OBJECTIVES

- To provide guidance on the use of pharmacological, environmental, mechanical and physical restraint as a last resort.
- To promote a safe and healthy environment for patients, staff, family and visitors.

APPLICABILITY

Compliance with this document is required by all Alberta Health Services employees, members of the medical and midwifery staffs, Students, Volunteers, and other persons acting on behalf of Alberta Health Services (including contracted service providers as necessary) working with adult inpatients in Acute Care.

Note: This document does not apply to Critical Care, Emergency Departments/ Urgent Care Centres, or Inpatient Addiction and Mental Health settings. Refer to the AHS Restraint as a Last Resort - Critical Care, Emergency/Urgent Care, or Addiction and Mental Health - Inpatient Procedure(s). When working with older adults, refer to the Restraint as a Last Resort – Older Adult Procedure, where appropriate.

ELEMENTS

1. Comprehensive patient assessment (see Appendix C: Information to Consider)
   
   1.1 Identify the reason(s) for considering a restraint.
   
   1.2 Identify factors that contributed to the reason for considering restraint (e.g., consider unmet patient needs, acute change in clinical condition).
1.3 Initiate an assessment by the appropriate members of the multidisciplinary team (e.g., Occupational Therapist/Physical Therapist, Psychiatry, Geriatrics, consider family/support persons, nursing).

1.4 In an emergency situation, where no pre-existing orders are in effect, staff may initiate the use of non-pharmacological restraint intervention in circumstances where nursing assessment indicates restraint is the only means of preventing serious bodily harm to the patient or others.

Note: Pharmacological restraints require Physician or Nurse Practitioner order prior to administration.

2. Consent

2.1 Consent is not required in emergency situations when there is an immediate threat to safety or emergency treatment is being provided.

2.2 Consent shall be obtained in non-emergency circumstances where restraint is part of the treatment plan in accordance with the Alberta Health Services Consent to Treatment/Procedure(s) policy suite.

3. Use of alternate interventions prior to considering use of restraint (see Appendix B: Alternative Interventions)

3.1 Discuss options with the patient/alternate decision-maker including the role of hired sitters or having family members stay with the patient.

3.2 Consider and address unmet needs that may be contributing to the situation (e.g., toilet the patient, address thirst and/or hunger, assess for pain).

3.3 When restraints are deemed necessary, the least restrictive restraint shall be used, for the least amount of time, balanced with ensuring safety of patients, caregivers and others, and respecting patient liberty.

4. Planning

4.1 Staff shall develop an individualized care plan with the patient and family.

4.2 Restraints shall be applied as a result of collaborative decision-making following a comprehensive assessment, case review, and documented attempts at alternative interventions.

4.3 A Physician or Nurse Practitioner order is required and informed consent must be obtained from either the patient or the alternate decision-maker prior to restraint being applied.

4.4 Restraints shall only be used for the shortest interval required and, where possible, not as a long-term intervention.

4.5 The least restrictive restraint shall be used (see Appendix A and C).
a) Restraint shall be used in accordance with manufacturer’s guidelines.

4.6 For agitated patients, refer to AHS Seniors Delirium Protocol.

4.7 Any application of restraint shall be done only by staff who are educated and trained on appropriate restraint use.

4.8 With pharmacological restraint, medications are used at the lowest possible dose appropriate given the patient’s physical and mental condition. Refer to AHS Appropriate Use of Antipsychotics (AUA) on Insite or the AUA external website.

5. Monitoring

5.1 All restraint use (including pharmacological) shall include an ongoing assessment such as, but not limited to the following:

a) any indication of discomfort, pressure, or trauma associated with the use of restraints.

   (i) Monitor the safety of the patient during application of the restraint (including pharmacological) for:
   
   • injury from entrapment or fall;
   
   • skin breakdown;
   
   • deconditioning;
   
   • delirium; and/or
   
   • unprotected airway.

b) circulation and range of motion in the extremities;

c) changes in behaviour or level of agitation;

d) nutritional status including adequate hydration;

e) elimination; and

f) hygiene.

5.2 The above assessment shall occur:

a) every 30 minutes with any pharmacological restraint (or more frequently if identified by product monograph);

b) every 30 minutes with environmental, mechanical or physical restraint (or more frequently if suggested by manufacturer); or
c) every 15 minutes for four (4) point restraints or greater.

5.3 Behaviour mapping shall be completed every shift until successful discontinuation of the restraint.

5.4 At least every two (2) hours and more often if necessary or if recommended by the restraint’s manufacturer, staff shall mobilize the patient, provide range of motion exercises, and/or reposition the patient as well as release the restraint, if appropriate. Hydration is to be offered and the guidelines of Comfort Rounds to be followed including:

a) assessment and management of pain or discomfort;

b) assisting the patient with elimination needs, e.g., assisting to the toilet;

c) assisting with mobility/re-positioning; and

d) supporting orientation (use of hearing aids/glasses, conversations about current location, time of day, etc.).

