PROCEDURE

TITLE
RESTRAINT AS A LAST RESORT - ACUTE CARE EMERGENCY/URGENT CARE

SCOPE
Provincial: Emergency Department/Urgent Care Centres

DOCUMENT #
HCS-176-03

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Senior Operating Officer, Glenrose Rehabilitation Hospital

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Restraint as a Last Resort Policy (#HCS-176)

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NOTE: The first appearance of terms in bold in the body of this document (except titles) are defined terms – please refer to the Definitions section.

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OBJECTIVES

- To provide direction on the use of restraint based on the principle of restraint as a last resort and the practice of least restrictive restraint to guide safety-related care decisions in the Emergency Department (ED) and Urgent Care Centers (UCC).

- To assist staff in minimizing risk when patients presenting to Emergency Departments and Urgent Care Centers require the use of physical, mechanical, environmental and/or pharmacologic restraints to ensure their safety and the safety of the health care team.

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 in the Emergency Department and Urgent Care Centres.

Note: When working with Pediatric and/or Older Adult patients, refer to the Restraint as a Last Resort – Acute Care Inpatient - Pediatric Procedure and/or Restraint as a Last Resort – Older Adults Procedure, where appropriate.
ELEMENTS

1. Guiding Principles

1.1 The patient’s sense of dignity is to be respected at all times.

1.2 The use of physical, mechanical, environmental and/or pharmacologic restraint may place the patient at a greater risk for an adverse event.
   a) The use of restraint increases the frequency of patient monitoring.

1.3 Restraints are not a substitute for close patient surveillance or for other modifications to care and/or the environment.

1.4 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 patients’ liberty.

1.5 Restraint shall not be used:
   a) As a punishment or threat;
   b) as a substitute for other effective treatment or interventions; or
   c) as a response to refusing treatment.

1.6 Communication regarding the rationale for the use of restraint is essential with the patient/alternate decision-maker and family.

2. Points of Emphasis

2.1 Emergency Department/Urgent Care staff may maintain the use of restraints that have been applied by Emergency Medical Services or law enforcement personnel until the patient is assessed by an Emergency Department/Urgent Care Physician/Nurse Practitioner.

2.2 A Physician or Nurse Practitioner order for the application of mechanical and pharmacological restraint is required.

   Exception: A regulated health care professional may apply restraint, prior to Physician/Nurse Practitioner assessment and order only where immediate action is necessary to prevent serious bodily harm. An order must subsequently be obtained as soon as possible for continued use of the restraint.

2.3 Mechanical restraints may include the following:
   a) Four (4) point limb;
   b) wrist;
c) lower limb;
d) torso/waist; and/or
e) shoulder.

2.4 If a regulated health care professional initiates mechanical restraints the following shall be completed:

a) initiate the (AHS) *Emergency/Urgent Care Patient Restraint Monitoring Record*;

b) document on the health record:
   (i) The type of restraint used,
   (ii) time restraint initiated and
   (iii) the rationale for this intervention; and

c) inform attending Physician or Nurse Practitioner as soon as possible.

2.5 Mechanical restraints shall be used in a manner that allows for quick release in an emergency situation. Quick-release knots are to be used to tie restraint straps. Keys for locked restraints are to be kept at the bedside.

2.6 Placing an agitated patient in the prone position with pressure applied to the back increases the risk of sudden cardiac death.

2.7 The use of restraint has been identified as a risk factor that may trigger or aggravate delirium and should be used with caution in the elderly (see *Restraint as a Last Resort - Older Adults Procedure*).

2.8 Ongoing documentation of patient safety criteria is completed on the AHS *Emergency/Urgent Care Patient Restraint Monitoring Record*. A summary of this protocol appears on page two (2) of this form.

3. Consent

3.1 Restraint may be applied in an emergency without consent if it is necessary to preserve the patient’s life, or where immediate action is necessary to prevent serious bodily harm to the patient or to another person. Subsequently, appropriate consent shall be obtained for ongoing restraint.

3.2 In non-emergency situations, consent is required prior to restraint use. The methods, risks, and benefits of restraint and non-restraint shall be discussed by the patient’s Physician or Nurse Practitioner with the patient and/or alternate decision-maker in accordance with the AHS *Consent to Treatment/Procedure(s)* policy suite.
4. **Assessment**

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

4.2 Except in emergent situations, prior to the application of a restraint on a patient, a health care professional shall perform an assessment to determine:
   
   a) the safety and care needs of the patient, others and the environment;
   
   b) the specific factors contributing to the action(s), behaviour(s) and medical condition(s) that present a risk;
   
   c) that alternative interventions to restraints have been unsuccessful to eliminate or reduce risk, including the patient’s ability or willingness to control their actions or behaviours; and
   
   d) the type of least restrictive restraint devices that may be required.

