Brockville General Hospital

Title:	Least Restraint and Alternative Approaches		☑ Policy ☑ Procedure
Category:	General Clinical Policies	**Sub Category:**	Clinical
Original Date:	August 2000	**Number:**	CLIN-018
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PURPOSE

To ensure that restraints and seclusion are considered an emergency and temporary measure after all alternatives have been explored and to balance the safety needs of the patients, healthcare providers and/or others. The decision to use restraints/seclusion is made in partnership with the patient or substitute decision maker (SDM), and the healthcare team, unless used as an emergency measure.

In accordance with the Patient Restraint Minimization Act (PRMA, 2001), a patient may be restrained only when one or more of the following criteria is met:

1. It is necessary to prevent serious bodily harm to the patient or another person.
2. It gives them greater freedom or greater enjoyment in life.
3. Placing them under restraint is authorized by a plan of care to which the patient (or their SDM) has consented.
4. Such other criteria as may be prescribed by regulation for restraining or confining a patient are met.

Restraint devices categorized as Least Restrictive can at times be used for non-restraint purposes. When the primary intention for the use of these devices is not to restrain, their use will not be governed under this policy. Healthcare providers must use high levels of caution in recognizing that if a patient attempts to remove this device and is unable, it then becomes a restraint and the following policy applies.

The use of restraint devices, regardless of the intended purpose, carries a potential risk to the physical safety and psychological well-being of the patient to whom the restraint is applied. Limiting a patient's freedom of movement in any way carries with it a responsibility on the part of the healthcare providers to exercise the highest degree of caution and care. The following principles and guidelines will be upheld:

1. Healthcare providers will make all reasonable attempts to implement alternative approaches, and document them as ineffective prior to applying restraints. Healthcare providers will continue to reassess and consider the use of alternative approach instead of restraints. Refer to Appendix E for examples of alternative approaches.
2. Healthcare providers will adhere to least restraint practices, using the least restrictive type of restraint for the least amount of time. Restraints are never to be used for punitive reasons or ordered PRN (PRMA, 2001).
3. Only BGH approved restraints will be used (Appendix A). All commercially manufactured hospital approved restraints are to be used as intended and not to be modified or adapted in any way.
4. Highly restrictive restraints will only be used as a last resort in emergency situations where a patient's aggressive or violent behaviour presents an immediate risk of serious bodily harm to self or others.

An Unusual Occurrence Report must be completed to report circumstances where a restraint/seclusion is applied for all emergency situations/Code Whites and where use is not part of the ongoing patient treatment plan. The minimum Level of Harm is Level 5 – *A situation where an event reached a patient but the patient outcome is not symptomatic or no symptoms are detected AND no treatment is required*. When a highly restrictive restraint is initiated, the program manager or the Administrative Coordinator (ACO) must be notified as soon as reasonably feasible during their regular business hours.

DEFINITIONS

Least restraint – Applying the least restrictive intervention for the least amount of time to limit a patient's freedom of movement, control their mobility, or inhibit behaviour(s).

Alternative approach – Interventions to address behaviours and/or safety concerns for an individual in order to avoid the use of restraints. These interventions impose less control on the patient than restraining or using a monitoring device (PRMA, 2001).

Restraint – Any intervention used to limit a patient's freedom of movement, control their mobility, or inhibit behaviour(s) that may be injurious to themselves or others. All BGH Approved Restraints are outlined in Appendix A. Categories include:

1. **Mechanical restraint** – Any approved device used with the primary intent to restrict the patient's movement. NOTE: devices used for positioning where a patient has consented and can remove it without assistance are not categorized as restraints. Positioning devices used during surgery and swaddling infants are also exempt.
2. **Chemical restraint** – A STAT pharmacological intervention administered to control a patient's movements (OHA, 2016). NOTE: not included in the definition of chemical restraint are psychotropic medications that are used for treatment purposes as part of an ongoing plan of care for an established diagnosis. Medication that is prescribed PRN and established with the person or SDM as part of his or her plan of care is also excluded (Patient Safety Institute, 2017).
3. **Environmental restraint** – Any barrier that limits the locomotion of a patient, and thereby confines them to a specific geographical area or location.
4. **Physical restraint** – The intentional restriction of a patient's movement with physical force (e.g., holding a patient down).

Seclusion – A type of environmental restraint. Confinement of a patient alone in a locked room, specifically designed for the purpose of seclusion, from which the patient cannot leave.