5.5 Reference the product monograph for additional monitoring points when using pharmacological restraints.

5.6 When caring for a patient who is restrained, the staff are accountable for monitoring (as set out above) and evaluation.

6. Documentation

6.1 For all restraint use document the following:

a) assessment of the patient;

b) adherence to the care plan;

c) alternative interventions attempted;

d) duration of restraint application;

e) frequency of monitoring;

f) observations during monitoring;

g) evaluation of the outcomes; and

h) family/support present.
6.2 For Pharmacological restraint, in addition:
a) document the behaviour of the patient;
b) use behaviour mapping every shift;
c) implement and chart alternative interventions and consequences; and
d) evaluate the outcome if medication is considered.

6.3 Accurate, timely and complete documentation is critical to help ensure patients safety.

6.4 Document above as per unit standards using an approved AHS documentation tool.

7. Training and Education

7.1 Education and training on restraint use shall be completed in new hire orientation and annual education for all direct care staff.

7.2 Whenever possible and practical, information shall be made available to patient(s) and/or family or alternate decision-maker on the following:
a) alternatives to restraints;
b) the application and discontinuation of restraints; and
c) how to care for patients being restrained.

7.3 Prior to applying a restraint or caring for a patient with a restraint, staff are responsible to be knowledgeable regarding alternatives to restraints, the application and discontinuation of the specific restraint being used, and the care needs of the patient being restrained.

DEFINITIONS

Alternate decision-maker means a person who is authorized to make decisions with or on behalf of the patient. These may include, specific decision-maker, a minor’s legal representative, a guardian, a ‘nearest relative’ in accordance with the Mental Health Act [Alberta], an agent in accordance with a Personal Directive, or a person designated in accordance with the Human Tissue and Organ Donation Act [Alberta].

Informed consent means the agreement of a patient to the patient undergoing a treatment/procedure after being provided with the relevant information about the treatment/procedure(s), its risks and alternatives and the consequences of refusal.

Family(-ies) means one or more individuals identified by the patient as an important support, and who the patient wishes to be included in any encounters with the health care system, including, but not limited to, family members, legal guardians, friends and informal caregivers.
Least restrictive restraint means the lowest degree of restraint, used for the least amount of time, as appropriate given the patient’s mental and physical condition, necessary to inhibit movement in order to enable treatment or support control of the patient for safety.

Order means a direction given by a regulated health care professional to carry out specific activity(-ies) as part of the diagnostic and/or therapeutic care and treatment to the benefit of a patient. An order may be written (including handwritten and or electronic), verbal, by telephone or facsimile.

Patient means an adult or child who receives or has requested health care or services from Alberta Health Services and its health services providers or individuals authorized to act on behalf of Alberta Health Services. This term is inclusive of residents, clients and outpatients.

Restraint means any measure used to limit the activity or control the behaviour of a patient or a portion of their body.

Restraint as a last resort means all possible alternative interventions considered and rejected with consideration of the patient’s mental and physical condition before deciding to use a restraint.

REFERENCES

- Appendix A: Restraint Algorithm
- Appendix B: Alternative Interventions
- Appendix C: Information to Consider
- Alberta Health Services Governance Documents:
  - Consent to Treatment/Procedure(s) Policy suite (#PRR-01)
  - Restraint as a Last Resort Policy (#HCS-176)
  - Restraint as a Last Resort - Critical Care Procedure (#HCS-176-07)
  - Restraint as a Last Resort - Emergency/Urgent Care Procedure (#HCS-176-03)
  - Restraint as a Last Resort Addiction and Mental Health - Inpatient Procedure (#HCS-176-06)
  - Restraint as a Last Resort - Older Adult Procedure (#HCS-176-01)
  - Seniors Delirium Protocol (#09628)
- Alberta Health Services Resources:
  - Appropriate Use of Antipsychotics (AUA) website

VERSION HISTORY

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<th>Date</th>
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<td>June 22, 2018</td>
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<tr>
<td>August 21, 2018</td>
<td>Non-substantive change</td>
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**APPENDIX A**

**Restraint Algorithm**

**To Prevent Falls**

1. Assess the cause
2. Consult PT/OT for assessment and management.
3. Refer to local Falls Prevention strategy
4. Consider consulting Geriatrics if patient greater than 65.

**Behaviours/Agitation/Wandering**

1. Assess the cause
2. Use behaviour mapping to identify triggers and target the interventions
3. Consider unmet needs.
4. Assess for Delirium and initiate appropriate investigations, refer to Delirium Guideline.
5. Consider consulting Geriatrics if patients greater than 65.

**Behaviours either from ETOH (alcohol) or previous Mental Health Concern**

1. If ETOH (alcohol)-related, refer to CIWA (Clinical Institute Withdrawal Assessment) protocol.
2. If patient has mental health concerns, consult Psychiatry.
3. Consider role for behaviour mapping.

