



TITLE

RESTRAINT (INTERIM)

SCOPE

Provincial: Seniors/Continuing Care

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Not applicable

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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 in support of the Alberta Health Services *Restraint as a Last Resort* policy for:
 - older adults in all health care settings including acute care (including psycho-geriatric units), **continuing care**, and community (e.g. clinics); and
 - adults in continuing care settings where no other procedure directs restraint use for this population.
- To provide evidence-informed practices intended to promote a culture of least restraint.
- To provide direction intended to minimize risk when any form of restraint is implemented.

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 Seniors and Continuing Care.

ELEMENTS

1. Risk assessment

- 1.1 Identify **patients** who are at risk of being restrained e.g. at risk of developing delirium, falling, wandering and/or presenting with challenges in their ability to communicate.

- 1.2 Risk assessment will be conducted utilizing a variety of evidence based assessment tools such as RAI (Resident Assessment Instruments). Additional tools can be accessed at <http://www.albertahealthservices.ca/auatoolkit.asp> under Responsive Behaviours.

2. Plan of care

- 2.1 Staff responsible for developing the plan of care will involve the whole care-team (physician, nursing staff including Health Care Aides, allied health staff including Therapy Assistants) in identifying and implementing strategies that support no or least restraint.

- 2.2 Involve patient / **alternate decision-maker** in developing the plan of care:

- a) discuss with patient/alternate decision-maker the benefits of avoiding use of restraints and strategies to avoid the need to use a restraint;
- b) provide education materials; and
- c) if applicable, ask family to participate in strategies aimed at preventing the use of restraints (frequent visits, staying during the night if the person becomes agitated, etc.).

- 2.3 Ensure plan of care considers or includes the following components of **comfort rounds**:

- 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.).

Note: For patients at risk of being restrained, comfort rounds are required at least every two (2) hours during the day and evening, and when the patient is awake at night.

- 2.4 Address additional care needs in the plan of care, considering: rest, elimination, nutrition/hydration, exercise, comfort and diversions to help prevent need for restraint.

- 2.5 Environmental considerations for the plan of care:

- a) consider strategies to provide a calm, safe environment for the patient; and
- b) provide orientation cues and modify the environment as much as possible to prevent behaviours known to result in restraint.

- 2.6 Staff approach when providing care:
- a) consider consistent staffing;
 - b) calm approach by staff;
 - c) clear/simple explanations;
 - d) emotional support;
 - e) consistent use of hearing and vision aids/pocket talker;
 - f) involve the patient in conversation; and
 - g) active listening.

3. When patient displays a behaviour that puts them at risk of being restrained

- 3.1 Engage the whole-team and family/alternate decision-maker to investigate the possible underlying causes of any behaviour that may lead to the use of any form of restraint.
- a) Rule out delirium causes, e.g. medication, infection, etc.;
 - b) Consider behaviours such as agitation or striking out as they may occur as a response to the person's unmet needs or the environment;
 - c) Track the behaviour for a minimum of three (3) days prior to implementing a restraint in non-emergency situations; and
 - d) Review the documentation to identify behaviour patterns.
- 3.2 Modify plan of care based on the team assessment.
- 3.3 Continue the tracking of the behaviour on a behaviour map after the initiation of the restraint to assess the impact of the restraint on the behaviour.
- Note:** Agitation is known to increase when any form of physical or mechanical restraint is used.
- 3.4 Consider involving others in the assessment and development of the plan of care, such as: Allied Health, specialized geriatric services, mental health/psychiatry.
- 3.5 Consider use of one to one (1:1) time, e.g. staff/volunteer/paid companions/family, in an effort to avoid the use of any form of restraint.
- 3.6 Restraints are not to be used as a substitute for inadequate levels of staffing.