Least restrictive restraint – Restraints that minimally restrict a patient's movement, and have the ability to be used for other intentions other than restraining (e.g., positioning, comfort, safety).

Highly restrictive restraint – Restraints that highly restrict a patient's movement, included in this category are: 4, 5, and 6 point Pinel restraints, handcuffs, and seclusion.

Patient – Encompasses all individuals who receive health services across the continuum of care.

Substitute decision maker (SDM) – A person who is authorized to give or refuse consent to a treatment on behalf of a person who is incapable with respect to the treatment (Health Care Consent Act, 1996).

Staff – Includes all BGH employees (permanent full time, part time, casual, volunteers, students).

Healthcare provider – All regulated staff who provide or manage patient care/activities/treatment and those individuals who have been granted privileges to practice with BGH.

Most responsible physician (MRP) – The physician who has the responsibility and accountability for the medical/psychiatric care of the patient.

Routine observation – Routine observation is the baseline level of observation and frequency is once every 60 minutes, day and night. This is the minimal level for all patients and applies to patients who are considered to be low risk of vulnerability, disturbed behaviour, suicide, self-harm, or harm to others.

Close observation – When a patient requires observation over and above that provided as routine due to increased acuity of presenting symptoms, potentially uncontrolled behaviour and actions, or for safety measures only. The person is potentially but not immediately at risk of vulnerability, disturbed behavior, suicide, self-harm, or harm to others. Requires assessment and documentation every 30 minutes.

Constant observation – Requires one staff member be the Observing Staff and remains in attendance with the patient at all times. The patient on constant observation is visible to the Observing Staff at all times. Any time the Observing Staff is required to leave the patient, constant observation of the patient must be assigned to another staff member. Regardless of "who" is observing the patient, the Assigned Nurse remains accountable for the care of the patient.

Assigned Nurse – A nurse who has the responsibility and accountability for the care of the patient. Can be a registered nurse (RN) or a registered practical nurse (RPN).

Observing Staff – A staff member who has been delegated by the Assigned Nurse to be an observer of a patient. The Observing Staff can be an unregulated healthcare provider (UCP) (e.g., personal support worker, security).

PRN – Pro re nata - a Latin phrase meaning "in the circumstances" or "as the circumstance arises". It is commonly used in medicine to mean "as needed" or "as the situation arises." It is generally abbreviated to PRN in reference to dosage of prescribed medication that is not scheduled; instead administration is left to the nurse or the patient's prerogative. PRN administration of medication is not meant to imply and should never allow for exceeding a prescribed daily regimen.

STAT – Medical term used to imply urgent or rush. It may appear in lower case letters as stat or in capital letters as STAT, as in "Treatment may include STAT surgery." The term is derived from the Latin word "statim" which means immediately.

Emergent – A situation where immediate action is necessary to prevent serious bodily harm to the patient or another person.

Non-emergent – A situation that does not meet the definition of "emergent".

PROCEDURE

This process map outlines requirements and provides guidelines for the implementation of restraints.

A - TRAINING AND EDUCATION

All staff will complete the Least Restraint Module during orientation and every two years thereafter.
Any staff who will be applying restraints to a patient must complete the in-person Restraint Application Training Session followed by the Restraint Application Module every two years thereafter.
Both the Least Restraint Module and the Restraint Application Module are available through MyBGH on My Learning Portal.

Prior to applying a restraint or caring for a patient with a restraint, staff are responsible to be knowledgeable regarding alternative to restraints, the application and discontinuation of the specific restraint being used, and the care needs of the patient being restrained. (Alberta Health Services, 2019)

B - Initial Assessment

Patients will be assessed on an ongoing basis and at the discretion of the healthcare provider for the need to implement least restraint(s) and/or alternative approach(es). Assessments developed in Quadramed to help the healthcare provider with decision making regarding the use of restraints include: Confusion/Delirium Assessment Method (CAM), ICU CAM, Violence/Aggression Assessment, and Fall Assessment.

Other considerations to assist the healthcare provider in decision making for a plan of care include:

- Known or suspected history of physical or sexual abuse or other severe trauma
- Any history of triggers for, aggressive/violent behaviour, and context of such behaviours
- Behaviour Alert previously documented
- Previous restraint use and previous successful alternatives to restraint interventions
- Previous de-escalation strategies and their effectiveness
- The patient's medical condition(s), include present and past history
- Physical well being
- Mental well being
- Pharmacological interventions, include past and present
- Caregiver/family support

The healthcare team will collaborate with patients, their SDMs and/or families to determine a plan that includes alternatives to restraint in the event the patient meets the criteria to restrain.

