AUTHOR:	Interprofessional Practice	**FOLDER:**	Ethics and Research
APPROVED BY:	Senior Management Medical Advisory Committee	**REVIEW FREQUENCY:**	3 years
RESPONSIBILITY:	Director, Interprofessional Practice & Education or Designate	**ORIGINAL APPROVAL DATE:**	31/12/03
		REVISED/REVIEWED DATE	17/07/2014 27/09/2017

210.914.914.005 RESTRAINT MINIMIZATION POLICY

POLICY:

Markham Stouffville Hospital (MSH) will deliver patient care that complies with the Restraint Minimization Act (2001). As such, staff will consider the use of a physical, chemical or environmental restraint to manage a patient's behavior ***only*** as a last resort.

EXPECTED OUTCOMES:

Members of the interprofessional health care team will:

1. Support a patient to manage their behaviour by using all applicable strategies and interventions ***prior*** to the consideration of using any kind of restraint.
2. Use the least restrictive form of restraint for the shortest duration possible.
3. Learn about the philosophy of restraint minimization at MSH during orientation to the organization and via on-line and/or in-person training.

DEFINITIONS:

Alternative Approach: An approach that imposes less control on the patient than restraining or confining the patient or using a monitoring device on the patient.

Close Observation: Assessment of a patient every 15 minutes (q15min) by nursing.

Emergency Situation: Any event when a restraint can be applied, without the consent from the patient/family/SDM, because the patient is at imminent danger of causing harm to self or others.

Intensive Observation: Assessment of a patient more frequently than q15min, which may include assistance from devices such as security cameras and involve the continuous physical presence of a staff member in the same environmental vicinity as the patient.

Involuntary Patient: A patient who has been detained in a psychiatric facility under the certification of involuntary admission or certificate of renewal.

Monitoring Device: An electronic device worn by the patient that protects against the patient wandering off the unit or eloping by sounding an alarm and locking the door when the patient nears the exit (e.g. patient wandering system).

Non-emergency Situation: An event when a restraint shall not be applied without informed consent from the patient/family/SDM as the patient is not at imminent danger of causing harm to self or others.

Personal Assistance Support Device (PASD): A device used to assist a person with a routine of daily living, e.g. a lap tray for meals that the patient can remove

Psychiatric Intensive Care Unit (PICU): A designated area in the Inpatient Mental Health Unit for acutely ill patients who may require a short-term level of intensive visual observation by a designated staff member

Restrain: To place a patient under control by minimal use of force, mechanical, or chemical means as is reasonable having regard to the person's physical and mental condition.

Restraint: physical, environmental or chemical measures used to control the physical or behavioural activity of a person or a portion of his/her body.

- Environmental restraints control a client's mobility (e.g. Psychiatric Intensive Care Unit or locked area in the emergency department).
- Physical restraints limit movement of the whole or a portion of a patient's body as a means of controlling their physical activities.
- Chemical restraints are any form of psychoactive medication used not to treat illness, but to intentionally inhibit a particular behaviour or movement.

SBARD (Situation, Background, Assessment, Recommendations, Documentation): Communication tool used for transfer of patients between units to communicate the following patient-related information: situation, background, assessment, recommendations, documentation.

Substitute Decision Marker (SDM): A person who is authorized to give or refuse consent to treatment on behalf of another person who is not capable of making decisions for their own treatment.

Voluntary Patient: A patient who is capable of making a decision about staying or leaving the psychiatric or mental health unit of a hospital, and cannot be detained or restrained involuntarily. Unless otherwise specified, voluntary patients are also presumed to have the capacity to make decisions about their treatment options and personal health information on the basis of informed consent.

ROLES AND RESPONSIBILITIES:

- As appropriate, the nurse will assess the patient for risk of restraint use using assessment skills and clinical judgment and will communicate restraint risk to the appropriate interprofessional team members.

- The ordering provider (e.g. physician, nurse practitioner) will collaborate with the interprofessional team to prevent and manage the use of restraints (i.e. assessing alternate approaches to restraint use).

- Patient/family/substitute decision maker (SDM) will be made aware of their potential risk for restraint use and will work with the interprofessional team to establish an individualized plan of care that minimizes restraint use.

