Alberta Health Services

PROCEDURE

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RESTRAINT AS A LAST RESORT

SCOPE
Provincial

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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.
- To promote consistency in the decision-making processes related to least restrictive restraint.
- To provide guidance in the consideration of alternatives to restraint.
- To support a balance between the safety of the **patient**, **health care providers**, and others while providing guidance on the use of **physical**, **mechanical**, **pharmacological**, and **environmental** (including **seclusion**) **restraints**.

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).

This procedure does not apply to the means used to prevent patients from leaving a facility (e.g., locked unit or someone guarding the door) when the patients are detained pursuant to legislation (examples of which include but are not limited to detention pursuant to the *Mental Health Act* [Alberta], *Criminal Code of Canada*, *Public Health Act* [Alberta], or Alberta Review Board).

ELEMENTS

1. Points of Emphasis

1.1 Alberta Health Services (AHS) is committed to the principle of restraint as a last resort. Restraint shall be used only when other strategies have been deemed ineffective or inappropriate for the circumstances.

1.2 **Informed consent** is required for all non-emergent restraint use (see Section 5 below).

1.3 Restraint shall be used only in circumstances where:

a) there is an immediate threat (e.g., physical assault, self-harm) to the safety of patients, health care providers, or others and immediate action is necessary to prevent serious bodily harm to the patient or to another person;

b) emergency **treatment(s)/procedure** must be provided, including but not limited to resuscitation, emergency assessment, and transport; and/or

c) a treatment regimen or care plan must be followed because the patient is unable or unwilling to cooperate in the care setting (e.g., ICU care, severe cognitive impairment, wrist/arm restraints post-op cleft lip/palate repairs).

1.4 Restraint shall not be used to coerce, discipline, threaten, or punish the patient, for retaliation, or for convenience.

2. Risk of Restraint Use

2.1 The use of restraint has been identified as a risk factor that may precipitate the following outcomes, including but not limited to:

a) increased risk of asphyxiation and sudden cardiac death when agitated patients are restrained in the prone position with pressure applied to the back;

b) increased risk of pulmonary embolism if inability to ambulate;

c) increased risk of agitation, delirium, and aspiration pneumonia; or

d) increased risk of falls, fall injuries, deconditioning, and skin breakdown.

3. Assessment Prior to Non-Emergency Restraint Use

3.1 The **health care professional** shall assess the patient for the following, including but not limited to:

a) history of aggression (i.e., assaults, damage to property, self-injury, **behavioural emergency**);

b) history of drug or substance use;

c) delirium and other medical concerns (e.g., medication side effects);

d) risk for falls or elopement;

e) psychological and social factors (e.g., mental health status, emotional/psychological triggers, history of trauma, development needs);

f) ability to communicate; and

g) care needs (e.g., personal care, toileting, nutrition, hydration).

3.2 Collaboratively explore alternatives to restraint (see Appendix A below) with the patient, **alternate decision-maker(s)**, **family**, and the health care team. Where possible, identify previous interventions or care plans that have been effective for the patient.

3.3 Identify consequences/risks of behaviour for the patient and others (e.g., potential for or actual injury).

3.4 Best practice for restraint use recommends a standardized method to record behaviour to assess need for restraint. For patients with a history of **responsive behaviour(s)**, impaired cognition, or receptive or expressive communication barriers:

a) consider tracking the patients' behaviour (e.g., AHS *Behaviour Mapping Chart*, AHS *Agitated Behaviour Mapping Tool*) to identify potential contributing reasons for behaviour:

(i) patterns, triggers, and frequency;

(ii) unmet needs (e.g., pain, dehydration, toileting); and

(iii) environmental factors (e.g., noise, lighting, over-stimulation).

3.5 Consider consultations with other health care team members (e.g., Social Worker, Psychologist, Child Life Worker, Occupational Therapist, Clinical Nurse Specialist, or Geriatrician).

4. Individualized Plan of Care, Safety Plan, or Treatment Plan

4.1 It is recognized that in an **emergency situation** or behavioural emergency, creating an **individualized plan of care** may not be practically possible. However, if use of restraint is to extend beyond the emergency situation or behavioural emergency, health care providers should refer to Sections 4.2 to 4.4 below.

4.2 The health care team including the patient where reasonably possible, creates an individualized plan of care, **safety plan**, or treatment plan which may include

restraint. The risks and benefits of restraints should be considered. These plans should include but are not limited to:

a) rationale, including:

(i) current cognitive and developmental functioning;

(ii) mental and behavioural state;

(iii) medical status;

(iv) intended outcomes of restraint;

(v) potential effects of restraint;

(vi) frequency and conditions for use of restraint; and

(vii) criteria and timelines for discontinuation;

b) alternatives to restraint or the least restrictive restraint (see Appendix A below);

c) frequency of observation/monitoring or **observation level**, if assigned or ordered; and

d) plan for reassessment and/or discontinuation of restraint.

4.3 Specific care settings (e.g., Addiction & Mental Health, **Continuing Care**) may require the inclusion of additional elements (e.g., current cognitive and developmental functioning or mental and behavioural state, or **comfort rounds**). Refer to the AHS *Restraint as a Last Resort Toolkit* and program processes.

4.4 Involve the family (with patient consent). Whenever possible, practical information shall be made available including:

a) alternatives to restraint such as frequent visits, reassurance and support, and/or staying during the night if the person becomes agitated or develops delirium;

b) the risks of restraint (e.g., full side rails and increased risk of fall injuries);

c) application and removal of restraints; and

d) how to care for restrained patients.

5. Informed Consent

5.1 Informed consent shall be obtained if restraint is required for the patient's individualized plan of care and for all non-emergency restraint use. This will include a discussion about the methods, risks, and benefits of restraint and non-

restraint with the patient and/or alternate decision-maker(s), in accordance with the AHS *Consent to Treatment/Procedure(s)* Policy Suite.