C - Prior to Implementing Restraint

All possible alternative approaches to halt or de-escalate behaviours should be explored before a restraint intervention is implemented (Patient Safety Institute, 2017). Refer to Appendix E for examples of alternative approaches.

There must be documented evidence the patient's clinical record that, despite consideration and/or implementation of alternative approaches, the patient continues to exhibit behaviour that places self or others at risk of serious bodily harm.

Efforts must be made 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 behavioural expectations to the patient, including the reason(s) for restraint and the behaviour necessary for discontinuing the restraint.
- Acknowledging and considering any history of abuse/trauma that may be a relative contraindication for use of restraint.
- Exploration of previous experience and effects of restraint that the patient has encountered.

When all reasonable alternative approaches have been exhausted and the behaviour persists, the healthcare provider will determine the appropriateness of restraint use and implement the least restrictive type of restraint for the least amount of time in collaboration with the MRP, the healthcare team, and when possible, patient and/or the SDM/family.

Ordering

A physician's order is required, prior to or immediately after application, to authorize restraint use on a patient. A physician's order must include the type of restraint and the reason for its use. In the absence of immediate access to a physician, when the application of a restraint is indicated, an RN may authorize the application of restraint. The MRP will be notified and a written or verbal order authorizing restraint use will be obtained as soon as reasonably possible.

Re-orders for Least Restrictive Restraints and More Restrictive Restraints require a physician face-to-face assessment of ongoing need of the restraint, and are necessary:

- Within 24 hours of initial application
- 72 hours after re-order
- Weekly x1
- At least monthly thereafter

Re-orders for Highly Restrictive Restraints require a physician face-to-face assessment of ongoing need of the restraint, and are necessary:

- Within 24 hours of initial application
- Every 24 hours thereafter, until discontinued

Should a highly restrictive restraint use continue for a period of 3 days (72 hours), the MRP must obtain a restraint reassessment (as a consult) from another physician. This restraint reassessment is required after any 72 hour period. The goal of the restraint reassessment is to provide a second opinion regarding the use of psychotropic medications and alternative strategies to promote release from mechanical restraint. The physician providing the restraint reassessment must complete a face-to-face assessment of the patient and send the restraint reassessment summary to the MRP within 24 hours of receiving the request. The MRP must document the review of the restraint reassessment.

Consent

Consent must be obtained prior to, or as soon as reasonably possible, after restraints are applied from the patient or SDM. The Consent to Restrain Form (Appendix D) will be completed and filed in the patient's chart. If consent is obtained from the SDM by telephone, the healthcare provider will complete the Consent to Restrain Form and indicate that consent was received over the phone.

In emergent situations, where consent cannot be obtained by the patient and/or SDM, the patient may still be restrained in accordance with the Patient Restraint Minimization Act (PRMA, 2001).

D - Application of Restraint

Communicate with the patient about the type of restraint that will be applied and the reason for the restraint application. The staff member can give the patient instructions on what he or she needs to do to avoid the use of restraint.

- Explain to the patient what will happen when the restraint process begins.
- Protect the safety of the patient's head and ensure that the patient is in a position that protects his or her ability to breathe (on back or side) (Patient Safety Institute, 2017).

If the healthcare team deems it necessary, a code white can be called overhead to engage additional assistance. Ensure there is enough available staff needed to safely apply the restraint.
Pharmacological intervention should always be considered to help reduce to need to use highly restrictive restraints.

Mechanical Restraints

Only a BGH approved mechanical restraint will be applied and only as per manufacturer instruction. The restraint must be in good working order and have no post-manufacturer modifications. A minimum of 2 point restraint is required for limb restraints starting with the patient's wrists. Posey and Pinel waist restraints must always be used in combination with a pelvic strap. Physical restraint may be needed temporarily until the mechanical restraint is secured. Ensure the restraint is applied with an appropriate amount of slack and that no harm is caused (e.g., circulation is not impaired). Never attached a restraint to a moving part of a bed or wheelchair. Identify how to quick release the restraint and have any needed equipment readily available (e.g., key to Pinel restraint).

