SCOPE:

This policy applies to all staff who have been approved through legislation and/or hospital policy to be involved in the use of physical, environmental, and/or chemical restraint of clients at the Royal Victoria Regional Health Centre (RVH). It has been designed as a resource and reference for staff at RVH. It is expected that all staff shall adhere to the principles outlined in this policy.

POLICY STATEMENT:

It is the policy of RVH to use physical, environmental, and/or chemical restraints (named further generically restraints), only as an exceptional and temporary measure. Restraints are used as the last resort when required to manage a client who is aggressive or violent, or where there are indicators of immediate risk of physical harm to self or others.
Restraints are used for the shortest possible duration, as part of the care plan based on clinical assessment to ensure safe management of the situation. Restraints are only used after alternative (refer to Appendix I: *Alternative Approaches*), less restrictive measures and de-escalation techniques (refer to Appendix II: *De-Escalation Interventions*) have been tried and deemed ineffective.

Under the Mental Health Act (MHA), involuntary/ formed clients may be restrained without consent, should the clients be assessed as a risk to themselves or others. Mental Health clients who are voluntary or informal cannot be restrained without consent or the consent of their Substitute Decision Maker (SDM).

Restraints shall be used in emergency situations when aggressive or violent behaviour of a client presents an immediate risk of physical harm to self or others, regardless of the legal status of the client. Under the common law, health care providers have the duty to restrain clients when immediate action is necessary to prevent serious bodily harm to themselves or others.

The restraint of a voluntary client requires an assessment by the Most Responsible Provider (MRP) as soon as possible to determine the client's legal status.
No measures of restraint shall ever be used for punitive reasons.
There shall be no ongoing PRN orders for any form of restraint.

DEFINITIONS:

Alternatives to Restraint: interventions to address the behaviour and safety of an individual in order to avoid restraints. These interventions (refer to Appendix III: *Interventions to Assist the Client to Cope*) impose less control on the client than restraining or confining the client or using a monitoring device.

Chemical Restraint: Any form of psychoactive medication used not to treat illness, but to inhibit intentionally a particular behavior or movement. (CNO 2012)

Constant Observation: The client requires constant visual surveillance with an observer in sight and hearing distance at all times. The observer shall not be distracted by unrelated activities (Royal Victoria Regional Health Centre *Corporate Policy and Procedure: Enhanced Levels of Observation*).

Critical Incident Debriefing: an informal review and discussion of a restraint event for those involved, may include staff, clients, and/or visitors. This includes a review of the precipitating factors and the process of restraint including client and team response and outcome. The debriefing shall take place forthwith for any event that has significant emotional or physical impact on the participants.

Duty to Restrain: Health care professionals have an obligation not found in statute law, to restrain or confine a person in an emergency situation when immediate action is necessary to prevent serious bodily harm to the person or others.

Emergency Situation: Any event when a restraint can be applied, under common law without the consent, because the client is at imminent risk of causing harm to self or others.

Environmental Restraints: Any location or area providing control on a client's mobility. Examples include a secure unit or section of a unit, seclusion or a time-out room.

Interprofessional Team: A team made of professionals from different disciplines. Each professional performs a discipline-specific assessment and, upon completion, exchanges information with other team members to collaboratively develop treatment goals and plan client care.

Seclusion: The confinement of a client in a locked room designated as a seclusion room to restrict movement from one location to another. (Also referred to as environmental restraint)

Medical Immobilization: mechanisms that are used to restrict movement when they are considered standard practice during medical, surgical, diagnostic procedures, tests or treatments. This refers to restricted movement during medical, diagnostic, and/or surgical

procedures and the related post-procedure care process only (e.g. limb restraint during surgery, limb restraint during IV or catheter insertion).

Physical Restrain: The use of an appliance that restricts free movement and is attached to, adjacent to, or worn by the client when there is potential for injury to self and/or others.

