

	State of Indiana Indiana Department of Correction	Effective Date 4/1/2022	Page 1 of 6	Number 3.16A
HEALTH CARE SERVICES DIRECTIVE-ADULT Manual of Policies and Procedures				

Title RESTRAINTS IN GENERAL MEDICAL USAGE (NON-PSYCHIATRIC)

Legal References (includes but is not limited to) IC 11-8-2-5 IC 34-4-12.6	Related Policies/Procedures (includes but is not limited to) 01-02-101 01-02-106	Other References (includes but is not limited to) National Correctional Healthcare Standards
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I. PURPOSE:

This Health Care Services Directive (HCSD) provides guidelines for the use of restraints in the treatment of medical and surgical patients.

II. DEFINITIONS:

For the purpose of this HCSD, the following definitions are presented:

- A. ACUTE MEDICAL RESTRAINT: The application of any physical or mechanical device which limits the patient's mobility and the restraint supports the medical healing of the patient.
- B. CLINICAL CARE RESTRAINT: The use of a physical or mechanical device, material or equipment, for certain specific clinical procedures or for the treatment of medical conditions (e.g., delirium, post-traumatic brain injury, etc.) to protect the patient from harm or to ensure a necessary medical procedure can be performed safely.
- C. EMERGENCY: A situation where the patient's behavior is violent or aggressive and where the behavior presents an immediate and serious danger to the safety of the patient, other patients, staff, or others.
- D. PHYSICAL RESTRAINT: The direct application of physical force to a patient, without the patient's permission, to restrict freedom of movement. Physical force may be human, mechanical, or a combination of these interventions which are attached to the patient's body so that they cannot easily remove. Holding a patient in a manner that restricts their movement constitutes physical restraint.

III. GUIDELINES:

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Mechanical devices which are used to support proper body position, alignment or balance, orthopedic devices, protective helmets or mittens, and other durable health equipment which support activities of daily living are not considered restraint. Devices which are customarily employed during nursing, medical or diagnostic procedures that are considered routine safety measures (e.g., lap belts in wheelchairs, arm boards for peripheral IVs) which are standard practice for the procedure or intervention are not considered restraints.

On occasion the safe management of a patient with a medical or physical disorder may require restrictive and/or intrusive interventions to protect the patient, a staff member or others from harm. Acute medical restraints may be applied when they are necessary to support the healing of the patient. Clinical Care Restraints are used when the patient does not have rational decision making capability and there is significant danger to the patient if they dislodge or terminate a line, catheter, or tube. The type of restraint is not specific to the setting the patient is in, but to the situation the restraint is being used to address.

Physical or mechanical restraint must be used as an intervention of “last resort” only when the intervention is necessary to ensure the physical safety of the patient and other less restrictive interventions have been tried and found ineffective or interference or resistance is reasonably anticipated.

During the use of restraints, the patient’s dignity and well-being must be protected and respected. Health care personnel are absolutely forbidden to utilize restraints for purposes of retaliation, punishment or for any disciplinary purpose.

In order of increasing restrictiveness, the interventions available are:

- A. An evaluation to rule out the possibility that the symptoms represent a significant change in clinical status;
- B. Increased surveillance by staff;
- C. Additional pain relief or other comfort measures;
- D. Physical activity or exercise;
- E. Meaningful distraction;
- F. Environmental modification;
- G. Placing the patient on close observation with regular fifteen (15)-minute checks;
- H. Assign a companion or sitter for the patient;
- I. Mittens;
- J. Soft restraints for one (1) or two (2) extremities;
- K. Soft restraints for three (3) to four (4) extremities; and/or,
- L. Leather restraints.

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Movement should be restricted only so far as necessary to maintain safety. Restraints should be individualized, applied for the patient's benefit, afford as much dignity to the patient as the situation allows, and should be humanely and professionally administered. Restraint usage must be terminated as soon as clinically feasible.

A patient should never be restrained face-down, hog-tied or spread-eagled and no restraints should be used around the patient's neck.

In an emergency, a patient who lacks capacity for decision making is at risk for loss of life or limb if treatment is not provided may be restrained in order to permit care to be provided.

IV. PROVIDER'S ORDERS FOR RESTRAINTS:

Restraint may be implemented only on the order of a physician, nurse practitioner or physician assistant. Orders for restraint must contain date and time, reason and type of restraint, duration of order, specific criteria for which the restraint may be removed, and the name of the provider and nurse if a verbal order.

For acute medical restraint, the duration of the order may not exceed 24 hours. At 24 hours, the nurse must perform a comprehensive assessment and obtain a new order. The order may be renewed every 24 hours up to a maximum of 72 hours. At the end of 72 hours, if restraint is still necessary the treating provider must conduct a face to face evaluation of the patient. The treating provider must consult with the Health Services vendor's Regional Medical Director for guidance on ongoing management.

