

TITLE

RESTRAINT AS A LAST RESORTSCOPE

Provincial

DOCUMENT

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 regarding restraints.
- To support a balance between the safety of the **patient** and others and the limitation imposed on the patient's personal liberty when decisions are made regarding restraint.

PRINCIPLES

- Using a patient centred care approach eight (8) procedures have been developed to accompany this policy based on specific patient populations and different care team requirement(s).
- Consent is required for all non-emergent restraint use.
- Alberta Health Services 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 in the circumstances.
- All reasonable efforts shall be made to identify and apply a non-restraint strategy.
- When restraint is indicated the least restrictive restraint suitable to achieve the intended outcome shall be used.
 - Restrained patients shall be monitored with sufficient frequency to minimize risk of any potential harm which varies depending on the patient and care area but at a minimum is

- required every eight (8) hours of continuous restraint particularly while sleeping (see relevant procedure for each care area for more specifics).
- Once restraints are applied they shall be removed at the earliest and safest opportunity.
 - Restraints shall be used in a manner that allows for quick release in an emergency situation (e.g., codes).
 - Staff caring for patients at risk for the use of restraints (or all patients with potential or real behavioral challenges) shall receive education on appropriate restraint use and application.
 - Program areas shall identify training requirements for staff.
 - Restraint shall be used only in circumstances where:
 - There is an immediate threat to the safety of patients, caregivers, or others (e.g., physical assault, self-harm) and immediate action is necessary to prevent serious bodily harm to the person or to another person;
 - Emergency treatments must be provided, including but not limited to resuscitation, emergency assessment and transport;
 - An approved treatment regimen or care plan must be followed because the patient is unable to cooperate in the care setting (e.g., ICU care, severe cognitive impairment);
 - The patient's behaviour is severely disruptive and/or interferes with the provision of care to other patients; and/or
 - It is necessary as part of the patient's treatment plan for patient safety, such as lap belts on wheelchairs.

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 policy does not apply to restraint by non-AHS Corrections Authorities for purposes of custody, detention, and public safety reasons.

ELEMENTS

1. Consent

- 1.1 Consent is not required in emergency situations, including but not limited to:
- a) risk of serious bodily harm to patient or others;
 - b) immediate threat to safety; or

- c) emergency treatment being provided.
- 1.2 Consent shall be obtained in all non-emergency circumstances. Consent shall be obtained in accordance with the AHS *Consent to Treatment/Procedure(s)* policy suite.
- 1.3 Physician or Nurse Practitioner **orders** are required for non-emergency restraints.
- 1.4 When a restraint is used in an emergency situation, Physician or Nurse Practitioner order shall be obtained as soon as possible if restraint is ongoing.

Note: Pharmacological restraints cannot be used without an order.

2. Principles

- 2.1 Four (4) principles that guide the use of restraint(s) are:
- a) Respect for persons:
 - (i) The patient's dignity shall be respected at all times and under all circumstances.
 - (ii) Informed consent (in accordance with *Consent to Treatment/Procedure(s)* policy suite) and the principle of choice are applied in all possible circumstances.
 - (iii) Early intervention may be able to control difficult behaviour before the situation escalates and a patient may be able to participate and choose less restrictive options.
 - b) Maximum benefits and minimum harm:
 - (i) Restriction of movement limits the patient's liberty and is thus potentially harmful. The safety benefits of restraints shall be weighed against the harm they cause prior to making a decision regarding the restraint.
 - (ii) Patients shall be carefully observed in order to immediately address harm.
 - (iii) Patient response to restraint shall be tracked, documented and reviewed to assist further decision making.
 - c) Minimal restriction: When restraints are deemed to be necessary, the least restrictive restraint shall be used, for the least amount of time. This must be balanced with ensuring safety and respecting liberty. As restraint may take away the patient's ability to care for themselves, staff may need to take over the responsibilities that have been taken away from the patient.

- d) Fairness and consistency: Health care teams shall apply this policy consistently across health service settings. In all patient encounters care teams shall work with patients and/or the **alternate decision-maker** to use restraint as the last resort.

3. Types of Restraint

3.1 Alberta Health Services recognizes the use of the following types of restraint:

- a) Pharmacological: the use of pharmaceutical products to control behaviours, actions, and/or restrict freedom of movement, but which purpose in the situation is not to treat an identified medical or psychiatric condition.
- b) Environmental: any barrier or device that limits the **locomotion** of an individual, and thereby confines an individual to a specific geographic area or location.
- c) Mechanical: 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.
- d) Physical: the direct application of physical holding techniques to a patient that involuntarily restricts their movement.