Restrain: To "place the person under control by the minimal use of such force, mechanical means or chemicals as is reasonable having regard to the person's physical and mental condition, and "restraint" has a corresponding meaning" (Patient Restraints Minimization Act, 2001).

Substitute Decision Maker (SDM): A person who is authorized to give or refuse consent to a treatment on behalf of a person deemed incapable with respect to the treatment. Depending on the circumstances, this could be a guardian or Power of Attorney (POA) for personal care, a representative appointed by the Consent and Capacity Board (CCB), a spouse, common-law spouse, partner, family member, other relative or the Public Guardian and Trustee (PGT).

PROCEDURE:

Emergent Situations:

1. If there is an immediate risk of serious bodily harm to the client and/or others, and the situation cannot be managed by attending staff, call a Code White for extra support.

When all reasonable interventions/alternatives have been exhausted and behaviour persists:

2. If a restraint is needed, the assigned staff shall collaborate with other interprofessional team members as well as the client, to determine most appropriate and least restrictive restraint for use.
3. Staff assigned to the client to be restrained, shall obtain a verbal or written order from the MRP as soon as possible.
4. Restraints shall be implemented as per manufacturer instruction (physical/environmental) or RVH Medication Administration Policy (chemical).
5. Assigned staff shall monitor and provide appropriate care to the restrained client (see Care of restrained clients, below).
6. Staff assigned shall document restraint decision (refer to Appendix IV: *Restraints Decision Diagram*) in the interprofessional progress notes of the client's health record. Application, monitoring, assessment and care of client while restrained shall be documented using the Restraint Application/Monitoring/Removal intervention. The Restraint Documentation Record (RVH-0830) is to be utilized during downtime.

7. Discontinue restraints as soon as the client's presentation no longer meets the criteria for restraint use.
8. Physical restraints shall be laundered according to manufacturer's direction after each use for infection prevention and control purposes.
9. A Critical Incident Debriefing shall occur as soon as possible, with a 24hour time frame and an incident report shall be submitted in the Safety Learning System.

Non-Emergent Situations, for Clients in Circumstances Governed by the Health Care Consent Act (HCCA):

1. Utilize the Checklist for Best Practice Assessment of Decision to use Restraint (refer to Appendix V: *Checklist for Best Practice Assessment of Decision to Use Restraints – Non-Emergent Situations*).
2. The interprofessional team, in collaboration with the client or SDM, shall identify and thoroughly assess the behaviour of concern using the Responsive Behaviour intervention.
3. Based on this assessment, identify the potential causes of the noted behaviour using the decision-making tool entitled, Potential Causes of Behaviour (refer to *Appendix II: Potential Causes of Behaviour*).
4. Implement all reasonable interventions to address potential causes of behaviour and alternatives to restraints.
5. Document assessment, interventions, alternatives and effectiveness of interventions/alternatives.

When all reasonable interventions/alternatives have been exhausted and behaviour persists:

6. Determine appropriateness of restraint use (refer to Appendix IV: *Restraint Decision Diagram*).
7. If a restraint is needed, collaborate with other interprofessional team members as well as the client (if capable) or SDM (if client is incapable), to determine the most appropriate and least restrictive restraint for use.
8. Staff assigned to the client to be restrained shall obtain a verbal or written order from the MRP as soon as possible.
9. The member of the interprofessional team proposing restraint (considering appropriate scope of practice) shall obtain, either in person or by telephone, informed consent from the client (if capable) or SDM (if client is incapable) prior to restraint application. If the client or SDM refuse to provide consent for restraint, the assigned nurse shall ask the client or SDM to review and sign the Consent for Restraint Use/Refusal of Restraint Use form (RVH-0836).
10. Immediately following the informed consent conversation or within 48 hours, have the client or SDM sign the Consent for Restraint Use/Refusal of Restraint Use form (RVH-0836). Placing a legible copy or faxed version of the signed consent on the chart is acceptable.

