Guideline

Guideline Title: Physical Restraints

Summary: Liverpool Hospital supports and aims for a restraint free service, however, at times restraints may be required to ensure the safety of the patient, visitors and staff. Restraints will be used appropriately only after other avenues of care have been considered. Documented clear restraint guidelines should be included in the health care record and discussed with the next of kin/ carer and consent obtained. Observations will be recorded and reviewed by appropriate clinical staff. Patients who require the application of physical restraints to ensure their safety and achieve vital health care will be restrained for the minimal amount of time required and in a safe and respectful manner.

Approved by: Director of ICU

Publication (Issue) Date: January 2015

Next Review Date: January 2018

Replaces Existing Policy/ Guideline:

Previous Review Dates: 2003, 2011

Background
The use of physical and chemical restraints are only to be used in specific, well defined circumstances in order to optimise the patient’s health status and or, prevent actual or potential harm to the patient, other patients, visitors or staff. An emergency situation requiring the use of restraints is one that involves unanticipated, aggressive, confused, violent or destructive behaviour that presents an immediate danger to the safety of the patient or others.

Following placement of restraint, contact the key member of the family/carers to notify of the need for restraints. Document the contact (or attempt to contact - message left) in the case notes.

It is vital that the nurse caring for the patient explains to relatives and carers the need for such restraint.

1. Introduction:
The risk addressed by this policy:

Patient safety and patient comfort
The Aims / Expected Outcome of this guideline:

| Aim is for a restraint free service; however, at times restraints may be required to ensure the safety of the patient, visitors and staff. Restraints will be used appropriately only after other avenues of care have been considered. The outcome is that no injuries occur to patients, visitors or staff due to the use of inappropriate restraints. |

Related Standards or Legislation
- NSQHS Standard 1 Governance
- National Standard 4 Medication Safety

Related Policies
- LH_PD2013_P01.09 Therapeutic Restraint of a Patient

Note: This guideline must be read in conjunction with the hospital guideline on Therapeutic restraint of a patient.

2. Policy Statement
- All care provided within the Liverpool Hospital will be in accordance with infection control guidelines, manual handling guidelines and minimisation and management of aggression guidelines.
- The use of physical restraint must be prescribed and documented by a Medical Officer.
- The above prescription is valid for a period of 24 hours. This must then be re-assessed and renewed, if required, by the medical officer.
- Patients in restraints will be monitored frequently and assessed for their restraint requirements. This will include safely releasing the restraint and checking skin to ensure no harm is caused by the restraint and reapplying if required.
- The least restrictive restraint to accomplish therapeutic outcomes is to be used.
- Restraint use will be limited to emergencies in which there is an imminent risk of a patient physically harming him/herself, staff, or others; and where non-physical intervention would not be effective/appropriate.
- In an emergency situation nurses may initiate physical restraint. This must be reviewed as soon as possible by a medical officer and documented.

3. Principles / Guidelines

Indications
Nursing staff may need to restrain a patient in order to:
- Protect the patient from injury.
- Protect themselves from unnecessary risk or harm.
- Prevent removal of vital treatment modalities, such as:
  - removal of an endotracheal tubes where the patient's airway is compromised.
  - decannulation of access lines including arterial lines, central lines, vascaths and peripheral cannulae, compromising therapy.

Therapeutic Restraints
If all alternative measures have been considered and implemented and are unsuccessful, then the use of physical restraints may be considered.
Physical Restraint: This is a device or physical force used for behavioural or safety purposes. Approved Restraints include:
- Arm/leg cuffs in various materials
- Mitten restraints which are least intrusive for people pulling out lines etc
- Vest type restraints

Informing the next of kin/carer
- When considering the need for physical restraint use, it is important to inform the next of kin/ family /caregiver/public guardian of the need for restraint use.
- Ensure that the key family member for notification has been informed of the need to apply a restraint; as soon as possible following the restraint’s placement. Document attempts to phone this person (Message left and to whom, number(s) phoned and person to whom you spoke with).

Patient Assessment.
- Assess patient compliance - does he/she still require restraint.
- Request for restraint is to be regularly reviewed and modified as required.
- The nurse allocated to the patient will remain in a position to visualise the restrained individual.
- Hourly assessment and documentation will occur regarding the following:
  → Correct placement of restraints
  → Skin integrity, presence of peripheral pulses, temperature, colour and limb sensation of restrained body part.
- Provide sensory input as appropriate and reassurance/orientation as needed.
- Care should be taken not to inflict pain or bruising when placing or removing restraints which may occur easily in the elderly population.

Release of restraint
- Remove and reapply restraint to provide skin care and allow supervised movement.
- Supervised movement prevents loss of muscle strength, pressure ulcers, strangulation, psychological distress, confusion and aggression.
- Assess for requirement of more frequent release / pressure area care.
- Observe all access lines/catheters to ensure that they are positioned correctly and therapy continues uninterrupted.

Clinical Issues
- Explain to patient and family/carer the need for the restraint.
- Bed rails are to be used on all patients with neurological compromise or who are at risk for falls.
- Patients who are alert, orientated and cooperative may be nursed with the bedsides down, at the discretion of the nurse. The bed must be kept in the lowest possible position when staff are not attending to the patient.

Chemical Restraint
- Sedation may be required for patients whose behaviour puts them or others at immediate risk of serious harm and where the behaviour is unable to be constrained by other means. Please refer to the ICU guidelines on ‘Sedation management’ and ‘Delirium management’.
Procedure

- Application of arm and vest restraints as per product specifications:

(Kimberly-Clark Corporation - Product information, Roswell Georgia. 5/1999).
**Flowchart for determining need for physical restraint**

**Physical restraint:** Any manual method or physical or mechanical device, material, or equipment attached or 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.

**Chemical restraint:** Any medication used for the specific purpose of restricting the patient’s movement which is not a standard treatment for the patient’s medical or psychiatric condition.

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4. **Performance Measures**

All incidents are documented using the hospital electronic reporting system: IIMS and managed appropriately by the NUM and staff as directed.

5. **References / Links**


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