4. Use of restraint as a last resort

- 4.1 Use of restraint requires an authorized prescriber order as per the Alberta Health Services *Restraint as a Last Resort* policy.
- 4.2 In accordance with the *Continuing Care Health Service Standards* the order must be obtained within 72 hours.
- 4.3 The decision to use a restraint should be made only after alternatives to the use of the restraint have been exhausted.
- 4.4 The least restrictive or least impacting form of the restraint must be selected (e.g. partial rails instead of full side rails).
- 4.5 With the team, determine a realistic goal of the restraint (e.g. a reduction in the frequency of a responsive behaviour versus the elimination of a behaviour that may be associated with dementia).
- 4.6 Once a decision to use a restraint is made, continue to trial alternatives to minimize the duration of the restraint use. Address underlying causes of the need to use the restraint, such as delirium.
- 4.7 Promote the dignity of the patient while restrained; take measures to prevent negative psychological consequences of being restrained.

5. Consent

- 5.1 Provide education on least restraint approach.
- 5.2 Collaborate with family to determine alternatives to restraint.
- 5.3 In the event that restraint is required in non-emergency situations, ensure that consent is obtained in accordance with the Alberta Health Services *Consent to Treatment/Procedure(s)* policy suite.
- 5.4 Document the discussion in patient's health record.

6. Pharmacological restraint

- 6.1 In the absence of appropriate indication (e.g. schizophrenia), antipsychotics (e.g. risperidone, olanzapine, quetiapine, haloperidol), benzodiazepines (e.g. lorazepam), and other medications may be considered a form of pharmacologic restraint.

Note: In older patients benzodiazepines may worsen the behaviours they are intended to manage and should be reserved for older patients experiencing a delirium caused by withdrawal from alcohol.

- 6.2 Where alternatives to a pharmacological restraint have proven ineffective, or where treatment of an underlying medical condition has not yet been effective, a

pharmacological restraint may be appropriate for a time-limited period, when the patient:

- a) has significant distress due to agitation or psychotic symptoms (e.g. hallucinations);
- b) requires an assessment or treatment; and/or
- c) is at risk of harming themselves or others.

6.3 Prescribing information

- a) smaller than usual dosing is recommended for antipsychotic medications as a consequence of how these medications are metabolized and utilized in older adults;
- b) in the order, the prescriber should describe the intended goal of the medication on the targeted behaviour;
- c) ensure the pharmacological restraint (e.g. antipsychotic medication) is being prescribed for a behaviour where there is known efficacy. Behaviours that are not responsive to antipsychotic use include:
 - (i) wandering/exit-seeking;
 - (ii) hoarding;
 - (iii) inappropriate dressing;
 - (iv) repetitive behaviours or vocalizations;
 - (v) eating in-edibles;
 - (vi) interfering with others;
 - (vii) tugging/removing restraints; and
 - (viii) inappropriate elimination.

6.4 Monitor for consequences/side-effects of antipsychotic medications

- a) staff shall ensure falls prevention strategies are implemented as antipsychotic medications are associated with increased falls; and
- b) extrapyramidal side-effects include akinesia (inability to initiate movement) and akathisia (inability to remain motionless) and tardive dyskinesia (e.g. repetitive tongue protrusions/lip smacking).

6.5 Reassessment

- a) Continued tracking of the targeted behaviour while on an antipsychotic/pharmacological restraint assists in the monitoring of the effectiveness of the medication and allows for timely withdrawal/discontinuation as the behaviour resolves;
- b) Behaviour tracking:
 - (i) shall occur shift by shift for the first three (3) days; and/or
 - (ii) shall occur with each change in dose/frequency.
- c) If pharmacological restraint (e.g. antipsychotic) is deemed necessary on an ongoing basis, reassessment of behaviour shall occur:
 - (i) weekly for a minimum of one (1) month;
 - (ii) a minimum of monthly thereafter;
 - (iii) reviewed monthly by the physician and interdisciplinary team; and
 - (iv) in accordance with the *Continuing Care Health Service Standards* the order must be reviewed monthly by the physician and interdisciplinary team.
- d) Where the antipsychotic medication is no longer required, a Physician or pharmacist will document instructions regarding the process for gradual dose reduction and discontinuation.