4. Restraint Decision-Making Components

4.1 Restraint shall not be used for discipline or convenience.

4.2 Clinical evaluation of each individual patient situation will determine:

- a) if there is a need for restraint;
- b) the type of restraint to be used;
- c) when to discontinue the restraint; and
- d) how effective the restraint was.

4.3 In non-emergency situations alternatives to restraints shall be first attempted or implemented, assessed, and documented.

- a) If alternatives to restraint are non-effective this shall be documented prior to the implementation of restraint.

- 4.4 Except for emergent circumstances, the following are required prior to restraint use:
- a) identification of factors contributing to the actions or behaviours that are perceived to require restraint and acting where reasonably possible to eliminate or reduce these factors;
 - b) immediate situational assessment of patient status and their ability and/or willingness to control their actions and/or behaviours perceived to require restraint;
 - c) identification of any existing and potential risks to the patient, others and the environment;
 - d) evaluation of potential risks of restraint and non-restraint;
 - e) consent shall be obtained if restraint is required for patient's treatment plan 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 in accordance with the AHS *Consent to Treatment/Procedure(s)* policy suite. Consideration of alternative less restrictive strategies have been or are understood by staff to be ineffective or inappropriate in the circumstances, having regard to the patient's physical and mental health;
 - f) a Physician or Nurse Practitioner order which has been ordered and reviewed as indicated in the applicable restraint procedure; and
 - g) consider rationale for restraint use:
 - (i) intended outcomes of restraint;
 - (ii) potential effects of restraint;
 - (iii) frequency of monitoring and documentation review;
 - (iv) frequency and conditions for use of restraint; and
 - (v) criteria and timelines for discontinuation of restraint.

5. Restraint as a Last Resort Procedures

- 5.1 The following practice settings within AHS will provide procedures pertaining to the use of restraint (see references for procedure(s) titles):
- a) Emergency/Urgent Care;
 - b) Adult Inpatient;
 - c) Pediatric Inpatient;

- d) Critical Care;
- e) Addiction and Mental Health - Inpatient;
- f) Acquired Brain Injury and Rehabilitation - Adult;
- g) Older Adults;
- h) Protective Services; and
- i) other(s) as required.

6. Documentation

- 6.1 Document assessment, rationale, consent obtained and plan in accordance with applicable sector procedure.

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].

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.

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.

Locomotion means the movement of an individual from place to place/room to room.

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.

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

REFERENCES

- Appendix A: *Information to Consider*
- Alberta Health Services Governance Documents:
 - *Consent to Treatment/Procedure(s) Policy suite (#PRR-01)*
 - *Restraint as a Last Resort - Acute Care Inpatient - Adult Procedure (#HCS-176-04)*
 - *Restraint as a Last Resort - Acute Care Inpatient - Pediatric Procedure (#HCS-176-05)*
 - *Restraint as a Last Resort - Addiction and Mental Health - Inpatient Procedure (#HCS-176-06)*
 - *Restraint as a Last Resort - Acquired Brain Injury and Rehabilitation - Adult Procedure (#HCS-176-02)*
 - *Restraint as a Last Resort - Critical Care Procedure (#HCS-176-07)*
 - *Restraint as a Last Resort - Emergency/Urgent Care Procedure (#HCS-176-03)*
 - *Restraint as a Last Resort - Older Adults Procedure (HCS-176-01)*
 - *Restraint as a Last Resort - Protective Services Procedure (HCS-176-08)*
- Non-Alberta Health Services Documents:
 - *Mental Health Act (Alberta)*
 - *Personal Directives Act (Alberta)*
 - *Adult Guardianship and Trusteeship Act (Alberta)*

VERSION HISTORY

Date	Action Taken
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APPENDIX A

Information to Consider

The following information should be considered when restraint is used:

1. Clinical Assessment

- 1.1 medical symptoms, and patient's 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 patient's actions and/or behaviours prior to consideration of restraint use.

2. Environmental Assessment

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

3. Planning

- 3.1 any discussion with the patient or alternate decision-maker;
- 3.2 rationale for and goals of restraint use;
- 3.3 least restrictive restraint selected; and
- 3.4 plan for reducing or eliminating restraint use.

4. Implementation

- 4.1 recommended timeline to notify 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;
- 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).