Title: Restraint - Least Restraint	
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PURPOSE:
Brant Community Healthcare System (BCHS) is committed to providing a safe environment for patients, staff, and visitors. In accordance with the Patient Restraints Minimization Act, 2001 (Bill 85), BCHS supports a policy of least restraint and the use of alternative measures with respect for and preservation of the patient's dignity, rights, values, and preferences.

This document outlines BCHS policy for least restraint and summarizes the safe and appropriate use of restraint (which includes chemical, mechanical, and environmental) in emergency situations and as part of a patient's plan of care. It includes guidelines on the initial assessment, administration, application, monitoring, documentation, and discontinuation of restraints and the use of alternative activities to mitigate risk and minimize use of restraint.

This policy applies to all inter-professional clinical staff and security staff. It is an expectation of BCHS that all staff maintain competency in preventing and managing aggressive and/or combative behaviour and all staff are responsible for knowledge and implementation of this policy. It is the responsibility of the Clinical Program Managers to ensure all levels of staff receive education, training, and regular updates regarding this policy, the equipment available and Code White procedures. Security staff are responsible for maintaining competency in implementing the policy and utilizing BCHS approved restraint devices in collaboration with the inter-professional clinical team.

POLICY STATEMENT:
BCHS has a legal and ethical responsibility to support a least restraint policy that respects the dignity, rights, and independence of the patient while ensuring a safe and therapeutic environment that is consistent with legislation, professional standards, and evidence based best practice.

Restraint will be viewed as a last resort. Restraint will be used only in circumstances where there exists an imminent risk of harm to the patient or others, only after careful assessment by a regulated healthcare professional, and only after determining that available alternatives would be inadequate. Restraint is not to be used for convenience or punitive (disciplinary) purposes.

In all cases, when a restraint is deemed necessary to meet the needs of the patient, the least restrictive restraint necessary to mitigate risk will be used. Restraint is to be deemed as a temporary measure and will be used for the shortest possible duration

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based on continuing clinical assessments. All assessments and interventions (including alternative methods attempted) will be documented.

The use of restraint must be authorized by the patient and/or his/her substitute decision maker (SDM). In the event that restraint is used in an emergency situation of imminent risk, the family and/or SDM should be informed as soon as possible. BCHS has an obligation to mitigate risk and the use of restraint may occur when immediate action is necessary to prevent serious bodily harm to self and/or others within the hospital environment.

A physician's order is required for restraint. In an emergency situation, when imminent risk of harm to the patient or others exists, a regulated healthcare professional may initiate restraint, however, the most responsible physician must be notified as soon as reasonably possible and an order received (within 2 hours) or the restraint is to be discontinued. Ongoing restraint use must be reordered every 24 hours. For patients with a plan of care that includes the use of restraint, ongoing restraint use must be reordered every week as clinically indicated by documented inter-professional assessment and through collaboration with patient and/or SDM.

An order for restraint must indicate the purpose (i.e. anticipated reason) and the timing. There are no standing orders or as needed (i.e. PRN) orders for mechanical restraint.

The use of chemical or mechanical restraint (including the use of hand cuffs by security staff) may be required to safely transport a patient within BCHS where there is an immediate risk of violent or aggressive behaviour that cannot be mitigated through the use of alternative measures (i.e. transport of patient from Emergency Department to In-Patient Mental Health Unit). If restraint is required for transfer the patient must be accompanied by the appropriate regulated healthcare professional.

The use of any restraint must be fully documented in the patient's health record (paper or electronic) and plan of care.

The initiation of restraint, including the brief holding of a patient prior to administration of chemical restraint, application of mechanical restraint, or initiation of environmental restraint, will be carried out with the minimal use of such force as is necessary while maintaining dignity and respect for the patient. Any level of force will be consistent with the techniques taught in the approved BCHS Safety Management training program.

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DEFINITION (S):

Restraint

To place under control when necessary to prevent serious bodily harm to the patient or another person by the minimal use of such force, mechanical means or chemicals as is reasonable having regard to the physical and mental condition of the patient (Mental Health Act, 1990; Patient Restraints Minimization Act, 2001).

Mechanical Restraint

The use of an appliance that restricts free movement (of the whole or a portion of the person's body) and is attached to, adjacent to, or worn by the patient.

