The use of physical restraints in mental health

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Use of restraints in mental health set-ups brings forth ethical issues. However, this method is being used for highly agitated and violent patients in psychiatric hospitals in order to protect the patients and others for possible physical harm.[1,2] In all circumstances, the least restrictive restraint that is effective should be used and restraints should never be used for the sake of convenience.[3] In saying this, is it imperative that healthcare workers understand and follow proper protocol and procedures when restraining a patient to ensure safety and dignity of the patient.[4] Failure to follow proper protocol can have major consequences for the patient and also for health authorities and staff in the form of legal ramifications.[5]

Restraint of a patient can come in many different forms. Broadly, these can be classified into chemical, physical and environmental restraints. There are many steps that can be taken prior to resorting to the use of restraint for a patient. The initial assessment of a patient must ensure the behaviour or action is not the result of a dangerous organic source.[6] If a potentially dangerous organic cause is found is it imperative to treat rather than focusing the attention on restraining the patient. Clinical judgment must be applied to determine if it is safe to proceed with the clinical evaluation after potential life threatening causes have been ruled out. Verbal de-escalation strategies should be attempted prior to the use of any form of restraint.

Practice guidelines are crucial for guidance in controversial topics such as physical restraints. There are no guidelines generated from international platform. In lieu, institutions are required to examine the literature and produce institutional guidelines. As a result of this restraint practices varies significantly from one institution to the next.

At our institution (Memorial University of Newfoundland) the usage of physical restraint is guided by two policy guidelines. The initial guideline is a nursing practice policy that discusses the usage of physical restraints in addition to chemical and environmental restraints. The policy is targeted to the general medical population. The second guideline is aimed specifically at the mental health patient population and focuses on the utilization of emergent use of 5-point restraints. Both policies outline the following key areas of restraint use to be:

a. Assessment

b. Consent

c. Application

d. Discontinuation

e. Documentation

a. Assessment:

- Policy stipulates that physical restraints should only be utilized when agreed upon by the interdisciplinary team and other alternatives have failed. A physician must write the order for the restraint within 12 hours of application of the restraint.

- If there is a dispute from a team member, patient or family member the opinion of a second physician is recommended.

- There are forms of immobilization that are not considered restraint and therefore do not require a consent and physicians order. These include:

- Immobilization of a part of a body for medical purposes.

- Temporary immobilization of a part of a body while patient care is being employed.

- Temporary immobilization during transportation.

- Use of devices to maintain desired body position for patients with functional deficits eg. belts for wheelchair bound patients.

- Assessment indicates that a hazardous situation may arise eg. extubation of patients in the Operating Room.

- Use of locked table trays on geriatric chairs to facilitate meals and/or other activities or therapies.

b. Consent:

- Informed consent must be attained as per our institutions Consent Policy at the time of or within 12 hours

of initiation of restraint.

c. Application

- Physical restraints are to be applied according to the manufacturers specifications allowing for patient safety, movement, comfort and body alignment.

- Close observations should be maintained at a minimum of 30 minutes with appropriate documentation.

- Restraints should be assessed and/or released every two hours for inspection of skin integrity and circulation. Documentation should be made on the appropriate surveillance record.

- Physical restraints should be released at regular intervals for "free times" or for patients to have time unreleased from restraints.

- Patients whose behaviour and/or physical condition require restraint should be reassessed for the requirement of restraint at least 24 hours with a physician.

d. Discontinuation:

- Restraints may be discontinued at any time if it is deemed that continued use will jeopardize the health or safety of the patient.

- Discontinuation of the restraint requires a physician's order.

e. Documentation:

1. Initial documentation must include:

a. assessment of the patient and the situation

b. alternatives considered and/or tried

c. consent obtained

d. type of restraint used

e. date and time of the restraint application

f. discussion with family/patient and interdisciplinary team

2. At the time of restraint review, documentation must include

a. reassessment of the patient and situation

b. outcome of the review

While this represents our practice towards physical restraint there will undoubtedly be variation from institution to institution. With so many differing views on the use of restraints patient safety can come into risk. A universal guideline in the form of a national or international practice guideline would help remove potential dangers to the patients. In developing countries like Pakistan, such policies appear to be non-existent in majority of the mental health institutions. There may be a possibility of application of some suggested guidelines by some of the institutions. Is it not important to have international and national guidelines?

References

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