VMMC &Safdarjung Hospital,
Ministry of Health & Family Welfare,
Government of India, New Delhi.

सत्यमेव जयते

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Document No.	**TITLE**		
E/ NABH/ SJH/ Policy/25	**Patient Physical & Chemical Restraint Policy**		
Effective Date:01/02/2021			
Function	**Name**	**Designation**	**Signature**
Prepared By	Ms. Jeesha Shree Kumar	Member Quality Cell	
Reviewed By	Dr. K. C. Tamaria Dr. G Usha	OIC, Quality Cell HOD, Anaesthesia	
Approved By	Dr.S. V. Arya	Medical Superintendent	16/03/2021

Distribution: Quality Cell, Medical Superintendent, Safety Committee, Security Head, All Head of Departments

REVISION SUMMARY		
Version No.	Effective Date	Revision History
1.0	01/02/2021	00

1.0 INTRODUCTION

The use of physical restraint in health-care settings is common and complex practice as it has physical, psychological, judicial, ethical, and moral issues. Physical restraints are most often applied when behavioural expressions of distress and/or a change in medical status occur. It should be an intervention focused at managing the concerned behaviour for a given point of time.

2.0 PURPOSE

- To prevent interference /obstruction with medical treatments (such as self extubation and intubation).
- To protect medical devices (such as intravenous lines, in - dwelling urinary catheters, and feeding tubes).
- To prevent falls and injury of any kind.
- To control disruptive behavior (such as agitation, wandering, and combativeness).
- To preclude the possibility of harming self, staff and other patients

3.0 SCOPE

This policy applies to all healthcare workers (HCW) within the organization who apply physical restraint to patients those who are admitted.

4.0 DEFINITION

Physical restraint:

The direct application of physical force to a patient, without the patient's permission, to restrict his or her freedom of movement (JCAHO, 2000). The physical force may be human, mechanical devices, or a combination thereof.

5.0 ABBREVIATION

HOD- Head of the Department

MS- Medical Superintendent

Addl MS- Additional Medical Superintendent

HCW- Health Care Workers

NABH- National Accreditation Board for Hospitals & Healthcare Providers

NPO- Nil by Mouth

ROM- Range of Motion

6.0 RESPONSIBILITY

Nursing staff, Physicians, Support Staff (Describe)

7.0 PROCEDURE

Policy:

Restraint may only be used to ensure the immediate physical safety of the patient, staff or others and must be discontinued at the earliest possible time. Alternative and nonphysical interventions are attempted prior to use of restraints.

Patient dignity should be maintained during restraint.

Physician Orders

- Restraints shall be applied with only a physician's order that defines the reason for restraint, less restrictive alternatives attempted/considered, type of restraint to be used, and duration for which the restraint may be applied.
- The time limit shall not exceed one calendar day, after which new orders are required if restraints must be continued.
- In emergency situations, (i.e., self-extubation), if the physician is not available to issue the restraint order, restraint is initiated by a registered nurse based on an appropriate assessment of the patient.
- In that case, the physician is notified within 12 hours of the initiation of restraint and a written order is obtained from that physician and entered into the patient's medical record.

- If a renewal order is required after the initiation of restraint, the first renewal order must be obtained within one calendar day of initiation.

Ongoing Care and Monitoring:

- Patients shall be monitored at least every two (2) hours to determine the following and make adjustments as necessary:
- Position, circulation, and skin integrity of restrained area
- Maintenance of privacy and comfortable body and room temperature.
- Appropriate application of the device(s).
- Toileting and fluid needs.
- Nutrition
- Range of motion
- Restraint reduction or removal

Documentation in the medical record shall reflect the required monitoring.

- Patients shall be positioned for safety and comfort.
- Patients shall have active or passive range of motion to the affected joint(s) as medically necessary.
- The patient and/or family, whenever possible, shall be educated regarding:
- Reason for restraint
- How the patient/family can avoid restraint
- Criteria necessary for release from restraint.

Reassessment of Use:

- The Consultant, in collaboration with the health care team, shall evaluate the patient at
- the end of the prescribed duration of restraint to determine the need for continued use
- of the device(s). If restraint remains necessary, the order must be renewed. In the
- absence of order renewal, restraints shall be removed by the responsible Nursing staff.

