State of Iowa Department of Corrections
Policy and Procedures

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Chapter 6: HEALTH SERVICES
Sub Chapter: MENTAL HEALTH
Related DOC Policies: IO-SC-19, IO-SC-08, HSF-710A, HSF-710B
Administrative Code Reference: N/A
Subject: HEALTH CARE RESTRAINTS
ACA Standards: 5-ACI-3A-16, 5-ACI-3A-18, 5-ACI-6C-13
Responsibility: Dr. Jerome Greenfield
Effective Date: November 2020
Authority:

1. PURPOSE

To ensure that the use of restraints for health reasons is medically authorized, and is used only as necessary to ensure safety of patient and others. These measures are not intended, and shall not be used, as a means of discipline. (Refer to IDOC Policy **IO-SC-08**, *Use of Force and Restraints*)

2. POLICY

The use of restraints for medical and psychiatric purposes must be medically authorized. Only appropriate health services staff shall authorize their use.

3. DEFINITIONS

A. Medical Restraints – Medically authorized restraints used for non-security purposes

B. See IDOC Policy AD-GA-16 for additional Definitions.

4. PROCEDURE

A mentally ill or mentally disordered patient may be so impaired and explosively assaultive that restraint is required in order to reduce the risk of injury to self and/or others. Restraints may be used to limit or terminate self-injurious or assaultive behavior. Once a situation is contained, appropriate health care staff should be notified and an assessment completed.

A. Alternatives and communication/de-escalation techniques may be attempted as appropriate to the circumstances prior to the use of restraint/segregation. Refer to IDOC Policy **HSP-713**, *Crisis Intervention*.

   Prior to the use of restraints, the following alternatives may be used for patients in restricted status when writing materials or devices for distractions such as TV are not available:

   1. Therapeutic communication/motivational interviewing/active listening with staff

   2. Listening to music played on the unit radio/CD player

   3. Food or fluid (snack)

   4. PRN (as-needed) medication

B. Written Orders for Use of Restraint

   1. To protect the patient and/or others, any staff can initiate placing an impaired or assaultive patient in restraints as soon as appropriate, after other less restrictive means have been considered or are exhausted.

   2. The attending or on-call provider will be contacted as soon as possible (within 60 minutes of placement) and informed of the status of a patient needing medical restraints in order to protect themselves or others from harm. The purpose of medical restraints is as a protective measure not punitive; therefore, no written order is required at the time of restraint placement in order to promote quick and effective action to prevent harm.

   3. Within the first hour of placing a patient in medical restraints, a medical/mental health care provider must be notified for authorization.

      The nurse shall have seen and assessed the patient's needs prior to calling the medical/mental health care provider for authorization/an order. Restraint/segregation orders shall contain:

      a. Date/time of order.

      b. Type of restraint used.

      c. Reason for use (actual behavior of patient or patient's request)

d. Length of time restraint may be used. **ORDER CANNOT EXCEED 24 HOURS**. (Example: Four-point restraint to bed up to 4 hours, or as appropriate, to prevent harm to self or others due to combative/assaultive behavior toward others.)

e. The medical/mental health care provider may add to the order, "After calm and in control, staff may begin gradual release until free from restraint."

f. Orders for restraint or segregation shall not be written as a PRN or standing order.

g. If the patient requests restraints and is assessed as being a harm to themselves or others, document "at the patient's request."

h. Documentation must support placement into restraints.

i. The practitioner must be notified every 24 hours if continued use of restraints are indicated.

4. If continued restraint is not authorized by the medical/mental health care provider, the patient must be released from restraints.

5. All restraint orders shall be for the least amount of time necessary to prevent injury to the patient or others.

6. If not already in effect, an SSIP status must be initiated and remain in effect until completion of an evaluation by mental health staff. Appropriate documentation must be completed and support release to a less secure status.

7. Maximum initial duration of restraint order is 24 hours; any restraint longer than 24 hours requires a new assessment and restraint order. The authorizing provider must review the order with the Health Services Administrator/designee.

8. Orders for the restraint bed require the psychiatrist/mental health provider be contacted every four hours and provided with an update on the patient's status and renewal of the orders.

9. Psychiatric/psychological/medical provider consultation will occur as soon as possible.

a. A nursing assessment will be conducted within the first hour of restraint. The assessment will be documented in Medical ICON and include:

   1) History of medical conditions which could be adversely affected by the application of restraints, e.g. respiratory disease, convulsive disorders, cardiovascular disease, A-V shunt for hemodialysis, etc. The attending medical provider or mental health care provider on call shall be contacted and notified of any adverse condition to determine if restraint placement should continue.