Chemical Restraint

When there is a need for a chemical restraint, an oral form should be offered to the patient, but given the nature of behavioural emergencies requiring restraint, an injection is most commonly used. To give the chemical restraint, physical restraint may be needed. In these instances, the patient should be informed of what will occur prior to applying physical and chemical restraint. Medication given for the purpose of restraint should be in a short-acting form.

Seclusion/environmental

Prior to introducing seclusion, the safety of the seclusion room should be ensured. In other words, the room should not contain furniture that could be moved or used as a weapon and the glass through which the person is monitored should be unbreakable. The exit should be easy to identify.

Seclusion is a temporary measure and, if possible, should be avoided with patients who may be experiencing suicidal ideation or may otherwise be at risk of harm to themselves (e.g., banging head against wall). Seclusion may exacerbate their distress and causes of suicidal ideation (Patient Safety Institute, 2017).

Physical Restraint

When a patient is physically restrained, that patient is physically/bodily held by others (e.g., healthcare provider, security) to restrict his or her movement. Physically restraining a patient is used as a last resort and never considered part of treatment. Physical restraint may be needed temporarily until a safer restraint is implemented or secured. During physical restraint use there is a need for continued verbal interventions from staff to help calm the patient. Extreme caution is needed in their application to prevent injury (Patient Safety Institute, 2017).

E - Assessment, Monitoring, and Reassessment

All patients, regardless of the type of restraint in use, will be assessed by a staff member on an ongoing basis. The basic dignity of patients who have been restrained or secluded will be protected and minimum standards of care must be upheld. These minimum standards will be provided at least every 2 hours and include providing patients with regular personal hygiene, bathroom breaks or continence care, exercise, social engagement, restraint breaks, and nutritional and fluid breaks. Patients must also be ambulated for a minimum of 15 minutes every 8 hours (Review of Seclusion and Restraint Practices in Ontario Provincial Psychiatric Hospitals, 2001). The Guidelines for Restraints (Appendix C) and the Restraint Monitoring Form (Appendix E) further defines and mandates required documentation and frequency for these standards of care.

F - Documentation

Following the initial application of a restraint, documentation in the patient's clinical record must include all of the following:

- The circumstances precipitating the application of the restraint
- The alternatives considered and why those alternatives were inappropriate

- The ordering physician, what restraint was ordered, and any instructions relating to the order
- Consent
- The staff member who applied the restraint and the time of application

Ongoing Documentation will be completed using the Restraint Monitoring Flowsheet (Appendix E). If observation will be provided by an UCP, the Assigned Nurse will ensure the UCP:

- Is competent to perform their duties, by demonstrating understanding of the extent of their responsibilities and ongoing effectiveness in their interventions.
- Knows when and who to ask for assistance, and
- Knows when, how, and whom to report the outcome of the procedure, and
- Knows not to leave duties until responsibilities are transferred to the next assigned person.

G - Discontinuation of Restraint

Restraint must be discontinued as soon as assessed to be feasibly safe. Assess the patient for indicators that the restraint can be safely discontinued (e.g. no longer presenting a risk of self-harm or harm to others, calm, cooperative). De-restraining may be implemented in a gradual, staged process. An RN, in consultation with other healthcare team members, can initiate discontinuing restraints without a physician's order. All assessments and activities related to the discontinuation of restraints must be documented in the patient's clinical record.

Following the use of restraint the healthcare team will acknowledge to the patient the impact that the event has had on the therapeutic relationship. It is important that the team keep an open dialogue with the patient through the period of restraint. The team and the patient will collaborate to determine a plan to counsel and support the patient during the period of restraint and during re-integration following restraint use.

The use of restraints can present significant infringement of an individual's right to autonomy and is associated with significant morbidity and mortality (Review of Seclusion and Restraint Practices in Ontario Provincial Psychiatric Hospitals, 2001). Due to the high risks associated with restraint use, it is recommended debriefings are conducted for the patient and SDM/family, and for all staff who participated in the care, especially if a highly restrictive restraint was used in an emergent situation. Continuous improvement of the clinical response to episodes of restraint is enhanced through regular reviews of these processes. Guidance for debriefing patient and family is outlined in Appendix F, and guidance for debriefing staff is outlined in Appendix G.

H - OTHER CONSIDERATIONS

1. **Patients in Custody of Police or Correctional Services**
   When a patient is in custody the healthcare team and police or correctional officer(s) will work collaboratively to ensure patient, staff, and community safety. When a patient is restrained in a police or correctional officer(s)' restraint, restraint use decisions and management of the restraint lies with the police or correctional officer(s). A BGH restraint is never to be used in addition of police of correctional officer(s)'s restraint(s).