- All clinical staff will be made aware of the patient's identified restraint risk and will follow appropriate strategies/interventions to minimize use of restraints.

- Diagnostic imaging and laboratory staff will be made aware of the patient's potential risk for restraint use and will support the identified strategies.

- Security will:
    - Respond to all Code White calls
    - Accompany a nurse or porter for transport of any patient in physical restraints (e.g. Pinel)

- Pharmacists will make recommendations to the ordering provider if a drug interaction, polypharmacy or medication regimen may increase the risk for restraint use

- When referred, physiotherapy will complete a balance and mobility assessment for all restraint-risk referred patients and make recommendations about appropriate alternatives to restraints use**.**

- As required, occupational therapy staff will assess cognitive status of restraint-risk referred patients and make recommendations about appropriate alternatives to restraint use.
- As required, dieticians will complete a nutritional assessment for all restraint-risk referred patients and recommend appropriate diets and supplements.

- As required, social work will provide support and education to families for all restraint-risk referred patients.

- As appropriate, interprofessional health care providers (e.g. chaplain, Therapeutic Recreation Specialist) who interact with patients will be made aware of a patient's identified restraint risk and will follow appropriate strategies/interventions to minimize use of restraints.

- Support services, facilities staff, volunteers and students will be made aware of the Restraints Minimization program and will support a safe environment of care.

PROCEDURE:

A. <u>ASSESS for Risk of Restraint Use</u>

Accurate and timely assessment and documentation of patient cognition, behaviours and functionality will assist the interprofessional team in identifying patients who may require support in managing their behavior and therefore be at risk for requiring restraints while in hospital.

Nurses will:

1. Assess patients who may be exhibiting any of the factors in Table 1 and therefore be at risk for restraint use
2. Document assessment findings:
    - In the Restraints Minimization Assessment Screen
    - In the Interprofessional Kardex

The following factors may increase risk for restraint use (either singly or in combination):

Table 1 – Risk Factors for Restraint Use

Cognitive	Behavioural	Physical and Functional
• Alcohol/substance withdrawal • Delirium/acute confusion • Diagnosis of dementia/long-term memory deficit • Unable to follow instructions/retain information • Impulsive/poor judgment • Hallucinations • Frustration	• Agitation • Elopement/wandering • Exit seeking • Potential for harm to self/others • Pulling out medical equipment (e.g. tubes/drains) • Resistance to care	• ADL dependence • Inability to communicate needs • Mobility/balance poor • History of falls • Medication side effects • Pain • Previous restraint use • Sensory impairment • Need for frequent toileting • Environmental hazards in physical space • Insufficient light • Call bell/important items out of reach

B. IMPLEMENT strategies that support a patient to manage their behaviour and minimize risk of restraint use (See Appendix A):

Restraints are only to be used after alternative, less restrictive measures, and de-escalation strategies have been implemented. Restraints are never used for punitive reasons, or for the convenience of staff.

In a non-emergency situation, members of the interprofessional team will:

1. Initiate and evaluate alternatives to restraint use for all identified patients using the "CLEA(R) Strategies" (Appendix A), prioritizing non-restraint interventions and considering a restraint as a last resort.
2. Discuss decisions related to alternative strategies with the patient/family/SDM.
3. Consider the following options when "CLEA(R)" strategies are implemented:
    a. If the patient's behavior improves, continue to employ CLEA(R) strategies
    b. If the patient's behavior is unaffected, try additional alternate strategies
    c. If the patient's behavior is still unaffected, continue the CLEA(R) strategies and
    d. As a last resort, consider the least restrictive restraint possible, for the shortest period of time
4. Document **CLEA(R)** strategies implemented (see Appendix A)
5. Communicate restraint risk when a patient is transported from one department to another - the sending department will communicate the patient's restraint risk directly to the receiving department using the SBARD Transfer Tool and to the individuals (e.g. nurse, security, porter) transporting the patient.

C. AS A LAST RESORT, INITIATE the use of a restraint:

- If risk of harm to the patient or others persists despite implementation of alternative strategies, implement the Algorithm for Restraint Minimization (see Appendix B).
- The patient will NOT be restrained unless the restraint:
    a. Is necessary to prevent serious bodily harm to self or others *and*
    b. Is authorized by a plan of treatment to which the patient/family/SDM has consented.

