

60-101-
State Inst San

DEPARTMENT OF PUBLIC WELFARE

TO: SUPERINTENDENTS Attention: Director of Nurses

Anoka	Brainerd
Fergus Falls	Cambridge
Hastings	Faribault ✓
Moose Lake	Gillette
Rochester	Minnesota State San.
St. Peter	Owatonna
Willmar	Children's Center, St. Paul

FROM: David J. Vail, M.D.
Medical Director

SUBJECT: Restraint

DATE: September 30, 1960

This is a very difficult and complex subject. It touches on many critical issues of personal liberty, medical and psychiatric practice, and various relationships within the department and any given hospital, principally those between nurse and patient, physician and nurse, central office and institution, and the relations of all of us to the general public.

The two simplest solutions would be to let the thing go willy-nilly or to declare by fiat that no form of restraint shall be used. Unfortunately life isn't this easy. (At least in this country: I note that in some Norwegian hospitals mechanical restraint has been outlawed since 1880.)

My main objective has been to develop a procedure for the use of restraints that would be consistent with the most progressive trends in Open Hospital philosophy and to institute a reporting system that would be accurate, informative, and economical. Because of its nature as a very sensitive public issue, I think that it will necessarily involve a greater uniformity of procedure than I normally feel comfortable about. It is also clear that to some extent we will have to proceed by trial and error, I hope in a positive direction; that is, I would rather begin with a cumbersome system that becomes simpler than to go the opposite way.

1. Basic Assumption: Restraint is fundamentally inimical to Western ideals of individual privacy and freedom and is therefore an evil to be tolerated only when absolutely necessary.

2. Definition:

A. General. A broad definition of restraint is any measure which deprives or tends to deprive the individual of freedom of movement. This definition would then include enclosure in a locked private room (seclusion) or a locked ward or portion of a ward. This is not entirely practicable, since it would be very difficult to tabulate such data on a large scale in a way which would make much sense -- the exception to this would be individual seclusion which can be tabulated fairly easily. Unfortunately one cannot gain a full picture of the use of restraint unless one takes into account the total ward; thus a locked ward with no restraint may "look better" than an open ward with restraint applied to one or two patients. I will work up a separate reporting procedure for open vs. closed wards.

B. Specific. One of the first problems which we encountered is the fact that restraints go by different names and thus there is an immediate communication difficulty. I think that the following definitions should be used as standard. The underlined word or term should be used as the official term for reporting purposes:

- (1) Muffs
- (2) Mittens
- (3) Cuff-and-bed Cuffs used to secure hands or feet to the bed itself; includes wristlets and anklets.
- (4) Cuff-and-belt Cuffs looking to belts designed for this purpose.
- (5) Chair holds Posey belts, flannel ties, etc. Includes chair-boards or other similar benign devices for keeping patient from falling out of chair.
- (6) Tying jackets Alias sleeveless camisoles, vests, boleros. (A more restrictive version of 5.)
- (7) Bed ties (sheet restraints, etc.)
- (8) Seclusion Refers to individual seclusion only.
- (9) Bed-cage Includes any measure such as bedside rails, netting, crib-sides and cribs which tend to make an enclosed space of the bed itself.
- (10) Arm boards Alias "Yucca" boards. To prevent bending of arms for purposes of self-defense.

The following are or should be discontinued as unnecessary and/or dangerous -- still a number is assigned for reporting purposes:

- (11) Camisoles Alias strait jackets. Refers to half or full-length.
- (12) Restraint Suits Armless rompers.

Of the remainder above, number (1), Muffs, number (3), Cuff-and-bed, and number (4), Cuff-and-belt are the most obnoxious and every effort should be made to discontinue them. The cuff-and-belt in particular is just as restrictive and frightful as the camisole.

I may have missed some. If so, please let me know. What I am striving for is the simplest possible classification system.

3. Reasons for Restraints:

I know of only four authentic categories:

- A. Aggression-out: Includes damage to other patients or personnel and serious or extensive damage to property.
- B. Aggression-in: Includes self-abuse, as in self-biting, head-banging, or other activities causing actual injury to the body. Does not include masturbation, unless this is actually injuring body tissues, as through excoriation. Includes suicidal intent.
- C. Discoordination: A general term referring to ataxia, danger of injury from falling out of chair or bed, etc.
- D. Medical: Inability to cooperate with urgent medical procedures, e.g., pulling out i.v.'s or stomach tubes, etc.

Of all the above number, "D. Medical" is the only one, in my opinion, that refers to a problem which could ultimately only be handled by mechanical restraint. In any case restraint is only justified by a clear and present danger that a given event will take place. Under no circumstances are "discipline" or "punishment" or "elopement" considered as justification for restraint as herein defined. Experience seems to indicate that judicious medication and above all the ward milieu and ward program are the proper means of preventing untoward events.

4. Relief

For purposes of simplicity, let us state that the patient shall be free of the restraint, in whatever form, at least ten minutes of every hour, unless there is literally danger

to the patient's life in granting this. See also Section 7.

