

HEALTH SERVICES POLICY & PROCEDURE MANUAL

North Carolina Department Of Public Safety
Prison

SECTION: Care and Treatment of
Patient – Restrictive Procedures

POLICY # TX III-3

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SUBJECT: Use of Restraints for Medical
Purposes

EFFECTIVE DATE: October 2014
SUPERCEDES DATE: October 2007

References:

Related ACA Standards

4th Edition Standards for Adult Correctional
Institutions 4-4405

PURPOSE

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

POLICY

The offender has the right to be free from any physical or chemical restraints imposed by the medical staff for the purposes of discipline or convenience. Restraints are 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 offender's condition. Only a registered nurse or medical provider has the authority to initiate and discontinue restraints based on clinical judgment.

During acute medical and post-surgical care, a restraint may be necessary to ensure that an intravenous or feeding tube will not be removed or when an offender who is temporarily or permanently incapacitated with a broken hip will not attempt to walk before it is medically appropriate. That means a 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 offender 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, a medical condition or symptom(s) that indicate a need for a protective intervention.

If the offender needs emergency care, restraints may be used for brief periods to permit medical treatment to proceed unless the facility is aware that the offender has previously made a valid refusal of the treatment in question. If an offender's unanticipated violent or aggressive behavior places him/her or others in imminent danger, the offender 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 offender and others. Use of any medical restraint must not extend beyond the immediate episode of needed care.

Custody or therapeutic restraint may be appropriate in some situations when an offender displays violent or aggressive behavior. (See Health Care Policy TX III-2)

DEFINITIONS

Physical Restraints – Any physical or mechanical device, material, or equipment attached to or adjacent to the offender's body that the offender cannot easily remove; restricts freedom of movement or normal access to one's body

Physical restraints include but are not limited to:

- o leg restraints,
- o arm restraints,
- o hand mitts,
- o soft ties and vests
- o lap cushions
- o lap trays
- o side rails (keep patient from voluntarily getting out of bed)
- o tucking in or using Velcro to hold a sheet, fabric or clothing tightly so that the offender's movement is limited

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- devices used in conjunction with a chair such as trays, tables, bars and belts that the offender cannot easily remove and they prevent the patient from rising,
- placing a chair or bed so close to the wall that the wall prevents the offender from rising or voluntarily getting out of bed.

Chemical restraint - Any medication that is used for discipline or convenience and not required to treat medical symptoms.

Convenience - Any action taken by the healthcare staff to control an offender's behavior or manage an offender's behavior with a lesser amount of effort by the medical staff and not in the offender's best interest.

Custody Restraint Device – Any device such as handcuffs, manacles, shackles and other restraint devices governed by Federal and State law and regulations for use by correctional officers and other law enforcement personnel; monitored and maintained by custody officers who make determination when the device can be removed in accordance with NCDPS policy/procedure; maybe used when an unanticipated outburst of severely aggressive, violent or destructive behavior occurs that poses an imminent danger to the offender and/or others

Medical staff are responsible for appropriate assessment and provision of care for the offender when custody restraint devices are in use.

PROCEDURE

I. ASSESSMENT

- A. Document a thorough evaluation of the offender's needs
- B. Determine risk to offender should restraint be used or not
- C. Assess and document how the selected restraint will benefit the offender
- D. Assess whether a less restrictive device/intervention could offer the same benefit at less risk.

II. **ORDERS**

- A. Before initiation of restraint, a provider's order is required
- B. In emergency situations, order must be obtained
 1. Either during the application of the restraint or
 2. Immediately after the restraint is applied.
- C. Restraint orders must include
 1. The intent of the order (specific reason) and
 2. 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
 1. The attending physician will be consulted as soon as possible and
 2. The order signed at the next visit.
 3. Any consultation will be documented.

II. **MONITORING**

- A. All restrained offenders will be monitored
 1. At least every 15 minutes
 - (a.) To insure that they are not suffering any local or systemic harmful effect(s) due to restraint
 2. Documentation of monitoring recorded on DC-422S [Observation Log] or in electronic health record.

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- B. Restraint to be released at least every two (2) hours to all for
 - 1. Exercise of restrained body part
 - 2. Change in position
- C. Nursing notifies provider when
 - 1. Any harmful effect that cannot be improved without discontinuing the restraints is noted, the provider should
 - 2. Decision needed to determine overall benefit of continued use of restraints

III. DOCUMENTATION

- A. Nursing will document the following in progress note and on the DC422S [Observation Log]
 - 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) on which restraints used.
 - 5. The patient's response to the use of the restraint
 - 6. The overall condition of the patient and the condition of the patient's skin and extremities every 15 minutes.
 - 7. Input and output every 8 hours.
 - 8. Any signs of injury
 - 9. 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.
 - 10. The patient's specific symptoms indicating that the restraint can be safely removed and the time the restraint was removed.
- B. Provider will document in progress note
 - 1. Patient's history and use of restraints at initiation of restraints
 - 2. Clinical findings daily during use of restraints

IV. USE OF RESTRAINTS FOR SECURITY PURPOSES

- A. Healthcare staff not to be involved in the use of custody restraints for security purposes
 - 1. Except to periodically monitor the health status of the restrained offender
- B. Healthcare staff who note what they consider to be improper use of custody restraints by custody personnel are to
 - 1. Communicate their concerns as soon as possible to the custody personnel responsible for the offender
 - 2. Communicate their concerns to Facility Head/designee if not resolved by custody personnel responsible for offender
 - 3. Communicate to Chief of Health Services/Medical Director if no response from Facility Head/designee

Paula Y. Smith, M.D.

5/21/2014

Paula Y. Smith, MD, Chief of Health Services

Date

SOR: Chief of Health Services/ Medical Director/Director of Nursing

Addendum:

[Form DC422S Observation Log](#)