1. In a non-emergency situation (i.e. no imminent harm to self or others):

- Obtain informed consent for restraint use (See Appendix C for consent form/s):
    a. The ordering provider (e.g. physician, nurse practitioner) proposing the treatment will obtain informed consent.
    b. Document consent given by patient/family/SDM and sign the "Consent to Restraint" form. Document refusal of consent on the "Release of Liability - Refusal of Restraints" form, including the understanding of the associated risk.
    c. Consent is not required for involuntary Mental Health patients certified under the Mental Health Act, but *is* required for voluntary Mental Health patients.

d. A new consent is required for each new restraint because consent is specific to the product being used.

- Obtain an order for restraint use.
  a. An order must be obtained prior to restraining a patient.
  b. The order MUST include all of the following:
     - The type of restraint to be used;
     - The reason for which a restraint is being used (blanket orders to use restraints "when needed or PRN" are not acceptable);
     - The maximum length of time that the restraint is to be used.
  c. The restraint(s) must be reordered:
     - Every 24 hours in mental health and the emergency department
     - Every 48 hours in acute care
     - Every 2 weeks for patients designated as or considered as
       - Alternative Level of Care (ALC)
       - Palliative Care
       - Reactivation and Restorative (R&R)
       - Rehabilitation
       - Complex Continuing Care

2. <u>In an emergency situation (i.e. imminent harm to self or others):</u>

- Consent (for *voluntary* patients) and an order (for *all* patients) must be obtained within 12 hours of initiation of the restraint.
- A CODE WHITE will be called when extra support is required to prevent imminent serious harm to self or others (at the Uxbridge site call 911).
- Police and/or security will apply handcuffs at their discretion:
  - Handcuffs applied by security will be used for the shortest duration possible until appropriate alternative restraints can be applied. At the Markham site, security services are tendered and this third party service is responsible for ensuring its personnel are trained and carry the appropriate license to carry and apply handcuffs.
  - Handcuffs applied by police will be used at the discretion of the responding police officer who is solely responsible for this practice.

3. <u>Care of the patient in restraints:</u>

- Evaluate and minimize environmental, physical or medical factors which may increase agitation or confusion;
- Reposition patient q1H as needed and massage/perform ROM exercises on restrained limb(s);
- Assess bony prominences for redness and signs of pressure;
- Provide diet as ordered with fluids offered q2H;
- Provide the opportunity to void q2H while awake;
- Provide psychosocial support.

4. <u>Assessment and documentation during restraint use (see Appendix D):</u>

To ensure optimal patient safety during restraint use, assess and monitor the patient as per parameters and timing in Appendix D (Table 2 – Assessment and Documentation Parameters).

Nursing and members of the interprofessional team will document assessment findings (as per Appendix D) as follows:

1. **Restraints Minimization Assessment Screen** – document factors that may indicate patient is at risk for being restrained and all alternative strategies used
2. **Restraints Minimization Focus Note** – document initiation, change and discontinuation of restraints.

Nursing will document monitoring findings (as per Appendix D) as follows:

1. **Restraints Monitoring Record** – document all monitoring findings during restraint use

5. Equipment and approved restraints (see Appendix E):

- Commercially manufactured physical and environmental restraints are to be used as intended by the manufacturer and are not to be modified or adapted in any way.
- Prescribed anti-anxiety medications, antipsychotics, and sedatives will be used solely for the purposes of managing a patient's behaviour.
- Concealing restraints with gown or linen so they are not visible is prohibited.