   2) Time of last meal.

   3) Determination of circumstances that precipitated the use of restraints. This will allow the nurse to determine if a more extensive assessment is applicable.

   4) Assessment for circulatory or respiratory distress.

   5) Injury

   6) Nausea

   7) Discomfort

   8) Numbness or tingling in any extremities: each extremity will be assessed for pain, paralysis, paresthesia, pulse and pallor.

b. The patient will be assessed by the nurse at least once during the ordered restraint time for mental status and behavior that is congruent with criteria for release.

c. The licensed nurse will consult with the medical/mental health care provider when a patient has physical contraindications for the use of medical restraints and alternative measures must be used to restrain them, i.e. leg irons or handcuffs that cannot be used due to the girth of a patient. The medical/mental health provider will make the decision to use alternative restraints.

d. Restraint placement should not be so tight as to impede or compromise circulation to extremities or impede respirations.

   1) Check that pulse are present distally to restraints

2) Check capillary refill

3) Color and temperature of skin; should be warm and without cyanosis

4) Restraint should have two fingers spaces between the restraint and the chest if the chest restraint is used

5) Vital signs when patient calm enough to cooperate

e. Signs that require **IMMEDIATE ACTION**:

1) Respiratory distress (difficulty breathing)

2) Vomiting

3) Circulatory distress

4) Change/loss of consciousness

C. Types of Restraint

The following types of medical restraint are available to assist in protecting the mentally ill/disordered patient from risk of injury to self and/or others:

1. Ambulatory Wrist Restraint – Restrains wrists only

2. Ambulatory Ankle Restraint – Restrains ankles only

3. Full Ambulatory Restraint – Restrains ankles and wrists

4. Restraint Bed – Designated bed equipped in the manner designed per manufacturer's specifications. Four/five/six point restraints are used only in extreme instances and only when other types of restraints have proven ineffective or the safety of the patient is in jeopardy. Advance approval is secured from the mental health care provider before a patient is placed in a four/five/six point restraint. Subsequently, the IDOC Health Services Administrator or designee should be notified to assess the patient's medical and mental health condition, and to advise whether, on the basis of serious danger to self or others, the patient should be referred to IMCC for emergency involuntary treatment with sedation and/or other medical management, as appropriate.

a. The patient is placed on his/her back **(Do not place in a prone position)** in an appropriate Suicide Self-Injury Prevention (SSIP) room if available. If an appropriate room is unavailable, the Medical Director/designee will be called for room approval.

b. Any restraints four-point and above require specific documentation of the patient's behavior and progressive failed interventions attempted, that led to the type and number of restraints utilized.

c. Documentation will include, at a minimum, the following:

    1) Release of at least one extremity for exercise 1-2 minutes hourly. Range of motion/circulation checks will be rotated to involve all extremities, either one at a time or in multiples and documented on HSF-720A form.

    2) Toilet and fluids offered every two hours, or as needed, with position accommodation as indicated.

    3) During mealtime, release one arm if behavior is appropriate. Arrangements for adequate nutrition will be offered.

    4) Vitals and circulation checks of all extremities must be obtained and documented by nursing staff in ICON Medical on each shift.

d. When the patient presents in a calm state, the mental health care professional shall be notified for evaluation for removal from the restraint bed.

    To ensure the safety of the patient and staff, a gradual release from restraint may be utilized. At no time should only one extremity be restrained to the bed.

    Restraints shall be removed in the following order:

    1) Thigh strap

    2) Chest strap

    3) Right arm

    4) Left leg

    5) Left arm and right leg together

e. Restraint release plan must be documented in the health record and security staff notified of the plan.

f. If the patient escalates during the release process, he/she shall be placed back into restraints and the medical provider called for further instruction and the patient's associated behavior documented in the patient's health record.

5. Special Restraint

a. Special restraint devices are available for use in situations in which added security/control is needed.

b. Special restraint devices are not intended for use as standard restraint.

c. Helmet

1) Only appropriate medical device helmets approved by the Health Services Administrator/designee (On-call psychiatrist) will be used on patients.

2) A helmet, with or without bite bar, may be used for patients whose behavior places them at serious risk for injury, e.g. banging head, biting.

