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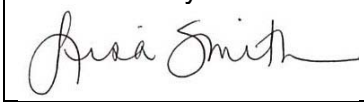
Approval: Lisa Smith, Executive Sponsor Clinical Policy and Procedure Committee 	**Date:** September 2, 2020

PURPOSE
To outline the use of restraints and the minimum standards of care for restrained patients at HSN.

POLICY STATEMENT
The use of restraints has inherent physiological and psychological risks. For this reason, HSN follows the philosophy of least restraint. Any restraint intervention is only implemented for the benefit and safety of the person receiving care and/or when the safety of others is in danger.

PROCEDURE
Special Instructions
- Under current health care legislation, a patient cannot be restrained or confined unless he or she consents to such interventions. Exceptions to this right to freedom exist pursuant to the *Mental Health Act* (MHA) and in other circumstances where such freedom threatens the safety of the patient or others.
- HSN is a designated psychiatric facility under the MHA, meaning that patients at HSN will sometimes be detained under the MHA. When the patient is detained under the MHA, any restraint or confinement must occur in accordance with the MHA. Otherwise, a patient may be restrained or confined in certain circumstances as permitted under the *Patient Restraints Minimization Act* (PRMA) and the *Health Care Consent Act* (HCCA).
- In emergency situations, the MHA, HCCA, and PRMA preserve the common law duty of a caregiver to restrain or confine a person without consent when immediate action is necessary to prevent serious bodily harm to the person or to others.
- All reasonable alternatives to restraints must be considered and implemented first whenever possible **(Appendix B)**. The Restraint Decision Making Model **(Appendix C)** must be used when restraint use is a possibility to ensure proper patient assessment, prevent restraint use as much as possible, and meet legal requirements.
- Excited delirium is a life-threatening condition and a risk when restraints are used. Awareness of the signs and symptoms of this condition, and prompt intervention when it occurs, is required **(Appendix A)**.
- All nursing units must use the standardized Pinel mechanical restraint system.

Method

1. Restraints are to be used for as brief a period as possible in order to provide safety for patient, staff and visitors. Restraints must be protective and not restrictive.
2. Restraints may be used without consent if immediate action is needed to prevent serious bodily harm to the patient or others.
3. A nurse may initiate mechanical or environmental restraints without a physician's order, but a physician must be notified and an order received within 1 hour of the initiation of restraint use.
4. For patients not detained under the MHA, the use of restraints will be explained to the patient/family/substitute decision-maker (SDM) and consent for restraint use will be obtained within 12 hours of the initiation of restraint use. If no patient/family/SDM is available, the Office of the Public Guardian and Trustee will become the SDM of last resort.
5. For patients detained under the MHA, the use of restraints will be explained to the patient. Restraint use is also explained to the family if consent to disclose information has been provided by the patient. If the patient is incapable to consent to treatment of a mental disorder, the patient's SDM must be notified of the use of restraint.
6. Minimum nursing care requirements for restrained patients are based on the type of restraint used:

Restraint	Minimum Nursing Care Requirements
Chemical	• **Minimum level of observation:** Q 15 minutes for the first hour then, Q1H or more frequently based on clinical judgement • Q1H assessment of airway patency, range of motion, skin integrity, and vital signs • The patient's bed must be in its lowest position with the bed rails raised at all times while the patient is in bed or unattended
Mechanical (Pinel)	• **Minimum level of observation:** o Pediatric patients with 2 or more restraints: Constant observation o Access to call bell: Constant observation if the patient is unable to access or properly use the call bell due to restraints. Q 15 minutes if the patient has easy access to a call bell. o 4 or more point restraint: Constant observation o 1 to 3 point restraint: Q 15 minutes for the first hour, then Q1H or more frequently based on clinical judgement • Q 15 minutes assessment of airway patency, peripheral circulation and skin integrity until stable, then re-assess Q1H • Q2H release of restraints for skin care and range of motion exercises • Q4H fluids, toileting, and assessment of vital signs • Q8H ambulation for at least 15 minutes when safe and physically able • Assistance with eating and drinking at regular meal times • Attachment of restraints out of patient's reach with Pinel key accessible in the room at all times • The patient's bed must be in its lowest position with the bed rails raised at all times while the patient is in bed or unattended
Environmental (Seclusion)	• **Minimum level of observation:** Q 15 minutes • Q4H fluids, toileting, and assessment of vital signs • Provision of food and drink at regular meal times

7. For patients not detained under the MHA, the use of restraints must be re-assessed and re-ordered by a physician **at least once every 24 hours**.
8. For patients detained under the MHA, the use of restraints must be re-assessed and re-ordered by a physician **at least once every 12 hours**.
9. For all patients, restraint use is discontinued as soon as safely possible. Use of restraints may be discontinued without a physician's order.

10. Any patient transferring to an off-unit area in Pinel restraints (i.e. diagnostic testing) must be accompanied by a clinical staff member from the unit. The clinical staff member accompanying the patient must carry a Pinel release key for use in emergency situations.
11. Any patient transferring via EMS to another health care facility should have Pinel restraints removed at the time of transfer unless accompanied by an HSN clinical staff member. EMS is responsible for the safe transport of patients, using equipment authorized by EMS.
12. For patients admitted from correctional facilities with correctional workers, the decision to use restraints is made by the correctional workers. If those restraints interfere with the patient receiving treatment, a discussion must occur between the care team and the correctional workers regarding the removal of restraints and alternative methods of ensuring safety.
13. Required documentation for restrained patients is as follows:
    - The *Restraint Consent Form* is used to document patient/family/SDM consent for the use of restraints for all patients not detained under the MHA.
    - The *Seclusion and Restraint* pre-printed orders are used for all restraint orders. This form must be reassessed by a physician every 24 hours for all patients not detained under the MHA and every 12 hours for patients detained under the MHA.
    - The *Restraint Application Flow Sheet* is used to document assessment and care of restrained patients, the type of restraint used, and the time restraint use is discontinued.
    - The *Interdisciplinary Patient Progress Notes* are used to document the circumstances warranting restraint use, the rationale for restraint use, additional notes regarding nursing assessment and interventions prior to and during restraint use, communication with the family/SDM, and discontinuation of restraint use.