6. What is NOT a restraint

- Personal Assistive Service Devices (PASD) that assist a patient in activities of daily living (e.g. lap tray when applied as a positioning device for meals or as a work surface, with the tray secured where the patient can remove it). Written consent is NOT required prior to implementing a PASD or monitoring device when used as in this way.
- A seat belt, when applied to maintain upright positioning, that a patient can release independently
- Exit alarms that sound to alert staff a patient has moved outside of a designated location (e.g. bed or chair exit alarm) that does *not* involve a monitoring device attached to the patient.
- All bed rails used in the raised position is not considered a restraint if used:
    - as a position device or mobility aid (e.g. to help a patient to turn themselves in bed)
    - at the request of the patient
    - on stretchers or other transferring equipment
    - in treatment rooms
    - following medical treatment as approved practice (e.g. administration of a sedative)
- **NOTE: Use of all bed rails in the raised position for the purpose of confining an exit seeking patient in the bed, is considered a restraint

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Markham Stouffville Hospital (2017?) 580.914.917.015 INTERNAL PATIENT TRANSFERS

Markham Stouffville Hospital (2017) 580.914.914.015: EXTERNAL PATIENT TRANSPORT

ENDORSEMENTS:
Interprofessional Advisory Committee; September 19, 2017
Medical Advisory Committee; September 27th, 2017
Patient Services Executive Team – September 14th, 2017

APPENDIX A: STRATEGIES THAT SUPPORT A PATIENT TO MANAGE THEIR BEHAVIOUR and MINIMIZE RISK OF RESTRAINT USE

CLEA(R) Strategies that Support a Patient to Manage Their Behaviour and Minimize Risk of Restraint Use)
NOTE: Implement based on clinical judgment & equipment available in each area

Cognitive:
- Re-orientation
- De-escalation
- Request delirium work-up
- Increase observation
- Assess past coping strategies, optimize mood
- Family at bedside
- Consider sitter at bedside in consultation with family/SDM and interprofessional team (where possible limit attendants of opposite gender from attending vulnerable patients)

Location/limits:
- Move patient closer to nursing station and away from exits
- Increase social interactions as appropriate
- Clearly explain expectations for behaviour
- Set clear limits for inappropriate behaviour

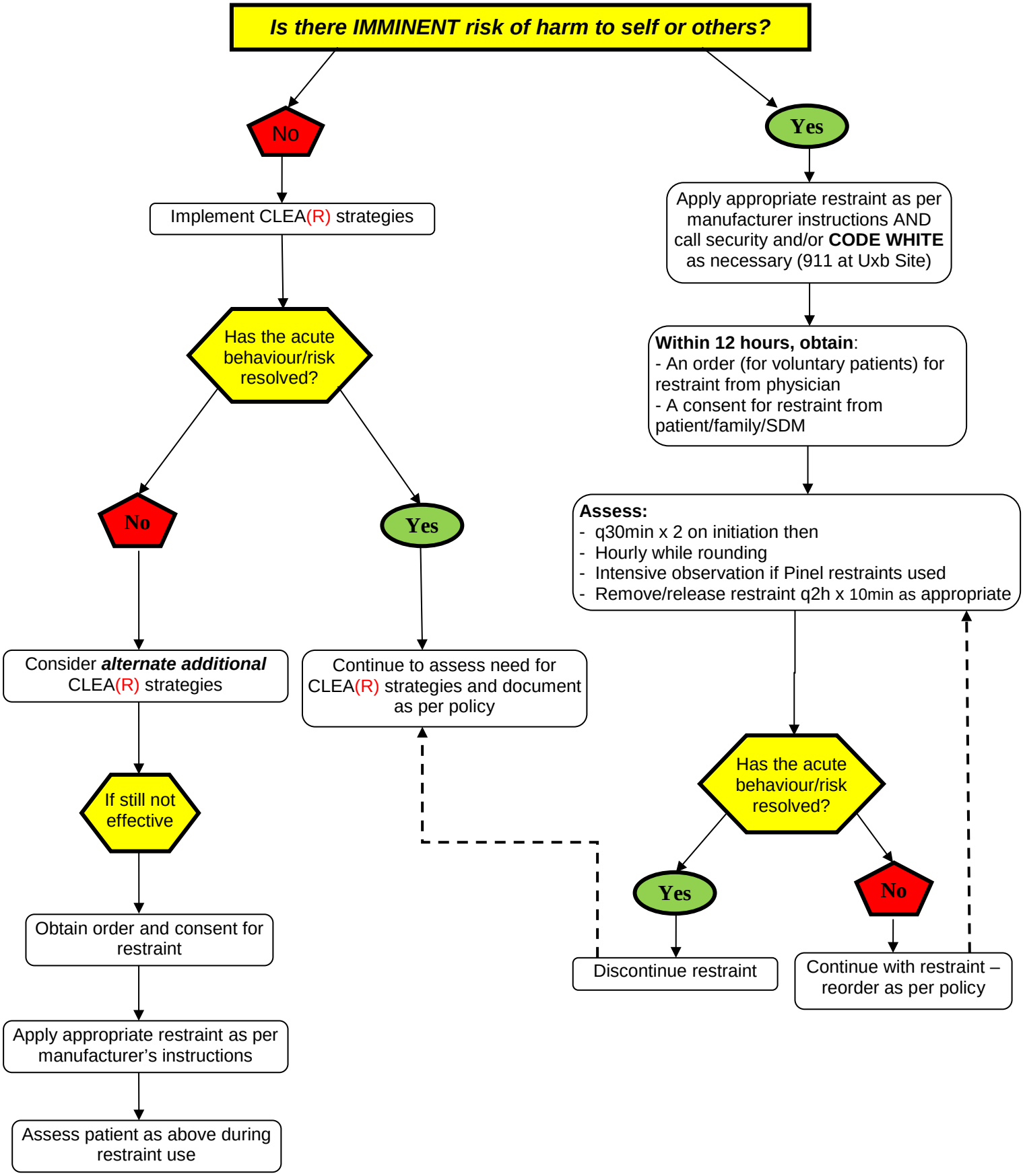
Environment:
- Leisure or meaningful activities to create diversion – consider Recreation Therapy consult
- Room change
- Minimize noise
- Call bell, personal items, fluids, gait aids, sensory aids within easy reach
- Caregiver of same gender, if possible
- Bed in lowest position
- Bed/chair exit alarms