2. **Monitoring Devices**
   Monitoring devices are available at BGH that do not meet the criteria, and are therefore not categorized as restraints. These devices do not to limit a patient's freedom of movement, control their mobility, or inhibit behaviour(s) that may be injurious to themselves or others (e.g. wander guards without locking doors, bed alarms, infant monitoring devices, etc.). When these devices are initiated consent should be obtained from the patient and/or SDM using the Consent to Restrain Form (Appendix D), however these devices can still be used if the patient meets the criteria to restrain as per the Patient Restraints Minimization Act (2001). Alternative

approaches as outlined in Appendix A must also be considered, implemented, and documented in the patient's record prior to implementing. Routine standards of care and documentation will be upheld for all patients with monitoring devices, although healthcare providers must use a high degree of caution as the use of monitoring devices can lead to the use of physical restraining, at which point this policy in its entirety would become applicable.

3. **Patients Requiring Intermitted Restraint Use**
   The MRP can order an intermittent mechanical restraint that is not categorized as a highly restrictive restraint. This type of restraining is not considered PRN and therefore does not require a new order each time the restraint is applied. The patient must be assessed by the MRP and the order must include the type of restraint and outline when its use is indicated (e.g., applying a table top or seatbelt when the patient is up in their wheelchair). Initial consent for intermittent restraint use must be obtained from the patient or the patient's SDM and documented using the Consent to Restrain Form (Appendix D). Implied or implicit consent can be sought for applications thereafter.

4. **Maintenance of Mechanical Restraints**
   The responsibility of ongoing maintenance, laundering, and replenishment of mechanical restraints will reside with each program.

RELATED POLICIES

- CLIN-017 Falls Prevention
- ORG-003 Behaviour Alert
- EP-026 Code White – Violent or Behavioural Situation

ASSOCIATED DOCUMENTS

Appendix A - Alternative Approaches to Restraint
Appendix B - Approved Restraints
Appendix C - Guidelines for Restraints
Appendix D - Consent to Restrain Form
Appendix E - Restraint Monitoring Form (Initial Assessment and Flow Sheet)
Appendix F - Debriefing Patient and Family
Appendix G - Debriefing Staff

REFERENCES

[1] Bill 85, Patient Restraints Minimization Act (2001) https://www.ola.org/en/legislative- business/bills/parliament-37/session-2/bill-85

[2]RNAO Best Practice Guideline- Promoting Safety: Alternative Approaches to the Use of Restraints https://rnao.ca/bpg/guidelines/promoting-safety-alternative-approaches-use-restraints

[3]CNO "Understanding Restraints" https://www.cno.org/en/learn-about-standards-guidelines/educational-tools/restraints/

[4]OHA A Practical Guide to Mental Health and the Law in Ontario (2016) https://www.oha.com/Legislative%20and%20Legal%20Issues%20Documents1/OHA_Mental%20Health%20and%20the%20Law%20Toolkit%20-%20Revised%20(2016).pdf

[5]Patient Safety Institute Module 13d: Mental Health Care: Seclusion and Restraint: When All Else Fails (2013) https://www.patientsafetyinstitute.ca/en/education/PatientSafetyEducationProgram/PatientSafetyEducationCurriculum/Documents/Module%2013d%20Seclusion%20and%20Restraint.pdf

[6]Review of Seclusion and Restraint Practices in Ontario Provincial Psychiatric Hospitals (2001) https://www.sse.gov.on.ca/mohltc/ppao/en/Documents/PPAO%202001%20Restraint%20and%20Seclusion%20Report.pdf

[7]Mental Health Act, R.S.O. 1990, c. M.7 https://www.ontario.ca/laws/statute/90m07

[8]A guide to the Long term Care Home Act 2007 http://health.gov.on.ca/en/public/programs/ltc/docs/ltcha_guide_phase1.pdf

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[16]Royal Victoria Regional Health Centre (2011), CORPORATE CLINICAL POLICY & PROCEDURE, *Least Restraint (Physical, Environmental, Chemical, Restraints)*

[17]Lakeridge Health (2019), Interprofessional Practice, *Least Restraint: Prevention, Administration, and Management – Policy and Procedures*

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[19]Grey Bruce Health Services (2011), *Restraint*, Professional Practice