11. Implement restraint as per manufacturer instruction (physical/environmental) or RVH Medication Administration Policy (chemical).
12. Provide the client or SDM with the Patient/Family Guide to Least Restraint (RVH-3321).
13. Assigned staff shall monitor and provide appropriate care to the restrained client (see Care of restrained clients, below).
14. Staff assigned shall document restraint decision in the interprofessional progress notes of the client's health record. Application, monitoring, assessment and care of client while restrained shall be documented using the Restraint Application/Monitoring/Removal intervention. The Restraint Documentation Record (RVH-0830) is to be utilized during downtime.
15. Discontinue restraints as soon as the client's presentation no longer meets the criteria for restraint use.

For Clients In Situations Governed By The Mental Health Act:

1. Collaborate with client and family (with consent) or SDM to determine a plan that includes alternative to restraints in the event of an aggressive episode. Complete the De-escalation preference assessment with the client and family as an ongoing reference for alternatives to restraint.
2. Assess and review client history in relation to triggers for aggressive/violent behavior, context of such behaviors, previous restraint use, and previous alternatives to restraint and de-escalation strategies and their effectiveness. Indicate and document the cent's preferences and choices regarding strategies, alternatives, and restraint measure to maintain safety; known or suspected history of physical or sexual abuse or other severe trauma; and document on the Client's health record. Discuss the use of restraint as a last resort and the different restrain measures.
3. A comprehensive ongoing assessment of the client's mental and physical status shall be completed and documented in the client's health record. Assessment should include but not be limited to the following:
    a. History of violence (including context and surrounding factors)
    b. Risk factors for violence
    c. History of substance use/abuse and current substance use/abuse
    d. Psychiatric conditions/concerns (i.e., delirium, mania, uncontrolled psychosis, Neuroleptic Malignant Syndrome)
    e. Legal Status
    f. Medical conditions (i.e. musculoskeletal/joint problems, epilepsy, difficulty swallowing)
    g. History of medication sensitivities
    h. Age
    i. Neurological, cognitive, and functional deficits/impairments

When all reasonable interventions/alternatives have been exhausted and behaviour persists:

4. In situations when the client may be aggressive, staff should attempt to implement least restrictive strategies that include giving the client limited choices for behavioral management.
5. When there is an active episode of aggression or violence that is of immediate risk of physical harm to self or others and alternative interventions are ineffective, restraints may be used as a last resort.
6. All restrains require an order from the MRP.
7. When restraints must be used, they should be implemented in a manner that ensures protection of the client's safety, dignity and emotional wellbeing.
8. In the event that the MRP is not present at the time of the behaviour requiring restraints, the assigned nurse in collaboration with the Interprofessional Team may initiate the use of restraints.
9. The assigned nurse must notify without delay the MRP who shall provide an order that includes type of restraints and the specific behaviors for its use. The MRP will assess the restrained client as soon as possible, review his or her legal status, and document acknowledgement of the event, and clinical findings.
10. An order for restraints will be in effect for a period no greater than 24 hours. During this 24 hour period, another physician's order is not required when de-restraining efforts are unsuccessful and the client must be placed back into restraints following a release trial. De-restraining assessments and activities must be documented in the client's health record at least every 2 hrs.
11. The team will continue to ensure the safety and dignity of the client and offer alternative options, as appropriate.
12. The brief holding of a client prior to application of restraint or the administration of chemical restraint must be consistent with techniques in the Crisis Prevention Institute training program.
13. An ongoing mental status examination, rationale for restraint use, and plan for removal of restraints shall be documented in the client's health record.
14. Family members (with consent) and SDM shall be informed of changes in client's condition and/or status. An ongoing plan of communication regarding further changes in condition and/or status should be arranged and documented in the client's health record.
15. Staff assigned shall document restraint decision in the interprofessional progress notes of the client's health record. Application, monitoring, assessment and care of client while restrained shall be documented using the Restraint Application/Monitoring/Removal intervention. The Restraint Documentation Record (RVH-0830) is to be utilized during downtime.
16. Discontinue restraints as soon as the client's presentation no longer meets the criteria for restraint use.