For clinical care restraint, the time frame for the order is limited to the duration of the clinical need. Clinical care restraint must be discontinued when criteria is no longer met either by removal of the tube, invasive lines, catheters, etc., or the patient's decision making capacity has been restored.

If the restraint is discontinued prior to the expiration of the original order, a new order must be obtained prior to reapplying restraint.

Orders for the use of restraint must never be written as a standard order or on an as needed basis (i.e., PRN). When an on-call provider is not the patient's primary care provider, the order for restraint the patient's primary care provider must be consulted as soon as possible.

In emergency situations, when restraint is necessary to preserve the patient's life or is necessary for the management of aggressive or combative behavior, a licensed nurse may initiate restraint and obtain a verbal or telephone order from the primary care or on call provider within one (1) hour.

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V. APPLICATION OF RESTRAINTS:

Restraints must be applied in the least restrictive manner possible, in accordance with safe and appropriate restraining technique, and ended at the earliest possible time. Restraints may only be applied by personnel who have been trained in their use. A Registered Nurse must be present to witness the application and ensure appropriateness.

VI. MONITORING OF RESTRAINT:

The frequency of monitoring should be determined based on the assessed needs of the patient. At a minimum, the following assessments and services shall be provided and documented in the EMR:

- An immediate assessment must be done after the patient is restrained to ensure the restraint was properly and safely applied
- At 15 minute intervals, staff must observe the patient for any signs of injury or physical distress.
- Within one hour after the patient is placed in restraint, the patient must be seen face-to-face by a Registered Nurse to determine if the patient still meets criteria for the restraint.
- Obtain vital signs every 2 hours
- Assess the patient's mental status (i.e., orientation and cognitive function) and level of distress every 2 hours
- Assess circulation including an assessment of capillary refill, the patient's ability to move fingers and toes and the presence or absence of edema. The last circulation check should be done two (2) hours after restraints have been removed
- Conduct range of motion activities for the restrained extremities every 4 hours
- Assess skin integrity to the extent possible with the range of motion activities
- Attend to hydration needs every 2 hours while awake
- Provide an opportunity to attend to elimination and personal hygiene needs every 2 hours while awake
- Support nutritional needs as prescribed

Health Services personnel shall obtain vital signs, conduct the 15 minute checks, conduct range of motion activities, and assist the patient with hydration, nutritional support and elimination with oversight by a RN. The RN is responsible for completing and documenting all assessments.

At each assessment the patient should be evaluated for the opportunity to remove the restraints. Restraints should be discontinued at the earliest possible time when the

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patient's actions no longer warrant the use of restraints or the clinical treatment is discontinued (i.e., I-V lines, catheters, etc., has been removed).

When restraints are used for emergency treatment, the restrained patient must be continuously monitored.

VII. HEALTH RECORD DOCUMENTATION:

Health record documentation shall include:

- A. The patient's behavior prior to restraint;
- B. All attempts to gain the patient's cooperation or that making such attempts would delay the necessary emergency treatment and further jeopardize the patient's life and safety;
- C. A description of the failure of less restrictive methods of restraint including verbal reminders or verbal attempts to convince the patient to cooperate;
- D. Information that was provided to the patient when the reasons for restraint were explained;
- E. The patient's understanding of the criteria that must be met for the removal of restraint;
- F. A description of the type of restraint (soft, leather, mechanical) used
Identification of the limbs or body part restrained;
- G. A description of any injuries that occurred before, during or after the restraints were applied;
- H. Descriptions of the patient's mental status and behavior before and after the restraints were applied;
- I. Documentation regarding the patient's status at least every fifteen (15) minutes;
- J. Assessments including vital signs and mental status, and skin integrity;
- K. Range of motion activities and notations regarding the provision of hydration and nutrition and how and when elimination needs were met; and,
- L. With each new order for restraint, the results of the comprehensive assessment and the rationale for the continued use of restraint.

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VIII. STAFF TRAINING:

Health Services staff with direct patient contact must have continuing education and training in the proper and safe use of restraints. At a minimum, the following topics are to be included in staff training:

- A. Underlying causes of aggressive or combative behaviors (e.g. hypoglycemia, postictal state following a seizure, delirium with fever);
- B. De-escalation techniques;
- C. Safe use of restraints including the application and removal of restraints;
- D. Signs and symptoms of physical distress in restrained patients;
- E. Frequency of vital signs, circulation checks, and range of motion activities;
- F. Addressing hygiene and elimination needs;
- G. Components of the comprehensive assessment; and,
- H. Recognizing the patient's readiness for discontinuation of restraints.

IX. APPLICABILITY:

This HCSD is applicable to all facilities providing Health Services to incarcerated adults.

signature on file

Kristen Dauss, MD
Chief Medical Officer

Date