Note: Consent is not required for the environmental restraint of having unit doors which lock when patients are detained pursuant to legislation (e.g., *Mental Health Act* [Alberta], *Public Health Act* [Alberta], Court Order).

5.2 In an emergency situation or behavioural emergency, informed consent is not required for restraint use.

a) If continued restraint use is necessary, then informed consent shall be obtained as soon as reasonably possible.

6. Restraint Orders

6.1 All restraints require an **order** from a Physician or Nurse Practitioner (NP).

Exception: Use of non-pharmacological restraints during an emergency situation or behavioural emergency does not require an order.

6.2 Obtain an order as soon as practically possible within 24 hours. In Continuing Care settings, in accordance with the *Continuing Care Health Service Standards* (Alberta):

a) the order shall be obtained within 72 hours when alternatives have been considered, and restraint is part of the individualized plan of care and used as a last resort; and

b) an order is not required for **secure spaces** (see Appendix B below).

6.3 The restraint order shall include the date, time, and type of restraint. A new order should be obtained if the type of restraint is altered (e.g., changing from an environmental to a mechanical restraint).

6.4 Pharmacological Restraint Orders

a) A pro re nata (PRN) pharmacological restraint order may be used when it is part of the individualized plan of care and informed consent has been obtained.

(i) However, there may be unique circumstances in Addiction & Mental Health settings when PRN orders are required in anticipation of emergency situations where the patient lacks the ability to consent and it is impractical to obtain consent from the alternate decision-maker(s) (refer to Appendix C below).

Note: Pharmacological restraints cannot be initiated or used without an order.

6.5 In addition to the restraint order, a Physician or NP may order observation levels if clinically indicated by the patient's response and condition (refer to Section 7

below). Where observation levels (e.g., **constant observation**) have been ordered, these shall remain in place until the order is reviewed by a Physician or NP.

6.6 An order is not required in the following circumstances:

a) therapeutic care approaches (e.g., gentle hand holding with reassurance and diversion strategies);

b) pediatric **comfort positions**;

c) support or stabilization of a body part (e.g., motion reduction devices) to facilitate diagnostic imaging, procedures, and/or treatment;

d) **positioning devices** that are used in wheelchairs, seating, or other therapeutic positioning devices;

e) locked unit doors when used as a common security feature;

f) safety devices used in everyday care of children (e.g., appropriate use of crib rails, arm boards, and equipment that are part of products such as highchairs, swings, strollers, or car seats);

g) bed rails for sedated or unconscious patients in acute care settings; or

h) products used to comply with legislation (e.g., seatbelts in vehicles).

7. Observation and Monitoring for Restraint Type

7.1 Observation is the physical task of watching the patient. This task can be performed by any member of the health care team. If the task to monitor or assess is not within the health care provider's scope of practice, then they shall report any relevant observations to a health care professional or to the Physician or NP who ordered the restraint and document as appropriate.

7.2 Monitoring is the activity of checking on a patient's condition either personally and/or by means of an electronic monitor (e.g., cardiac monitor); this requires a level of assessment.

7.3 Health care providers should observe and/or monitor up to the highest level authorized by their scope of practice and as per their clinical judgement.

7.4 Observation/monitoring and/or observation levels may be ordered by a Physician or NP (refer to Section 6.5 above). These orders shall be clearly communicated to the health care provider caring for the restrained patient.

7.5 For additional information regarding assigned observation levels, practice settings may refer to the AHS *Use of Observation, Privileges, and Passes* Policy Suite (Addiction & Mental Health).

7.6 The minimum observation/monitoring requirements are outlined in Sections 7.7 to 7.10 below and are determined based on the patient's response and condition. Refer to Sections 14 to 21 below for specific program monitoring requirements.

a) If patient safety is a factor, the health care provider should increase the frequency of observation and report the increase and any relevant observations to a health care professional or a Physician or NP to determine the need to increase the frequency of observation/monitoring.

7.7 Physical restraint is holding a patient to restrict their movement.

a) Observation and/or Monitoring:

(i) During physical restraint:

- Constantly observe/monitor (e.g., airway and respiratory status) the patient, and use minimal physical restraint to avoid injury to self, the patient, or others.

(ii) Following physical restraint:

- Observe/monitor the patient for adverse effects (e.g., psychological, skin tears, and bruising).

7.8 Environmental restraint may include but is not limited to seclusion, half doors, alarmed doors which lock, crib canopies, and locked doors to rooms.

a) Locked unit doors to many inpatient units is a common security feature. Denying patients the ability to leave through locked doors is an environmental restraint.

(i) Environmental restraint does not include the use of secure spaces in Continuing Care settings (refer to Appendix B below for additional information and monitoring requirements which must be met for secured spaces in Continuing Care settings).

b) Observation and/or Monitoring:

(i) During initial use of environmental restraint:

- observe/monitor the patient's condition every 15 to 30 minutes, at minimum; and

- observe/monitor for psychological status, risk of injury associated with self-harm, and readiness for restraint discontinuation.

(ii) Once the patient becomes clinically stable, observe/monitor the patient at minimum, every hour within the first 24 hours and

ongoing at minimum, every two (2) hours, and PRN, dependent on the patient's clinical condition, response, and care needs.

7.9 Mechanical restraint may include but is not limited to bed rails that prevent the patient from exiting the bed, seatbelts the patient cannot release, chairs with locking table tops, chairs the patient cannot easily exit (e.g., recliner chairs), any limb, hand, shoulder, or torso restraint, and/or any device where the effect is restraint and the patient is not able to release themselves.

a) Ensure the restraint is applied in accordance with manufacturer recommendations and used in a manner that allows for quick release in an emergency situation (e.g., codes) or behavioural emergency.

(i) Quick-release clips or knots shall be used when restraint straps are required.

