OBJECTIVES

- To facilitate safe, quality patient care by ensuring that staff, Physicians and Nurse Practitioners practice in accordance with considerations for the use of restraint as a last resort, and only to be used as a type of control to prevent harm at times of:
  - behavioral emergencies; or
  - as part of treatment plans in non-emergency situations.

- To provide consistency in the decision-making processes and clinical practices regarding the use of restraints, including seclusion.

- To guide restraint as a last resort best practice at the program/Unit level in the development of processes, as required.

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 inpatients within Addiction and Mental Health settings.
ELEMENTS

1. Points of Emphasis

1.1 Alberta Health Services (AHS) is committed to the principle of restraint as a last resort. Assessment and management of patients begins with establishing welcoming, hopeful, strength-based, trauma-informed and empowering partnerships with patients and their families.

1.2 Use of restraint(s) with patients shall be considered on a case-by-case basis. Restraints shall only be used when other strategies have been or are understood by staff to be ineffective or inappropriate given the patient’s physical and mental health.

Note: Restraint measures are never to be used to coerce, threaten or punish the patient or for staff convenience.

1.3 When using restraint as a last resort staff shall:

   a) Use compassionate and respectful engagement with the patient;
   b) Use recovery-oriented and trauma-informed approach;
   c) Understand patient history of behavioral emergencies, triggers, successful strategies, history of restraint use;
   d) Use collaborative safety planning; and
   e) Understand that the use of restraint should be considered a last resort and should be discontinued as soon as possible based on assessment of the patient.

1.4 At times of behavioral emergencies, restraint(s) can be part of the emergency care of any patient (voluntary and involuntary) and consent is not required. A Physician or Nurse Practitioner order is required as soon as possible thereafter.

1.5 Restraints in non-emergent circumstances require a Physician or Nurse Practitioner order and consent from the patient or alternate decision maker.

1.6 Locked unit doors to many inpatient Units is a common security feature.

Note: Staff shall use privileges and passes as a patient safety measure, understanding that voluntary patients legally may not be denied a privilege or pass (see Use of Observation, Privileges, and Passes Policy Section 5.1).

Note: Denying voluntary patients an ability to leave through locked doors is an environmental restraint.

1.7 Each occasion of restraint use in a behavioural emergency is an opportunity for staff to learn how to identify, anticipate and modify triggers that triggered the
patient’s behavioural emergency. This learning opportunity may offer interventions to the patient that assist them to maintain or regain behavioural control information and can be incorporated in the patient’s safety plan. This learning opportunity may also provide Unit-level information for the interdisciplinary team’s consideration.

2. Consent

2.1 Use of restraint(s) can be part of the care of any patient (voluntary or involuntary) at times of behavioral emergencies in order to prevent serious bodily harm to the patient or to another person and consent is not required. Refer to AHS Consent to Treatment/Procedures(s) policy suite for details pertaining to emergency situations, any patients (voluntary, involuntary and mature minors).

2.2 In the event that restraint is required in non-emergency situations, as part of the patient’s treatment plan, consent shall be obtained in accordance with the AHS Consent to Treatment/Procedure(s) policy suite.

3. Understanding the Patient’s History of Behavioral Emergency(-ies) and Safety Planning

3.1 At the earliest appropriate opportunity of each patient’s admission, a health care professional authorized to perform a restricted psychosocial intervention shall (if appropriate and with consent if required in accordance with the Consent to Treatment Policy Suite):

a) Complete a comprehensive risk assessment, which shall include:

(i) Current cognitive and developmental functioning;

(ii) mental and behavioral state;

(iii) medical status; and

(iv) past history of:

• restraint use and related circumstances, if applicable;

• other related personal history, (e.g., aggression, abuse, trauma, self-injury, suicide attempt, patient triggers); and

• alternative interventions which have been successful;

b) provide information to the patient and/or alternate decision-maker on the philosophy of restraints as a last resort; and

c) as indicated by assessment, collaborate with the patient and/or alternate decision-maker to develop a safety plan that reflects the patient’s needs and preferences.
**Note:** Involvement of other members of the family should be discussed with the patient and/or the alternate decision-maker.