[20]Alberta Health Services (2019), *Restraint as a Last Resort – Critical Care*, Restraint as a Last Resort Policy (#HCS-176)

[21]St Joseph's Health Centre Toronto (2017), *Least Restraint Policy*, Interprofessional Advisory Committee and Medical Advisory Committee

[22]Saskatoon Health Region (2014), *Least Restraint – Mechanical and Environmental*, Nursing Professional Practice and Education

[23]Mackenzie Health (2020), *Least Restraint Policy*, Professional Practice

Approved By:	_____ Linda Hunter, VP Clinical Services _____ Dr. Rob Malone, Chief of Psychiatry
Retired Date:	

APPENDIX A – ALTERNATIVE APPROACHES TO RESTRAINT

Cognitive Impairment (Dementia)	
Individualized care plan (routine) – involve family Toileting Routine Assess for pain, hunger, heat or cold Label environment (i.e. door signs: "bathroom") Redirect with simple commands Give space & control as possible, permit pacing	Reminiscence Diversion activities Clutter free rooms Validation therapy (if the person insists that something is true, do not argue) Allow patients to vent – respond calmly
Acute Confusion (Delirium)	
Medication Review Reorientation Work-up for underlying cause Pain relief/comfort measures, hunger Toileting routine	Individualized care plan (Increase or decrease social interactions, Assess past coping strategies) Redirect with simple commands Alarm/monitoring devices Gentle touch
Hitting, pacing, spitting, swearing, pinching, etc	
Recognize the reason for behaviour and document Positive verbal communication and body language Validate/acknowledge (emotions, experience) Mobility/ambulation/exercise routine Medication review Toileting routine	Relaxations techniques Increase or decrease social interactions Permit pacing Provide clear & simple limits Provide choice/options as appropriate Individualized care plan
Wandering (Sun downing)	
Assess for hunger, pain, heat or cold Toileting routine Buddy with Patient Observer if appropriate Involve family in care plan Label environment (i.e. door signs: "bathroom")	Relaxations techniques Increase or decrease social interactions Permit pacing Provide clear & simple limits Provide choice/options as appropriate Individualized care plan
Pulling out Invasive Tubes	
Pain relief/comfort measures Increase social interaction Redirect with simple commands Call bell demonstration Stimulation/meaningful distraction	Explain procedures/treatment Gentle touch Involve family in care plan Arm splint or Abdominal binder over PEG Change IV to intermittent
De-escalation/communication techniques	
Give choices as appropriate Be empathic Clarify messages Respect personal space Be aware of your body position Ignore challenging questions	Avoid instructions like "relax" and "calm down" Validate patient's feelings Permit verbal venting when possible Set and enforce reasonable limits Keep your nonverbal cues nonthreatening Avoid overreacting Use physical techniques only as a last resort

Adapted From Mackenzie Health

APPENDIX B – APPROVED RESTRAINTS

Least Restrictive to Most Restrictive

Least Restrictive	More Restrictive	Highly Restrictive
Posey mitt	Soft Velcro wrist restraint	4 point Pinel
Wander guards (locking door)	2 point Pinel wrist restraint	5 point Pinel
Bed rails	Pinel waist restraint (with pelvic strap)	6 point Pinel
Seat belt	Posey waist restraint (with pelvic strap)	Seclusion (only IPMH & ED)
Seat belt sleeve/cover	Chemical (appropriate dosing)	Handcuffs (only Security)
Locking wheelchair		Physical (holding)
Velcro door barrier		
Tilting chair		
Tilting bed		
Tray table secured to chair		

Examples:

Posey mitt

Velcro door barrier

Posey waist with pelvic strap

Soft Velcro wrist restraint

Tray table secured to chair
(e.g., Lumex or Geri chair)

Pinel Restraint (5 point)