(ii) Keys for locked restraints are to be readily available (e.g., at the bedside) for immediate release of the restraint.

b) Observation and/or Monitoring:

(i) Observe/monitor the patient for pain/discomfort, skin integrity, risk for entrapment (i.e., restricted movement), circulatory impairment (e.g., pulmonary embolism), compression of the abdomen or chest, joint stiffening, falls, agitation, incontinence, and delirium to minimize the risk of adverse effects to the patient.

(ii) During initial use of mechanical restraint, observe/monitor the patient's condition every 15 to 30 minutes at minimum, until clinically stable.

- Four (4) point restraint or greater, the above observations/monitoring shall occur at every 15 minutes and the patient should be located within visual range of a member of the health care team.

- The need for constant observation shall be determined by a health care professional.

(iii) Once the patient becomes clinically stable, the method and frequency of monitoring is:

- determined in collaboration with the health care team;

- dependent on the patient's condition and care needs;

- dependent on patient assessment, patient response, and may vary dependent on care setting requirements. Refer to Sections 14 to 21 below for specific monitoring requirements:

- If a patient is in continuous restraint, particularly while sleeping, observation/monitoring is required every eight (8) hours, at minimum; and

- documented in the patient's **health record** in accordance with the AHS *Clinical Documentation* Directive and/or program requirements.

c) Positioning devices are used to promote function and healing, support the patient in functional postural support, enable occupation, prevent contracture, or reduce the risk of other complications (e.g., skin shearing or breakdown). (Refer to the AHS *Restraint as a Last Resort in the Context of Occupational Therapy and Physiotherapy Practice Professional Practice Notice*).

(i) Regardless of whether the device is used for positioning, safety, or restraint use, close observation/monitoring, care and documentation is required to prevent risks (e.g., injury or strangulation).

7.10 Pharmacological restraint is the use of pharmaceutical products to control behaviours, actions, and/or restrict freedom of movement, but for which the purpose in the situation is not to treat an identified medical or psychiatric condition.

a) In the absence of appropriate indication (e.g., schizophrenia), antipsychotics, benzodiazepines, and other medications may be considered a form of pharmacological restraint.

b) Observation and/or Monitoring:

(i) Observe/monitor for adverse effects (e.g., falls, dizziness, drowsiness, confusion, delirium, movement, non-movement side-effects) as identified by the medication monograph.

(ii) For long-term pharmacological restraint as part of an individualized plan of care, observation/monitoring should also include behaviour mapping to monitor for effectiveness of pharmacological restraint and non-pharmacological strategies. For additional information regarding antipsychotics, practice settings may refer to the AHS *Appropriate Use of Antipsychotics Toolkit.*

(iii) For PRN pharmacological restraint following initial administration, vital signs should be monitored:

- commencing 15 minutes post-administration, if safe to do so;

- whenever the medication is expected to reach peak onset and then every four (4) hours for 24 hours; and

- more frequent or additional observation/monitoring as determined by a Physician or NP, medication monograph, and/or the AHS *Provincial Parenteral Manual* (e.g., respiratory rate, oxygen saturation, continuous cardiac monitoring, sedation level [e.g., Glasgow Coma Scale, Richmond Agitation Sedation Scale]).

- Any relevant observations/concerns shall be communicated to the **most responsible health practitioner (MRHP)**, Physician and/or NP.

8. Behavioural Escalation

8.1 Where there are signs of increasing lack of behavioural control (e.g., violent, damaging, or reactionary behaviour where affect may be harmful to themselves or others) by the patient, health care providers shall attempt to obtain the patient's voluntary cooperation (e.g., employ de-escalation strategies, provide the patient with a choice of options to enable them to regain control, follow the individualized plan of care, safety plan, or treatment plan).

8.2 If interventions are ineffective and an emergency situation or behavioural emergency occurs, a health care professional may:

a) engage the least restrictive non-pharmacological restraint;

b) contact a Physician or NP to obtain a restraint order and discuss pharmacological restraint if the use of restraint is necessary to extend beyond the emergency situation or behavioural emergency;

(i) If a PRN pharmacological order has been received for use in anticipation of future behavioural emergencies, refer to Section 6.4 above and Appendix C below.

c) if appropriate, discuss the incident with the patient's alternate decision-maker(s) or family (see Section 11 below).

8.3 When the patient is no longer at risk of injury to themselves or others and is able to tolerate discontinuation (i.e., to "no restraint") or reduction to less restrictive restraint (e.g., from mechanical restraint to seclusion), the health care professional shall collaborate with the patient and health care team to reduce or discontinue restraint.

9. Reassessment

9.1 When restraint is part of an individualized care plan, the need for restraint including the restraint order, shall be reviewed as per timeframes established by the program setting to ensure the least restrictive restraint for the shortest time.

a) Reassessment shall occur within 24 hours in the following care settings:

(i) Acute Care (Critical Care, Pediatrics);

(ii) Addiction & Mental Health; and

(iii) Emergency Department and Urgent Care.

b) Continuing Care: If non-pharmacological restraint is deemed necessary on an ongoing basis, reassessment of behaviour shall occur on a frequency determined by the health care team based upon the evaluation of the effectiveness of the patient's care plan and goals of care for the patient (e.g., weekly for a minimum of one [1] month, a minimum of monthly thereafter).

c) Rehabilitation and Acquired Brain Injury settings: Restraint shall be reviewed by a Physician or NP on a weekly basis, at minimum.

10. Discontinuation

10.1 When restraint is indicated, the least restrictive restraint suitable to achieve the intended outcome shall be used. Once restraints are applied, they should be removed at the earliest and safest opportunity. Refer to Sections 14 to 21 below and program processes.

10.2 A Physician or NP order is not required to reduce or remove a non-pharmacological restraint. A health care professional may authorize the reduction or removal of a non-pharmacological restraint unless immediate removal is necessary to preserve the patient's imminent health and safety.

10.3 Where observation levels (e.g., constant observation) have been ordered by a Physician or NP, these shall remain in place until the order is reviewed by a Physician or NP and a new order is obtained.