- At BCHS only approved mechanical restraints can be used (see Appendix C). Restraints cannot be modified or adapted.
- Devices used for the safety and/or support of patients during treatment and/or diagnostic procedures are not considered restraint devices, provided staff maintain ongoing observation of the patient during the procedure.
  Examples of treatment or procedural devices include:
  - Immobilization of part of the body as required for medical treatments (i.e. splint and/or cast)
  - Temporary immobilization of a part of the body while a nursing procedure is being performed
  - Temporary immobilization during transportation (i.e. belts on stretcher)
  - Items used to maintain desired body position for clients with paralysis (i.e. belt for wheelchair)
- Single use limb holders are a soft mechanical restraint used in the short term to prevent treatment interruption (e.g. inadvertent medical tube dislodgment, such as self-extubation or decannulation of a vascular access device).

Chemical Restraint

The use of pharmacological intervention administered to manage a patient who exhibits aggressive or violent behaviour that presents an immediate risk of serious harm to self or others. At BCHS, a physician's assessment and order is required for chemical restraint. The use of pharmacological intervention as a restraint is distinct from pharmacological interventions used to treat illness, which is governed by the Health Care Consent Act and is not within the scope of this policy.

Environmental Restraint

The use of a barrier or device that changes or modifies a person's surroundings to restrict or control movement. Environmental restraints (i.e. locked unit), with the

exception of the use of a seclusion room, do not require a physician's order. Electronic surveillance is also considered an environmental restraint (Park & Tang, 2007).

Serious Bodily Harm
Injury, to a person or self, of a physical or psychological nature that is more than trivial or transient in nature. Psychological harm is considered serious where it substantially interferes with the health or wellbeing of the individual.

Examples of situations where the immediate risk of serious bodily harm exists may include, but are not limited to:

- Threat to harm self or others (e.g. cutting self, hitting head against wall)
- Risk of being punched and/or pushed
- Physical agitation which is likely to result in harm to another
- Verbal agitation by a person with a known history of serious agitation resulting in serious physical or psychological harm to another

Alternative Measures
The use of general care measures, recreational activities and environmental manipulation and/or modification. Activities that promote wellness and comfort means therapeutic measures that are employed in collaboration with the patient to empower and support the person.

Close Observation
The patient is directly monitored and observed by a designated individual every 15 minutes (q 15 minutes), with interventions as required and documented, to ensure safety. Close observation may be required for behavioural and/or physical reasons as determined by the physician.

Constant Observation
The patient has one-to-one direct monitoring and observation by a designated individual 24 hours a day to ensure safety. Care that is within arm's reach of and maintaining an eye on the patient while they are out of their room. When the patient is in his or her room, assigned staff shall observe the patient from the doorway of the patient's room. Constant observation may be required for behavioural and/or physical reasons as determined by the physician.

PROCEDURE:

1. Decision to Restrain

a. The decision to restrain shall be based on an assessment of the patient's behaviour (including underlying cause) and/or contributing factors with an

exploration of all possible alternatives by the inter-professional clinical team in collaboration with the patient and/or SDM.

b. An inter-professional comprehensive assessment of the patient will be completed including, but not limited to:
   - Cognitive status (level of confusion);
   - Physical assessment;
   - Risk for falls;
   - Risk for wandering;
   - A review of prior application of restraints;
   - Identification of underlying cause(s) for current behaviour (i.e. pharmaceutical, cognitive, emotional, pain and physical assessment).

c. In the event of an emergency situation, the full assessment of the patient is to be completed as soon as it is safe to do so (i.e. after the situation is no longer critical).

d. Consideration of alternatives to restraint use (see Appendix B for alternatives to restraint) will be explored with patient, family and/or SDM including, if applicable:
   - Identification of measures used at home to ensure patient's safety and well-being;
   - Family and/or caregiver availability to assist with patient's care while in hospital (i.e. sitting with patient).

e. General considerations to consider and/or implement as an alternative to restraint include, but are not limited to:
   - Alternative location (changing proximity to nurse's station, moving patient to a more or less stimulating environment);
   - Ensuring bed is in the lowest position;
   - Call bell within easy reach;
   - Removal of obstacles in the room;
   - Providing companionship and supervision, especially at night;
   - Post signs to help patient find his/her room;
   - Diversion and/or distraction by the use of television or music;
   - Regular toileting;
   - Review of patient's medications in consultation with pharmacy (i.e. side effects and appropriateness of medications ordered).