5. **Monitoring**

5.1 Monitor the restrained patient frequently and provide patient care as required (toileting, hygiene, hydration).

5.2 For patients requiring mechanical restraints, the following applies:

   a) A regulated health care professional conducts an assessment and documentation of patient’s safety every 30 minutes, or more frequently as patient condition or manufacturer’s instructions warrant, using AHS Emergency/Urgent Care Patient Restraint Monitoring Record, or Physician or Nurse Practitioner order, until the restraints are removed.

   b) Remove restraints to provide skin care and reposition patient every two (2) hours.

   c) The patient should be located so that they remain within visual range of a member of the health care team.

      (i) The need for **constant observation** shall be determined by the health care team as deemed necessary.

5.3 For patients who are receiving parenteral pharmacologic restraint, the following applies:

   a) A regulated healthcare professional performs observation of patient’s safety and documents it, using the AHS Emergency/Urgent Care Patient Restraint Monitoring Record.
(i) Such observation and related documentation should occur every 30 minutes or more frequently as patient condition warrants, for a minimum of one (1) hour and until patient is able to speak coherently and walk unassisted with a steady gait.

b) In the following cases:

(i) adult patients who received more than 10 mg of haloperidol intramuscularly or haloperidol in combination with benzodiazepines (orally, intramuscularly, or intravenously);

(ii) pediatric patients who received a second dose of haloperidol or a single dose of haloperidol was combined with benzodiazepines (orally, intramuscularly, or intravenously);

As soon as safety permits, the patient should be:

- Located so that they remain within visual range. The need for constant observation will be determined by the health care team as deemed necessary;
- have continuous cardiac and oxygen saturation monitoring, with alarms activated;
- vital signs (blood pressure, heart rate, respiratory rate, oxygen saturation) will be documented every 30 minutes (or more frequently as patient condition warrants) until patient is able to speak coherently and walk unassisted with a steady gait; and
- level of consciousness using Glasgow Coma Scale documented every hour, or more frequently as patient condition warrants.

c) When safety permits, patient to be placed in the recovery position.

d) If intravenous pharmacologic restraint is being used the patient must have continuous cardiac and oxygen saturation monitoring with alarms activated.

e) Supplemental oxygen should be administered to patients demonstrating any respiratory depression (dyspnea or limited breathing) and/or oxygen saturations less than 92 percent.

**Note:** If patient states or the clinician suspects that they have chronic hypercapnia (a carbon dioxide retainer), an oxygen saturation of 88 percent may be reasonable, and oxygen therapy may not be required. A Physician or NP order for oxygen is required in this population.
f) Notify Emergency Department Physician/Nurse Practitioner if respiratory rate is less than 10/minute or oxygen saturations are less than 92 percent.

5.4 For patients who receive both pharmacologic and mechanical restraints the following applies:

a) A regulated health care professional conducts an assessment and documentation of patient’s safety every 30 minutes, or more frequently as patient condition or manufacturer’s instructions warrant, using the AHS Emergency/Urgent Care Patient Restraint Monitoring Record.

b) Continuous cardiac and oxygen saturation monitoring with alarms activated.

c) Vital signs (blood pressure, heart rate, respiratory rate, and oxygen saturations) and documented every 30 minutes (or more frequently as patient condition warrants).

d) Level of consciousness using Glasgow Coma Scale documented every hour, or more frequently as patient condition warrants.

e) The patient should be located so that they remain within visual range of a member of the health care team.

(i) The need for constant observation shall be determined by the health care team as deemed necessary.

f) Supplemental oxygen should be administered to patients demonstrating any respiratory depression (dyspnea or limited breathing) and/or oxygen saturations less than 92 percent on room air.

