Least Restraints (Physical, Environmental, and Chemical)			
Approval:	*Vice President, Clinical Chief Nursing Executive*		
Approval Date:	19-09-2024	Effective Date:	20-09-2024

Contents

SCOPE:

This policy applies to all staff who have been approved through legislation and/or hospital policy to be involved in the use of physical, environmental, and/or chemical restraint for patients at the Royal Victoria Regional Health Centre (RVH). This has been designed as a resource and reference for staff at RVH. It is expected that all staff shall adhere to the principles outlined in this policy.

POLICY STATEMENT:

It is the policy of RVH to use physical, environmental, and/or chemical restraints, hereafter collectively referred to as restraints, only as an exceptional and temporary measure intended to preserve safety.

Restraints are used as the last resort when required to safely manage a patient's aggressive or violent behaviour, or when there are indicators of immediate risk of physical harm to self or others.

Restraints are used for the shortest possible duration, as part of the standard of care, based on clinical assessment to ensure safe management of the situation. Restraints are to be used only after alternative, less restrictive measures (see Appendix I *Alternative Approaches*) and de-escalation techniques (see Appendix II: *De-Escalation Interventions*) have been tried or considered but deemed ineffective. A trauma-informed approach will be used when de-escalating and/or restraining after all other alternatives to restraints are exhausted.

Under the Mental Health Act (MHA) involuntary/formed patients may be restrained without consent, should the patients be assessed at risk to themselves or others. Mental Health patients who are voluntary or informal cannot be restrained without asking for consent or the consent of their Substitute Decision Maker (SDM) unless in an emergency.

Restraints shall be used in emergency situations when aggressive or violent behaviour of a patient presents an immediate risk of physical harm to self or others, regardless of the legal status of the patient. Under the common law, health care providers have the duty to preserve safety, even if that requires restraints, when immediate action is necessary to prevent serious bodily harm to themselves or others.

The restraint of a voluntary patient requires an assessment by the Most Responsible Provider (MRP) as soon as possible to determine the patient's legal status if needed.

No measures of restraint shall ever be used for punitive reasons.

There shall be no ongoing orders for any form of restraint. Restraints are to be re-ordered every 24hrs if still necessary.

Trauma-informed approach follows best practice when providing care. It is based on the understanding that most patients who access health and social services might have had experiences of trauma in their lives. Application of this approach requires consideration of cultural, historical, age and gender issues. Furthermore, the involvement of people who have experienced trauma, in decisions about type, pace, and extent of the support they receive is valued and respected (RNAO 2017).

DEFINITIONS:

Alternatives to Restraint: Interventions to address the behavior and safety of an individual to avoid restraints. These interventions (see Appendix III: *Interventions to Assist the Patient to Cope*) impose less control on the patient than restraining or confining the patient or using a monitoring device.

Chemical Restraint: Any form of psychoactive medication used not to treat illness, but to inhibit intentionally a particular behaviour or movement (College of Nurses of Ontario, 2012).

Constant Observation: Constant visual surveillance with an observer in sight and at hearing distance. The observer shall not be distracted by unrelated activities. For more information, see RVH Corporate Policy and Procedure: *Enhanced Levels of Observation*. May also be referred to as “one to one” observation.

Critical Incident Debriefing: An informal review and discussion of a restraint event for those involved, may include staff, patients, and/or visitors. This includes a review of the precipitating factors and the process of restraint including patient and team response and outcome. The debriefing shall take place immediately, for any event that has significant emotional or physical impact on the participants.

De-Escalation Techniques: The most minimally intrusive and least restrictive ways to manage violence and avoid the use of restraints unless absolutely necessary.

Environmental Restraints: Any location or area providing control of a patient’s mobility. Examples include, but are not limited to, a secure/locked unit or section of a unit, seclusion, or a time-out/quiet room.

Seclusion: The confinement of a patient in a locked room designated as a seclusion room to restrict movement from one location to another. This can also be referred to as an environmental restraint.

Medical Immobilization: Mechanisms that are used to restrict movement when they are considered standard practice during medical, surgical, diagnostic procedures, tests, or treatments. This refers to restricted movement during medical, diagnostic, and/or surgical procedures and the related post-procedure care process only (e.g., limb restraint during surgery, limb restraint during IV or catheter insertion).

Physical Restraint: (see Appendix IV: *List of Currently Approved Restraints*)**:**
The use of an appliance that restricts free movement and is attached to, adjacent to, or worn by the patient when there is potential for injury to self and/or others. In conjunction, consider using a chemical restraint to treat the underlying cause and reduce the time spent in physical restraints.

Restrain: To "place the person under control by the minimal use of such force, mechanical means, or chemicals as is reasonable having regard to the person's physical and mental condition, and 'restraint' has a corresponding meaning" (Patient Restraints Minimization Act, 2001, 1(1)).

