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.

- This procedure will provide support to those working in acute pediatric units, regardless of environment/context when the consideration of using restraint occurs.

- This procedure does not apply to safety restraints used in everyday care of children (e.g., appropriate use of crib rails, arm boards, and restraints that are part of products such as highchairs / swings / strollers / car seats) or to a ‘time-out’ for the purpose of regaining emotional control.

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 pediatric inpatients of Acute Care.

Note: This document does not apply to pediatric inpatients of Addictions and Mental Health. Refer to the AHS Restraint as a Last Resort - Addictions and Mental Health – Inpatient Procedure.
ELEMENTS

1. Points of Emphasis

1.1 Given the developmental and cognitive stages that must be considered when working with children, AHS uses alternative approaches (as listed in Appendix A) to gain cooperation from patients for procedures (e.g., nasogastric tube insertion), investigations (e.g., an x-ray), or therapies (e.g., ventilation).

   a) When alternative approaches are insufficient, AHS recognizes that the use of least restrictive restraints may be required.

1.2 Restraints shall not be used for the following:

   a) As a form of punishment;
   b) for the convenience of the Unit/staff;
   c) as replacement for personal attention to the patient;
   d) to accommodate staff shortages; or
   e) to reduce the need for staff supervision/medical treatment of the patient.

1.3 Consent is not required where the situation escalates to an emergency and warrants the use of a restraint to safely perform a medically necessary procedure, investigation, or therapy.

1.4 A Nurse Practitioner or Physician order is required prior to use of any pharmacologic restraint and for ongoing application of any type of restraint.

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

1.6 Where a pediatric patient has mental health concerns please also refer to the AHS Restraint as a Last Resort – Addiction and Mental Health Inpatient Procedure.

2. Consent

2.1 Restraints may be applied in an emergency without consent if it is necessary to prevent serious bodily harm to the patient or to another person.

2.2 In the event restraints are required in non-emergency situations, AHS pediatric programs may restrain or confine a patient if the restraint is ordered and guided by a plan of care to which the mature minor or alternate decision-maker has consented in accordance with the AHS Consent to Treatment/Procedure(s) policy suite.
3. **Assessment prior to restraint use**

3.1 **Health care professionals** faced with a situation where restraining techniques may be required in excess of what would reasonably be required to safely perform a medically necessary procedure, investigation, or therapy are responsible to obtain a Nurse Practitioner or Physician order, appropriate consent in a non-emergency and initiate a comprehensive assessment of the patient and the patient’s behavior prior to the application of restraints.

3.2 Assess and document the following information, in addition to the requirements as set out in 4.4 of the Policy:

   a) History of physical or sexual abuse, post-traumatic stress disorder or history of trauma;

   b) patient’s cognitive functioning, physical limitations and special needs;

   c) patient’s ability to communicate (receptive and expressive);

   d) patient’s physical and mental health status including pre-existing medical conditions/physical disabilities and limitations that would place the patient at greater physical risk (including neurological, pulmonary and cardiac conditions); 

   e) current medications being used and illicit drug use;

   f) information about aggressive behaviors including triggers, frequency, patterns and types of aggressive behaviors usually exhibited by this patient. Also obtain from patient, parents, or alternate decision-maker, known best responses to aggressive behaviors;

   g) past history of aggressive behavior (i.e., assaults, damage to property etc.), self-injuring behavior, or any other information relevant to the provision of care and patient’s response to previous restrictive interventions;

   h) alternatives which could be effective in decreasing the need for the use of restraint (i.e., predictable routine, single room, room closer to nursing station, TV in room, increased supervision, one to one (1:1) care, family presence, and exercise);

   i) consultations with other health care team members such as Social Workers, Psychologists, child life worker, etc.; and

   j) any additional information that could minimize the use of and/or guide the use of restraint/seclusion.
4. Monitoring/Observation

4.1 **Most responsible health practitioner** shall initiate regular assessment of the patient:

a) patients who are pharmaceutically, environmentally, physically or mechanically restrained or in seclusion shall be assessed every 15 minutes until the behavior stabilizes; and

b) once stable, assess every 30-60 minutes as indicated by the patient’s response/condition. It is appropriate for a health care professional to increase the frequency of assessment for a restrained patient at any time without a prescriber order.