APPENDIX C – GUIDELINES FOR RESTRAINTS

Restraint Type	Minimum Level of Observation	Patient Care Guidelines	Potential long Term Restraint	Unusual Occurrence Report required
• Wander Guard (locking door) • Velcro Door Barrier	Routine	• Requires Q1 hour documentation on Restraint Monitoring Flowsheet • Document location of the device	Yes	No
• Full Bed Rails • Locking wheelchair • Tilting bed or wheelchair • Seat belt (with or without sleeve/cover) • Tray table secured to chair • Waist restraint with pelvic strap (Pinel/Posey)	Routine	• Requires Q1 hour documentation on Restraint Monitoring Flowsheet • Document when restraint is required	Yes	No
• Posey mitt(s)	Routine	• Requires Q1 hour documentation on Restraint Monitoring Flowsheet • Include CSM assessment	No	No
• Soft Velcro wrist restraint • 2 point Pinel wrist restraint	Close	• Requires Q30 minutes documentation on Restraint Monitoring Flowsheet • Document respiratory rate, and CSM (for restrained limbs) Q30 minutes	No	No
• Chemical	Based on patients clinical status	• Monitor the patient Q15 minutes until desired effect achieved; thereafter based on properties of the medication and the patient's clinical status	No	No
• 4 point Pinel • 5 point Pinel • 6 point Pinel • Seclusion (only IPMH and ED)	Constant	• Requires an Observing Staff to remain with Q15 minutes documentation on Restraint Monitoring Flowsheet • Document respiratory rate, and CSM (for restrained limbs) Q30 minutes	No	Yes
• Handcuffs (only Security) • Physical	Constant	• Only to be used as a means to secure/transport a patient to a space in which a safer more therapeutic restraint can be applied	No	Yes

Note: Restraint devices categorized as Least Restrictive can at times be used for non-restraint purposes. When the primary intention for the use of these devices is not to restrain, their use will not be governed under the Least Restraint and Alternative Approaches policy. Healthcare providers must use high levels of caution in recognizing that if a patient attempts to remove this device and is unable, it then becomes a restraint and this policy applies.

APPENDIX D – CONSENT TO RESTRAIN FORM

Patient Information

Consent to Restrain

Type of Restraint Device: ☐ Mechanical ☐ Environmental ☐ Chemical

Specify each type of restraint to be used: _____
_____

Purpose of the restraint: _____
_____

Frequency Restraint Application:
☐ Continuous
☐ Intermittent
- ☐ When in bed
- ☐ When up in chair
- ☐ With Meals
- ☐ Other: _____

I understand the potential benefits and risks of restraint use. I understand the healthcare teams evaluation and proposed use of the outlined restraint:

☐ I **DO** consent to the use of restraints as outlined above.
I understand that I have the right to refuse the use of restraints and can revoke this consent at any time.

☐ I **DO NOT** consent to the use of restraints as outlined above, and acknowledge the related risks as outlined by the practitioner.

Client/Patient Consent	
Client Signature:	Date:
Staff Signature:	Date:
OR Substitute Decision Maker Consent (in person)	
SDM Name (print):	SDM Relationship to patient:
Signature:	Date:
Staff Signature:	Date:
OR Substitute Decision Maker Consent (via telephone)	
SDM Name (print):	SDM Relationship to patient:
# SDM can be reached at:	Date:
Staff Signature:	Date:

APPENDIX E – RESTRAINT MONITORING FORM

Patient Information

Initial Assessment Form

Behaviours present prior to restraint application:

☐ Physical aggression ☐ Verbal aggression (threatening)
☐ Exit seeking ☐ Wandering
☐ Thrashing/restless ☐ Falling/climbing out of bed

Additional Information: _____

_____

Alternatives & interventions attempted:

☐ 1:1 Engagement ☐ Limit setting
☐ Exercise ☐ PRN medication
☐ Toileting ☐ Pain management
☐ Separate from situation ☐ Family presence
☐ De-escalation techniques ☐ Ask HALT**
☐ Other (e.g., diversional activities, glasses, hearing aides, etc.) _____

_____

**HALT=Hungry, Angry, Lonely, Tired

Restraint Application

Date/time _____ Ordering Physician _____

Register Staff Applying Restraint (list if applicable): _____

Reason for Restraint: ☐ Risk of self harm ☐ Risk of harm to others ☐ Improve freedom/enjoyment of life

Code White: ☐ Yes ☐ No **Unusual Occurrence Report completed:** ☐ Yes ☐ No

Consent to Restrain Form completed: ☐ Yes ☐ No

Type of Restraint Applied:

Least Restrictive

☐ Seat Belt (with/without sleeve) ☐ Locking wheelchair/tilting bed or wheelchair ☐ Posey mitt
☐ Wander Guard (locking door) ☐ Bed rails ☐ Velcro door barrier
☐ Tray table secured to chair

More Restrictive

☐ Soft Velcro wrist restraint ☐ Posey waist restraint (including Pelvic Strap) ☐ Chemical
☐ 2 point Pinel wrist restraint ☐ Pinel waist restraint (including Pelvic Strap)