3) A helmet may be used as an addition to all restraints listed above.

d. Mittens

1) Only appropriate medical safety mittens approved by the Health Services Administrator/designee will be used on patients.

2) Mittens may be used for patients whose behavior places them at risk for injury.

3) Mittens may be used as an addition to all restraints listed above.

e. Pregnant Patients

Medical restraints shall not be used on pregnant patients unless authorized by the Health Services Administrator/designee. For off-site appointments/transfers, refer to IDOC Policy **IO-SC-12**, *Escorted Trips*: Procedure E, Pregnant Patients.

D. Documentation and Monitoring

1. All Psychiatrist/Medical Provider authorized use of restraint must be supported by objective data and specific plan, which are documented in the patient's electronic medical record. The order for restraint may not exceed 24 hours (4 hours for psychiatric restraint bed). If order is for use of multiple restraints, specific documentation (see Type of Restraint) must be included in the plan of care.

2. All Mental Health Care/Medical Provider authorized use of restraints must be documented on the *Restraint Release Log*, **HSF-720**.

3. Health Services staff will review and sign patient contact on the *Health Services Segregation Log*, **HSF-710A** every four hours.

4. Assessments will be completed by the nurse while in restraints for behavior and intent congruent with their safe release every 4 hours and documented in a nursing encounter to include review of food intake, sleep, etc.

5. Documentation is to include any efforts provided to the patient to help meet criteria for discontinuing restraints or efforts to provide less restrictive treatment alternatives, i.e. talking with a counselor.

6. Each on-site administrative day, a note is to be written by the psychologist documenting the patient's current mental health status.

7. Patients on a restraint bed must be observed continuously with five (5) minute checks by IDOC staff or an appropriately trained patient observer, who is directly in view of the patient, which will be documented on the *SSIP Observation Log*, **HSF-710B**. Security staff will document 15 minute checks on the *Health Services Segregation Log*, **HSF-710A**. Completed observation and restraint/segregation logs are to be scanned into ICON Medical.

8. Cell/room checks are to be completed at a minimum of one time per 24 hours and recorded on the *Health Services Segregation Log*, **HSP-710A**.

9. Psychology/Psychiatry/Medical Provider and/or nursing staff are to be notified of any significant behaviors and/or concerns immediately via telephone or face-to-face contact.

10. Psychiatrist/Medical Provider/Psychologist/Nursing Staff has final responsibility for discontinuing restraints; health services staff should be notified and documentation written in the patient health file. The mental

health provider will be notified of final restraint removal. **(4-4190)(4-4405)**

E. Continuation/Re-Evaluation

1. Re-evaluation of the patient and the need for continued restraint is assessed by the nurse and occurs at least a minimum of every four hours and documented in a nurse encounter. The mental health provider is to be notified of re-evaluation. Gradual release may be utilized when the patient is calm and their behavior is appropriate depending upon the circumstance and the patient's cooperation and safety. Re-evaluations must be documented and include:

2. Patient's behavior – include actual behavior and statements that are made.

3. Attempts to lessen restraint gradually, if possible.

4. Documentation by the unit officer on the *Health Services Segregation Log*, **HSF-710A**, of exercise, offering and actual intake of food and fluids, and toileting.

5. Documentation by nursing staff of circulation checks of all extremities at the onset of restraint and every four hours thereafter.

6. The behavior criteria for discontinuing restraint have been discussed with the patient and the patient's response to the criteria is appropriate to include being able to control self and verbalize no intent of harm to self/others.

7. After an evaluation, a nurse may discontinue use of restraints at any time if the patient is calm, behavior is appropriate, and meets the criteria for release. Gradual release will be initiated by the nurse and the shift supervisor shall be notified of the plan.

F. Storage, Cleaning and Replacement of Restraints:

1. Medical restraints are stored on the unit and cleaned/disinfected between uses with a spray antimicrobial and allowed to air dry before return to storage.

2. During the cleaning process, restraints are inspected for serviceability. Restraints found to be compromised (tears, holes or other damage) are removed from service and replaced.

3. Health Care restraints found to be compromised (tears, holes or other damage) are removed and appropriate personnel notified for replacement.

G. After Incident Review

1. An after incident review shall be completed by the facility's Nursing Services Director within 7 working days.

2. Any concerns regarding the review shall be addressed and sent in writing to the IDOC Health Services Administrator and the facility's warden.