- Reapplication of Restraint
- The patient is continually assessed to ascertain his or her condition and to determine if restraint can be discontinued.
- If a patient, who was recently restrained, must be placed back into restraints, new physician order is required.
- A temporary release that occurs for the purpose of caring for a patient's needs (e.g., toileting, feeding, and range of motion) is not considered a discontinuation of the intervention.

Assessment, Care, and Monitoring:

Each aspect of patient assessment and care is considered complete

- Position: Proper alignment of the restrained limb(s) is maintained.
- Circulation: The affected limb(s) has been checked and device application has been determined not to impair circulation to the extremity:
- Nail bed blanched in less than 3 seconds
- Pulse is present above and below restraint.
- Skin Integrity: Skin integrity has been checked under and around the device(s), and at all bony prominences and no pressure or reddened areas have developed.
- The patient is covered either by gown, sheet, or curtain and is protected from public view.
- Device Application: The device is applied according to the manufacturer's guidelines and in a manner that is secure but not tight. Straps are secured to bed or chair frame (never to side rails or other moveable parts); and quick release is possible.
- Fluid Needs: Fluids are administered as ordered by the physician. If the patient is not on fluid restriction, oral fluids are offered at least every two hours. If the patient is nothing-by-mouth (NPO), oral care is provided at least daily to maintain integrity of oral mucosa.

- Toileting Needs: Elimination needs are attended to, either by foley catheter (only if ordered for other medical necessity) or by offering the patient the bed pan or assistance to bathroom or bedside commode chair.
- Nutrition Offered: Nutritional needs are met as ordered by the physician. If oral intake is allowed, the patient is offered and assisted with meals and snacks.
- Range of Motion: Active or passive range of motion in the affected limb(s) is completed either by the patient or the caregiver. For patients requiring limb restraints, ROM is recommended at least every 2 hours.
- Evaluation for Restraint Reduction or Removal: Need for the use of restraint(s) is evaluated frequently (at least every two hours) and restraints are discontinued at the earliest possible time.

8.0 REFERENCES

1. Joint Commission Hospital Accreditation Manual, July 2009, restraints and seclusion
2. Hatice Balci and Selda Arslan, Nurses' Information, Attitude and Practices towards Use of Physical Restraint in Intensive Care Units, J Caring Sci. 2018 Jun; 7(2): 75–81.
3. Restraint guidelines for mental health services in India, Indian J Psychiatry. 2019 Apr; 61(Suppl 4): S698–S705.

9.0 VALIDITY STATEMENT

This document is valid for one year from the date of issue.

10.0 APPENDICES AND FORMS

* Annexure A: consent for use of restraints
* Annexure B: Amendment Sheet
* Annexure C: Training log

Annexure A: consent for use of restraints

वर्धमान महावीर मेडिकल कॉलेज एवं सफदरजंग अस्पताल, नई दिल्ली-110029

Vardhman Mahavir Medical College & Safdarjung Hospital, New Delhi-110029

शारीरिक /रासायनिक संयम सूचित सहमति

PHYSICAL/CHEMICAL RESTRAINT INFORMED CONSENT

हम आपकी लिखित सहमति के बिना शारीरिक /रासायनिक संयम का उपयोग नहीं कर सकते। कृपया उचित प्रत्युत्तर की जांच करके नीचे अपनी सहमति या इनकार दर्शाएं। सभी मामलों में, आपका हस्ताक्षर इस बात की पुष्टि करता है कि संयम के उपयोग से जुड़े संभावित लाभों और जोखिमों को आपको समझाया गया है और आपके साथ चर्चा की गई है।

We cannot use a physical/Chemical restraint without your expressed written consent. Please indicate your consent or refusal below by checking the appropriate response. In all cases, your signature validates that the potential benefits and risks associated with restraint use have been explained to and discussed with you.