3.2 Staff member(s) coming on shift shall familiarize themselves and members of the interdisciplinary team with the current state of their patients and their safety plans, as appropriate.

4. **Leading Up To and At the Time of a Behavioral Emergency**

4.1 At the time of signs of increasing lack of behavioral control, staff shall attempt to obtain the voluntary inclusive cooperation of the patient as they engage the safety plan and employ de-escalation strategies. At the earliest opportunity, and considering patient and staff safety, staff shall:

a) Refer to the patient’s safety plan, if applicable; and

b) provide the patient with a choice of options to enable them to regain control.

4.2 If a behavioral emergency occurs, a health care professional authorized to perform a restricted psychosocial intervention shall assume the lead and shall, at the earliest appropriate opportunity, considering staff and patient safety:

a) Engage the **least restrictive restraint**;

b) notify the Physician or Nurse Practitioner and obtain an order. If not possible due to the circumstances, a Physician or Nurse Practitioner order is necessary as soon as possible thereafter if the restraint is necessary to extend beyond the emergency circumstance;

(i) A Physician or Nurse Practitioner order is required for any pharmacological restraint use at any time; and

(c) ensure that the alternate decision-maker, if any, is informed of the behavioral emergency, the use of restraints, the patient’s status and the patient’s safety plan, if applicable.

4.3 A Physician or Nurse Practitioner order for use of restraints shall include:

a) Type of restraint(s) (**mechanical**, **physical**, pharmacological (including dosage and route), environmental);

b) observation level, if higher than the specific observation level identified in Section 5; and

(c) date and time of order.

4.4 The interdisciplinary team rationale for restraint use shall include:

a) Intended outcomes of restraint;
b) potential effects of restraint;

c) frequency of observation and documentation review;

d) frequency and conditions for use of restraint; and

e) criteria and timelines for discontinuation of restraint.

4.5 Orders for restraint related to a behavioural emergency are time limited and cannot exceed twenty four (24) hours without further Physician or Nurse Practitioner order.

4.6 The Physician or Nurse Practitioner shall conduct a face-to-face assessment of the patient at least every 24 hours and within 24 hours after a restraint is removed.

4.7 The Physician shall evaluate any voluntary patient within 24 hours after initiation of restraint use for behavioural emergency, regardless of whether a restraint is still in use, so as at a minimum, to determine whether to issue an admission certificate under the Mental Health Act.

4.8 Pro rea nata (PRN) pharmacological restraint orders shall not be used, except when part of the safety plan and appropriate consent has been obtained.

5. Application of Restraint, Monitoring and Observation of Patients During the Use of Restraint

5.1 At the time of the use of the restraint for a behavioral emergency, a health care professional authorized to perform a restricted psychosocial intervention shall assume leadership and shall ensure that:

a) The interdisciplinary team is briefed on:
   (i) any information related to the patient’s safety plan, if applicable;
   (ii) patient’s or alternate decision-maker’s expressed choice on restraints;
   (iii) patient’s restraint and behavioral history; and
   (iv) any medical concerns.

b) Protective Services staff, if utilized, shall take direction from the health care professional on how to assist;

c) clinically acceptable and developmentally-appropriate de-escalation practices are followed, including making every reasonable effort to gain the patient’s cooperation and assist with settling, including explaining why the restraint is being used, the conditions needed for discontinuation and reminding the patient of their safety plan;
d) environmental factors are considered and modified as reasonable, if required, in a manner to promote patient and staff safety; and

e) care is provided for basic health and physical needs as per unit protocol.

5.2 When a physical restraint (manual, most temporary method of restraint) is used for a behavioral emergency, staff shall use positions that do not restrict lung functioning in any way. Standing, seated, supine and side lying positions are preferred. Prone positions may only be used in an emergency by staff trained in techniques that protect respiratory function.