5. Ordering:

The use of restraints demands professional judgment. The decision must be based on the professional person's own objective evaluation of the situation and never solely on the recommendation of non-professional personnel. This means, of course, that in all but absolute emergency situations, a doctor or nurse must see the patient prior to the application of restraint. Any local procedure for restraint must be based on the above principles.

The order should be entered, specifying type and duration, on the patient's doctor's order sheet, together with a brief justification and signed or initialed by the physician giving or approving the order. The 48-hour stop order as used for dangerous drugs (see "Hospital Accreditation References", pp. 36-37) also applies to restraint.

6. Reporting:

A. Locally

The superintendent should receive a daily report from wards. The information should also be recorded at monthly intervals, in the progress notes of the clinical chart of the individual patient.

B. Centrally

I want a simple statement for each calendar month, coming in by no later than the 10th of the following month, showing (by designations in 2 B and 3 above), type of restraint, reasons, number of unduplicated patients, and total hours, based upon the type of, and reason for, restraint.

Example: Month of September, 1960

<u>Type</u>	<u>Reason</u>	<u>No. of Cases</u>	<u>Total Hours</u>
Tying jacket	Discoordination	18	200
Cuff-bed	Aggression-out	3	60
" "	Aggression-in	8	150
" "	Medical	1	18

N.B. Combinations to be reported by singling out the most important justification. Total hours mean total time ordered; e.g., two hours, including two ten-minute relief periods, would still be reported as two hours.

7. Exception:

Category (5), Chair holds and category (9), Bed-cage are so general and so closely related to basic nursing care, that they (1) need not be ordered or approved by a physician, (2) need require no relief and (3) need be reported only by reason and total number of unduplicated patients.

8. Mechanics:

You may devise such local forms and procedures as you wish. I would suggest that there be some consistency of forms used for local reporting purposes so as to comply with the spirit of the law (246.017, subd. 1) which in fact requires that record forms and procedures be "precisely uniform". I think that the medical records committee should study this problem.

For reporting to my office, I will devise and distribute a simple form, a facsimile of which is shown.

9. Effective Date:

Effective date is December 1, 1960, the recording to begin for the month of December. The first report to me, therefore, is due January 10 for the month of December.

For discussion at Superintendents' Meeting, October 28, 1960.

and

at Nursing Directors' Meeting, November 4, 1960.

Please discuss this with your Nursing Directors so that we can all agree on a reasonably final procedure. Any amendments to this document will be published prior to the effective date of December 1.

c Ron Lang

60-RSP-DSV
State Inst San

DEPARTMENT OF PUBLIC WELFARE

TO: SUPERINTENDENTS Attention: Director of Nurses

Anoka	Brainerd
Fergus Falls	Cambridge
Hastings	Faribault ✓
Moose Lake	Gillette
Rochester	Minnesota State San.
St. Peter	Owatonna
Willmar	Children's Center, St. Paul

FROM: David J. Vail, M.D.
Medical Director

SUBJECT: Restraint

DATE: September 30, 1960

This is a very difficult and complex subject. It touches on many critical issues of personal liberty, medical and psychiatric practice, and various relationships within the department and any given hospital, principally those between nurse and patient, physician and nurse, central office and institution, and the relations of all of us to the general public.

The two simplest solutions would be to let the thing go willy-nilly or to declare by fiat that no form of restraint shall be used. Unfortunately life isn't this easy. (At least in this country: I note that in some Norwegian hospitals mechanical restraint has been outlawed since 1880.)

My main objective has been to develop a procedure for the use of restraints that would be consistent with the most progressive trends in Open Hospital philosophy and to institute a reporting system that would be accurate, informative, and economical. Because of its nature as a very sensitive public issue, I think that it will necessarily involve a greater uniformity of procedure than I normally feel comfortable about. It is also clear that to some extent we will have to proceed by trial and error, I hope in a positive direction; that is, I would rather begin with a cumbersome system that becomes simpler than to go the opposite way.

1. Basic Assumption: Restraint is fundamentally inimical to Western ideals of individual privacy and freedom and is therefore an evil to be tolerated only when absolutely necessary.

2. Definition:

A. General. A broad definition of restraint is any measure which deprives or tends to deprive the individual of freedom of movement. This definition would then include enclosure in a locked private room (seclusion) or a locked ward or portion of a ward. This is not entirely practicable, since it would be very difficult to tabulate such data on a large scale in a way which would make much sense -- the exception to this would be individual seclusion which can be tabulated fairly easily. Unfortunately one cannot gain a full picture of the use of restraint unless one takes into account the total ward; thus a locked ward with no restraint may "look better" than an open ward with restraint applied to one or two patients. I will work up a separate reporting procedure for open vs. closed wards.