Activity:
- Investigate reasons for exit-seeking
- Falls prevention education
- Minimize tethered equipment (e.g. IV, oxygen)
- Gait aids within reach
- Toilet q2H when awake
- Pace activities to prevent fatigue
- Consider bed/chair exit alarm

Restraint (Last Resort):
- Monitoring device (e.g. patient wandering system)
- Environmental restraints (e.g. PICU in Mental Health or locked area in the Emergency Department)
- Chemical restraints (e.g. ativan or haldol)
- Physical restraints:
  - Disposable wrist/ankle restraints
  - Lap tray/lap belt that patient cannot remove on their own
  - Siderails when used to prevent patient from exiting bed
  - Specialty chairs from which patient cannot exit independently (e.g. Broda)
  - Pinel restraint (any number of points)

Adapted with permission from The Johns Hopkins Health System Corporation (2007); The Ottawa Hospital(2008); Peterborough Regional Health Centre (2010).

APPENDIX B: ALGORITHM FOR RESTRAINT MINIMIZATION



APPENDIX C: CONSENT TO RESTRAINT

I have been informed by _____
(Name and position)
of Markham Stouffville Hospital that the hospital follows a policy of restraint minimization, and that restraints are used as a last resort only.

I understand that restraints can be in the form of physical, chemical (medications) or environmental controls that may be necessary to prevent harm to the patient and/or others. Restraints are used *only* if alternative strategies for supporting a patient to manage their behaviour have been tried and found to be ineffective.

I understand the following:

- If restraints are used as part of the plan of care for _____,
(Name of patient)
the least restrictive method will be used for the shortest time possible
- The team will assess the patient frequently
- The team will reduce or stop using the restraint as soon as possible
- I consent to the use of restraints as part of the plan of care for _____,
(Name of patient)

when other ways of reducing harm and/or enhancing quality of life have been ineffective.
I understand that the team will make reasonable efforts to notify me before using restraints and that I can contact the team to discuss treatment goals and strategies.

_____
Date

_____ _____
Print Name of Patient/Substitute Decision Maker and Relationship to Patient | Signature of Patient/Substitute Decision Maker

_____ _____
Print Name of Witness | Signature of Witness

_____ _____
Print Name of Interpreter (if required) | Signature of Interpreter (if required)

RELEASE OF LIABILITY - REFUSAL OF RESTRAINTS

I have been advised by _____
(Name and position)
of Markham Stouffville Hospital that use of a restraint for a limited period of time may prevent _____ from harming themselves or others.
(Name of patient)

I do not consent to the use of restraints in the care of _____.
(Name of patient)
I confirm that potential risks associated with my refusal have been explained to me, and I fully understand and accept the consequences of my refusal.