10.4 The health care provider shall ensure the discontinuation or reduction of the restraint is in collaboration with the health care team, including the Physician/NP, patient, and the alternate decision-maker(s) as appropriate.

a) Clearly communicate the rationale for non-pharmacological restraint removal to members of the health care team.

b) Document this communication and decision on the patient's health record.

10.5 The Physician or NP shall document instructions regarding weaning and/or discontinuation of pharmacological restraint.

11. Post-Restraint Debriefing

11.1 When practical and clinically appropriate after an emergency situation or behavioural emergency that necessitated restraint use, a post-restraint debrief

should occur. The health care provider should discuss circumstances of the incident with the following:

a) Health care team: The Unit or Program Manager should discuss aspects of the incident and consider recommendations for improvements; and

b) Patient, alternate decision-maker(s), and/or family: Explore their perspectives and reactions regarding the intervention and discuss coping mechanisms and alternate strategies, should similar situations arise. The discussion should include the patient, alternate decision-maker(s), and/or family, as appropriate, and cover:

(i) the circumstances leading to the behavioural emergency, including what may have triggered the escalation of the patient's behaviour and why a restraint intervention was initiated;

(ii) the patient's views on the behavioural emergency, any questions or concerns with respect to the use of the restraint, including triggers;

(iii) a review and possible revision of the patient's individualized plan of care;

(iv) informed consent discussions where restraint may become a necessary part of the patient's safety/care plan;

(v) validation of the emotional responses of the patient, alternate decision-maker(s), family, and health care providers; and

(vi) a message of support and concern to the patient, alternate decision-maker(s), and family, as appropriate.

11.2 A debriefing shall occur if requested by any member of the health care team, patient, alternate decision-maker(s), and/or family.

12. Documentation

12.1 Health care providers shall document restraints in the patient's health record. The documentation shall include but is not limited to:

a) patient assessment, including behaviour mapping, risk assessment, and safety plan if applicable;

b) discussions with the patient, alternate decision-maker(s), and/or family;

c) rationale for the utilization of restraint;

d) the individualized plan of care, including alternatives to restraint that have been considered and trialed:

e) date and time restraint was initiated;

f) type of restraint used and dosage (if applicable);

g) frequency of monitoring or observation level;

h) interventions provided;

i) criteria for discontinuation of the restraint (if appropriate); and

j) patient's response (e.g., tolerance) and/or adverse effects.

12.2 Refer to program-specific processes for additional documentation requirements (e.g., *Continuing Care Health Service Standards* [Alberta], *Mechanical Restraint Monitoring Record*, *Monitoring and Documentation in Critical Care, Emergency/ Urgent Care Patient Restraint Monitoring Record*).

13. Education and Quality Improvement

13.1 Prior to applying a restraint or caring for a patient with a restraint, health care providers are responsible for being knowledgeable about the:

a) alternatives to restraints;

b) care needs of the patient being restrained; and

c) safe application and discontinuation of restraints used.

13.2 The Unit or Program Manager, in collaboration with the health care team, shall ensure ongoing review of restraint use which includes:

a) identifying contributing factors leading to restraint use (e.g., staff approach, environment or unit routines, unsafe prescribing) and taking actions to minimize those factors (e.g., decrease noise and over-stimulation, review and reduce medications, education regarding de-escalation strategies, responsive behaviours in dementia, trauma-informed care);

b) reviewing incidents when restraints are applied in emergency situations or behavioural emergencies and evaluating program processes to support use of least restraint; and

c) providing education and training to support restraint as a last resort (e.g., during staff orientation and annually for direct health care providers).

13.3 If there is a potential or actual patient safety incident, health care providers should submit a report to the AHS Reporting and Learning System as per the AHS *Recognizing and Responding to Hazards, Close Calls and Clinical Adverse Events* Policy.

Considerations for Program Settings, Populations, and Protective Services

14. Acute Care Inpatient Adult

14.1 For agitated patients, refer to the AHS *Seniors Delirium Protocol* Form.

14.2 For pharmacological restraint:

a) Medications are used at the lowest possible dose appropriate, given the patient's physical and mental condition (refer to Choosing Wisely Canada).

b) Document the behaviour of the patient and use behaviour mapping every shift until successful discontinuation of the restraint.

15. Addiction & Mental Health

15.1 For behavioural emergencies, the Physician or NP shall conduct a face-to-face assessment of the patient (**voluntary** and **involuntary**) at least every 24 hours for continuous restraint and in the absence of a care plan, within 24 hours after a restraint is removed.

a) As part of this assessment, a Physician shall evaluate any voluntary patient who was restrained in a behavioural emergency to determine whether to issue an admission certificate under the *Mental Health Act* (Alberta).

15.2 In the event a telephone order has been received for the use of mechanical restraints on a patient under the age of 18 during a behavioural emergency, a Physician or NP shall conduct a face-to-face assessment within one (1) hour of restraint application.

a) If a face-to-face assessment is not conducted, the mechanical restraint should not continue past two (2) hours from the time of initial application.

15.3 When a patient is in environmental restraint (e.g., seclusion) for a behavioural emergency, in addition to the restraint order, a Physician or NP may order observation levels if clinically indicated by the patient's response and condition.

a) Observe/monitor the patient's condition every 15 minutes at minimum as per the AHS *Use of Observation, Privileges and Passes* Policy Suite (Addiction & Mental Health); adjust the frequency as appropriate to the patient's age, developmental and mental status.

(i) Health care providers shall observe/monitor from outside the room, except if the patient is less than 18 years of age, then observation may be from within the room.

(ii) Health care providers shall use privileges and passes as a patient safety measure, understanding that voluntary patients legally may

not be denied a privilege or pass (see the AHS *Use of Observation, Privileges, and Passes* Policy Suite [Addiction & Mental Health]).

15.4 When mechanical restraint is used for a behavioural emergency, staff shall monitor the patient constantly and record the patient's respirations and circulation in the patient's extremities at least every 15 minutes.