17. Physical restraints shall be laundered according to manufacturer's direction after each use for infection prevention and control purposes.
18. A Debriefing should occur as soon as possible, with a 24hour time frame and an incident report shall be submitted in the Safety Learning System.

Care of the Restrained Client:

1. When a restraint is used Constant Observation of the client is mandatory and shall be documented using the Restraint Application/Monitoring/Removal intervention in the client's health record. The Restraint Documentation Record (RVH-0830) is to be utilized during downtime.
2. Other documentation sources that may be used include the interprofessional progress notes, kardex, and vitals flow record and fluid balance record.
3. Monitoring of the restrained client shall include, but is not exclusive to, assessment of circulation, skin condition, proper application and position of restraint, pain/discomfort, level of alertness, orientation, client behaviour, emotional response to restraints, need for care, specifically applicable to the type of restraint used. Vital signs shall be checked according to clinical judgment. For clients requiring 4 or 5 – point restraints, the above mentioned assessments shall be conducted and documented every 30 minutes.
4. Specific medications used as chemical restraints may require special consideration depending on their side effect profile (i.e. hallucinations, restlessness, insomnia, extra pyramidal signs).
5. Clients should be released from physical restraints for at least 10 minutes at a minimum of every 2 hours.
6. While clients are restrained, provisions should be made to meet physical, emotional and social needs (i.e. toileting, hygiene, ambulation, nutrition, hydration, socialization and opportunity to discuss feelings/thoughts about being restrained, etc.).
7. Physical/environmental restraints do not need to be released if the client is sleeping and is able to turn independently from side to side in bed or if it is extremely unsafe to release the restraints (i.e. extremely aggressive client).

Reassessing Restraints:

1. Interventions to eliminate restraints should be attempted on an ongoing basis.
2. Reassessment of the need for restraint use should be ongoing, and should be documented at a minimum of every 4 hours.
3. Restraints should be discontinued when the criteria for restraint use are no longer met (refer to Appendix IV: *Restraint Decision Diagram*). Neither consent nor an order is required to remove a restraint. Documentation should support client behaviour and reasons for removal.

CROSS REFERENCES:

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Falls	• Medication review • Toileting regularly • Quad exercise: mobility/ ambulation • Routine positioning (every 2 hours) • Increased participation in activities of daily living • Pain relief/comfort measures • Normal schedule/individual routine • Assess for hunger, pain, heat, cold • Glasses, hearing aids, walking aids easily available • Increase social interactions • Redirect with simple commands • Call bell demonstration • Involve family in planning care • Diversion activities: pets, music, puzzles, crafts, cards, snacks • Scheduling daily naps • Alarm devices - bed/chair/ door • Clutter-free rooms • Mattress on floor or lower bed • Non-slip strips on floor • Night light • Helmet • Acceptance of risk
Cognitive Impairment – e.g. Dementia	• Toileting regularly • Normal schedule/individual routine • Assess for hunger, pain, heat, cold • Label environment (i.e. bathroom door) • Increase social interactions • Redirect with simple commands • Gentle touch • Assessing past coping strategies • Involve family in planning care • Diversion activities: pets, music, puzzles, crafts, cards, snacks • Reminiscence • Scheduling daily naps • Pacing permitted • Alarm devices - bed/chair/door • Clutter-free rooms • Night light • Glasses, hearing aids, walking aids easily available
Acute Confusion - Delirium	• Medication review • Work-up for underlying cause - see Pre-Printed Orders • Pain relief/comfort measures

