HEALTH SERVICES POLICY & PROCEDURE MANUAL

North Carolina Department Of Correction
Division Of Prisons

SECTION: Care and Treatment of Patient – Restrictive Procedures

POLICY # TX III-3

SUBJECT: Use of Restraints for Medical Purposes

EFFECTIVE DATE: October 2007
SUPERCEDES DATE: April 2005

PURPOSE

To provide guidelines on the use of physical restraints for medical and/or post-surgical purposes**.**

POLICY

The patient has the right to be free from any physical or chemical restraints imposed by the medical staff for the purposes of discipline or convenience, and not required to treat the patient's medical symptoms. Restraint is only to be used when clinically necessary to improve the patient's well-being and when other less restrictive measures have been found to be ineffective to protect the patient from harm. The restraint should be ended at the earliest possible time based on assessment and reevaluation of the patient's condition. Only a Registered Nurse or medical provider has the authority to initiate and discontinue restraints based on clinical judgment.

If the patient needs emergency care, restraints may be used for brief periods to permit medical treatment to proceed unless the facility has a notice indicating that the patient has previously mad a valid refusal of the treatment in question. If a patient's unanticipated violent or aggressive behavior places him/her or others in imminent danger, the patient does not have the right to refuse the use of restraints. In this situation, the use of restraints is a measure of last resort to protect the safety of the patient or others and must not extend beyond the immediate episode. Law enforcement restraint or therapeutic restraint (See Health Care Policy Manual TX III-2) may be appropriate.

PROCEDURE

Definitions

Physical Restraints are defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the patient's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. In acute medical and post-surgical care, a restraint may be necessary to ensure that an intravenous or feeding tube will not be removed, or that a patient who is temporarily or permanently incapacitated with a broken hip will not attempt to walk before it is medically appropriate. That is, medical restraint may be used to limit mobility or temporarily immobilize a patient related to a medical, post-surgical or dental procedure. The rationale that the patient should be restrained because he/she "might" fall is an inadequate basis for using a restraint. In this case, the patient should be assessed for history of falls or a medical condition or symptom that indicates a need for a protective intervention. Physical restraints include but are not limited to:

- leg restraints,
- arm restraints,
- hand mitts,
- soft ties and vests,
- lap cushions, and
- lap trays, the patient cannot remove easily
- side rails that keep patient from voluntarily getting out of bed,
- tucking in or using Velcro to hold a sheet, fabric or clothing tightly so that the patient's movement is restricted,
- devices in conjunction with a chair such as trays, tables, bars and belts that the patient can not easily remove, that prevent the patient from rising,
- placing a patient in a chair that prevents the patient from rising, and

- placing a chair or bed so close to the wall that the wall prevents the patient from rising or voluntarily getting out of bed.

Chemical restraint is defined as any drug that is used for discipline or convenience and not required to treat medical symptoms.

Convenience is defined as any action taken by the medical staff to control a patient's behavior or manage a patient's behavior with a lesser amount of effort by the medical staff and not in the patient's best interest.

Devices not regarded as restraints include:

- Orthotic body devices used solely for therapeutic purposes to improve the overall functional capacity of the patient,
- Partial side rails that assist the patient to enter and exit the bed independently
- An enclosed framed wheeled walker, with or without a posterior seat in which the patient can open the gate
- Voluntary mechanical support used to achieve proper body position, balance, or alignment so as to allow greater freedom of mobility than would be possible with the use of such a mechanical support, such as leg, neck, head and back braces,
- Positioning or securing device, which is medically necessary and voluntary in order to maintain the position, limit mobility or temporarily immobilize during medical, dental, diagnostic or surgical procedures,
- Medically necessary restraint used in recovery from anesthesia in a recovery room; however, when moved to another unit or recovers from the effects of the anesthesia, a restraint order would be necessary.

Law Enforcement Restraint Devices are handcuffs, manacles, shackles and other restraint devices governed by Federal and State law and regulations for use by correction officers. The officers are responsible for monitoring and maintaining the custody of the patient, and the officers will determine when the patient's restraint device can be removed in accordance with NCDOC policy/procedure. The medical staff are still responsible for appropriate assessment and provision of care for the patient.

If the intervention is undertaken because of an unanticipated outburst of severely aggressive, violent or destructive behavior that poses an imminent danger to the patient or others, law enforcement restraint or therapeutic restraint (Health Care Policy Manual TX III-2) may be appropriate.

PROCEDURES

I. ASSESSMENT

A. A thorough evaluation of the patient and his/her needs is to be documented

B. The use of any restraint should be based on the assessment of the device or what constitutes the least risk for the patient (the risk of what might happen if the device is not used versus the risk it poses as a restraint.)

C. The assessment should include how the restraint will benefit the patient and whether a less restrictive device/intervention could offer the same benefit at less risk.

II. ORDERS

A. All restraints must have a provider's order before initiating **each** episode of restraint use.

B. In emergency situations, the order must be obtained either during the application of the restraint or immediately after the restraint is applied.

C. Restraint orders must include the intent of the order (specific reason) and have a specified time period for usage (time limited.)

D. Restraint orders may never be written as a standing order or on an as needed basis (PRN)

E. If the order is obtained by a provider other than the attending physician, the attending physician will be consulted as soon as possible and the order signed at the next visit. Any consultation will be documented.

II. MONITORING

A. All restrained patients will be monitored at least every 15 minutes to insure that they are not suffering any local or systemic harmful effect(s) due to being restrained. Documentation of this monitoring will be recorded on form DC-422M.

B. The patient will be released, exercised and positions changed at least every 2 hours.

C. If the nursing staff notes any serious harmful effect that can not be improved without discontinuing the restraints, the provider should be contacted promptly to decide whether or not continuing the restraints would still be of overall benefit to the patient.

III. DOCUMENTATION

A. Nursing will document the following:

1. The patient's specific symptoms necessitating the restraint and the intervention used

2. The rationale for the use of the restraint including alternatives attempted and other less intrusive measures considered first

3. Time that the restraint was applied.

4. The type, number, and location (body part) of restraints used.

5. The patient's response to the use of the restraint and the overall condition of the patient and the condition of the patient's skin and extremities every 15 minutes. The progress note should summarize the care rendered to the patient and documented on the flowsheet, DC-422M.

6. Input and output every 8 hours.

7. Any signs of injury

8. Significant changes in the patient's behavior and/or environment (i.e. the presence of family or sitter) that might allow for the altering of the restraint order.

9. The patient's specific symptoms indicating that the restraint can be safely removed and the time the restraint was removed.

B. During the next visit following the restraint episode, the attending physician will evaluate the patient's history and the use of restraints. This evaluation will be documented in the progress notes.

IV. USE OF RESTRAINTS FOR SECURITY PURPOSES

A. Health care staff are not to be involved in the use of law enforcement restraints for security purposes except to periodically monitor the health status of the involved inmate

B. When and if health care staff members note what they consider to be improper use of law enforcement restraints by custody personnel, they should communicate their concerns as soon as possible to the custody personnel responsible for the inmate.

1. If this does not resolve the issue, then the head of the facility/designee should be immediately notified.

2. If improper use of restraint continues after the above steps then the Division of Prisons Health Services Director/designee should be notified.

Paula Y. Smith, M.D.

10/25/07

Paula Y. Smith, MD, Director of Health Services Date

SOR: Deputy Medical Director
Director of Nursing