5.3 When a mechanical restraint is used for a behavioral emergency:

a) It shall only be done by staff trained in the use of the mechanical restraint;

b) staff shall ensure that the restraint is correctly applied and permits a quick release;

c) staff shall not place the patient in a prone position;

d) the patient is to be maintained in a private room, on constant observation within plain sight as per the AHS Use of Observation, Privileges and Passes Policy and procedures;

e) staff shall monitor the patient constantly and record patient’s respirations and circulation in the patient’s extremities at least every fifteen (15) minutes;

f) staff shall attend to basic health and physical needs at minimum every two (2) hours, including but not limited to range of motion or repositioning of patients as appropriate and as per local process; and

g) the mechanical restraint shall be removed by a minimum of two staff members;

5.4 When a patient is on seclusion for a behavioral emergency, staff:

a) Shall monitor, at a minimum once every fifteen (15) minutes as per the AHS Use of Observation, Privileges and Passes Policy and procedures, adjusting the frequency within the observation level as appropriate to the age, developmental and mental status of the patient;

b) staff shall monitor from outside the room, provided a patient can fully see the staff and staff can observe and hear the patient,

(i) except if the patient is a child or adolescent and then monitoring may be from within the room; and

Note: Audio-visual surveillance does not replace staff presence.
5.5 When a pharmacological restraint is administered for a behavioral emergency, the health care professional will monitor for effectiveness, vital signs, and the development of adverse reactions, as identified by the medication monograph.

6. Reassessment and Discontinuation of Restraint

6.1 Once any restraint is applied, it must be decreased and discontinued at the earliest and safest opportunity.

6.2 The charge Nurse or delegate shall ensure that a health care professional authorized to perform a restricted psychosocial intervention re-assesses the patient within fifteen (15) minutes of the application of any restraint and at least every two (2) hours thereafter during which time they will engage the patient, the alternate decision-maker and the interdisciplinary team as appropriate, in dialogue about the conditions necessary for restraint discontinuation and patient readiness for restraint discontinuation.

6.3 The charge Nurse or delegate shall review the assessment findings and determine, in the case of all restraints except pharmacological, the continued need for restraint use within the two-hour period.

6.4 In the case the patient has regained sufficient control to tolerate discontinuation (i.e., to "no restraint") or reduction from more restrictive to less restrictive restraint (e.g., from mechanical restraint to seclusion), the health care professional shall ensure the discontinuation or reduction of the restraint, in collaboration with the patient, the alternate decision-maker if applicable, the patient’s Physician or Nurse Practitioner and as available the interdisciplinary team.

Note: Observation levels remain in place until the Physician or Nurse Practitioner reviews. A Physician’s or Nurse Practitioner’s order is not required to reduce or remove a restraint.

6.5 When a restraint is discontinued:

a) Current observation levels shall remain in place until reviewed by the Physician or Nurse Practitioner; and

b) the health care professional shall notify the Physician or Nurse Practitioner as soon as reasonably possible, except:

(i) when a mechanical restraint is discontinued (such as in the case of a patient on a unit without a seclusion room). Immediate notification of the Physician or Nurse Practitioner is required so that the constant observation order can be reviewed as soon as reasonably possible.
6.6 When restraint is reduced, refer to Section 5 for the appropriate observation level.

6.7 In the case the patient continues to need restraint:
   a) The charge Nurse or delegate shall determine the conditions of continued restraint and shall document within the health record (see Section 8);
   b) In cases where a physical restraint is used, if the patient’s behaviour does not stabilize within fifteen (15) minutes, consideration shall be given to the use of less hazardous measures, such as mechanical restraints or seclusion where available; and
   c) If the continuation of a restraint order is determined by a health care professional other than the Physician or Nurse Practitioner, they shall notify the Physician or Nurse Practitioner as soon as possible.

6.8 In the event a telephone order has been given for the use of mechanical restraints with a child or adolescent related to a behavioural emergency, a Physician or Nurse Practitioner shall conduct a face to face assessment within one (1) hour of mechanical restraint application.
   a) If a face-to-face Physician or Nurse Practitioner assessment is not conducted, the mechanical restraint should not continue past two (2) hours from time of initial application.

6.9 The re-assessment and removal of the restraint should include safety measures in case of adverse reactions. Staff will develop a plan to reintegrate the patient back onto the unit.

7. **Post-Restraint Debriefing**

7.1 When mechanical or physical restraint or seclusion have been used in a behavioural emergency, post-restraint debriefings shall be conducted by the health care professional with the patient and/or alternate decision maker, if applicable, and appropriate members of the interdisciplinary team. Involvement of other members of the family should be discussed with the patient and/or the alternate decision maker.

