

Ordering for Physical Restraint

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The use or application of restraint seems to be a convenient and a readily available means to control patient's physical behavior. On one hand, there is this nagging accusation that sometimes its application is not for the patient's best interest but solely for the convenience of the medical staff. Repeated calls from nurses, interns or residents might tempt the attending physician to order restraint without fully assessing the medical condition of the patient. Sometimes, a family member may request a restraint be used, usually for safety. Still it is the attending physician's duty to assess whether that request is appropriate. Lack of available "watcher" should not automatically prompt the attending physician to order use of restraint. The attending physician must carefully balance justifiable use of physical restraint, respect for patient's autonomy and the family's wishes.

Restraint¹ is a device or medication that is used to restrict a patient's voluntary behavior.² Manual restraint is the use of a hands-on technique in a reflexive way to guide or redirect a person away from potential harm/injury, consistent with what could reasonably be considered the exercise of a "duty of care" towards the person (e.g., momentary contact to guide or redirect a person, lasting for no more than approximately 30 seconds); Physical restraint is the sustained or prolonged use of any part of a person's body to prevent, restrict, or subdue movement of the body or part of a body of another person (e.g., lasting more than 30 seconds; not a reflexive manual restraint); Mechanical restraint is the use of any device to prevent, restrict or subdue movement of a person's body for the primary purpose of behavioral control, but excluding the use of an authorized mechanical restraint recommend by a medical practitioner or therapist for use at identified times and places for therapeutic purposes (i.e., explicitly to enhance health and wellbeing) and an authorized mechanical restraint recommend by a medical practitioner or therapist to support a person participate in identified activities of daily living (e.g., at meal times), or to enable a person to be transported safely according to law. Chemical restraint is the use of a chemical substance to control or subdue a person's behavior (be it regularly administered or prescribed as required), but which excludes any drug prescribed by a registered medical practitioner for the sole purpose of treating a diagnosed physical illness or condition, or by a psychiatrist for the sole purpose of treating a diagnosed mental illness. Also excluded from the definition of chemical restraint would be any drug prescribed to control a person's behavior so that a person can undergo a medical examination or related diagnostic procedure or receive treatment for a physical illness or condition, but only where the specific

date, time and place of the treatment, examination or identified diagnostic procedure has been authorized by the treating physician.³

There is an enormous sense of judgment that goes into the decision to use or not to use restraint (or safety device).⁴ Whether or not a patient is put under restraint is a matter of medical judgment and the attending physician can, in the exercise of his medical judgment, declined to authorize physical restraints because he felt such would be dangerous to the patient.⁵ That medical judgment is influenced by patient's behavior, cause of the patient's discomfort, current patient's medication, and the patient's need to be ambulatory. The (attending physician) must also assess whether the patient has the ability and opportunity to harm himself or herself. Ultimately, the (attending physician) must also decide on the proper manner of restraint: physical or chemical.⁶

The risk of using a restraint must be weighed against the risk of not using one. In fact, the decision to use restraint must compel the attending physician to "look back" and determined whether an acute medical condition has occurred or whether the medications have something to do with it. A thorough review of the patient's history, treatments attempted and their duration, and doses of medication administered and the patient's responses to these should be undertaken by the treating team, and may be the subject of a case conference. A second opinion external to the treating team may also be sought.⁷

Lawsuits are being won for harmful outcomes from using restraints; but fewer and fewer are won for harmful outcomes from non-use of restraints.⁸ Even an informed consent can sometimes fail as a defense in case of subsequent injuries. The attending physician should get involved in decision-making regarding use of restraints. Always bear in mind that use of restraint is the last option, not the first choice.

References

1. Manual, physical and mechanical restraints will be collectively termed as "physical restraint".
2. John Ellis Agens, Chemical and Physical Restraint in the Older Person; *British Journal of Medical Practitioners*, March 2010; Vol. 3 No. 1
3. McVilly, K. (2008). Physical restraint in disability services: current practices; contemporary concerns and future directions.
4. Gerard v. Sacred Heart Medical Center, 937 P.2d 1104 (1997)
5. Id.
6. Id.
7. Id.
8. "Restraints & Falls: Legal Perspective"; <http://primaris.org/> last accessed March 13, 2016

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