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2. Application of Restraint

If there is no safe alternative and restraint application is deemed necessary (see Appendix A - Decision Making Tree for Least Restraint), the least restrictive form to meet the patient's needs will be considered for the shortest time possible.

- The condition for which the restraint is to be used must be defined, including the type of restraint, and monitoring requirements.
- Application of restraint is the responsibility of a regulated healthcare professional with the knowledge, skill, and judgement required to complete a full assessment. An unregulated healthcare provider (i.e. personal support worker) can provide assistance to the regulated healthcare professional in the application of the restraint only.
- Only approved restraints can be used at BCHS (see Appendix C – Approved Restraints). Restraints must be used in accordance with manufacturer guidelines and cannot be modified or adapted.
- Restraints must be examined prior to application to ensure that they are in good working condition. Any broken or damaged pieces must be reported to the Clinical Manager and will be taken out of circulation to ensure patient safety. The Clinical Manager will contact the Mental Health Clinical Manager or his/her delegate regarding broken or damaged pieces to initiate process for replacement (if replacement is required).
- Consideration may be given to any underlying medical problems and the presence of any disabilities that may be impacted by the use of restraints (i.e. open wounds, broken bones).
- Restraints must be attached to the designated bed or stretcher frame. Do not attach directly to a side rail.
- Brakes are NOT to be placed on the bed or stretcher while an individual is restrained in the bed.

Restraints are to be deemed a **temporary** measure to be used as a protective device after a thorough assessment and intervention plan is made in collaboration with the patient, the SDM, and the inter-professional clinical team. When need for continued restraint is identified:

- Patient assessment and trial of alternatives with patient response will be documented
- The need for ongoing restraints will be re-evaluated and reordered by the most responsible physician every 24 hours, as clinically indicated by documented inter-professional assessment

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- Ongoing restraint use must be reordered every week for patients with a plan of care that includes restraint, as clinically indicated by documented inter-professional assessment and through collaboration with patient and/or SDM

Restraints must be discontinued as soon as possible. The documentation of restraint use and the discontinuation/removal of restraint is the legal and professional responsibility of the healthcare professional. An order is not required to remove mechanical restraints.

3. Physical Restraints as an Emergency Intervention

A physician's order is required for restraint. However, in an emergency situation where it is deemed necessary to protect the patient or other people from bodily harm, members of the healthcare team can make the decision to restrain a patient **temporarily**, without a patient's consent and/or without a physician's order (see Appendix A – Decision Making Tree for Least Restraint).

If a patient is restrained, physician review and order is required within two (2) hours of emergency application of mechanical restraint. The restraint will be discontinued when there is no longer an emergency situation, as soon as clinically possible. The assessment and decision process for the initiation of restraint MUST be clearly documented.

If the violence, or immediate danger of violence, cannot be managed by the available staff, a Code White will be called.

The patient's dignity and safety will be promoted by:

- Making all reasonable efforts to gain the patient's cooperation and proceeding with the least restrictive options
- Providing the patient with a choice of options to enable him/her to regain control
- Clearly communicating the reasons for using the restraint and the behavioural criteria for release to the patient

4. Chemical Restraint

A physician's order is required for any chemical restraint. A physician may order a chemical restraint to be given to prevent harm to the patient and/or others in the environment. The chemical restraint may be given without the patient's consent in an emergency situation where it is deemed necessary to protect the patient or other people from bodily harm.

Documentation must support the belief that the patient may imminently cause serious bodily harm to self or to others within their environment if a PRN chemical restraint is

given. If chemical restraint is used, monitoring will involve the recording of vital signs as clinically indicated and documentation of effectiveness in managing behaviour.