Highly Restrictive

☐ 4 point Pinel (limbs) ☐ 5 point Pinel (limbs and waist with pelvic strap) ☐ Seclusion
☐ 6 point Pinel (limbs, waist with pelvic strap, and chest strap/long utility belt)

Assessment on Initiation

Relevant PMHx _____

Please indicate if any of the below conditions were noted on initiation of the restraint:

☐ SOB/Difficulty breathing ☐ Delirium/hallucinations ☐ Change in skin colour
☐ Cut/scrape/abrasion ☐ Bruising ☐ Pain
☐ Other: _____
☐ Please describe emotional state: _____

Patient Information

Restraint Monitoring Flowsheet (Ensure Initial Assessment Form is completed)

Date _____ **Level of Observation:** ☐ Routine (document q1hour) ☐ Close (document q30min) ☐ Constant (document q15min)

Time→																
A: Behaviours Observed																
B: Alternative/Interventions *Restraint release q2h, as appropriate*																
C: Care Provided (q2h minimum) *Ambulate for a minimum of 15 minutes q8h, as appropriate*																
CSM check – Y or N (for any restrained limbs)																
Vitals Signs – Y or N (see Quadramed)																
Observing Staff Initial *(as needed)*																
Assigned Nurse initial																

A: Behaviours being Observed
1. Verbally aggressive
2. Physically aggressive
3. Thrashing/restless
4. Unable to follow commands
5. Disorientated/confused
6. Attempting to harm self
7. Exit seeking
8. Climbing out of bed or chair
9. Calm/cooperative
10. Asleep

B: Alternatives/Interventions Implemented
a. 1:1 engagement
b. Pain management
c. Breathing exercises
d. De-escalation techniques
e. Family/friend presence
f. Restraint release trial
g. Orientation X3
h. Other_____
i. PRN Medication
j. Support/reassurance
k. Music
l. Pet therapy
m. Temp adjustments
n. Redirection
o. Decrease stimulus
p. Consult (MH, OT, PT, SW, spiritual care)

C: Care Provided
a. Food/Fluid Offered
b. Toileting
c. Incontinence Care
d. Skin Care
e. Mouth Care
f. Ambulation
g. Repositioned
h. ROM
i. Other_____

Assigned Nurse Signature	Initials	Observing Staff Signature *(can be unregulated)*	Initials

APPENDIX F – DEBRIEFING PATIENT AND FAMILY

If clinically indicated, as soon as possible following the termination of restraint, the Program Manager/delegate will arrange for members of the interdisciplinary team to meet with the patient and family/significant others/SDM as appropriate, to participate in a debriefing of the restraint experience. A summary of the debriefing is to be documented in the progress notes of the patient's clinical record. The purpose of debriefing is to:

- Hear and record the patient/family/SDM perspective of the experience
- Provide an opportunity to identify and explore the circumstances that led to the use of restraint
- Attempt to establish or re-establish the therapeutic relationship
- Identify personal and/or environmental factors that may have contributed to or exacerbated the behavioural emergency
- Explore the effectiveness of de-escalation strategies used
- Identify any necessary modifications to the treatment plan
- Explore the patient's care preferences and future wishes regarding behavioural intervention
- Support the patient's re-entry into the milieu
- Identify and begin to address any trauma that may have occurred as a result of the experience
- Develop/review a written proactive crisis plan to reduce the potential for recurrence

The emotional needs of co-patients who witnessed or were otherwise impacted by the restraint episode should also be addressed, and the need for debriefing in these circumstances should be considered.

APPENDIX G – DEBRIEFING STAFF

Continuous improvement of the clinical response to behavioural emergencies is enhanced through regular reviews of these processes. Following restraint, where indicated, a staff debriefing may be conducted by a facilitator, appointed by the Program Manager/delegate, with all staff involved in the restraint event. The purpose of the debriefing is to:

- Determine the physical/emotional well-being of staff
- Identify strengths & weaknesses in the clinical response
- Identify the need for any process improvements
- Review of the circumstances that lead to the use of restraint to reveal any triggers that may have indicated that the patient was not in control there by potentially preventing future episodes
- Learn from the experience.

If staff involved in the incident requires post–incident support or help coping with the event, the Program Manager/delegate will notify them of the resources available (e.g. Employee Assistance Program (EAP), Occupational Health Services, Spiritual Care Services, union representative, etc.).