Substitute Decision Maker (SDM): A person who is authorized to give or refuse consent to a treatment on behalf of a person deemed incapable with respect to the treatment. Depending on the circumstances, this could be a guardian or Power of Attorney (POA) for personal care, a representative appointed by the Consent and Capacity Board (CCB), a spouse, common-law spouse, partner, family member, other relative or the Public Guardian and Trustee (PGT).

Trauma-Informed Approach: This term has expanded to include violence as well. Policies and practices that recognize the connections between violence, trauma, negative health outcomes and behaviours. These approaches increase safety, control, and resilience for people who are seeking services in relation to experiences of violence and/or have a history of experiencing violence. The key policy and practice principles are:

- Understand trauma and violence, and their impact on peoples' lives and behaviours.
- Create emotionally and physically safe environments.
- Foster opportunities for choice, collaboration, and connection.
- Provide strengths-based and capacity building approach to support patient coping and resilience.

PROCEDURE:

1. **Urgent Situations:**

If there is an immediate risk of serious bodily harm to the patient and/or others call a Code White for support.

When all reasonable interventions/alternatives have been exhausted and behaviours persist:

- If a restraint is needed, the assigned staff shall collaborate with other interprofessional team members, as well as the patient, to determine most appropriate and least restrictive restraint for use. Staff are to use a trauma-informed approach when identifying the least restrictive restraint.
- Staff assigned to the patient to be restrained shall obtain an order from the MRP as soon as possible.
- Restraints shall be implemented as per manufacturer instruction for physical/environmental restraints and/or RVH Policies (i.e., *Medication Administration*) for chemical restraints.
- Assigned staff shall monitor and provide appropriate care to the restrained patient. Please refer to the Care of restrained patients' section below.
- Staff assigned shall document restraint decision (see Appendix V: *Restraints Decision Diagram*) in the patient's health record. Application, monitoring, assessment, and care of patient while restrained shall be documented in the patient's health record.
- Discontinue restraints as soon as the patient's presentation no longer meets the criteria for restraint use and an accurate assessment has been done.

Note: A thorough assessment of the patient shall be done before removing any restraints.

- Staff shall complete a comprehensive ongoing assessment of the patient's mental and physical status. This assessment shall be documented as a note in the patient's health record. Assessment should include but not be limited to the following:
    - History of violence (including context and surrounding factors)
    - Risk factors for violence
    - History of substance use/abuse and current substance use/abuse
    - Psychiatric conditions/concerns (i.e., delirium, mania, uncontrolled psychosis, Neuroleptic Malignant Syndrome)
    - Legal Status
    - Medical conditions (i.e., musculoskeletal/joint problems, epilepsy, difficulty swallowing)
    - History of medication sensitivities
    - Age
    - Neurological, cognitive, and functional deficits/impairments
- Assess and review patient history in relation to:

- Triggers for aggressive/violent behaviour
- Context of such behaviours
- Previous alternatives to restraint and de-escalation strategies and their effectiveness
- Previous restraint use

2. **Non-Emergent Situations, for Patients in Circumstances Governed by the Health Care Consent Act (HCCA):**
   - Utilize the Checklist for Best Practice Assessment of Decision to use Restraints in Non-Emergent Situations (see Appendix VI: *Checklist for Best Practice Assessment of Decision to Use Restraints in Non-Emergent Situations*).
   - Assess and review patient history in relation to:
     - Triggers for aggressive/violent behaviour.
     - Context of such behaviours.
     - Previous alternatives to restraint and de-escalation strategies and their effectiveness.
     - Previous restraint use.
   - The interprofessional team, in collaboration with the patient or SDM, shall identify and thoroughly assess the behaviour of concern using the Behavioural Tracking Tool intervention.
   - Based on this assessment, identify the potential causes of the noted behaviour using the decision-making tool called Potential Causes of Behaviour (see Appendix VII: *Potential Causes of Behaviour*).
   - Implement all reasonable interventions to address potential causes of behaviour and alternatives to restraints.
   - Document assessment, interventions, alternatives, and effectiveness of interventions/alternatives.
   - A comprehensive ongoing assessment of the patient's mental and physical status shall be completed and documented in the patient's health record. Assessment should include the following:
     - Restraints assessment
     - History of violence (including context and surrounding factors)
     - Risk factors for violence.
     - History of substance use/abuse and current substance use/abuse.
     - Psychiatric conditions/concerns (i.e., delirium, mania, uncontrolled psychosis, Neuroleptic Malignant Syndrome)
     - Legal Status
     - Medical conditions (i.e., musculoskeletal/joint problems, epilepsy, difficulty swallowing)
     - History of medication sensitivities

- Age
- Neurological, cognitive, and functional deficits/impairments

When all reasonable interventions/alternatives have been exhausted and behaviours persist:

- Determine appropriateness of restraint use (see Appendix V: *Restraint Decision Diagram*).
- If a restraint is needed, collaborate with other interprofessional team members as well as the patient (if capable) or SDM (if patient is incapable), to determine the most appropriate, and least restrictive restraint for use. Staff are to use a trauma-informed approach when identifying the least restrictive restraint.
- Staff assigned to the patient to be restrained shall obtain an order from the MRP as soon as possible.
- The member of the interprofessional team proposing restraint (considering appropriate scope of practice) shall request, either in person or by telephone, informed consent from the patient (if capable) or SDM (if patient is incapable) prior to restraint application. If the patient or SDM refuse to provide consent for restraint, the assigned nurse shall ask the patient or SDM to review and sign consent form.
- Immediately following the informed consent conversation or within 48 hours, have the patient or SDM sign the Consent for Restraint Use/Refusal of Restraint Use form (RVH-0836) and ensure evidence of consent is in the patient's health record.
- Implement restraint as per manufacturer instruction for physical/environmental restraints and/or the RVH Policy: *Medication Administration* for chemical restraints.
- Assigned staff shall monitor and provide appropriate care to the restrained patient, see Care of Restrained Patients below.
- Staff assigned shall document restraint decision in the patient's health record. Application, monitoring, assessment, and care of patient while restrained shall be documented.
- Provide the patient or SDM with the Patient/Family Guide to Least Restraint document (RVH-3321).
- Discontinue restraints as soon as the patient's presentation no longer meets the criteria for restraint use and an accurate assessment has been done.

Note: A thorough assessment shall be done before removing any restraints.

3. For Patients in Situations Governed by The Mental Health Act:

- Collaborate with patient or SDM, and family (with consent), to determine a plan that includes alternative to restraints in the event of an aggressive episode. Complete the De-escalation Preference Assessment with the patient and/or family as an ongoing reference for alternatives to restraint.

Staff are to use a trauma-informed approach when identifying the least restrictive restraint.

- Assess and review patient history in relation to:
  - Triggers for aggressive/violent behaviour.
  - Context of such behaviours.
  - Previous restraint use.
  - Previous alternatives to restraint and de-escalation strategies and their effectiveness.
- Indicate and document the patient's preferences and choices regarding strategies, alternatives, and restraint measures to maintain safety, as well as known history of severe trauma, and document in the patient's health record. Discuss the use of restraint as a last resort and the different restraint measures.
- A comprehensive ongoing assessment of the patient's mental and physical status shall be completed and documented in the patient's health record. Assessment should include the following:
  - History of violence (including context and surrounding factors)
  - Risk factors for violence
  - History of substance use/abuse and current substance use/abuse
  - Psychiatric condition/concern (i.e., delirium, mania, uncontrolled psychosis, Neuroleptic Malignant Syndrome)
  - Legal Status
  - Medical conditions (i.e., musculoskeletal/joint problems, epilepsy, difficulty swallowing)
  - History of medication sensitivities
  - Age
  - Neurological, cognitive, and functional deficits/impairments
- In situations when the patient may be aggressive, staff should attempt to implement least restrictive strategies that include, but are not limited to, giving the patient limited choices for behavioural management. Staff are to use a trauma-informed approach when implementing these alternatives to restraints.

When all reasonable interventions/alternatives have been exhausted and behaviours persist:

- When there is an active episode of aggression or violence with risk of physical harm to self or others and alternative interventions are ineffective, restraints may be used as a last resort.
- All restraints require an order from the MRP.
- When restraints must be used, they should be implemented in a manner that ensures protection of the patient's safety, dignity, and emotional wellbeing.

- If staff have received the proper de-escalation and crisis management training a brief holding of a patient prior to application of restraint, or the administration of chemical restraint must be consistent with those Crisis Prevention Institute (CPI) training program techniques. If not trained in CPI assist security and trained staff with non-holding techniques such as, but not limited to, restraint application.
- In the event that the MRP is not present at the time of the behaviour requiring restraints the assigned nurse, in collaboration with the interprofessional team, may initiate the use of restraints.
- The assigned nurse must notify, without delay, the MRP who shall provide an order that includes the type of restraints.
- The MRP will assess the restrained patient as soon as possible, review their legal status, and document acknowledgement of the event including clinical findings.
- An order for restraints will be in effect for a period no greater than 24 hours. During this 24-hour period, another physician's order is not required when de-restraining efforts are unsuccessful, and the patient must be placed back into restraints following a release trial. De-restraining assessments and activities must be documented in the patient's health record at least every two hours.

Note: A thorough assessment shall be done before removing any restraints.