15.5 A health care professional, in collaboration with the health care team, shall assess restraint use and determine the continued need for restraint (excluding pharmacological restraints as these require an order). The health care professional shall notify a Physician or NP as soon as reasonably practical when restraint is discontinued or reduced, except when:

a) a mechanical restraint is discontinued (such as in the case of a patient on a unit without a seclusion room). Timely notification as soon as reasonably possible to a Physician or NP is required so that the constant observation order can be reviewed.

16. Continuing Care and Seniors

16.1 When an antipsychotic medication is prescribed as a pharmacological restraint, the Interdisciplinary team, including the Physician or NP, shall conduct a monthly medication review, at minimum, to ensure the effectiveness and appropriateness of the restraint. For additional monitoring and documentation requirements, see the *Continuing Care Health Service Standards* (Alberta).

16.2 Following the initial use of or change in dose or frequency of a pharmacological restraint, consider behaviour tracking (e.g., 24-hour behaviour tracking for seven [7] days). Observe thereafter based on the patient's response or condition, as documented in the individualized plan of care.

16.3 Where care is scheduled or episodic (e.g., **Home Care**):

a) Health care providers shall follow the principle of restraint as a last resort and the practice of least restrictive restraint. When the patient requires restraint, the health care provider shall observe/monitor the patient during each visit, in collaboration with the alternate decision-maker(s) / family, and report and document any relevant observations to a health care professional and in accordance with program processes.

16.4 Physiological changes associated with aging alter the pharmacokinetic and pharmacodynamic properties of drugs and increase patient vulnerability to adverse drug effects. Geriatric dosing is significantly different for many medications used as pharmacological restraint (e.g., antipsychotic medications) (see the AHS *Delirium, Seniors - Inpatient Clinical Knowledge Topic*).

a) Benzodiazepines may worsen the behaviours they are intended to manage and should be reserved for older patients experiencing delirium caused by withdrawal from alcohol. Benzodiazepines may cause delirium.

b) Ensure fall prevention strategies are implemented with medications used as pharmacological restraint.

c) Antipsychotics may worsen behaviours such as wandering or exit-seeking, hoarding, inappropriate dressing, sexual disinhibition, repetitive behaviours or vocalizations, eating inedible items, interfering with others, tugging or removing restraints, and inappropriate elimination (refer to the AHS *Appropriate Use of Antipsychotic Medication* Guideline).

16.5 When the antipsychotic medication is no longer required, a Physician, NP, or Pharmacist will document instructions regarding the process for gradual dose reduction and discontinuation.

17. Critical Care

17.1 For additional monitoring and documentation requirements, refer to the *Monitoring and Documentation in Critical Care Decision-Making Tool* and program processes.

17.2 Refusal of restraint can be made in the absence of risk of serious bodily harm to others or self but it may affect whether or how treatment can proceed.

a) The benefits and risks of restraint removal shall be explained to the patient and/or their alternate decision-maker(s) by a Physician or NP and discussion documented on the patient's health record prior to removal of the restraint.

18. Emergency Department and Urgent Care

18.1 Refer to the AHS *Emergency/Urgent Care Patient Restraint Monitoring Record* for specific direction on all types of restraint and the **electronic health record**, where appropriate, for monitoring protocols.

a) Emergency Department or Urgent Care health care providers 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 or NP.

b) The restrained patient should be located so that they remain within visual range of a member of the health care team. The need for constant observation shall be determined by a health care professional.

c) For patients who receive pharmacological restraint, a health care professional performs observation/monitoring of the 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.

d) For patients who receive both pharmacological and mechanical restraint, a health care professional conducts an assessment and documentation of the 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*.

18.2 For detailed monitoring requirements, refer to the AHS *Emergency/Urgent Care Patient Restraint Monitoring Record*.

19. Pediatrics

19.1 For additional considerations for the patient under the age of 18 experiencing mental health concerns and/or other cognitive or behavioural issues, the health care provider should refer to Section 15: Addiction & Mental Health.

20. Protective Services

20.1 When safety is an immediate concern, Protective Services may be requested to assist for risk management and/or to collaborate with the health care provider(s) on the immediate or long-term plan of care.

a) **Protective Services Officers** / **Protective Services Guards** may restrain a patient in a manner consistent with their authority (including, if applicable, authority pursuant to the *Peace Officer Act* [Alberta]), training and the AHS *Restraint as a Last Resort* Policy.

b) When caring for older adults in Acute Care, certification under the *Mental Health Act* (Alberta) is not required to return the patient to the unit/facility:

(i) when the patient has capacity and agrees to return; or

(ii) when the patient lacks capacity and their alternate decision-maker(s) / family grants consent to Protective Services to return the patient to the unit/facility.

c) In addition to documentation as outlined in Section 12 above, the Protective Services Officer / Protective Services Guard shall complete a security occurrence report and store it in the Protective Services database. The security report shall include:

(i) the reason for restraint;

(ii) type of restraint used; and

(iii) the health care provider(s) who requested the restraint or the health care provider(s) notified after the restraint was implemented.

21. Rehabilitation and Acquired Brain Injury

21.1 In these program settings, the following are not to be utilized as mechanical restraints: Posy vests/jackets, bed linens/sheets, wheel chair trays with attached back fastening seatbelt, head straps, or immobilizers.

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) or an agent in accordance with a personal directive or a person designated in accordance with the *Human Tissue and Organ Donation Act* (Alberta). This also includes what was previously known as the substitute decision-maker.

Behavioural emergency means a situation when the patient is presenting with behaviour where immediate action is required to prevent serious bodily harm to themselves or others.

Comfort position(s) means use of therapeutic positioning techniques appropriate for the child's developmental level to reduce stress and anxiety and to promote safety during procedures. Oftentimes includes other diversion tactics such as blowing bubbles, giving the child toys to play with during the procedure, and/or telling the child about the procedure and providing a choice of positioning technique or whether or not they want to watch.

