousness of the patient. Vital signs shall be recorded every 4 hours or more often as needed.
- Offer fluids at least hourly or more frequently if the patient is dehydrated, unless fluids are restricted by a physician's order.
- The nurse shall promptly inform the physician if there is any notable change in the behavior of the patient.

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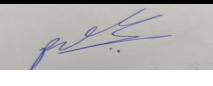
- This information shall also be documented in the patient's medical record.

The assessment shall include: -

- a. Evaluation of the continued need for restraints/ changes in patient's behavior/clinical condition regarding readiness for restraint discontinuation
- b. Alternatives/less restrictive restraint interventions
- c. Whether the restraint has been appropriately applied.
- d. Skin and circulatory assessment of the affected extremity
- e. Needs of patient regarding food/ toilet.
- f. Repositioning for comfort as possible
- g. Physical well-being, hygiene, dignity/rights maintained.
- h. Level of distress/agitation

Restrain Termination

1. Restriction of patient movement or activity by restraints shall be terminated at the earliest possible time.
2. The decision to terminate the restraint shall be based on observation and assessment that determines that (i) the patient no longer needs the restraint to protect self or

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others or (ii) behavioral guidelines ordered by the physician have been met and documented. The physician, after assessing the patient himself, makes the decision to terminate restraint use.

3. Once a restrain has been terminated, a fresh order must be obtained prior to reapplying the restraints.

9.0 RECORDS AND FORMATS:

- Consent for Restraint (Within the patient progress notes) & Monitoring form

COP 16.c. d & e – Refer ICU & Nursing Manual- COP 6 &COP 9

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