EDUCATION AND TRAINING

Definitions

1. Chemical Restraint (Acute Control Medications): Any pharmacologic agent given not to treat an illness, but to inhibit, control or restrict a patient's behaviour that presents a serious risk of harm to self or others. When a drug is used to treat specific medical symptoms rather than disruptive behaviour, it is not considered a restraint.
2. Detained under the *Mental Health Act*: The person is being held in a psychiatric facility and is either subject to an application for psychiatric assessment (Form 1), a certificate of involuntary admission (Form 3), a certificate of renewal (Form 4), or a certificate of continuance (Form 4A), or admitted with SDM consent under Section 24 of the *Health Care Consent Act* (an informal patient).
3. Environmental Restraint (Seclusion): The use of a separate room that confines a patient and from which he/she cannot exit freely. It is used when a patient is unable to control his/her violent emotions and there is the potential for immediate, harmful behaviour to self or others.
4. Mechanical (Physical) Restraint: Restricting or limiting a patient's freedom of movement with a device or appliance. This may include vest restraints, lap belts, pelvic restraints, wrist restraints, chairs that prevent rising, and sheets. It does not include temporary immobilization for medical reasons (a splint), transportation (a belt on a stretcher), or devices for body positioning (harnesses for individuals with paralysis).
5. Restrain: Placing a person under control by the minimal use of such force, mechanical means or chemicals, as is reasonable having regard for the person's physical and mental condition.

Education/Training Related Information

Gentle Persuasive Approach Training
HSN De-escalation self-learning package
HSN Pinel DE-Restraint System self-learning package
HSN Restraints self-learning package
Non-Violent Crisis Intervention Training

References and Related Documents

College of Nurses of Ontario. (2009). *Restraints*. Toronto, ON: Author.

Emanuel LL, Taylor L, Hain A, Combes JR, Hatlie MJ, Karsh B, Lau DT, Walton M, eds. (2010). *PSEP – Canada Module 13d: Mental Health Care: Seclusion and Restraints: When All Else Fails*. Ottawa, ON: Canadian Patient Safety Institute.

Health Care Consent Act, S.O. 1996, Chapter 2, Schedule A.

Mental Health Act, R.S.O. 1990, Chapter M.7.

Patient Restraints Minimization Act, S.O. 2001, Chapter 16.

Registered Nurses Association of Ontario (2004). *Caregiving Strategies for Older Adults with Delirium, Dementia and Depression.* Toronto, ON: Author.

Registered Nurses Association of Ontario. (2012). *Promoting Safety: Alternative Approaches to the Use of Restraints.* Toronto, ON: Author.

APPENDIX A

Excited Delirium

All restrained patients must be monitored for signs of excited delirium, including:

- Hyperthermia (may remove clothing)
- Tachycardia
- Diaphoresis
- Unexpected physical strength
- Bizarre behaviour/incoherent speech
- Agitation
- Paranoia/panic
- Aggression/violence

Excited delirium is a medical emergency that requires immediate medical attention. Treatment may include:

- Sedation with benzodiazepines
- External cooling
- IV fluids
- Cardiac and respiratory monitoring
- Treatment of rhabdomyolysis and hyperkalemia

APPENDIX B

Alternatives to Restraint Use

Patient Population	Alternatives
Patients who slide down/lean forward in their seats/wheelchairs	• Arrange occupational therapy seating assessment • Monitor and adjust sitting tolerance (time up in chair) • Ensure regular position changes • Support lower extremities with foot stool/foot support • Apply wedge seat that positions patient in a slightly recumbent position
Patients at risk for falls	• Refer to *Fall Prevention* standards of care for alternatives to restraint use
Patients who interfere with life support/medical equipment	• Assess and treat for delirium • Eliminate tubes which are causing distress as soon as possible • Evaluate whether treatment goals can be achieved by alternative methods • Provide distractions from tampering with tubes via recreational therapy, and visits from volunteers, family and friends • Restore sleep/wake cycle • Keep pain-free and comfortable • Ensure regular nutrition and opportunities for toileting
Patients who wander	• Apply a dark grid on the floor in front of the restricted area (with dark/light floor tiles or electrical tape) • Implement a system of identifying those who present a wandering risk (i.e. a vest/sweater of a particular colour) • Move door knobs/openers to unusual locations on the door • Apply mirrors on the door, which may have the effect of causing the patient to turn away from the door • Disguise elevator buttons • Offer finger food/fluids regularly to distract the patient from wandering
Patients at risk of harming themselves or others	• Use verbal de-escalation techniques • Obtain a psychiatric/geriatric consultation • Provide care in pairs, and during times in which the patient exhibits his/her most stable behaviour • Place soft objects such as sponges/wash cloths/stuffed animals in the patient's hands prior to care delivery • Eliminate noise in the environment • Bathe the patient only when absolutely necessary and employ a warm towel bed bath if a shower/tub bath is not tolerated • Enlist the help of family where possible • Devise a care plan and stick to it • Assign staff members that have a good rapport with the patient, and assign such staff to care for the patient as often as possible • Explain to the patient in simple terms the care you would like to provide and seek consent where possible • Do not insist on providing care if it is clearly not a good time: leave and return later with helpers • Refer to the *Acting Out Behaviour* policy for more information

APPENDIX C

Restraint Decision Making Model