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 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

- Informed consent is required for all non-emergent restraint use.

- 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.

- All reasonable efforts under the circumstances 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 observed and/or monitored depending on the type of restraint with sufficient frequency to minimize risk of any potential harm, which varies depending on the patient and care area. At a minimum, this is required every eight (8)
hours of continuous restraint particularly while sleeping. For specific monitoring requirements, refer to the AHS Restraint as a Last Resort Procedure.

- Once restraints are applied, they shall be removed at the earliest and safest opportunity.
  - The health care provider shall clearly communicate the rationale for restraint removal to members of the health care team, confirm appropriateness of restraint removal with the most responsible health practitioner (MRHP), and document this communication and decision.
  - Where observation levels (e.g., constant observation) have been ordered by a Physician or Nurse Practitioner (NP), these shall remain in place until the order is reviewed by a Physician or NP and a new observation order is written.

- 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 behavioural challenges) shall receive education on appropriate restraint use and application.
  - Program areas shall identify training requirements for staff.

- Restraints shall be used only in circumstances where:
  - there is an immediate threat (e.g., physical assault, self-harm) to the safety of patients, healthcare providers, or others, and immediate action is necessary to prevent serious bodily harm to the patient or to another person;
  - emergency treatments/procedures must be provided, including but not limited to resuscitation, emergency assessment, and transport;
  - a 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. Refer to the AHS Restraint as a Last Resort Procedure.

**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 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. Informed Consent

1.1 Informed 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 Informed consent shall be obtained in all non-emergency circumstances and in accordance with the AHS Consent to Treatment/Procedure(s) Policy Suite.

2. Restraint Orders

2.1 All restraints require an order from a Physician or NP.

   a) Exception: Use of non-pharmacological restraints during an emergency situation or behavioural emergency do not require an order:

      i) obtain an order as soon as practically possible within 24 hours; or
      ii) in Continuing Care settings, within 72 hours, in accordance with the Continuing Care Health Service Standards (Alberta).

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

3. Four Principles that Guide the Use of Restraints

3.1 Respect for persons:

   a) The patient’s dignity shall be respected at all times and under all circumstances.

   b) Informed consent (in accordance with the AHS Consent to Treatment/Procedure(s) Policy Suite) and the principle of choice are applied in all possible circumstances.

   c) Early intervention may be able to de-escalate difficult behaviour and support patient involvement.

3.2 Maximum benefits and minimum harm:

   a) 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.
b) Patients shall be carefully observed in order to immediately address harm.

c) Patient response to restraint shall be tracked, documented, and reviewed to assist further decision-making.

3.3 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.

3.4 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(s) to use restraint as the last resort.

4. Types of Restraint

4.1 AHS 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 for which the 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.

(i) In Continuing Care settings, the use of secure spaces does not require an order as per the Continuing Care Health Service Standards (Alberta).

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.

5. Restraint Decision-Making Components

5.1 Restraint shall not be used for discipline or convenience.

5.2 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.

5.3 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.

5.4 The following are required prior to restraint use except in emergency situations:

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) informed consent shall be obtained if restraint is required for the 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(s) in accordance with the AHS Consent to Treatment/Procedure(s) Policy Suite.

(i) Alternative, less restrictive strategies shall be considered and determined to be ineffective or inappropriate in the circumstances, having regard to the patient’s physical and mental health;

f) a Physician or NP order which has been ordered and reviewed, as per the AHS Restraint as a Last Resort Procedure;

(i) In Continuing Care settings, the use of secured spaces does not require an order, as per the Continuing Care Health Service Standards (Alberta). Refer to Appendix B in the AHS Restraint as a Last Resort Procedure.

g) the rationale for restraint use, which considers the following:

(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.

6. Documentation

6.1 Document the assessment, rationale, informed consent obtained, and plan in accordance with the AHS Restraint as a Last Resort Procedure and approved AHS documentation.

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.

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

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.

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.

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.

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 client 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.

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.

REFERENCES

- Appendix A: Information to Consider
- Alberta Health Services Governance Documents:
  - Clinical Documentation Directive (#1173)
  - Clinical Documentation Process Directive (#1173-01)
  - Consent to Treatment/Procedure(s) Policy Suite (#PRR-01)
  - Respectful Workplaces and the Prevention of Harassment and Violence Policy (#1115)
  - Restraint as a Last Resort Procedure (#HCS-176-01)
- Non-Alberta Health Services Documents:
  - Adult Guardianship and Trusteeship Act (Alberta)
  - Alberta Review Board
  - Continuing Care Health Service Standards (Alberta)
  - Criminal Code of Canada
  - Mental Health Act (Alberta)
  - Personal Directives Act (Alberta)
  - Public Health Act

© 2020, Alberta Health Services, Policy Services

This work is licensed under a Creative Commons Attribution-Non-commercial-Share Alike 4.0 International license. The licence does not apply to AHS trademarks, logos or content for which Alberta Health Services is not the copyright owner. This material is intended for general information only and is provided on an "as is", "where is" basis. Although reasonable efforts were made to confirm the accuracy of the information, Alberta Health Services does not make any representation or warranty, express, implied or statutory, as to the accuracy, reliability, completeness, applicability or fitness for a particular purpose of such information. This material is not a substitute for the advice of a qualified health professional. Alberta Health Services expressly disclaims all liability for the use of these materials, and for any claims, actions, demands or suits arising from such use.
APPENDIX A

Information to Consider

The following information should be considered when restraint is used:

1. **Clinical Assessment**
   - medical symptoms, and patient’s actions and/or behaviour leading to consideration of restraint use;
   - functional status / contributing factors leading to consideration of restraint use;
   - methods/strategies used to address medical symptoms, and patient’s actions and/or behaviours prior to consideration of restraint use; and
   - past history of restraint use and related circumstances, other related personal history (e.g., aggression, trauma, patient triggers) and alternative interventions which have been successful.

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

3. **Planning**
   - any discussion with the patient or alternate decision-maker(s);
   - rationale for and goals of restraint use;
   - least restrictive restraint selected; and
   - plan for reducing or eliminating restraint use.

4. **Implementation**
   - recommended timeline to notify Physician or Nurse Practitioner and obtain order needed (as soon as practically possible);
   - informed consent (in accordance with the AHS Consent to Treatment/Procedure(s) Policy Suite) and order;
   - use of Protective Services and/or number of staff involved;
   - search and removal of potentially harmful personal possessions;
   - use of restraint (type, size, period of time, documentation review); and
   - monitoring.

5. **Review and Evaluation**
   - review of need for continued use of restraint or for the discontinuation of restraint;
   - effectiveness of chosen restraint;
   - patient’s response to restraint, including debriefing with the patient if clinically possible; and
   - add relevant information to the Reporting and Learning System (recommended).