I hereby release Dr. _____ and Markham Stouffville Hospital and its staff from any ill effects, injuries or damages, including death, which may result from this refusal.

I understand the explanation and am satisfied that my questions have been answered.

_____
Date

_____ _____
Print Name of Patient/Substitute Decision Maker and Relationship to Patient | Signature of Patient/Substitute Decision Maker

_____ _____
Print Name of Witness | Signature of Witness

_____ _____
Print Name of Interpreter (if required) | Signature of Interpreter (if required)

APPENDIX D: ASSESSMENT AND DOCUMENTATION PARAMETERS

Table 2 – Assessment and Documentation Parameters					
Type of Restraint	**Monitoring Device (e.g. patient wandering system)**	**Environmental Restraint (e.g. PICU or locked area in the ED)**	**Chemical Restraint (e.g. lorazepam or haldol)**	**Physical Restraint (e.g. disposable wrist restraints)**	**Pinel Restraints**
Assessment parameters		**Intensive observation required for duration of restraint use			**Intensive observation required for duration of restraint use
	Assess on initiation and hourly while rounding as a minimum until restraint d/c'd: **1.** Behaviours observed (reason for ongoing restraint) **2.** Limb integrity as appropriate (e.g. bracelet) **3.** Need for continued restraint/opportunity to minimize restraint	**Assess:** **1.** Behaviours observed (reason for ongoing restraint) **2.** Respiration rate as appropriate **3.** Need for continued restraint/opportunity to minimize restraint	**Assess q30min x2 on initiation and hourly x6** **1.** Behaviours observed (reason for ongoing restraint) **2.** Respiration rate **3.** Level of Consciousness	**Assess q30min x2 on initiation and hourly while rounding as a minimum until restraint d/c'd:** **1.** Behaviours observed (reason for ongoing restraint) **2.** Positioning of restraint/s **3.** Limb/skin integrity under restraints **4.** Mobility of unrestrained limbs **5.** Circulation distal to restraint **6.** Respiration rate **7.** Need for continued restraint/opportunity to minimize restraint	**Assess:** **1.** Behaviours observed (reason for ongoing restraint) **2.** Positioning of restraint/s **3.** Limb/skin integrity under restraints **4.** Mobility of unrestrained limbs **5.** Circulation distal to restraint **6.** Respiration rate **7.** Need for continued restraint/opportunity to minimize restraint
Outcome of Reassessment	Outcome options following a reassessment include: **1.** To employ alternative approaches to allow restraint reduction (CLEA(R) strategies) or **2.** To continue the restraint or **3.** To continue the restraint and add an alternative method of restraint as needed or **4.** To change the type of restraint as ordered and as appropriate **5.** To discontinue the restraint **Note:** Notify family/SDM within 12 hours if patient's response to restraint and/or patient's behavior changes				