- The team will continue to ensure the safety and dignity of the patient and offer alternative options, as appropriate.
- An ongoing mental status examination, rationale for restraint use, and plan for removal of restraints shall be documented in the patient's health record.
- Family members (with consent) and SDM shall be informed of changes in the patient's condition and/or status. An ongoing plan of communication regarding further changes in condition and/or status should be arranged and documented in the patient's health record.
- Staff assigned shall document restraint decision in the patient's health record. Application, monitoring, assessment, and care of patient while restrained shall be documented.
- A debriefing should occur as soon as calm has been restored before any staff involved or affected by the event leave the location. The debriefing goals are to ensure that everyone is safe, to acknowledge the skills and techniques successfully used during the event and to identify potential triggers or de-escalation opportunities preceding the event.
- Staff debriefing is also an opportunity to gather all information required for documentation, incident report and potential later analysis.
- The staff debriefing is led, when possible, by the unit manager, hospital service leader, team leader or clinical educator.

- Discontinue restraints as soon as the patient's presentation no longer meets the criteria for restraint use and an accurate assessment has been done. The assessment shall be done before removing any restraints. Staff do not need an order to discontinue restraints.
- Physical restraints shall be laundered on-site according to manufacturer's direction after each use for infection prevention and control purposes.

Care of the Restrained Patient:

- Staff shall maintain safety, dignity, and emotional well-being of the patient using a trauma-informed approach.
- A patient debriefing will be attempted as soon as a clinical assessment indicates the suitability of such an action. If the patient is unable or unwilling to participate in a debriefing a note must be entered in the patient's medical record identifying the reason why it has not been done. Further patient debriefing attempts should also be recorded within 72 hours from the incident.
- The goals of patient debriefing are to capture and document the patient's perspective regarding triggers, escalating factors and potential preventing and effective de-escalation strategies.
- When a Pinel restraint system (magnetic restraint) is utilized in three or more points of contact with the patient, Constant Observation of the patient is mandatory and shall be documented in the patient's health record.
- When patients are requiring Pinel restraints (magnetic restraint) there shall be a minimum of 3 points of restraint, anything less poses a safety risk to the patient.
- Monitoring of the restrained patient shall include, but is not exclusive to:
    - Assessment of circulation
    - Skin condition
    - Proper application and position of restraint
    - Medication side-effects and monitoring based on the type of chemical restraint (i.e., hallucinations, restlessness, insomnia, extrapyramidal side effects [EPS])
    - Pain/discomfort
    - Level of alertness
    - Level of orientation
    - Patient behavior
    - Emotional response to restraints
    - Need for care, specifically applicable to the type of restraint used.
    - Vital signs shall be checked according to clinical judgment
- For patients requiring any type of physical restraint(s), the above-mentioned assessments shall be conducted and documented:

  - every 15 minutes during the first hour,
  - every 30 minutes during the second hour,
  - Every hour afterwards or more frequent as per clinical assessment or the unit standard.
- Patients should be released from physical restraints for a minimum of 10 minutes every two hours. Staff must assess patients' risk of harming self, and/or others before removing any of the restraints. Restraint removal can be rotated to accommodate a patient who cannot be removed from restraints completely due to safety risk.
- Any direct care measure that involves release of a limb or limbs should be performed with at least 2 staff members present. If the patient has demonstrated a risk of violence, consider having security staff present prior to removal of restraints.
- Any direct intervention regarding the restrained patients should not be attempted by any staff alone, but rather in consultation and collaboration with other team members who would have the knowledge, skills and judgement required for restraint situations.
- While patients are restrained, provisions should be made to meet physical, emotional, and social needs such as, but not limited to:
  - Toileting
  - Hygiene
  - Ambulation
  - Nutrition
  - Hydration
  - Socialization
  - Emotional support
- Physical/environmental restraints do not need to be released if the patient is sleeping, is able to turn independently from side to side in bed, and/or if it is unsafe to release the restraints (i.e., extremely aggressive patient). Ensure staff assess the patient before removing the restraining system.

Reassessing Restraints:

- Interventions to eliminate restraints should be attempted on an ongoing basis.
- Reassessment of the need for restraint use should be ongoing and should be documented at a minimum of every two hours.
- A trial release could be attempted as soon as the goals for discontinuation are met and documented in the EMR. If the physician's order remains valid (within the 24 hours), restraints may be reapplied despite a successful trial if the patient once again meets the criteria for restraint use.

- Restraints should be discontinued when the criteria for restraint use are no longer met (see Appendix V: *Restraint Decision Diagram*). Neither consent nor an order is required to remove a restraint. Documentation should support patient behaviour and reasons for removal.