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

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

Continuing Care means an integrated range of services supporting the health and wellbeing of individuals living in their own home, 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.

Electronic health record means computer-based clinical data for an individual across multiple locations. This longitudinal health record includes data from a number of different interoperable electronic medical records and electronic patient records, and is shared across multiple jurisdictions. (Canadian Health Information Management Association).

Emergency situation means a circumstance which requires immediate health care that is necessary to preserve life, to prevent serious physical or mental harm, or to alleviate severe pain.

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(-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.

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 care provider means any person who provides goods or services to a patient, inclusive of health care professionals, staff, students, volunteers and other persons acting on behalf of or in conjunction with Alberta Health Services.

Health record means the collection of all records documenting individually identifying health information in relation to a single person.

Home Care means publicly funded personal and healthcare services to help people remain well, safe and independent in their home or congregated living setting (e.g., a lodge) for as long as possible.

Individualized plan of care means the communication of key strategies to safely prevent and minimize restraint use, written by a health care professional, ideally in consultation with the patient and/or alternate decision-maker. It is sometimes referred to as a safety plan, or is part of a treatment plan.

Informed consent means the patient's agreement (or alternate decision-maker) to undergo a treatment/procedure after being provided, in a manner the patient can understand, with the relevant information about the nature of the treatment/procedure(s), its benefits, potential risks and alternatives, and the potential consequences of refusal.

Involuntary patient means any patient who did not request a health service but who is required by court order or some other legal authority to attend for health service(s) (this group includes but is not limited to formal patients).

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.

Most responsible health practitioner (MRHP) 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.

Observation levels means the provision for the safe care of patients at risk of suicide, elopement, aggression, and other kinds of risk behaviours. Observation levels are assigned and ordered by the treating Physician or a Nurse Practitioner, in collaboration with the interdisciplinary team, based on an assessment of the patient's emotional, physical, cognitive, behavioural, and neurological status and the assessed potential for risk of harm to self or others.

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 all persons, inclusive of residents and clients, who receive or have requested health care or services from Alberta Health Services and its health care providers. Patient also means, where applicable: (a) a co-decision-maker with the person; or (b) an alternate decision-maker on behalf of the person.

Pharmacological restraint means the use of pharmaceutical products to control behaviours, actions, and/or restrict freedom of movement, but for which the purpose in the situation is not 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.

Positioning devices means devices that are used as mechanical supports – that is, items that provide postural support, stability, pressure distribution and/or pressure relief, or those that promote healing and prevent contracture or reduce the risk of other complications (e.g., skin sheering/breakdown), or items whose intent is to enable occupation or promote function and achieve proper body position, balance, or alignment so as to allow greater freedom of mobility than would be possible without the use of such an item.

Protective Services Guard means all contract security guards, under contract with Alberta Health Services, Protective Services.

Protective Services Officer means Protective Services Officers with Community Peace Officer appointments pursuant to the *Peace Officer Act* (Alberta).

Responsive behaviour means a significant subset of the behavioural and psychological symptoms of dementia (BPSD) that are thought to be an expression of: a) an unmet need; b) a response to a stimulus in a patient's environment; c) a psychological need; or d) a response to the approach of health care providers or other patients.

Restraint means any measure used to limit the activity or control the behaviour of a patient or a portion of their body. A restraint is pharmacological, environmental, mechanical or physical that is used with the intention of protecting a patient from self-harm or preventing harm to another person. For clarity, a restraint does not include a secure space within Continuing Care settings, in accordance with the *Continuing Care Health Service Standards* (Alberta).

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

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.

Secure space means a secure unit within a facility, a secure facility, or a technological measure that limits a patient's ability to exit a facility or unit that is used with the intention of protecting a patient from harm. For clarity, a technological measure includes, but is not limited to, a wander alert system as per the *Continuing Care Health Service Standards* (Alberta).

Treatment/procedure means a specific assessment, treatment, investigative procedure(s), or series of treatments/procedures planned to manage a clinical condition, these can be presented as a treatment plan.

Voluntary patient means a patient seeking health care on their own volition who is not required by court order or some other legal authority to attend for health service(s).

REFERENCES

- Appendix A: *Alternate and Least Restraint Interventions*
- Appendix B: *Use of Secure Spaces in Continuing Care Settings*
- Appendix C: *Use of Pro Re Nata (PRN) Pharmacological Restraints in Addiction & Mental Health Settings when the Patient Lacks the Ability to Consent and it is Impractical to Obtain Consent from their Alternate Decision-Maker(s)*
- Alberta Health Services Governance Documents:
  - *Appropriate Use of Antipsychotic Medication* Guideline (#PS-26-01)
  - *Clinical Documentation* Directive (#1173)
  - *Clinical Documentation Process* Directive (#1173-01)
  - *Consent to Treatment/Procedure(s)* Policy Suite (#PRR-01)
  - *Medication Orders* Policy (#PS-93)
  - *Medication Orders* Procedure (#PS-93-01)
  - *Recognizing and Responding to Hazards, Close Calls and Clinical Adverse Events* Policy (#PS-95)
  - *Respectful Workplaces and the Prevention of Harassment and Violence* Policy (#1115)
  - *Restraint as a Last Resort* Policy (#HCS-176)
  - *Safety Precautions* Policy (Addiction & Mental Health) (#AMH-03)
  - *Use of Observation, Privileges and Passes* Policy Suite (Addiction & Mental Health) (#AMH-01)
- Alberta Health Services Forms:
  - *Agitated Behaviour Mapping Tool* (#19626)
  - *Behaviour Mapping Chart* (#19895)
  - *Emergency/Urgent Care Patient Restraint Monitoring Record* (#101593)
  - *Mechanical Restraint Monitoring Record* (Connect Care Downtime) (#21482)
  - *Mechanical Restraint Monitoring Record* (#21270)
  - *Seniors Delirium Protocol* (#09628)
- Alberta Health Services Resources:
  - *Appropriate Use of Antipsychotics Toolkit*
  - *Appropriate Use of Antipsychotics (AUA)* website
  - *Clinical Decision-making Algorithm for Occupational Therapists & Physiotherapists Mechanical Restraints versus Positioning Devices*
  - *Delirium, Seniors - Inpatient Clinical Knowledge Topic*
  - *Frailty, Seniors – Acute Care Clinical Knowledge Topic*
  - *Monitoring and Documentation in Critical Care Decision-Making Tool*