	• Glasses, hearing aids, walking aids easily available • Toileting regularly - start every 2 hours • Normal schedule/individual routine • Assess for hunger, pain, heat, cold • Label environment (i.e. bathroom door) • Increase/decrease social interactions • Redirect with simple commands • Gentle touch • Assessing past coping strategies • Involve family in planning care • Scheduling daily naps • Alarm devices - bed/chair/door • Clutter-free rooms • Night light
Agitation	• Mobility/ambulation/exercise routine • Routine positioning (every 2 hours) • Medication review • Pain relief/comfort measures • Toileting regularly • Normal schedule/individual routine • Assess for hunger, pain, heat, cold • Increase social interactions • Redirect with simple commands • Relaxation techniques (i.e. tapes, dark environement) • Gentle touch • Assessing past coping strategies • Involve family in planning care • Diversion activities: pets, music, puzzles, crafts, cards, snacks • Scheduling daily naps • Pacing permitted
Wandering	• Assess for hunger, pain, heat, cold • Buddy system among staff/consistency • Label environment (i.e. bathroom door) • Increase social interactions • Redirect with simple commands • Assessing past coping strategies • Involve family in planning care • Diversion activities: pets, music, puzzles, crafts, cards, snacks • Tape (stop) line on floor • Alarm devices - bed/chair/door • Clutter-free rooms • Night light

	• Room close to nursing station • Glasses, hearing aids, walking aids easily available
Sliding	• Consults to Occupational Therapy (OT)/Physiotherapy (PT) • Routine positioning (every 2 hours) • Pain relief/comfort measures • Call bell demonstration • Wedge cushions/tilt wheelchairs (consult OT/ PT) • Non-slip cushion (consult OT)
Aggression	• Medication review • Pain relief/comfort measures • Assessing past coping strategies • Normal schedule/individual routine • Assess for hunger, pain, heat, cold • Increase/decrease social interactions • Relaxation techniques (i.e. tapes, quiet and/or dark room) • Involve family in planning care • Pacing permitted • Soothing music
Pulling out invasive tubes	• Pain relief/comfort measures • Increase social interactions • Redirect with simple commands • Call bell demonstration • Stimulation/meaningful distraction • Explain procedures/treatments • Gentle touch • Involve family in planning care • Camouflage tubing on IV • Abdominal binder over percutaneous endoscopic gastrostomy tube • Change IV to intermittent as soon as possible • Arm splint (prevent elbow bending)
Unsteadiness	• Mobility/ambulation/exercise • Medication review • Increase social interactions • Call bell demonstration • Scheduling daily naps • Clutter-free rooms • Mattress on floor or lower bed • Non-slip strips on floor • Night light • Acceptance of injuries • Glasses, hearing aids, walking aids easily available