निम्नलिखित सबसे कम प्रतिबंधात्मक, वैकल्पिक गैर-संयम दृष्टिकोण अप्रभावी साबित हुए हैं

The following least restrictive, alternative non-restraint approaches have proven to be INEFFECTIVE

मैं समझता हूँ कि मेरे काय-चिकित्सक, डॉ..... ने सूचीबद्ध विशिष्ट चिकित्सा लक्षणों के लिए निम्नलिखित संयम(मों) का आदेश दिया है।

I understand my physician, Dr._____has ordered the following restraint(s) for the specific medical symptoms listed.

संयम प्रकार, आवृत्ति, अवधि	चिकित्सा लक्षण	निर्मोचन एवं पुनर्स्थिति की अनुसूची
Restraint Type, Frequency, Duration Schedule	**Medical Symptoms**	**Release and Reposition**

प्रकार

Type:_____ **आवृत्ति** Frequency:_ **अवधि** Duration:_

प्रकार

Type:_____ **आवृत्ति** Frequency:_ **अवधि** Duration:

मैं ---------- (रोगी का रिश्तेदार नाम और संबंध) लाभ और जोखिम की समीक्षा और चर्चा के उपरांत के साथ-साथ संयम के उपयोग के कारणों को अच्छी तरह से समझनें के बाद एक शारीरिक /रासायनिक संयम के उपयोग के लिए सहमति देता हूँ। समुचित स्वास्थ्य पेशेवरों ने इस तरह की आवश्यकता का आकलन किया है और एक निरोधक उपकरण को मेरी देखभाल की अनुशंसित योजना के हिस्से के रूप में इंगित किया गया है। मैं समझता हूं कि मैं इस अनुमति को वापस लेने के लिए अपने अधिकारों का प्रयोग कर सकता हूं। मैं एक ----------
-- के शारीरिक /रासायनिक संयम के उपयोग के लिए सहमत हूं। **(संयम का प्रकार)**

I ---------- (Patients Relative name and relation) DO consent to the use of a physical/chemical restraint following review and discussion of benefits and risks as well as the reason for the use of the restraint. The appropriate healthcare professionals have assessed the need for such and a restraining device is indicated as part of my recommended plan of care. I understand I can exercise my rights to withdraw this permission. I agree to the use of a

_____ Physical/chemical restraint.
(Type of Restraint)

मैं ---------- (रोगी का रिश्तेदार नाम और संबंध) चिकित्सा लक्षणों के उपचार के लिए संयम के उपयोग के लिए सहमति नहीं देता हूँ।

I ---------- (Patients Relative name and relation) DO NOT consent to the use of restraints for treatment of medical symptoms.

मुझे ---------- (रोगी का रिश्तेदार नाम और संबंध) संभावित लाभ और संयम का उपयोग करने के जोखिम के बारे में सूचित किया गया है (जैसा कि पीछे समझाया गया है) और इसके द्वारा मेरे निर्णय से संबंधित किसी भी प्रतिकूल परिणामों के लिए पूर्ण दायित्व लेता हूँ। मुझे मेरे सवालों के जवाब पूछने और प्राप्त करने का अवसर प्रदान किया गया है।

I ---------- (Patients Relative name and relation) have been informed of the potential benefits and risks of restraint use (as explained on the reverse) and hereby assume full liability for any adverse outcomes related to my decision. I have been afforded the opportunity to ask and receive answers to my questions.

मैं समझता हूं कि मुझे किसी भी समय संयम से संबंधित अपने निर्णयों को बदलने का अधिकार है और किसी भी परिवर्तन को लिखित रूप में सूचित किया जाना चाहिए।

I understand that I have the right to alter my decisions concerning restraints at any time and that any change must be communicated in writing.

रोगी के रिश्तेदार के हस्ताक्षर Signature of patients relative----------

संबंध Relation ----------

Annexure B

AMENDMENT SHEET

VMMC & Safdarjung Hospital, New Delhi

Sr No.	Page No.	Clause No.	Date of Amendment	Amendment Made	Reasons	Signature of Officer In-charge	Signature of Medical Superintendent
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							

Annexure C

VMMC & Safdarjung Hospital, New Delhi

TRAINING LOG (Contents, Deviation and Amendment)

Sr. No	Training Attendee, Designation	Place of posting	Signature
1			
2			
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Officer In-charge