5. Consent

Informed consent is required for the use of any device that restricts a patient's freedom of movement. To ensure informed consent, the potential risks and harm associated with the use of restraint must be discussed with the patient and/or SDM. The discussion surrounding consent must be documented in the patient's medical record and should include, but is not limited to, the following information:

- Rationale for restraint use
- Type of restraint recommended
- Alternative methods attempted and results
- Risks and benefits associated with restraints
- Risk of not restraining
- Process for ordering restraints, repositioning and monitoring of patients while in restraints
- Anticipated timeframe restraints may be needed

In an emergency situation where there exists a serious threat of harm to the individual or others, and all other measures have been considered and/or implemented and deemed unsuccessful, restraints may be applied without informed consent. The initiation of restraint constitutes an important change in a patient's status. If SDM is involved, all reasonable efforts must be made as soon as possible to contact the SDM to inform of the change of status and the course of action that was required to mitigate risk. An ongoing plan of communication with the patient and his/her SDM regarding further changes in condition or status will be arranged and clearly documented. Emergency situations are time limited and must be reviewed by the most responsible physician within 2 hours of application.

The use of restraint must be authorized by the patient and/or his/her SDM. The patient and/or SDM has the right to refuse the application of restraint and accept the dignity of risk when it does not involve serious harm to self or others.

6. Documentation

The documentation of restraint use is the legal and professional responsibility of the healthcare professional. Documentation will include, but is not limited to:

- Reason for restraint initiation and application
- Alternative, less restrictive measures and de-escalation strategies that were considered or implemented

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- Type of restraint
- Identification and description of the responsive and/or risk behaviour that required the patient to be restrained or continue to be restrained
- Patient and/or SDM involvement in the decision making process
- Monitoring, intervention, and assessment of restraints including alternatives implemented
- Consent

If chemical restraint is administered documentation will include, but is not limited to:
- Identification and description of the behaviour displayed that required chemical restraint
- Name of medication (chemical restraint) administered including the dose and method of administration
- Effect (patient response) of the medication (chemical restraint)
- Vital signs as clinically indicated

The Behaviour Observation Record, Behaviour Restraint Assessment and Check Restraint interventions will be added to standard care/intervention worklist for areas where e-documentation is available.

7. Monitoring and Repositioning of Restraints

Only approved restraints can be used at BCHS (see Appendix C – Approved Restraints). Restraints must be used in accordance with manufacturer intentions and cannot be modified or adapted. Staff that apply restraints are expected to be trained and maintain competency.

The use of mechanical restraints is considered an extraordinary measure and is used only when all other measures of least restraint have been considered and/or implemented and deemed to be ineffective or not appropriate.

If a patient is placed in mechanical restraints:
- The use of the waist belt will be accompanied by the pelvic strap (i.e. beaver tail)
- The patient will only be placed in 3 or 4 limb restraints while in the supine position. Where clinically indicated, the use of the shoulder strap and/or the waist belt and pelvic strap can be applied to safely manage patient behaviour in an emergency situation. The magnetic key will always be kept proximal to the patient to facilitate rapid release in emergency situations
- Any direct care measure that involves release of a limb cuff restraint should be performed with at least two (2) healthcare professionals present.

Monitoring of all patients in restraints shall be done according to the type of restraint used, the physician's order for observation level, and the needs of the patient, at a minimum of every fifteen (15) minutes.

While a patient is restrained, the healthcare team will conduct ongoing assessments based on their scope of practice and document in the restraint intervention (for areas with electronic documentation). Monitoring, intervention, and assessment will include, but is not limited to, the following:

- Correct positioning of the restraint
- Skin condition at the point of contact of the restraint
- Skin condition of areas prone to breakdown
- Circulation to extremities to which a restraint is applied
- Affect and emotional well-being
- Pain or discomfort related to the restraint
- Provide or offer fluids and food every hour while awake
- Provide the opportunity for toilet every hour while awake
- De-restraining assessments and activities:
    - Physical restraints must be released every two (2) hours and as needed for 10 minutes in order to assess for potential adverse effects
    - Four (4) point restraints require a rotation of individual restraint removal and documentation every hour
    - The release of a limb cuff restraint should be performed with at least two (2) healthcare professional present
- All other clinical observations, patient observation, interventions, and care while in restraint
- If seclusion is required, the patient will be maintained on direct monitoring by constant observation.