B. Specific. One of the first problems which we encountered is the fact that restraints go by different names and thus there is an immediate communication difficulty. I think that the following definitions should be used as standard. The underlined word or term should be used as the official term for reporting purposes:

- (1) Muffs
- (2) Mittens
- (3) Cuff-and-bed Cuffs used to secure hands or feet to the bed itself; includes wristlets and anklets.
- (4) Cuff-and-belt Cuffs looking to belts designed for this purpose.
- (5) Chair holds Posey belts, flannel ties, etc. Includes chair-boards or other similar benign devices for keeping patient from falling out of chair.
- (6) Tying jackets Alias sleeveless camisoles, vests, boleros. (A more restrictive version of 5.)
- (7) Bed ties (sheet restraints, etc.)
- (8) Seclusion Refers to individual seclusion only.
- (9) Bed-cage Includes any measure such as bedside rails, netting, crib-sides and cribs which tend to make an enclosed space of the bed itself.
- (10) Arm boards Alias "Yucca" boards. To prevent binding of arms for purposes of self-abuse.

The following are or should be discontinued as unnecessary and/or dangerous -- still a number is assigned for reporting purposes:

(11) Camisoles Alias strait jacket. Refers to half or full-length.

(12) Restraint Suits Armless rompers.

Of the remainder above, number (1), Muffs, number (3), Cuff-and-bed, and number (4), Cuff-and-belt are the most obnoxious and every effort should be made to discontinue them. The cuff-and-belt in particular is just as restrictive and frightful as the camisole.

I may have missed some. If so, please let me know. What I am striving for is the simplest possible classification system.

3. Reasons for Restraints:

I know of only four authentic categories:

- A. Aggression-out: Includes damage to other patients or personnel and serious or extensive damage to property.
- B. Aggression-in: Includes self-abuse, as in self-biting, head-banging, or other activities causing actual injury to the body. Does not include masturbation, unless this is actually injuring body tissues, as through excoriation. Includes suicidal intent.
- C. Discoordination: A general term referring to ataxia, danger of injury from falling out of chair or bed, etc.
- D. Medical: Inability to cooperate with urgent medical procedures, e.g., pulling out i.v.'s or stomach tubes, etc.

Of all the above number, "D. Medical" is the only one, in my opinion, that refers to a problem which could ultimately only be handled by mechanical restraint. In any case restraint is only justified by a clear and present danger that a given event will take place. Under no circumstances are "discipline" or "punishment" or "elopement" considered as justification for restraint as herein defined. Experience seems to indicate that judicious medication and above all the ward milieu and ward program are the proper means of preventing untoward events.

4. Relief

For purposes of simplicity, let us state that the patient shall be free of the restraint, in whatever form, at least ten minutes of every hour, unless there is literally danger

to the patient's life in granting this. See also Section 7.

5. Ordering:

The use of restraints demands professional judgment. The decision must be based on the professional person's own objective evaluation of the situation and never solely on the recommendation of non-professional personnel. This means, of course, that in all but absolute emergency situations, a doctor or nurse must see the patient prior to the application of restraint. Any local procedure for restraint must be based on the above principles.

The order should be entered, specifying type and duration, on the patient's doctor's order sheet, together with a brief justification and signed or initialed by the physician giving or approving the order. The 48-hour stop order as used for dangerous drugs (see "Hospital Accreditation References", pp. 36-37) also applies to restraint.

6. Reporting:

A. Locally

The superintendent should receive a daily report from wards. The information should also be recorded at monthly intervals, in the progress notes of the clinical chart of the individual patient.

B. Centrally

I want a simple statement for each calendar month, coming in by no later than the 10th of the following month, showing (by designations in 2 B and 3 above), type of restraint, reasons, number of unduplicated patients, and total hours, based upon the type of, and reason for, restraint.

Example: Month of September, 1960

<u>Type</u>	<u>Reason</u>	<u>No. of Cases</u>	<u>Total Hours</u>
Tying jacket	Discoordination	18	200
Cuff-bed	Aggression-out	3	60
" "	Aggression-in	8	150
" "	Medical	1	18

N.B. Combinations to be reported by singling out the most important justification. Total hours mean total time ordered; e.g., two hours, including two ten-minute relief periods, would still be reported as two hours.

7. Exception:

Category (5), Chair holds and category (9), Bed-cage are so general and so closely related to basic nursing care, that they (1) need not be ordered or approved by a physician, (2) need require no relief and (3) need be reported only by reason and total number of unduplicated patients.

8. Mechanics:

You may devise such local forms and procedures as you wish. I would suggest that there be some consistency of forms used for local reporting purposes so as to comply with the spirit of the law (246.017, subd. 1) which in fact requires that record forms and procedures be "precisely uniform". I think that the medical records committee should study this problem.

For reporting to my office, I will devise and distribute a simple form, a facsimile of which is shown.

9. Effective Date:

Effective date is December 1, 1960, the recording to begin for the month of December. The first report to me, therefore, is due January 10 for the month of December.

For discussion at Superintendents' Meeting, October 28, 1960

and

at Nursing Directors' Meeting, November 4, 1960.

Please discuss this with your Nursing Directors so that we can all agree on a reasonably final procedure. Any amendments to this document will be published prior to the effective date of December 1.

c Ron Lang