Table 2 – Assessment and Documentation Parameters					
Type of Restraint	**Monitoring Device (e.g. patient wandering system)**	**Environmental Restraint (e.g. PICU or locked area in the ED)**	**Chemical Restraint (e.g. lorazepam or haldol)**	**Physical Restraint (e.g. disposable wrist restraints)**	**Pinel Restraints**
Restraint Removal, Release or Minimization	N/A	• Out of environment trials as ordered and as appropriate	• N/A	• Minimize restraint as appropriate to give the patient greater freedom of movement	• Minimize restraint as appropriate to give the patient greater freedom of movement (e.g. use of Pinel restraints in walking formation)
Discontinuation of Restraint	Any member of the interprofessional team may discontinue the use of an elopement precaution tool if: • The patient no longer poses a threat of harm to self or others; or • The patient/family /SDM withdraws consent	• Ordering provider assessment and written order required	• N/A	Any member of the interprofessional team may discontinue the use of a restraint if: • The patient no longer poses a threat of harm to self or others; or • The patient/family /SDM withdraws consent	Any member of the interprofessional team may discontinue the use of a restraint if: • The patient no longer poses a threat of harm to self or others
Transportation of the Patient	• With supervision as per clinical judgment	• Must be accompanied by RN/RPN (and security as required) • The sending nurse will communicate the use of restraints to the porter and to the receiving nurse.	• With supervision as per clinical judgment	• Must be accompanied by RN/RPN/PSW at all times • The sending nurse will communicate the use of restraints to the porter and to the receiving nurse.	• Must be accompanied at all times by RN/RPN (and security as required) • The sending nurse will communicate the use of restraints to the porter and to the receiving nurse.
Documentation	**Restraint Minimization Assessment Screen:** • When any of the factors in Table 1 suggest risk for restraint	**Restraint Minimization Assessment Screen:** • When any of the factors in Table 1 suggest risk for restraint	**Restraints Minimization Intervention Screen:** • When any of the factors in Table 1 suggest risk for restraint	**Restraints Minimization Intervention Screen:** • When any of the factors in Table 1 suggest risk for restraint	**Restraints Minimization Intervention Screen:** • When any of the factors in Table 1 suggest risk for restraint

Table 2 – Assessment and Documentation Parameters					
Type of Restraint	**Monitoring Device (e.g. patient wandering system)**	**Environmental Restraint (e.g. PICU or locked area in the ED)**	**Chemical Restraint (e.g. lorazepam or haldol)**	**Physical Restraint (e.g. disposable wrist restraints)**	**Pinel Restraints**
	Restraint Monitoring Record: • On initiation, qshift and prn	**Restraint Monitoring Record:** • q30min x2 on initiation then q2H in Focus Note	**Restraint Monitoring Record:** • q30 min x2 on initiation and hourly x6 hours	**Restraint Monitoring Record:** • q30 min x2 on initiation • Document "Patient Checked Hourly" qshift unless not within defined limits	**Restraint Monitoring Record:** • q30 min x2 on initiation and hourly at a minimum
	Focus Note titled "Restraint Minimization": • When restraint initiated, changed or discontinued	**Focus Note titled "Restraint Minimization":** • When restraint initiated, changed or discontinued and q2H while under restraint	**Focus Note titled "Restraint Minimization":** • When chemical restraint initiated	**Focus Note titled "Restraint Minimization":** • When restraint initiated, changed or discontinued.	**Focus Note titled "Restraint Minimization":** • When restraint initiated, changed or discontinued.
	Vital Signs: • Routine	**Vital Signs** • As appropriate	**Vital Signs:** • q30 min x2 on initiation and hourly x6 hours **Medication Administration Record (MAR)**	**Vital Signs:** • Routine	**Vital Signs (esp. resp rate):** • q30 min x2 on initiation and hourly at a minimum

APPENDIX E: LIST OF APPROVED RESTRAINTS/MONITORING DEVICES & BANNED RESTRAINTS

APPROVED RESTRAINTS/ MONITORING DEVICES

Monitoring Devices (attached to patient):

- Patient wandering system

Environmental Restraints:

- Locked unit/area (PICU in Mental Health Unit or locked area in the ED)

Chemical Restraints:

- Anti-anxiety medications, antipsychotics, and sedatives used solely for the purposes of managing a patient's behavior

Physical Restraints:

- Disposable wrist/ankle restraints
- Lap tray/lap belt unless used for positioning, assisting a patient to move or at a patient's request
- All bed rails in the raised position when being used to confine an *exit-seeking patient* in the bed
- Specialty chairs from which patient cannot exit independently (e.g. Broda chairs in the tilted position)

Pinel Restraints:

- Two, three, four or five-point

BANNED RESTRAINTS

The following are not approved restraints, and their use is not permitted:

- Restraint jackets
- Leather wrist restraints with key lock
- Bed sheets used as restraints (exception; a pediatric patient where the sheet is being used to cocoon the infant/child during a procedure)
- Paralyzing agents when used to control behaviour and not for therapeutic purposes
- Narcotics, if used to reduce agitation or control behaviour and not for analgesia
- Homemade restraints such as bed linen, cling or tensor bandages

NOTE: Concealing physical restraints with gown or linen is PROHIBITED.