CROSS REFERENCES:

Royal Victoria Regional Health Centre. (2023). Corporate Administrative Policy and Procedure *Code White: Violent / Behavioural Situation.*

Royal Victoria Regional Health Centre. (2022). Corporate Clinical Policy and Procedure *Cleaning, Disinfection and Sterilization in Infection Control.*

Royal Victoria Regional Health Centre. (2021). Corporate Clinical Policy and Procedure *Documentation.*

Royal Victoria Regional Health Centre. (2021). Corporate Clinical Policy and Procedure *Medication Administration.*

Royal Victoria Regional Health Centre. (2021). Corporate Clinical Policy and Procedure *Transfer of Accountability (TOA).*

Royal Victoria Regional Health Centre. (2023). Corporate Clinical Policy and Procedure *Enhanced Levels of Observation for Patients.*

REFERENCES:

Backman, C., & Aebersold, M. (2019). Quality and Patient Safety in B.J., Astle, & W., Duggleby, (Eds.), *Canadian Fundamentals of Nursing* (872-898). Milton: Elsevier

College of Nurses of Ontario. (2022). *Understanding Restraints*. https://www.cno.org/en/learn-about-standards-guidelines/educational-tools/restraints/#:~:text=Nurses%20cannot%20use%20restraints%20without,2001%20and%20Consent%20practice%20guideline .

Gaynes, B., Brown, C., Lux, L., & Brownley, K. (2017). Preventing and De-escalating Aggressive Behavior among Adult Psychiatric Patients: A Systematic Review of the Evidence. *Psychiatric Services*, *68*,819-831.

Government of Canada. (2018). *Trauma and violence-informed approaches to policy and practice*. Trauma and violence-informed approaches to policy and practice - Canada.ca

Government of Ontario (2022). *Health Care Consent Act.* Ontario.
Hevener, S., Rickabaugh, B., & Maarsh, T. (2018). Using A Decision Wheel to Reduce Use of Restraints in A Medical-Surgical Intensive Care Unit. *American Journal of Critical Care*, *25*, 479-487

Mackenzie Health. (2023). *Least Restraint Policy*. Richmond Hill, Ontario.

Mangaoli, R., Cleverley, K., Peter, E. (2018). Immediate Staff Debriefing Following Seclusion or Restraint Use in Inpatient Mental Health Settings: A Scoping Review. *Clinical Nursing Research*, 1-40.

Martello, M., Doronina, O., Perillo, A., & Lavoie-Tremblay, M. (2018). Nurses' Perceptions of Engaging with Patients to Reduce Restrictive Practices in an Inpatient Psychiatric Unit. *The Health Care Manager, 37*, 342–353.

Government of Ontario (2015). Mental Health Act. Ontario. https://www.ontario.ca/laws/statute/90m07/v5

Government of Ontario (2017). *Patient Restraints Minimization Act.* Ontario. https://www.ontario.ca/laws/statute/01p16

Providence care. (2018). *Emergency Restraint- Mental Health Clinical Practice Manual*

Rakhmatullina, M., Taub, A., & Jacob, T. (2013). Morbidity and Mortality Associated with the Utilization of Restraints A Review of Literature. *Psychiatry Q, 84*, 499–512.

Registered Nurses' Association of Ontario. (2012). *Promoting Safety: Alternative Approaches to the Use of Restraints.* https://rnao.ca/bpg/guidelines/promoting-safety-alternative-approaches-use-restraints

Registered Nurses' Association of Ontario. (2017). *Crisis Intervention for Adults Using a Trauma-Informed Approach: Initial Four Weeks of Management*.
https://rnao.ca/bpg/guidelines/crisis-intervention

Snow, N., Davis, C., & Austin, W. (2018). Diagnostic, Interventions, and outcomes in Psychiatric and Mental Health Nursing in W., Austin, D., Kunyk, C.A., Peternelj-Taylor, & M.A., Boyd, (Eds.), *Psychiatric and Mental Health Nursing for Canadian Practice,* (193-210). New York: Wolters Kluwer

Waypoint Centre for Mental Health Care. (2023). Policy and procedure: Use of emergency restraints – physical, chemical, mechanical, and seclusion for prevention of serious bodily harm.

Alternative approaches

Falls	• Medication review • Toileting regularly • Quad exercise: mobility/ ambulation • Routine positioning (every 2 hours) • Increased participation in activities of daily living • Pain relief/comfort measures • Normal schedule/individual routine • Assess for hunger, pain, heat, cold • Glasses, hearing aids, walking aids easily available • Increase social interactions • Redirect with simple commands • Call bell demonstration • Involve family in planning care • Diversion activities: pets, music, puzzles, crafts, cards, snacks • Scheduling daily naps • Alarm devices: bed, chair, door • Clutter-free rooms • Mattress on floor or lower bed • Non-slip strips on floor • Night light • Helmet • Acceptance of risk • Consults to Occupational Therapy (OT)/Physiotherapy (PT).
Cognitive Impairment (e.g., Dementia)	• Toileting regularly • Normal schedule/individual routine • Assess for hunger, pain, heat, cold • Label environment (i.e., bathroom door) • Increase social interactions • Redirect with simple commands • Gentle touch • Assessing past coping strategies • Involve family in planning care • Diversion activities: pets, music, puzzles, crafts, cards, snacks • Reminiscence • Scheduling daily naps • Pacing permitted • Alarm devices - bed/chair/door • Clutter-free rooms • Night light • Glasses, hearing aids, walking aids easily available

