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HEALTH CARE SERVICES DIRECTIVE-YOUTH Manual of Policies and Procedures		4/1/2022	6	3.16Y

Title
RESTRAINTS IN GENERAL MEDICAL USAGE (NON-PSYCHIATRIC)

Legal References (includes but is not limited to)	Related Policies/Procedures (includes but is not limited to)	Other References (includes but is not limited to)
IC 11-8-2-5	01-02-101	National Correctional Healthcare Standards

I. PURPOSE:

This Health Care Services Directive (HCSO) presents guidelines for the therapeutic use of restraints in Division of Youth Services (DYS) facilities.

II. DEFINITIONS:

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

III. GUIDELINES:

Mechanical devices which are used to support body position, alignment, or balance and orthopedic devices, protective helmets or mittens and other durable medical

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equipment which supports 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, armboards for peripheral IVs) which are standard practice for the procedure or intervention are not considered restraints.

On occasion, the safe management of youth with a medical or physical disorder may require restrictive and/or intrusive interventions to protect the youth, a staff member, or others from harm. Acute medical restraints may be applied when they are necessary to support the medical healing of the youth. Clinical care restraints are used when the youth is found not to have decisional capacity and there is significant danger to the youth if they pull, dislodge, or terminate a line, catheter, or tube and does not have rational decision-making capabilities. This type of restraints is not specific to the setting the youth is in, but to the situation the restraint is being used to address. The qualified health professional must work directly with the Warden or designee when decisions to use clinical care restraints are considered.

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 youth and other less restrictive interventions have been tried and found ineffective or interference or resistance is reasonably anticipated.

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

The type or technique of restraint used must be the least restrictive intervention that will be effective to protect the youth, employees, and others. 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. Close observation with regular checks at 15 minute intervals;
- h. Mittens;
- i. Soft restraints for 1 or 2 extremities;
- j. Soft restraints for 3 to 4 extremities; and,
- k. 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 youth's benefit, afford as much dignity to the youth as the situation allows, and should be humanely and professionally administered. Restraint usage must be terminated as soon as clinically feasible.

A youth shall never be restrained face-down, hog-tied, or spread eagled and no restraint shall be used around the youth's neck.

In an emergency, a youth who is found not to have decisional capacity to refuse or consent to care due to altered mentation but 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.

The Warden, as legal guardian, and the Executive Director of Youth Services must be notified that the youth has been placed in restraint as soon as possible.

IV. PROVIDER ORDERS FOR RESTRAINT:

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 8 hours. At 8 hours, the nurse must perform a comprehensive assessment and obtain a new order. The order may be renewed every 8 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 youth. 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 youth'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 re-applying restraints.

Orders for the use of restraint must never be written as a standard order or on an as-needed basis (PRN). When an on-call provider gives orders for the use of restraint, the primary care provider must be consulted as soon as possible.

In emergency situations where restraint is necessary to preserve the youth's life or is necessary for the management of an aggressive or combative behavior, a licensed

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nurse may initiate restraint and obtain a verbal or telephone order from the primary care or on-call provider within one hour.

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 (RN) must be present to witness the application and ensure appropriateness.

VI. MONITORING OF RESTRAINT:

The frequency of monitoring shall be determined based on the assessed needs of the youth. An immediate assessment must be done after the youth is restrained to ensure the restraint was properly and safely applied.

At up to 15 minute intervals, staff must observe the youth for any signs of injury or physical distress.

Within one hour after the youth is placed in restraint, the youth must be seen face-to-face by an RN to determine if the youth still meets criteria for restraint. After the face-to-face evaluation, at a minimum the nurse shall:

- A. Obtain vital signs every 2 hours;
- B. Assess the youth's mental status (e.g., orientation and cognitive function) and level of distress every 2 hours;
- C. Assess circulation including an assessment of capillary refill, the youth's ability to move fingers and toes and the presence or absence of edema. The last circulation check should be done 2 hours after restraints are removed;
- D. Conduct range of motion activities for the restrained extremities every 4 hours;
- E. Assess skin integrity to the extent possible with the range of motion activities;
- F. Attend to hydration needs every 2 hours while awake;
- G. Provide an opportunity to attend to elimination and personal hygiene needs every 2 hours while awake; and,

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H. Support nutritional needs as prescribed.

At each assessment the youth shall be evaluated for the opportunity to remove the restraints. Restraints shall be discontinued at the earliest possible time when the youth's actions no longer warrant the use of restraints or the clinical treatment is discontinued (e.g., IV lines, catheter, etc., have been removed).

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

VII. HEALTH RECORD DOCUMENTATION:

Health record documentation shall include:

- A. The youth's behavior prior to restraint;
- B. All attempts to gain the youth's cooperation or that making such attempts would delay the necessary emergency treatment and further jeopardize the youth'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 youth to cooperate;
- D. Information that was provided to the youth when the reasons for restraints were explained.
- E. The youth'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;
- G. Identification of the limbs or body part restrained;
- H. A description of any injuries that occurred before, during, and after the restraints were applied;
- I. Descriptions of the youth's mental status and behavior before and after the restraints were applied;
- J. Documentation regarding the youth's status every 15 minutes minimally;
- K. Assessments including vital signs, mental status, and skin integrity;

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- L. Range of motion activities and notations regarding the provision of hydration and nutrition and how and when elimination needs were met; and,
- M. With each new order for restraint, the results of the comprehensive assessment and the rationale for the continued use of restraint.

VIII. STAFF TRAINING:

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

- A. Underlying causes of aggressive or combative behaviors (e.g., hypoglycemia, postictal state following a seizure, delirium with fever, etc.);
- 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 youth;
- 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 youth's readiness for discontinuation of restraints.

IX. APPLICABILITY:

This HCSD is applicable to all facilities providing Health Services to youth.

signature on file

Kristen Dauss, MD
Chief Medical Officer

Date