HEALTH HOLDING

HAFER ALBATIN HEALTH CLUSTER
MATERNITY AND CHILDREN HOSPITAL

Department:	Provision of Care		
Document:	Multidisciplinary Policy and Procedure		
Title:	Use of Restraints and Monitoring		
Applies To:	All Healthcare Provider		
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1. PURPOSE:

1.1 To establish guideline and maintain safe environment of the patient under restraints.
1.2 To establish a patient – focused process for the implementation, application and documentation of the use of restraints.
1.3 To ensure the maximum safety and security for patients while respecting the patient's rights and dignity and ensuring the patient's well – being in relation to the use of restraints.

2. DEFINITIONS:

2.1 **Physical Restraints** – is any manual method, physical or mechanical device, material, or equipment involuntarily or positioned adjacent to the patient's body that he or she cannot easily remove, that restricts freedom of movement or normal access to one's body.
2.2 **Soft Restraints** – are cloth type garments or limb/body holders, which prevent the patient, from climbing out of bed, wheelchair to immobilize one or more extremities for treatment procedures or to facilitate healing.
2.2.1 **Anklet** – a cloth band fastened around the ankle or leg.
2.2.2 **Wristlet** – a cloth band fastened around the wrist or arm.
2.3 **Seclusion** – is the involuntarily confinement of a person in a room or an area where the person is physically prevented from leaving.
2.4 **Therapeutic Devices** – are devices used to reduce the risk of injury but which are not considered restraints and which do not require orders for implementation. Therapeutic devices include the following:
2.4.1 **Procedure** – related Protective Immobilization, such as temporary use (i.e. for the duration of the procedure only) of an arm board during intravenous administration, body restraints during surgery, and soft wrist ties for incubated patients.
2.4.2 **Protective Devices** – such as the temporary use of bed rails; table top chairs, lap belts or table tops for patients in chair or those who are confused or at risk for falls.
2.5 **Chemical Restraints** – is a form of medical restraint in which drug is used to restrict the freedom of movement of a patient or in some cases to sedate a patient. These are used in emergency, acute, and psychiatric settings to control unruly patients who are interfering with their care who are otherwise harmful to themselves or others in their vicinity.

3. POLICY:

3.1 This policy states that all health care providers involve in the application of restraint shall adhere on the standards to ensure patient safety will be appropriately monitored.
3.1.1 Straps and/or restraints are applied when there is an order on the file by the physician stating clearly the clinical indication for using restraints and any requirement for continued use must be evaluated by the clinician every 24 hours.
3.1.1.1 The indication include, but not limited to:
3.1.1.1.1 Displaying behaviours that is putting themselves at risks of harm.
3.1.1.1.2 Displaying behaviour that is putting others at risk of harm.

3.1.1.1.3 Requiring urgent lifesaving treatment when patient is not cooperative.

3.1.2 With exception of infants, toddlers and children when placed in any mode of transportation i.e. wheelchair or stretcher and adults during transport, a clinician order is required to restrain patients. The validity of the orders expires after 24 hours.

3.1.3 The reason for restraints will be explained fully to the patients and relatives.

3.1.4 A minimum of two persons should be present when applying restraints.

3.1.5 Check patient's skin every 1 hour for pressure points and maintaining protective skin care. Restraints should be released every 2 hours to allow freedom of movement and to perform range of motion.

3.1.6 Ankle and wrist restraints will be explained fully to the patients and relatives.

3.1.7 Secure restraints to the bed frame at a point where the patient cannot reach.

3.1.8 Restraints should be released one at a time.

3.1.9 In the event of emergency, restraints may be removed from patient with scissors. Restraints should only be attached for the minimum required time, for the well-being of the patient. Give assurance at all times to patient and family. Based on the assessment of a competent staff member it can be determined when to discontinue restraint. The patient's privacy/ modesty and dignity must be preserved at all times.

3.1.10 The use of restraints shall be:

- 3.1.10.1 Initiated by Physician
- 3.1.10.2 Time limited
- 3.1.10.3 Documented in the patient's medical record.

3.1.11 Clinician's Orders:

- 3.1.11.1 The clinician's order shall be written.
- 3.1.11.2 Reasons for the use of restraints.
- 3.1.11.3 PRN orders for any kind of restraints are not acceptable.

3.1.12 Only trained and competent health care provider shall be permitted to apply, release and reapply, or remove restraints.

3.1.13 Emergency use of restraints/ staff initiated use of restraints:

- 3.1.13.1 Emergency use of restraints may be initiated prior to an order being written when a competent staff member determines that there is a need for immediate intervention.
- 3.1.13.2 The attending clinician shall be notified about the use of restraints within 1 hour after their application.
- 3.1.13.3 In case of emergency in other department (e.g. ER) an ER nurse can restraint the patient and documents in the Nurse's note and let Physician write on 2A form and sign within 1 hour of implementation or before patient will be shifted to another area.
- 3.1.13.4 The following shall be documented by the competent staff member initiating the emergency application of restraints.
  - 3.1.13.4.1 The events leading up to the use of restraints.
  - 3.1.13.4.2 The prior used of, or attempts to use alternative measures.
  - 3.1.13.4.3 The patient's response to alternative measures.
  - 3.1.13.4.4 The time the restraints were initiated.
  - 3.1.13.4.5 The type of restraint used.