7. Physical restraint

- 7.1 Physical restraint encompasses holding a person to allow an intervention to be performed.
- 7.2 Consider alternatives to physical restraint.
- 7.3 Prevention of injury while physically restraining an older patient.
 - a) Skin tears and bruising are common results of physically restraining an older patient. Consider using a blanket to 'swaddle' the patient to help prevent injury.

Note: If involved, direct Protective Services staff in how to assist.
- 7.4 Monitor for injury as a result of physical restraint and provide treatment as indicated.
 - a) Monitor for bruising in the first few days after physically restraining a patient and document any bruising noted that could be associated with

the episode of physical restraint. Un-explained bruising is an indication associated with physical abuse.

- 7.5 Use a calm reassuring care approach before, during and after physically restraining a patient. Monitor for adverse psychological effects of restraint.

8. Mechanical restraint

- 8.1 Mechanical restraint includes items such as:

- a) bed-side rails;
- b) seatbelts that cannot be un-fastened by the patient;
- c) chairs with locking table tops;
- d) Broda/Geri chairs;
- e) any limb restraint;
- f) mitt; and/or
- g) any positioning device where the effect is restraint and the patient is not able to release themselves.

- 8.2 Consider alternatives prior to using a mechanical restraint.

- 8.3 Identify least restrictive option if alternatives are not appropriate.

- 8.4 Monitoring

- a) Every 15 minutes within the first hour, every hour within the first 24 hours and ongoing at a minimum every two (2) hours;
- b) When restraint is used to manage a behavior, continue to monitor the behaviour with a behaviour map after the restraint is implemented to assist in timely discontinuation of the restraint;
- c) Monitor for (and implement care strategies to avoid) known side effects of mechanical restraints such as:
 - (i) injury from entrapment, falls, head injuries (e.g. strangulation);
 - (ii) monitor the agitated patient closely while in mechanical restraints; and
 - (iii) monitor constant to every 15 minutes for significantly agitated patients.

- d) Skin breakdown/joint stiffening:
 - (i) remove restraints a minimum of every two (2) hours and provide skin care and range of motion exercises; and/or
 - (ii) if the patient is asleep, assess for tissue perfusion every two (2) hours.
- e) Incontinence/constipation, deconditioning, increased pain, increased agitation/disorientation or development of delirium:
 - (i) remove restraints and provide personal care a minimum of every two (2) hours while awake (assist to bathroom, reposition, offer food/fluids if medically stable and sufficiently alert; assess for pain and treat); and
 - (ii) monitor for delirium, which is known to develop, when mechanical restraints are applied to prevent falls.

9. Environmental restraint

9.1 Environmental restraints include but are not limited to:

- a) half doors;
- b) Wanderguard;
- c) secured units; and/or
- d) secured outdoor space.

9.2 Monitoring

- a) every 15 minutes within the first hour, every hour within the first 24 hours, and ongoing at a minimum every two (2) hours; and
- b) battery operated devices should be checked daily to ensure function e.g. Wanderguard.

10. Reassessment

10.1 An order is required (within 72 hours) to continue restraint use. Reassessment by the interdisciplinary team for restraint will occur at least monthly, and with significant change in patient's responsive behaviour at which time an order for renewal shall be obtained.

Note: Secure Units reassessment will occur at a minimum annually at IDTC.

11. Discontinuation of the restraint

- 11.1 Once restraint has been removed, provide patient/alternate decision-maker with an opportunity to discuss their reactions to the intervention.
- 11.2 Clarify any misperceptions (e.g. related to hallucinations from delirium) that patient may have.
- 11.3 Provide patient/alternate decision-maker education regarding expecting the recovery from delirium to take three to six (3-6) months.