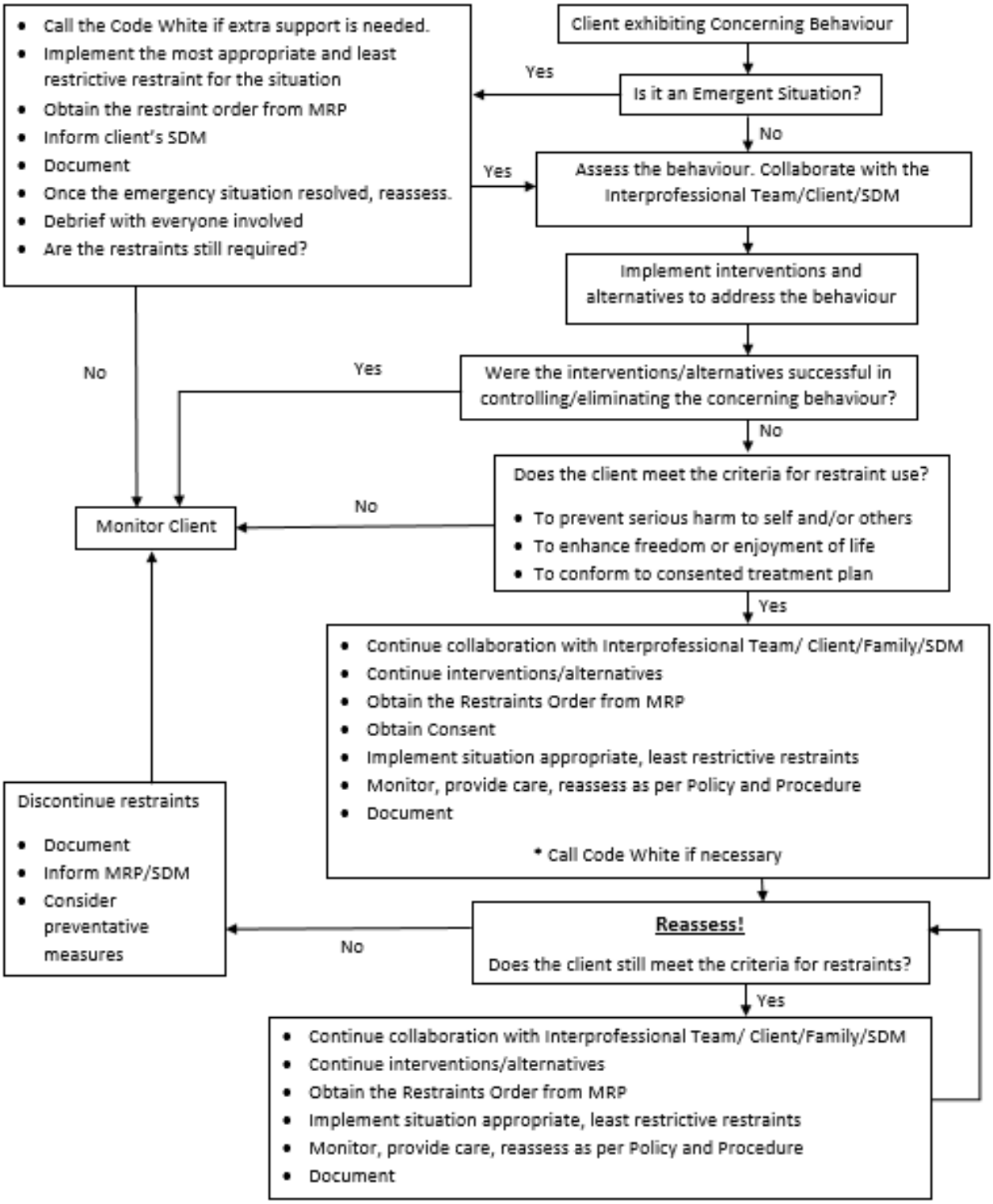
1. Always identify yourself.
2. Talk and think calmly.
3. Ask client how they are doing, or what is going on.
4. Ask client if they are hurt (assess for medical problems).
5. Ask client if they were having some difficulty or what happened before they got upset.
6. Remember why the client is in the hospital.
7. Find a staff member who has a good rapport/relationship with the client and have him or her talk to the client. Let the patent know you are there to listen.
8. Offer medication, if appropriate.
9. Help client remember and to use coping mechanisms.
10. If a client screams and swears, reply with a calm nod, okay, don't react.
11. Use team or third-party approach. If client is wearing down one staff, have another take over (10 minutes of talking might avoid a restraint incident).
12. Reassure clients and maintain professional boundaries (tell clients you want them to be safe, that you are there to help them).
13. Allow quiet time for client to respond – silent pauses are important.
14. Ask the client if he/she would be willing, could try to talk to you (repeat requests, persistently, kindly).
15. Respect needs to communicate in different ways (recognize possible language/cultural differences as well as the fear, shame, and embarrassment the client may be experiencing).
16. Empower clients. Encourage them with every step towards calming themselves they take.
17. Make it okay to try and talk over the upsetting situation even though it may be very painful or difficult.
18. Acknowledge the significance of the situation for the client.
19. Ask the client how else you can help.
20. Ask the client's permission to share important conversations with other caretakers for on-going discussion.