8. Education

- Staff will receive education and/or training in the prevention and management of aggressive behaviour.
    - Clinical managers are responsible for ensuring compliance
    - Staff are responsible for maintaining competence
- Staff are responsible for knowledge and implementation of this policy.
    - Clinical managers are responsible for ensuring regular updates regarding changes to policy and/or procedure
    - Staff are responsible for maintaining competence

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- Staff will receive education, training, and regular updates regarding least restraint
    - There is an expectation of mandatory compliance with annual learning
- Staff will receive training on proper application of restraints in accordance with manufacturer guidelines.
    - There is an expectation of mandatory compliance with annual learning
- Staff will receive training on Code White procedures.
    - There is an expectation of mandatory compliance with annual learning

RELATED PRACTICES AND / OR LEGISLATIONS:

Patient Restraint Minimization Act, 2001 – S.O. 2001, c. 16 (Bill 85). Available at: http://www.ontario.ca/laws/statute/01p16

Mental Health Act, 1990, R.S.O. 1990, Chapter M.7. Available at: http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90m07_e.htm

College of Nurses of Ontario. (2017). *Practice standard: Restraint practice standard*. Available at: http://cno.org/globalassets/docs/prac/41043_restraints.pdf

Registered Nurses of Ontario. (2012). *Promoting safety: alternative approaches to the use of restraints.* Available at: https://rnao.ca/bpg/guidelines/promoting-safety-alternative-approaches-use-restraints

REFERENCES:

Alzheimer's Society of Canada. (2007). Restraints. Available at: https://alzheimer.ca/en/Home/Living-with-dementia/Day-to-day-living/Safety/Restraints

Centre for Addiction and Mental Health (CAMH). (2016). Emergency Use of Chemical Restraint, Seclusion, and Mechanical Restraint.

College of Nurses of Ontario. (2017). *Practice standard: Restraint practice standard*. Available at: http://cno.org/globalassets/docs/prac/41043_restraints.pdf

CPI (2009). Joint commission standards on restraint and seclusion. Available at: https://www.crisisprevention.com/CPI/media/Media/Resources/alignments/Joint-Commission-Restraint-Seclusion-Alignment-2011.pdf

Park, M. & Tang, J.H. (2007). Changing the practice of physical restraint use in acute care. Journal of Gerontological Nursing. 33(2), 9-16.

Registered Nurses of Ontario. (2012). *Promoting safety: alternative approaches to the use of restraints.* Available at: https://rnao.ca/bpg/guidelines/promoting-safety-alternative-approaches-use-restraints

APPENDICES:
Appendix A: Decision Tree for Least Restraint
Appendix B: Alternatives to Restraints
Appendix C: Approved Restraints

Appendix A: Decision Tree for Least Restraint

Assess Patient Behaviour

Is this an **emergency** situation?

Yes

Violent Posing danger to self and/or others

If required, call **CODE WHITE**

Non-Violent Posing Immediate risk to self

Utilize Alternatives? (Appendix B)

Choose method of **LEAST RESTRAINT**

Obtain **consent** and physician **order** for specific restraints (within **2 hours** of application)

Document & Monitor Patient

Is the **Acute** Situation Resolved?

No

Yes

Remove Restraint

Collaborate with inter-professional team, patient, and/or SDM to identify:
- Contributing factors to patient's behaviour
- Potential methods to reduce risk of harm
- Alternatives to restraints

Document & Monitor Patient

No

Utilize Alternatives? (Appendix B)

Yes

Obtain Consult as Needed (i.e. Psychiatry)

No

Collaborate with inter-professional team, patient, and/or SDM to identify:
- Contributing factors to patient's behaviour
- Potential methods to reduce risk of harm
- Alternatives to restraints

Alternatives Implemented & Effective?