12. Documentation

- 12.1 Document in patient's health record and care plan:
 - a) patient assessment (prior to, during and after use of restraint);
 - b) alternatives used/considered;
 - c) reason for the restraint;
 - d) consent obtained;
 - e) describe the incident (e.g. number of staff involved, and type of hold used, etc.);
 - f) consideration of underlying causes; and
 - g) response to efforts to address unmet needs/triggers to the behaviour.
- 12.2 For patients who are restrained with a mechanical device or environmental restriction, document the following (every shift in acute care settings, and daily in continuing care settings) for the first seven (7) days.
 - a) frequency of monitoring the patient;
 - b) results of behaviour mapping and assessment of need to continue/discontinue restraint use;
 - c) strategies to minimize the need for the restraint (e.g. treatment of delirium);
 - d) patient's response to the restraint considering:
 - (i) level of consciousness/delirium assessment;
 - (ii) patient's emotional/affective state;
 - (iii) discussion with patient/family about restraint (concerns, emotions); and

- (iv) strategies carried out to prevent physical and psychological complications related to restraint use.
- e) For restraint use continuing after seven (7) days follow organizational documentation requirements.

13. Education/Training

13.1 Staff will 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 alternatives to restraints, the application and discontinuation of the specific restraint being used, and the care needs of the patient being restrained.
- b) Education and training on restraint use will be completed in new hire orientation and annual education for all direct care staff.
- c) Whenever possible information will 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.

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].

Comfort Rounds means patient focused intentional rounds that are scheduled, purposeful and involve key behaviors that focus on addressing unmet care needs

Continuing Care means an integrated range of services supporting the health and wellbeing of individuals living in their own home or in a supportive living or long-term care setting. Continuing care clients are not defined by age, diagnosis or the length of time they may require service but by their need for care.

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.

REFERENCES

- Appendix A: Information to Consider
- Alberta Health Services Governance Documents:
 - *Consent to Treatment/Procedure(s)* policy suite (#PRR-01)
 - *Appropriate Use of Antipsychotic Medication* guideline (#PS-26-01)
 - *Restraint as a Last Resort* policy (#HCS-176 effective February 1, 2018)

- Alberta Health Services Resources:
 - *Appropriate Use of Antipsychotics (AUA) Toolkit*
- Non-Alberta Health Services Documents:
 - *Continuing Care Health Service Standards (Alberta)*

VERSION HISTORY

Date	Action Taken
August 09, 2017	Non-substantive change
February 1, 2018	Revised
February 5, 2018	Revised with a title change

APPENDIX A

The following information should be considered when restraint is used:

1.1 Clinical Assessment

- a) medical symptoms, and patients' actions and/ or behaviour leading to consideration of restraint use;
- b) functional status/contributing factors leading to consideration of restraint use; and
- c) methods/strategies used to address medical symptoms, and patients' actions and/or behaviours prior to consideration of restraint use.

1.2 Environmental Assessment

- a) environmental factors contributing to behaviours leading to consideration of restraint use (e.g. noise, lighting, procedures, people).

1.3 Planning

- a) any discussion with the patient or alternate decision-maker;
- b) rationale for and goals of restraint use;
- c) least restrictive restraint selected; and
- d) plan for reducing or eliminating restraint use.

1.4 Implementation:

- a) recommended timeline to notify prescriber and obtain order needed (as soon as possible);
- b) use of Protective Services and/or number of staff involved;
- c) search and removal of potentially harmful personal possessions;
- d) use of restraint (type, size, period of time, documentation review); and
- e) monitoring.

1.5 Review and Evaluation

- a) review of need for continued use of restraint or for the discontinuation of restraint;
- b) effectiveness of chosen restraint;

- c) informed consent (in accordance with Alberta Health Services *Consent to Treatment/Procedures(s)* policy suite) and authorized prescriber order;
- d) patient's response to restraint, including debriefing with the patient, if possible; and
- e) add relevant information to the Reporting and Learning System (recommended).