	• Consults to Occupational Therapy (OT)/Physiotherapy (PT), Behaviour Specialist
Acute Confusion - Delirium	• Medication review • Work-up for underlying cause • Pain relief/comfort measures • Glasses, hearing aids, walking aids easily available • Toileting regularly - start every 2 hours • Normal schedule/individual routine • Assess for hunger, pain, heat, cold • Label environment (i.e., bathroom door) • Increase/decrease social interactions • Redirect with simple commands • Gentle touch • Assessing past coping strategies • Involve family in planning care • Scheduling daily naps • Alarm devices - bed/chair/door • Clutter-free rooms • Night light • Consults to Occupational Therapy (OT), Physiotherapy (PT), Behaviour Specialist
Agitation	• Mobility/ambulation/exercise routine • Routine positioning (every 2 hours) • Medication review • Pain relief/comfort measures • Toileting regularly • Normal schedule/individual routine • Assess for hunger, pain, heat, cold • Increase social interactions • Redirect with simple commands • Relaxation techniques (i.e., calming music, dark environnement) • Gentle touch • Assessing past coping strategies • Involve family in planning care • Diversion activities: pets, music, puzzles, crafts, cards, snacks • Scheduling daily naps • Pacing permitted

Wandering	• Assess for hunger, pain, heat, cold • Buddy system among staff/consistency • Label environment (i.e., bathroom door) • Increase social interactions • Redirect with simple commands • Assessing past coping strategies • Involve family in planning care • Diversion activities: pets, music, puzzles, crafts, cards, snacks • Tape (stop) line on floor • Alarm devices - bed/chair/door • Clutter-free rooms • Night light • Room near to the nursing station • Glasses, hearing aids, walking aids easily available
Sliding	• Consults to Occupational Therapy (OT)/Physiotherapy (PT). • Routine positioning (every 2 hours). • Pain relief/comfort measures. • Call bell demonstration. • Tilt wheelchairs (consult OT/ PT). • Non-slip cushion (consult OT).
Aggression	• Medication review. • Pain relief/comfort measures. • Assessing past coping strategies. • Normal schedule/individual routine. • Assess for hunger, pain, heat, cold. • Increase/decrease social interactions. • Relaxation techniques (i.e., tapes, quiet and/or dark room). • Involve family in planning care. • Pacing permitted. • Soothing music.
Pulling out invasive tubes	• Pain relief/comfort measures. • Increase social interactions. • Redirect with simple commands. • Call bell demonstration. • Stimulation/meaningful distraction. • Explain procedures/treatments. • Gentle touch. • Involve family in planning care. • Camouflage tubing on IV.

	• Abdominal binder over percutaneous endoscopic gastrostomy tube. • Change IV to intermittent as soon as possible. • Arm splint (prevent elbow bending).
Unsteadiness	• Mobility/ambulation/exercise when appropriate. • Medication review. • Increase social interactions. • Call bell demonstration. • Scheduling daily naps. • Clutter-free rooms. • Mattress on floor or lower bed. • Non-slip strips on floor. • Night light. • Acceptance of injuries. • Accessibility aids such as glasses, hearing aids, walking aids easily available. • Consult to Occupational Therapy and/or Physiotherapy.

De-Escalation Interventions

- Always identify yourself.
- Talk and think calmly.
- Ask the patient how they are doing, or what is going on.
- Ask patient if they are hurt (assess for medical problems).
- Ask the patient if they were having any difficulty or what happened before they got upset.
- Remember why the patient is in the hospital.
- Find a staff member who has a good rapport/relationship with the patient and have him or her talk to the patient. Let the patient know you are there to listen.
- Offer medication, if appropriate.
- Help patients remember and to use coping mechanisms.
- If a patient screams and swears, reply with a calm nod, okay, do not react.
- Use a team or third-party approach. If a patient is wearing down one staff, have another take over (10 minutes of talking might avoid a restraint incident).
- Reassure patients and maintain professional boundaries (tell patients you want them to be safe, that you are there to help them).
- Allow quiet time for the patient to respond – silent pauses are important.
- Ask the patient if he/she would be willing, could try to talk to you (repeat requests, persistently, kindly).
- Respect the need to communicate in diverse ways (recognize possible language/cultural differences as well as the fear, shame, and embarrassment the patient may be experiencing).
- Empower patients. Encourage them with every step towards calming themselves they take.
- Make it okay to try and talk over the upsetting situation even though it may be very painful or difficult.
- Acknowledge the significance of the situation for the patient.
- Ask the patient how else you can help.
- Ask the patient's permission to share important conversations with other caretakers for on-going discussion.

