Patient Rights During Restraint Use

The University of Texas MD Anderson Cancer Center Restraints Improvement Group

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Abstract

Beverly Mitchell RN, Joni Herman RN, Eden Bautista RN, Anna Mathew RN, Tracy Chien RN, Sara John RN, Anna Cherian RN, Mary Zacharih RN, Angela Arnold RN, Sirene Parreno RN, Maria Bunagan RN, Uselyn Deary RN, Gayle Balmaceda RN, Marian Wilson RN, Monique Vincent RN, The Quality Improvement Team, The Education Team, MICU & SICU Staff, Gregory Botz MD, Olivier Wenker MD

The condition of critically ill patients may not permit them to exert their rights to free choice and liberty. A patient's fundamental rights can not be overridden due to questionable patient capacity. The nurse's moral responsibility to uphold and respect the patient's dignity and autonomy is inviolate regardless of the patient's ability to reason or comprehend. (Reigle, J.,1996).

Basic human rights are not forfeited on entry to the hospital. Application of restraints violates a patient's freedom and right of self-determination. A competent patient has the right to refuse restraints unless he or she is at risk for harming others. (Moss & La Puma, 1991).

Paternalistic intervention, when justified, should be reliable and achieve the purpose intended. Once the immediate danger is suppressed, other alternatives must be explored for controlling the patient's behavior since the effectiveness of restraints is questionable. Restraints, when necessary, should be used as a short-term solution. The rationale that no harm occurred does NOT permit the recurrent and repeated use of physical restraints. (Reigle, J., 1996).

Paternalism occurs when the decisions or actions of an individual are overridden to maximize benefits or prevent harm to them. Paternalistic actions may be defended and ethically permissible when a patient is in danger of serious, yet preventable, harm or when the patient's behavior threatens the safety of others. Such action should be taken only when the intervention is likely to prevent harm. The nurse must choose the least restrictive intervention as paternalistic action suppresses another's autonomy and freedom. (Reigle, J., 1996).

Maintaining medical therapies, while minimizing patient confusion, preserves the patient's dignity and develops the patient's trust in the care provider. No ethical justification exists for the application of restraints as a punitive measure. Such a practice is abuse. (Reigle, J., 1996).

Restraint use should be consistent with the overall goals of therapy. For example, restraining a terminally ill patient near the end of life to maintain nutrition and hydration conflicts with the goal of providing pain relief and comfort care. Offering restraints to patients in place of proper medical evaluation, nursing care, and compassion is UNETHICAL. (Reigle, J., 1996).

PATIENT RIGHTS

- Every patient has the right to expect. . .
- Care that is respectful, high-quality, considerate with dignity
- Participation in decisions about treatment, benefits, risks, alternatives
- Consideration of personal beliefs and values

WE RESPECT THE RIGHTS OF EACH PATIENT

- WE ARE AWARE THAT EACH PATIENT HAS UNIQUE HEALTHCARE NEEDS. WE ENCOURAGE A PARTNERSHIP BETWEEN THE PATIENT AND THE HEALTHCARE

TEAM.

- THE UNIVERSITY OF TEXAS MD ANDERSON CANCER CENTER

MD ANDERSON RESTRAINT POLICY AND PROCEDURE DOCUMENTATION ON RESTRAINTS

PHYSICIAN ORDER FOR PROTECTIVE RESTRAINT (EVERY 24 HOURS)

The physician must sign restraint order form Order must be verified and signed by nurse Document clinical justifications (DO NOT document ventilator as a justification for restraints) Date and time each order Note type of restraint used, i.e. vest, wrist, etc.

RESTRAINT MONITORING AND DOCUMENTATION

- Document attempted alternatives to restraints. (see algorithm poster)
- Assess every two hours and document pts mental status in flow sheet, document on restraint form every shift.
- Document restrained patient care in nurses notes/flow sheet (ADL's, ROM, circulation checks, etc.)
- If no restraints at present, documentation required in nurses notes.
- Date and sign form

POLICY

Physical restraints may be used only when less restrictive measures prove inadequate to prevent an agitated or disoriented patient from injuring him/herself and/or others, and to prevent the patient from deleteriously interfering with medical treatment. Physical restraints should be used in a way that the safety and dignity of the patient is preserved. Restraints may not be used for convenience. The least restrictive type of restraint that will accomplish the intended purpose should be utilized. Only institutionally approved restraints, purchased by MDACC for this purpose, will be used for protective purposes. Leather restraints are not permitted.

DEFINITIONS

Restraint: protective devices to protect a patient or others from injury or to prevent patient interference with medical treatment. Seclusion: involuntary confinement. Seclusion is not used at M.D. Anderson Cancer Center. A psychiatric consult is available for any patient with behavior health needs.

Types of restraints:

- Hand mittens,
- soft wrist restraints,
- soft ankle restraints,
- and vests may be used.

DEVICES WHICH DO NOT CONSTITUTE RESTRAINT

Those devices customarily used in conjunction with medical diagnostic procedures, treatments, or movement/transfer of patients and are considered a regular or usual part of treatment. i.e. body restraint during surgery.

Restraint does not include safety restraint for children in cribs, high chairs, or strollers, or the use of medically indicated devices that stabilize a body part, i.e. back braces or splints.

Restraints do not include commonly used devices that allow all extremities uninhibited movement, such as table top chairs, lap trays, or seat belts in wheelchairs.

USE OF BED RAILS

Bed rails are not considered restraint when use is based on assessed safety and protective needs of the patient. The standard for MD Anderson Cancer Center is to raise the two upper bed rails to assist with mobility and as a reminder to the patient that he/she is in the hospital. All four bed rails are raised to remind patients to call nursing personnel for assistance if the patient is unstable due to low blood pressure, confusion, unsteady gait, has a femoral intra-arterial catheter or another deficit which would place the patient at risk if he/she got out of bed without assistance. In addition, all four bed rails may be raised in conjunction with medically indicated devices that are intended to stabilize a body part. Patients are to be individually assessed before all four bed rails are placed in the upright position. The call system is to be placed for easy use by the patient.

ORDERS FOR PATIENT RESTRAINT

A physician order is required to restrain a patient. The order

must be dated and timed, must indicate the period for which restraint is to be used, must indicate the alternative interventions employed prior to the restraint order, and must be renewed by the physician every 24 hours after assessing the patient for the continued need for restraints. PRN restraint orders are not acceptable.

Verbal or telephone orders to initiate restraints must be signed by the physician within 24 hours.

In an emergency, restraints may be applied prior to obtaining a physician's order to prevent the patient from harming him/herself or others. A physician must be contacted to obtain an order for restrain within one (1) hour of initiating restraints.

OBSERVATION/DOCUMENTATION

Documentation on the Restraint Monitoring form will include the alternatives used, type of restraint, and location of restrain.

Patient assessment and intervention is documented on the Restraint Monitoring form. Initials on this form indicate compliance with the standard for the defined period of time. Alterations from the standard are documented in the medical record.

Patients in limb restraints (including mittens) should be assessed every hour for skin irritation and circulation.

All restrained patients must be assessed every two hours for mental status, safety, and needs related to hydration, elimination, and nutrition.

Limb restraints (including mittens) must be removed every four hours and range of motion exercises provided.

References

Author Information

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