- *Provincial Parenteral Manual*
- *Restraint as a Last Resort in the Context of Occupational Therapy and Physiotherapy Practice Professional Practice Notice September 2018*
- *Restraint as a Last Resort Toolkit*
- *Senior's Guidance Document, Geriatrics Clinical Knowledge Topic*

- Non-Alberta Health Services Documents:
  - *Continuing Care Health Service Standards* (Alberta)
  - *Co-ordinated Home Care Program Regulation* (Alberta)
  - *Criminal Code of Canada*
  - *Mental Health Act* (Alberta)
  - *Peace Officer Act* (Alberta)
  - *Public Health Act* (Alberta)

APPENDIX A

Risks	Alternate and Least Restraint Interventions
Protection of Medical Devices, e.g., IV, ET tube	Assess for discomfort (e.g., obstruction of urinary catheter, interstitial peripheral IV). Convert IVs to saline locks or subcutaneous lines if possible. Assess necessity of lines/tubes and advocate for removal (with patient/family). Education: simple explanations and guided exploration of the tubes; repeat as needed. Cover and disguise tubes with sleeves, gauze, pants, abdominal or foam binder, etc. **Consider alternatives:** elbow splints (to keep arms straight) or neuro mitts (not secured).
Fall Risk	☑ Assess for risk factors (e.g., confusion, weakness, bowel or bladder urgency). ☑ Review and reduce medications. ☑ Assess gait and consider need for gait aids and strategies. ☑ Reduce room and hallway clutter; non-slip footwear and clean prescription glasses. ☑ Walk with the person (e.g., q1h while awake; toileting schedule). ☑ Mattress on floor, mat beside bed (slide under bed when not in use to avoid tripping). **Least Restraint**: side rails (partial, bed against wall) to prevent rolling out of bed (observe for risk of entrapment); short-term use of lap belt with ambulation/toileting q1h.
Purposeful Exit Seeking	☑ Assess patterns of behaviours (e.g., behaviour mapping) to identify precipitating factors, timing, duration, frequency and needs (e.g., pain, hunger, thirst, fatigue). ☑ Respond to emotions (e.g., "tell me about your home" versus "you can't go home"). ☑ Positive redirection (e.g., "let's have a cup of tea" instead of "don't go out/there"). ☑ Photos and familiar objects on room door; signage, e.g., washroom. ☑ Provide familiar objects at bedside (e.g., bedspread). ☑ Engage in social and meaningful/purposeful activities such as dining together with other patients, recreational activities, general mobilization/walking program, activities at nursing station. ☑ Arrange family and/or volunteer visits during identified times, e.g., during shift change. ☑ Camouflaged doors (e.g., same colors as walls, part of a mural). ☑ Destinations to walk to, e.g., lounge, mural, dining room.
Resistance to Care	☑ Consistent health care providers; calm, reassuring approach. ☑ Consider needs for dignity and privacy. ☑ Dementia education for staff (e.g., step-by-step instructions). ☑ Work with family and friends to get to know the person. ☑ Use of glasses, hearing aids, dentures, pocket talker; modified approach (e.g., lacks peripheral vision - approach from front); ensure adequate lighting. **Consider alternatives:** One person distracts with conversation or music and holds hands, another provides care. Recognize ability for client to decline care, modify care times, review sleep health, leave and attempt care at a later time.
Aggression	☑ Recognition of causes for agitation may prevent escalation of behaviours and reduce or eliminate the need for restraint (e.g., delirium, physical illness, pain, medications, fear, control issues, needs being ignored, information needs, etc.). ☑ Modify care/safety plan and routine as needed. ☑ Monitor for early signs of escalating behaviour (e.g., verbal abuse, conflict with others, pacing, agitation, anger, distress). ☑ Do not argue with or threaten; use de-escalation strategies. ☑ Offer choices to help patient regain control. ☑ Reduce environmental stimuli, close the door; you may need to walk away.