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

Interventions to Assist Patient to Cope

- Listen to the patient's concern even if you do not understand.
- Ask the patient to tell you what the problem is and listen sincerely.
- Recognize and acknowledge the patient's right to his/her feelings.
- Sit down, if possible, while maintaining safety and invite the patient to do likewise.
- Invite the patient to talk in a quiet room or area where there is less of an audience and less stimulation.
- Apologize if you did something that inadvertently upset the patient. Acknowledge feelings (not reasons) and state that it was unintentional.
- Let the patient suggest alternatives and choices.
- To maintain patients' and staff's safety, have adequate personnel available for crisis situations.
- Speak in a calm, even and non-threatening voice. Speak in simple, clear, and concise language.
- Use non-threatening, non-verbal gestures, and stance.
- Be aware of language, hearing and cultural difference(s).
- Assure the patient that he/she is in a safe place, and you are here to help.
- Recognize your personal feelings about violence and punishment and how it affects you when a patient is violent.
- Be aware of how other staff positively interact with angry patients and model their interventions.

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

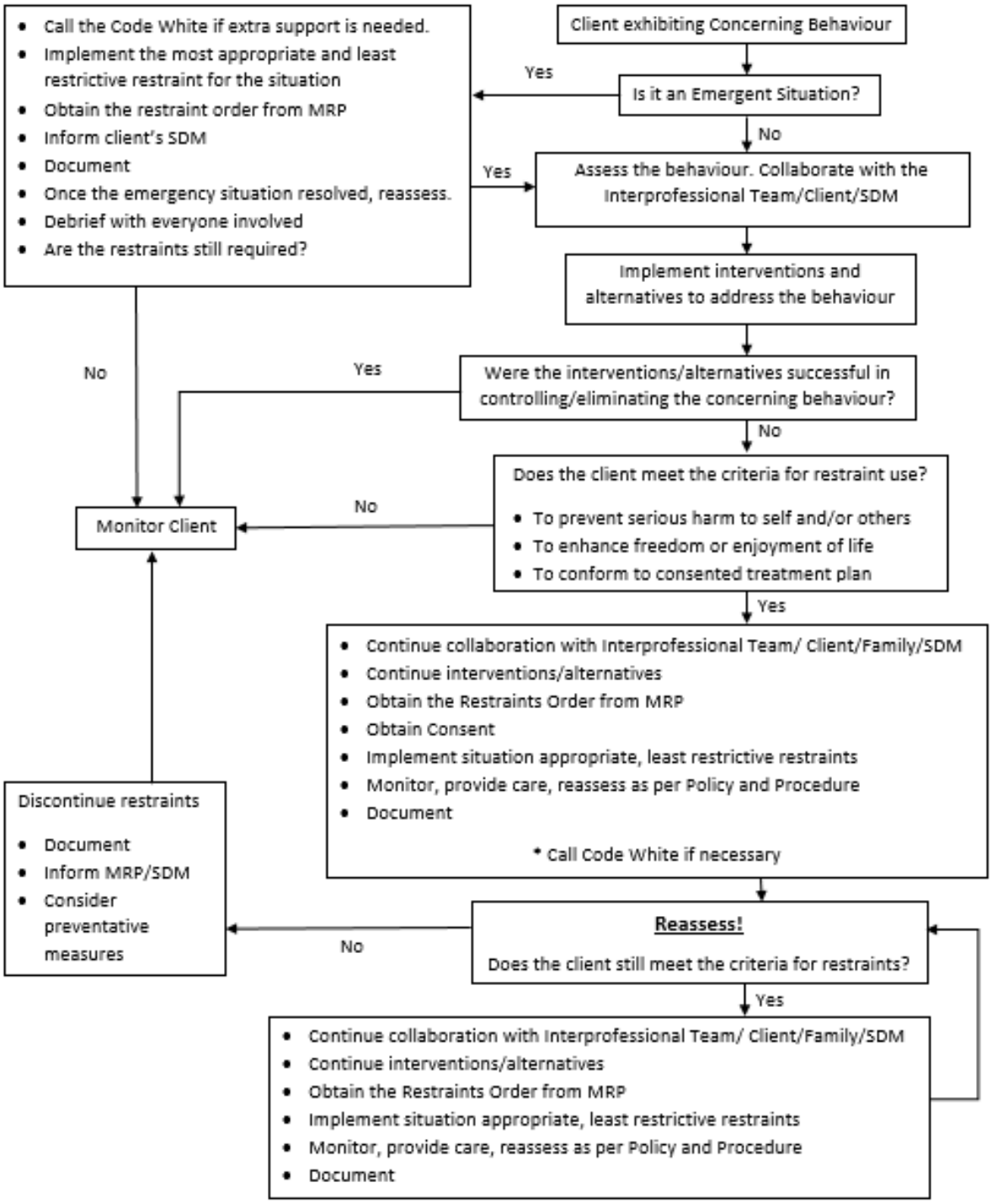
List of Currently Approved Restraints

Product	MD Order	Consent Needed	Availability	Indications for Use
Side Rails	No	No	All units	Automatic use of side rails is prohibited! **Side rails shall not be used as restraints.** They are used to: • facilitate turning and repositioning within the bed/stretcher. • facilitate transferring in/out of bed/stretcher. • facilitate a feeling of comfort and security. • access the bed controls. • remind the patient of the bed/stretcher perimeters or to call for a nurse for assistance. • ensure safety when transporting a patient while in a bed/stretcher. • facilitate medically indicated devices that are intended to stabilize a body part. • ensure safety for pediatric patients in cribs
Side Rail Padding	No	No	Specialized Seniors Care Unit (SSCU)	Used to reduce the risk of injury due to side rails
Soft Limb restraint Quick Release	Yes	Yes	All units through logistics	Limb restraint to prevent the disruption of medical treatment (i.e., IV's, catheters, N/G, etc.) or to prevent injury to the patient and/or others
Soft Pelvic Restraint	Yes	Yes	All units through logistics	Used to prevent forward sliding in wheelchairs or Geri-chairs

Appendix IV: List of Currently Approved Restraints

Product	MD Order	Consent Needed	Availability	Indications for Use
Wedge cushion	No	No	Mental Health Suite (MHS) in the Emergency Department (ED), Adult Mental Health Inpatient Unit (AMHIU) and Child and Youth Mental Health Inpatient Unit (C&Y-MH)	Used to prevent aspiration, and provide postural support and positioning (Required for patients restrained on platform beds to ensure Fowler's position)
Security Mitts	Yes	Yes	All units through logistics	Security Mitts to prevent the disruption of medical treatment (i.e., IV's, catheters, N/G, etc.) or to prevent injury to the patient and/or others
Magnetic Restraint System - Pinel®	Yes	Yes	Mental Health Suite (MHS) in the Emergency Department (ED), Adult Mental Health Inpatient Unit (AMHIU) and Child and Youth Mental Health Inpatient Unit (C&Y-MH) All other units to contact Security if this restraint is required	Multiple point restraint system used for combative and/or exceedingly agitated patients, to prevent the disruption of medical treatment (i.e., IVs, catheters, NGs, etc.) or to preserve safety of the patient and/or others.