7.2 Post-restraint debriefings are to be held within the shift or as soon as practical after restraint use. The discussion shall include the patient and family as appropriate and cover the following:
   a) Circumstances leading to the behavioral emergency, including what may have triggered the escalation of the patient’s behavior and why a restraint intervention was initiated;
   b) patient’s views on the behavioral emergency, any questions or concerns with respect to the use of the restraint, including triggers and a review and possible revision of the patient’s safety plan;
c) any ongoing consent requirements where restraint use may be necessary on an ongoing basis or become part of the patient’s safety plan;

d) validation of the emotional responses of the patient, co-patients, family and staff; and

e) a message of support and concern to the patient and alternate decision maker, as appropriate, emphasizing that staff wish to provide sufficient support to assist the patient to prevent future cases which may lead to a behavioural emergency.

7.3 The Unit Manager shall ensure reviews of incidents of restraint use during a behavioral emergency are conducted within a reasonable time period with the interdisciplinary team. The process is to emphasize learning from the incidents. Recommended discussion points include:

a) aspects of the incident that were handled well; and

b) recommendations for improvements in future incidents of restraint use during a behavioral emergency.

8. Documentation

8.1 The health care professional who took the patient’s history shall document the comprehensive risk assessment and the safety plan, if appropriate, in the health record.

8.2 In the event of restraint use, the Charge Nurse or delegate shall document in the health record in a manner that is comprehensive, accurate, legible and timely and shall include:

a) Type of restraint and associated observation level;

b) assessment and re-assessment results, explicit rationale for interventions used and other options considered;

c) information regarding the patient’s reaction, tolerance and any adverse effect during the use of restraint; and

d) observations as per the AHS Use of Observation, Privileges and Passes Policy and procedure, including, if required, monitoring of all vital signs.

8.3 Summaries of patient debriefing meetings shall be recorded in the patient’s health record.

9. Restraint Inventory

9.1 Each Unit Manager is responsible for the safe maintenance, inventory and replacement of the mechanical restraints available to that unit.
10. Training

10.1 Staff, physicians and Nurse Practitioners involved in assessing/reassessing for, administering, monitoring or removing a restraint shall complete a certified training or education program on effective de-escalation techniques and patients' emotional and physical response to a restraint and maintain such training.

10.2 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.

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

10.4 Whenever possible information shall be made available to patients and/or family/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.

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].

Behavioural Emergency means a situation when the patient is presenting with behaviour where imminent action is required to prevent serious danger of bodily harm to themselves or others.

Environmental restraint / Seclusion 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 or the Health Professions Act, and who practises within scope or 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.
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 patients’ free body movement to a position of choice 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.

Pharmacological restraint means the use of pharmaceutical products to control behaviour, actions, and/or restrict freedom of movement.

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

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

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

Safety Plan means, for the purposes of this document, part of the patient’s treatment plan to safely manage a behavioural emergency, written by a health care professional, ideally in consultation with the patient and/or guardian caregiver.

Seclusion (a form of environmental restraint) means the involuntary confinement of a person to a room from which they are prevented from leaving.

Voluntary Patient means someone who has decided to seek treatment and admitted themselves to hospital. Also referred to as an “informal” patient.

Involuntary patient means someone who has been examined by two Physicians and are hospitalized on the authority of two admission certificates. Also referred to as a “formal” patient.

REFERENCES

- Appendix A: Information to Consider
- Alberta Health Services Governance Documents:
  - Restraint as a Last Resort Policy (#HCS-176)
Procedure

**TITLE**
Restraint as a Last Resort - Addiction and Mental Health - Inpatient

**EFFECTIVE DATE**
February 1, 2018

**DOCUMENT #**
HCS-176-06

- Safety Precautions Policy (AMH-03)
- Consent to Treatment/Procedure(s) Policy suite (PRR-01)
- Use of Observation, Privileges and Passes Policy suite (AMH-01)
- Non-Alberta Health Services Documents:
  - Mental Health Act (Alberta)

**VERSION HISTORY**

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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 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 AHS 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 as per the AHS AMH Safety Precautions Policy;
   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).