Yes

Document & Monitor Patient

Debrief with patient and family if appropriate

No

Consult with patient/family/SDM to develop care plan for use of restraints

Choose method of **LEAST RESTRAINT**

Obtain **CONSENT** & physician **ORDER**

Implement plan Provide ongoing support to patient/family/SDM **DOCUMENT**

Continue to Monitor Patient

Appendix B: Alternatives to Restraints

Presenting Behaviour	Alternative
Wandering	• Family member/volunteer involvement in care (e.g. monitor whereabouts, purposeful and diversional activities) • Assess if behaviour is aimless or need based (intervene to help with toilet, thirst, hunger, fatigue, seeking family) • Consider use of safety devices to contain wandering and build rest periods into the day • Orientation to time and place • Provide adequate opportunities for patient to walk, exercise, and/or increase mobility in a safe area during the day to promote sleep at night • Increase social interactions • Redirection with simple commands • Assess past coping strategies • Schedule regular toileting • Apply signs with patient's name on room door • Develop routine of care, do not deviate from it • Assess for needs (e.g. hunger, pain, heat, cold) • Clutter free environment • Alarm devices (e.g. bed, chair, door)
Treatment Interference	• Cover up sites (tubing dressings) • Let patient hold and see supplies like those used in his/her treatment (guided visualization) • Consolidate invasive lines • Assess for signs and symptoms of delirium and treat appropriately • Eliminate tubes which are causing distress as soon as feasible • Evaluate whether treatment goals can be achieved by alternative methods • Provide distractions from tampering with tubes • Restore sleep/wake cycle • Keep pain free and comfortable • Ensure regular nutrition

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Presenting Behaviour	Alternative
	• Ensure opportunities for toileting
Positioning Issues (e.g. sliding down/leaning forward in seat)	• Occupational therapy assessment • Monitor and adjust sitting tolerance • Routine position changes • Support lower extremities with foot stool and/or foot support • Pain relief and comfort measures
Falls and/or Unsafe Mobility	• Assess to rule out medical reasons for fall (e.g. dizziness, weakness) • Consultation with physiotherapy for assessment or improvement of balance, strength, endurance • Promote everyday function – walk to bathroom, bed transfers with assistive equipment • Anticipate needs (e.g. routine toileting to avoid getting up unsupervised and/or unaided) • Ensure an uncluttered and well-lit environment, with accessible call bell and assistive devices (i.e. walking aids, glasses, hearing aids) • Consider use of safety devices • Assess sensory deficits (i.e. vision, hearing, and decreased communication) • Physician review of medications • Bed alarms • Solid, non-skid footwear • Raising head of bed to increase visual fields • Diversion activities • Family involvement in care planning • Routine positioning • Relocation of bed closer to nursing station
Agitation	• Routine mobility, ambulation, and exercise • Routine positioning • Review of medications • Pain relief and comfort measures • Assess bowel and bladder function (e.g. assess for constipation) • Routine toileting

Presenting Behaviour	Alternative
	• Relaxation techniques (e.g. music) • Diversional activities • Involve family in care planning • Assess for needs (e.g. hunger, pain, heat, cold) • Assess past coping strategies • Increase social interactions
Disorientation	• Communication • Orientating patient to person, place and time • Leaving a light on at night (if possible) • Raising the head of the bed to increase the patient's visualization of the room • Use of calendar • Assess sensory deficits (i.e. vision, hearing, and decreased communication) • Review of medications
Bed Exiting	• Engage patient in therapeutic activities to promote activation and prevent boredom • Involve family, friends or volunteers • Transfer into a chair (recline if possible to prevent forward falls if he/she falls asleep) • Learn about patient's usual routines • Ensure opportunities for toileting • Assess pain and treat if possible • Routine positioning if bed mobility is limited • Use of bed alarm • Relocation of bed closer to nursing station
Risk of Harming Self and/or Others	• Consider Psychiatric referral • Review of medication • Discuss relaxation techniques • Minimize noise in the environment • Involve family in care planning • Do not insist on providing care if it is clearly not a good time – return later with assistance • Learn about patient's usual routines

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Presenting Behaviour	Alternative
	• Assign staff members that have a good rapport with the patient, and assign such staff to care for the patient as often as possible • Explain to the patient in simple terms the care you would like to provide and seek consent where possible • Develop routine of care, do not deviate from it • Provide care in pairs, and during times in which the patient exhibits his/her most stable behaviour

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Appendix C: Approved Restraints

PINEL – Complete Kit Contents

Quantity	Equipment Item	
4	Limb straps with covers	
1	Long utility strap	
1	Shoulder strap	
1	Waist belt with 2 small utility straps	
1	Pelvic strap	
2	Short utility straps	
1	Extender	
3	Keys	
13	Button/pin/lanyards and 2 button/pins	
1	Emergency cutting knife	
1	Carrying bag	

	Soft Limb Holder	