3.1.14 Application of restraints (including emergency application)

- 3.1.14.1 A competent staff member shall do the following before applying restraints.
  - 3.1.14.1.1 Attempt/ implement alternative, less restrictive methods.
  - 3.1.14.1.2 Attempt to obtain the patient's voluntary submission to the use of restraints.
  - 3.1.14.1.3 Provide education to the patient/ family about alternative methods and the reason for application of restraints.

3.1.14.2 The least restrictive restraints possible shall be used e.g., hand mittens for a patient who is scratching an irritated skin rash may be just effective as the more restrictive soft wrist ties.

3.1.14.3 Competent staff members shall apply restraints correctly and appropriately.

3.1.14.4 If a restraint is attached to a bed frame and the bed is adjustable, the restrain shall be attached to a part of the bed that moves with the patient, in order to avoid constricting the patient.

3.1.14.5 Proper body alignment, circulation and skin integrity shall be maintained.

3.1.14.6 Body alignment, circulation and skin integrity shall be maintained. If circulation has been impaired, physician should be informed and appropriate intervention shall be done.

3.1.14.7 Key for leather restraints shall be readily available so that restraints may be released immediately in emergency situations. Scissors shall be available to cut cloth restraints/ knots, if necessary.

3.1.14.8 In cases that the patient is given tranquilizer (e.g. Haldol) assessment for side effects and its appropriate intervention.

3.1.15 Documentation:

3.1.15.1 Alternatives tried/ considered/ failed

3.1.15.2 Type of restraint used

3.1.15.3 Date and time of application

3.1.15.4 Patient's behavior and response to restraints

3.1.15.5 Monitoring of patient(continuously if behavioral restraint ordered)

3.1.15.6 Care provided a minimum of every two hours

3.1.15.7 Actions taken to meet patient's need

3.1.15.8 Reassessment for continuous restraint should be done in a minimum of 4 hours.

3.1.15.9 Skin and circulation assessments

3.1.15.10 Date and time of termination of restraint

3.1.15.11 Patient's response to release of restraint

3.1.15.12 Use of restraints in the patient's care plan

3.1.16 Patient's Right:

3.1.16.1 The patient's dignity and well – being shall be protected and the following shall be ensured.

3.1.16.1.1 Respect for the patient as an individual.

3.1.16.1.2 Safety and cleanliness of the environment.

3.1.16.1.3 Protection of the patient's modesty, privacy and body temperature.

3.1.16.1.4 The ability of the patient and/ or the patient's family to receive and/ or participate in the patient's care.

3.1.16.2 The patient and/ or the patient's family shall be given an explanation by a competent staff member regarding the use of restraints, to include the following:

3.1.16.2.1 The purpose and application of the restraints.

3.1.16.2.2 The alternative to the use of restraints.

3.1.16.2.3 The criteria for release of restraints.

3.1.16.2.4 The plan of care.

3.1.16.2.5 Immediate assistance for the family.

3.1.17 Supervision and companionship:

3.1.17.1 Ask family, friends or volunteers to stay with the patient.

3.1.17.2 Determine when the patient needs one – to – one attention (typically at night) and intervene accordingly.

3.1.17.3 Assess patient for all risk and correct reversible causes of falls.

3.1.17.4 Provide increase nursing rounds for patients at high risk of falls or pulling out tubes.

3.1.17.5 Teach family and caregivers about the patient's clinical condition (e.g. acute confusions, closed head injury, etc.) and appropriate interventions to manage behavior.

3.1.17.6 Watch for signs for confusions at high – risk patients.
3.1.17.7 Develop toilet routines to facilitate elimination and reduce falls related to elimination.

3.1.18 Method of restraint application
3.1.18.1 2 point – one arm and one leg on the opposite side of the body.
3.1.18.2 3 point – one arm both legs or one leg and both arms.
3.1.18.3 4 point – all four limbs.

4. PROCEDURE:

4.1 Assess the patient for indications of restraints application and document.
4.2 Obtain or verify a physician's order for application of restraint after non – physical interventions were tried and failed.
4.3 Assure that sufficient staff is available and capable.
4.4 Inspect the bed, chair, restraints and any other equipment that will be used in the restraint process.
4.5 Explain the procedure and the role of nurses to the patient and relatives.
4.6 Place the patients in supine position on bed and immobilize limbs and joints.
4.7 Remove harmful objects such as jewelries and the pad the extremity to be restrained.
4.8 Place the device on the patient's limbs to be restrained and secure; check for snug fitting wherein you should be able to slip 2 fingers.
4.9 Secure the distal part of restraint to the bed frame not to the side rails.
4.10 Once restrained, the patient should be in full view of the assigned staff.
4.11 Document observations and behaviors on the Restraint Patient Care and Monitoring Flow Sheet.
4.12 Assess and document adequacy of circulation, security of restraints and body alignment no less than every 30 minutes.
4.13 Reassess the patient until the criteria for removal was met or patient will be transferred to another unit.

5. MATERIAL AND EQUIPMENT:

5.1 Bedside Rails
5.2 Bed Sheet
5.3 Draw Sheet (for children)
5.4 Dressing Pads
5.5 Bandage
5.6 Wrist Cuffs
5.8 Elbow Restraints
5.9 Belt

6. RESPONSIBILITIES:

6.1 Physician
6.2 Nurse

7. APPENDICES:

N/A

8. REFERENCES:

8.1 Ministry of Health, General Nursing Administration Functions and Duties Policies and Procedures

9. APPROVALS:

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