1. Use alternative interventions.
2. Develop and document a care plan and associated outcomes.
3. Review case with multidisciplinary team.
4. Educate patient, staff, and family.

1. If patient is delirious, determine/address the causes, including developing an individualized care plan.
2. Use alternative interventions. Consider non-pharmacological management strategies.
3. Initiate regular comfort rounds – nutrition, hydration, hygiene/toileting, and pain assessment.
4. Address environmental factors – hearing aids, noise, glasses.
5. Review case with multidisciplinary team.
6. Educate patient, staff, and family.

1. Use alternative interventions.
2. Document the plan and outcome.
3. Review case with multidisciplinary team.
4. Educate patient, staff, and family.
### Alternative Interventions

<table>
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<tr>
<th>Causes</th>
<th>Alternative options</th>
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<tr>
<td><strong>Medical Problems (e.g., fluid overload, dehydration, infection, drug toxicity, offending medications)</strong></td>
<td>- Prompt treatment and ongoing evaluation.</td>
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| **Presence of Pain**                                                   | - Scheduled analgesia.  
|                                                                       | - Positioning and other non-pharmacologic interventions (such as massage, distraction, relaxation devices).  
|                                                                       | - Appropriate analgesic type and dose (avoid meperidine), ongoing pain assessment and evaluation. |
| **Unmet Care Need**                                                    | - Attend regularly to the needs of toileting, nutrition, hydration, comfort and sleep.  
|                                                                       | - Address sensory impairment. |
| **Fear and Anxiety**                                                   | - Companionship and/or supervision.  
|                                                                       | - Reassurance and calm approach  
|                                                                       | - Distraction techniques. |
| **Tampering with Tubes or Lines; Pulling IV's, NG's or OG's**           | - Frequent reassessment of need for therapy/treatment  
|                                                                       | - Kling wrap the IV site |
| **PEG tubes or Gastric tubes**                                         | - Use abdominal binder or a foam binder to eliminate the sight of the tube. |
| **Confused Elderly patient**                                           | - Use soft cloth dolls to keep hands occupied. Consider dolls with large fur covered pockets, zippers, Velcro shoe laces, etc. |
| **Agitated patient**                                                   | - Reassurance and calm approach  
|                                                                       | - Consider relaxation music, television, walks on the unit  
|                                                                       | - Consider unmet needs  
|                                                                       | - Have a family member or friend visit the patient. |
| **Elderly patient with a fall/ Gait instability and weakness**         | - Refer to Geriatrics or Falls Prevention Clinic to determine the cause of the fall and management plan  
|                                                                       | - Physiotherapist and/or Occupational Therapist to assess and recommend possible strategies.  
|                                                                       | - Use foam cushion on chairs in order to make it difficult to get up from the chair. Use Chair alarms.  
|                                                                       | - Non-slip grip soled slippers or running shoes to assure safety.  
|                                                                       | - Walk with the person.  
|                                                                       | - Individual gripper pads for chairs or beds to prevent sliding out and falling. |
| **Environment**                                                       | - Ensure there is enough light for the patient to see clearly.  
|                                                                       | - Avoid rooms near areas of high traffic and noise.  
|                                                                       | - Consider alarm devices.  
|                                                                       | - Develop a routine/regular patient checks. |
Information to Consider

The following information should be considered when restraint is used:

1. **Clinical Assessment**
   1.1 Medical symptoms, and patient’s actions and/or behaviour leading to consideration of restraint use;
   1.2 functional status/contributing factors leading to consideration of restraint use; and
   1.3 methods/strategies used to address medical symptoms, and patient’s actions and/or behaviours prior to consideration of restraint use.

2. **Environmental Assessment**
   2.1 Environmental factors contributing to behaviours leading to consideration of restraint use (e.g., noise, lighting, procedures, people).

3. **Planning**
   3.1 Any discussion with the patient or alternate decision-maker;
   3.2 rationale for and goals of restraint use;
   3.3 least restrictive restraint selected; and
   3.4 plan for reducing or eliminating restraint use.

4. **Implementation**
   4.1 Recommended timeline to notify Physician or Nurse Practitioner and obtain order needed (as soon as possible);
   4.2 informed consent (in accordance with Alberta Health Services Consent to Treatment/Procedures(s) policy suite) and order;
   4.3 use of Protective Services and/or number of staff involved;
   4.4 search and removal of potentially harmful personal possessions;
   4.5 use of restraint (type, size, period of time, documentation review); and
   4.6 monitoring.
5. Review and Evaluation

5.1 Review of need for continued use of restraint or for the discontinuation of restraint;

5.2 effectiveness of chosen restraint;

5.3 patient’s response to restraint, including debriefing with the patient, if possible; and

5.4 add relevant information to the Reporting and Learning System (recommended).