**Note:** If patient states or the clinician suspects that they have chronic hypercapnia (a carbon dioxide retainer), an oxygen saturation of 88 percent may be reasonable, and oxygen therapy may not be required. A Physician or NP order for oxygen is required in this population.

g) Notify Emergency Department Physician/Nurse Practitioner if respiratory rate is less than 10/minute or oxygen saturations are less than 92 percent.

h) As soon as pharmacologic restraints are effective, and safety permits, the mechanical restraints should be removed.

i) Once the mechanical restraints are removed, follow the pharmacologic restraint monitoring process.
5.5 For patients requiring environmental restraint such as a locked secure/seclusion room, the following applies:

a) The patient must be within visual range of the health care team.
   
   (i) The need for constant observation shall be determined by the health care team as deemed necessary.

b) Minimum documentation every 30 minutes, or more frequently based on clinical judgement that shall include but not be limited to:
   
   (i) Signs of injury associated with seclusion;
   
   (ii) psychological status; and
   
   (iii) readiness for discontinuation of restraint or seclusion.

c) When mechanical devices are in use, the door of the room shall never be locked.

d) If mechanical or pharmacologic restraint is in effect, monitoring shall be done according to corresponding Section (5.2 for Mechanical and 5.3 for Pharmacologic, or 5.4 if both).

e) Consider moving patient to a less secure environment when the patient has regained control of behaviour.

f) Protective Services may be accessed for assistance and risk management.

6. Documentation

6.1 When restraint is used the following information shall be included in the patient health record:

a) Date and time restraint initiated;

b) clinical assessment:
   
   (i) Medical symptoms, actions, or behavior leading to consideration of restraint use;
   
   (ii) contributing factors leading to consideration of restraint use; and
   
   (iii) strategies used to address medical symptoms, actions, or behaviours prior to consideration of restraint use.
c) planning:
   (i) Any discussion with the patient or alternate decision-maker;
   (ii) rationale for and goals of restraint use;
   (iii) least restrictive restraint selected; and
   (iv) plan for reducing or eliminating restraint use.

d) implementation:
   (i) informed consent (in accordance with AHS Consent to Treatment/Procedures(s) policy suite) and Physician or Nurse Practitioner order (if required);
   (ii) use of Protective Services, Law Enforcement and/or number of staff involved;
   (iii) use of restraint type and patient response; and
   (iv) monitoring: document observations on the AHS Emergency/Urgent Care Patient Restraint Monitoring Record.

e) review and evaluation:
   (i) review of need for continued use of restraint or for the discontinuation of restraint;
   (ii) effectiveness of chosen restraint;
   (iii) patient's response to restraint, including debriefing with the patient, if possible; and
   (iv) add relevant information to the Reporting and Learning System (recommended).

7. Training and Education

7.1 Shall include the following:

a) review of AHS Restraint as a Last Resort policy suite and resources;

b) proper positioning of patients;

c) proper application of mechanical restraints; and

d) monitoring and documentation standards using the AHS Emergency/Urgent Care Patient Restraint Monitoring Record.
7.2 Staff shall receive information and training on the use and risks of restraint use.

a) Prior to applying a restraint or caring for a patient with a restraint, staff are responsible to be knowledgeable regarding the following:
   (i) Alternatives to restraints;
   (ii) the application and discontinuation of the specific restraint being used; and
   (iii) the care needs of the patient being restrained.

b) Education and training on restraint use shall be offered in new hire orientation.

DEFINITIONS

Constant observation means an assigned staff member is with the patient at all times with unrestricted field of vision.

Environmental restraint means any barrier or device that limits the locomotion of an individual, and thereby confines an individual to a specific geographic area or location.

Family 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.

Health care professional means an individual who is a member of a regulated health discipline, as defined by the Health Disciplines Act (Alberta) or the Health Professions Act (Alberta), and who practises within scope and role.

Health record means the Alberta Health Services legal record of the patient's diagnostic, treatment and care information.

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.

Mechanical restraint means any device, material, or equipment attached to or near a patient which cannot be controlled or easily removed by the patient and which prevents a patient’s free body movement and/or a patient’s normal access to their body.

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.

**Pharmacologic restraint** means the use of pharmaceutical products to control behaviours, actions, and/or restrict freedom of movement, but which are not required to treat an identified medical or psychiatric condition.

**Physical restraint** means the direct application of physical holding techniques to a patient that involuntarily restricts their movement.

**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**

- 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 - Acute Care Inpatient Pediatric Procedure (#HCS-176-05)
  - Restraint as a Last Resort - Older Adults Procedure (#HCS-176-01)

- Alberta Health Services Forms:
  - Emergency/Urgent Care Patient Restraint Monitoring Record (#101593)

**VERSION HISTORY**

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