Agitation/ Emotional Distress	☑ Review and minimize medication use; correct abnormal lab values, hypoxia, infection, fluid overload. ☑ Reduce overstimulation from environmental noise, e.g., comfort rounds to reduce call bell usage, judicious use of chair and bed alarms, limit overhead paging, minimize machine beeps and alarms, e.g., IV pumps; consider quiet time in room, soft music. ☑ Work with families to get to know the person's needs and preferences. ☑ Support daytime activity, afternoon quiet period and sleep at night: o Minimize interruptions for staff routines, routine lab work, vital signs, glucose monitoring o Decrease light and noise on evenings and during afternoon rest period o Dark and quiet at night, bright light and activity in the day. o Avoid use of sedatives (drowsy in day, risk of falls, awake at night). ☑ Monitor pain using validated assessment tools (e.g., Critical Care Pain Observation Tool (CPOT), numeric pain scale, PAIN-AD for persons with dementia). ☑ Consider non-pharmacological interventions for pain: regular repositioning, mobilization/range of motion/ gentle stretching, massage, distraction, relaxation. Create a predictable daily routine to minimize adjustment to change. Consider distractions such as a game or activity, companionship, and/or 1:1 talk with staff. ☑ Offer food, beverage, or medications as appropriate. ☑ Monitor and correct abnormal lab values, hypoxia, infection, fluid overload. ☑ Introduce yourself and provide a calm, reassuring approach. Provide empathy, active listening, reassurance of safety and opportunity to work through negative emotions. ☑ Kindly but firmly explain expectations, intent to support, choices and limits (exception: cognitive impairment). ☑ End stage dementia: consider activity mats pockets, zippers, Velcro, etc. ☑ Assess comfort of seating for patients unable to mobilize: o Consider fatigue, pain, time of day, etc. o Avoid continuous use of Broda chairs. o Assess, e.g., sliding/leaning/falling forward/knees swept to one side. o Position hips, knees, and ankles as close to 90 degrees as possible (keep in mind injuries that may prevent this). Ensure buttocks and thighs are fully supported on the seat and weight is not on one small area. o Ensure feet are flat on the footrests or floor to prevent sliding, shifting, or leaning. Gripper mat in front of chair to prevent sliding out/falling. o Consider tilt position for rest periods and monitor skin integrity.
Delirium	☑ Safe mobilization when possible, to reduce agitation and support recovery. ☑ Address underlying causes of delirium, e.g., dehydration, drug toxicity, infection, constipation. Use anti-emetics with caution, avoid dimenhydrinate/strong anticholinergics with older adults. ☑ Antipsychotics are not a treatment for delirium and can cause or worsen delirium. Only consider a low dose of antipsychotic to temporarily ease suffering if appropriate, after other interventions fail and after discussion of risks and benefits with the resident's decision-maker; use with caution in dementia and Parkinson's disease (see *Delirium, Seniors – Inpatient Clinical Knowledge Topic*). ☑ Provide consistent health care providers and a consistent care plan, e.g., encourage family visits and involvement, familiar objects in room (e.g., family pictures), orientate to environment; clock and calendar in room, reassure and meet needs for comfort, support communication (glasses, hearing aids).
Pediatric Inpatients	☑ Consult Child Life Worker; create predictable daily routine and safe space, e.g., crib or bed. ☑ Redirection and limit setting, explain expectations, next steps, consequences. ☑ Provide support, empathy, attentive listening, and reassurance of safety. ☑ Encouragement to regain control of self, options/choices. ☑ Distraction/diversional activities (e.g., music, TV, 1:1 interaction with staff). ☑ Ensure a collaborative, consistent, family-centred care environment. ☑ Increased or decreased staff presence; pharmacological review of treatment interventions.

APPENDIX B

Use of Secure Spaces in Continuing Care Settings

According to the *Continuing Care Health Services Standards* (2018), a restraint does not include the use of a secure space within Continuing Care settings. For clarity, the following requirements and monitoring are outlined for patients assessed as requiring a secure space:

- Obtain informed consent in accordance with the AHS *Consent to Treatment/ Procedure(s)* Policy and provide information on the secure space to the patient and/or alternate decision-maker and family, prior to, or upon initiation of the secure space.
- Information about the secure space shall also be available upon request while the patient resides in or is subject to the secure space.
- With initial entry to the secure space, monitor the patient at minimum 15 to 30 minutes, or until patient stabilizes; monitor thereafter based on the patient's response/condition to the intervention, as documented in the plan of care.
- Monitor the patient for responsive behaviour(s) (e.g., exit seeking) in response to the use of the secure space.
- The following shall be documented in the patient's individualized plan of care and chart:
    - patient need for the secure space;
    - criteria or goal for discontinuation of the secure space;
    - method of monitoring and monitoring frequency while the patient is subject to the secure space;
    - review period(s) for determining the appropriateness and effectiveness of the secure space including:
        - at admission to, or initiation of the secure space;
        - upon significant change in the patient's behaviour or responsive behaviour that requires a secure space; and
        - scheduled review(s) at minimum annually and based upon patient need and response to the secure space.
    - plans for discontinuation of the secure space, as applicable, once the patient need for the secure space has been resolved (i.e., goal of the intervention has been met).
- Document assessments, behaviour tracking, monitoring conducted, and reviews of the appropriateness and effectiveness of the secure space on the patient's chart and care plan.

APPENDIX C

Use of Pro Re Nata (PRN) Pharmacological Restraints in Addiction & Mental Health Settings when the Patient Lacks the Ability to Consent and it is Impractical to Obtain Consent from their Alternate Decision-Maker(s)

☑ There may be unique circumstances where the use of PRN pharmacological restraint in the absence of patient consent is clinically indicated. In these cases, the order may be written when the following conditions are met:

- in anticipation of a future behavioural emergency;
- the patient lacks the ability to consent;
- it is impractical to obtain consent from their alternate decision-maker(s); and
- a PRN pharmacological restraint order is necessary to ensure the safety of both patient and health care providers.

☑ A Physician/NP may write a PRN order for pharmacological restraint without patient consent that clearly indicates for use in a behavioural emergency.

☑ Prior to writing the PRN order for pharmacological restraint, the Physician/NP shall ensure that a health care professional has:

- documented why the patient is believed to lack the ability to consent and all efforts to contact the patient's alternate decision-maker to obtain consent; and
- considered alternatives to restraint and determined these alternatives to be inappropriate or ineffective in accordance with the AHS *Restraint as a Last Resort* Policy.

☑ PRN orders for pharmacological restraint that are written in anticipation of a future behavioural emergency shall be outlined in the individualized plan of care and reviewed at least weekly, or sooner, if there is a material change in the patient's presentation relevant to the administration of a pharmacological restraint.

☑ When the pharmacological restraint is administered from a PRN order and the patient or alternate decision-maker(s) have not provided consent, the health care professional shall:

- ensure alternatives to restraint have been considered and determined to be inappropriate or ineffective in accordance with the AHS *Restraint as a Last Resort* Policy;
- contact a Physician or NP whenever possible and practical, prior to administering the restraint to obtain verbal authorization, and document efforts to do so. If not practical at the time, then as soon as possible thereafter; and
- clearly document the nature and circumstances of the behaviour emergency immediately preceding the use of the pharmacological restraint.