Registered Nurses' Association of Ontario. (2012). *Promoting Safety: Alternative Approaches to the Use of Restraints*. Toronto, ON: Registered Nurses' Association of Ontario.

1. Listen to the client's concern even if you don't understand.
2. Ask the client to tell you what the problem is, and listen sincerely.
3. Recognize and acknowledge the client's right to his/her feelings.
4. Sit down, if possible, while maintaining safety and invite the client to do likewise.
5. Invite the client to talk in a quiet room or area where there is less of an audience and less stimulation.
6. Apologize if you did something that inadvertently upset the client. Acknowledge feelings (not reasons) and state that it was unintentional.
7. Let the client suggest alternatives and choices.
8. To maintain client and staff safety, have adequate personnel available for crisis situations.
9. Speak in a calm, even and non-threatening voice. Speak in simple, clear and concise language.
10. Use non-threatening, non-verbal gestures and stance.
11. Be aware of language, hearing and cultural difference(s)
12. Assure the client that he/she is in a safe place and you are here to help.
13. Recognize your personal feelings about violence and punishment and how it affects you when a client is violent.
14. Be aware of how other staff positively interact with angry clients and model their interventions.

Registered Nurses' Association of Ontario. (2012). *Promoting Safety: Alternative Approaches to the Use of Restraints*. Toronto, ON: Registered Nurses' Association of Ontario.

Appendix IV: Restraints Decision Diagram



✓	Intervention
	Identify risk factors/behaviours that may result in the use of restraints.
	Complete and document a thorough assessment in collaboration with the interprofessional team and the client and/or SDM.
	Identify potential causes of the noted behaviour (refer to Appendix VI: *Potential Causes of Behaviour*).
	Address potential causes of behaviour and utilize the Safety Care Plan to focus and document on individualized, multi-component strategies for restraint alternatives.
	Continuously monitor and re-evaluate the care plan based on observation and/or concerns from the client and/or SDM.
	Ensure that all reasonable interventions/alternatives have been attempted and documented, including de-escalation and crisis management.
	If interventions are found to be unsuccessful, consult with the interprofessional team to consider use of the least restrictive, RVH approved restraint. The benefits and risks of all types of restraints along with the following criteria for use of Restraint must be carefully considered: • It is necessary to prevent serious bodily harm to the client and/or others. • It gives the client greater freedom or enjoyment of life. • It is authorized by a plan of treatment to which the client or his/her SDM has consented.
	Obtain a verbal or written order from the MRP as soon as possible.
	The member of the interprofessional team proposing restraint for non-emergent situations (considering appropriate scope of practice) must obtain, either in person or by telephone, informed consent from the client (if capable) or SDM (if client is incapable) prior to restraint application.
	Provide the client or SDM with the Patient/Family Guide to Least Restraint (RVH-3321).
	Document restraint decision and informed consent process.
	The least restrictive, RVH approved restraint is used. If the least restrictive form is ineffective, choose alternative restraints in a progressive format from the least restrictive to most restrictive.
	Ensure the restraint is used in accordance with the manufacturer's instructions, or RVH Formulary and Drug Regulations and Nursing Medication Policy (chemical), for the shortest time possible. Do not adapt the restraint in any way.
	Monitor and provide appropriate care to the client. (Refer to "Care of the restrained client" under "Procedure" section of policy).
	Attempt interventions to eliminate restraints on an ongoing basis. Reassess need for continued use of restraint frequently (document reassessment at a minimum of every 4 hours) and discontinue when criteria for use are no longer met.

Appendix VI: Potential Causes of Behaviour

When assessing for the causes of behaviour it is essential to understand the behaviour:

- What is the behaviour?
- When does it occur?
- What are the circumstances? (i.e. precipitating factors, who is present, family's response, new or recurring, what methods helped in past).

A behaviour log can often be useful to uncover a pattern. Once behaviour is clearly defined, physiological, psychosocial, environmental, spiritual and cultural factors should be considered in order to identify the underlying cause.