4.2 Monitoring should include but is not limited to:

a) proper application and positioning of a mechanical restraint device;

b) skin condition and circulation;

c) pain or discomfort related to the restraint;

d) patient’s behavior and the need for care provision (toileting, hygiene, nutrition);

e) safety of the patient environment as well as their physical and mental status; and

f) when appropriate, restrained patients should be repositioned hourly.

4.3 Patients being physically held or restrained must be reassessed as quickly as possible. If the behavior does not stabilize, consideration should be given to the use of mechanical restraints or seclusion where available.

4.4 Communicate regularly with patient, mature minor and/or alternate decision-maker.

5. Pharmacological restraints

5.1 Nurse Practitioner or Physician order must be obtained prior to administration of a pharmacological restraint.

5.2 Use of pharmacological restraints shall be documented in the appropriate medication record.

5.3 Following administration of a pharmacological restraint, vital signs shall be monitored:

a) commencing 15 minutes post administration, if safe to do so; or
b) whenever the medication is expected to reach peak onset and then every four (4) hours for 24 hours;

c) more frequently as determined by the Nurse Practitioner or Physician or Parenteral Manual; and

d) any concerns will be communicated to the Nurse Practitioner or Physician.

6. Discontinuation of restraint

6.1 Where appropriate, after each episode of restraint or seclusion, staff shall meet with the patient, family, or alternate decision-maker for the purpose of:

a) Assisting the team, patient and alternate decision-maker to develop an understanding of the causes which may have evoked the behavior necessitating the use of restraints.

b) Assisting the team, patient and alternate decision-maker to develop appropriate coping mechanisms or alternate behaviors that could be effectively utilized should similar situations arise.

7. Training/Education

7.1 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 for the following:

   (i) to be knowledgeable regarding 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 completed in new hire orientation and annual education for all direct care staff.

c) Whenever possible and practical, information shall be made available to patients and/or family/alternate decision-maker on alternatives to restraints, the application and discontinuation of restraints, and on how to care for patients being restrained.

8. Documentation

8.1 When restraint is used, document in the patient record:

a) the rationale for the utilization of the restraining technique;
b) the desired outcome;
c) type of restraint used;
d) date and time of application; and
e) the patient care plan.

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].

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.

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.

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.

Mature minor means a person aged less than 18 years, who has been assessed and determined as having the intelligence and maturity to appreciate the nature, risks, benefits, consequences, and alternatives of the proposed treatment/procedure, including the ethical, emotional and physical aspects.

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.

Most responsible health practitioner means the health practitioner who has responsibility and accountability for the specific treatment/procedure(s) provided to a patient and who is authorized by Alberta Health Services to perform the duties required to fulfill the delivery of such a treatment/procedure(s), within the scope of their practice.

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.
Pharmacological 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

- Appendix A: *Alternative Interventions*
- Appendix B: *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 Addiction and Mental Health - Inpatient Procedure (#HCS-176-06)
  - Restraint as a Last Resort - Critical Care Procedure (#HCS-176-07)

VERSION HISTORY

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Alternative Interventions

Alternative methods/interventions to restraint use include, but are not limited to, the following:

- Provision of support, empathy, attentive listening and reassurance of safety
- Creation of predictable daily routine for patient to minimize need for adjustment to change
- Offer patient available options/choices for positive resolution
- Creation of safe environment where patient can be given space
- Enlist help of other staff (more experienced, good rapport with patient)
- Verbal interaction, redirection and limit setting
- Clear explanation of expectations and next steps/consequences
- Encouragement given to patient to remain in control of self
- Removal of or decrease in environmental stimuli
- Involvement of patient and family in decision making
- Distraction/diversional activities (e.g., music, TV, 1:1 interaction with staff)
- Increased staff presence
- Use of time-out (unlocked quiet space) or move patient to a space (i.e., Bedroom) where risk to others is minimized
- Moving patient to a single room or closer to nursing station
- Increase supervision with RN, RPN, Child Youth Counselor (CYC) or sitter, as appropriate
- Pharmacological review or treatment interventions as ordered by the Physician/Dentist (e.g., use of PRNs)
APPENDIX B

Information to Consider

The following information should be considered when restraint is used:

1. Clinical Assessment
   1.1 Medical symptoms, and patients’ 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 patients’ 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 Nurse Practitioner or Physician 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).