Limb restraint Biothane®	Yes	Yes	**Only Security!** All units to contact security if this restraint is required	Limb restraint for combative and/or agitated patients to prevent the disruption of medical treatment (i.e., IVs, catheters, NGs, etc.) or to prevent injury to the patient and/or others

Restraints Decision Diagram



Checklist for Best Practice Assessment of Decision to Use Restraints in Non-Emergent Situations

✓	Intervention
	Identify risk factors/behaviours that may result in the use of restraints.
	Complete and document a thorough assessment in collaboration with the interprofessional team and the patient and/or SDM.
	Identify potential causes of the noted behaviour (refer to Appendix VI: *Potential Causes of Behaviour*).
	Address potential causes of behaviour and utilize the Safety Care Plan to focus and document on individualized, multi-component strategies for restraint alternatives.
	Continuously monitor and re-evaluate the care plan based on observation and/or concerns from the patient and/or SDM.
	Ensure that all reasonable interventions/alternatives have been attempted and documented, including de-escalation and crisis management.
	If interventions are found to be unsuccessful, consult with the interprofessional team to consider use of the least restrictive, RVH approved restraint. The benefits and risks of all types of restraints along with the following criteria for use of Restraint must be carefully considered: • It is necessary to prevent serious bodily harm to the patient and/or others. • It gives the patient greater freedom or enjoyment of life. • It is authorized by a plan of treatment to which the patient or his/her SDM has consented.
	Obtain an order from the MRP as soon as possible.
	The member of the interprofessional team proposing restraint for non-emergent situations (considering appropriate scope of practice) must obtain, either in person or by telephone, informed consent from the patient (if capable) or SDM (if patient is incapable) prior to restraint application.
	Provide the patient or SDM with the Patient/Family Guide to Least Restraint (RVH-3321).
	Document restraint decision and informed consent process.
	The least restrictive, RVH approved restraint is used. If the least restrictive form is ineffective, choose alternative restraints in a progressive format from the least restrictive to most restrictive.
	Ensure the restraint is used in accordance with the manufacturer's instructions, or RVH Formulary and Drug Regulations and Nursing Medication Policy (chemical), for the shortest time possible. Do not adapt the restraint in any way.
	Monitor and provide appropriate care to the patient. (Refer to "Care of the restrained patient" under "Procedure" section of policy).
	Attempt interventions to eliminate restraints on an ongoing basis. Reassess need for continued use of restraint frequently (document reassessment at a minimum of every 4 hours) and discontinue when criteria for use are no longer met.

Potential Causes of Behaviour

When assessing for the causes of behaviour it is essential to understand the behaviour:

- What is the behaviour?
- When does it occur?
- What are the circumstances? (i.e., precipitating factors, who is present, family's response, new or recurring, what methods helped in past).

A behaviour log can often be useful to uncover a pattern. Once behaviour is clearly defined, physiological, psychosocial, environmental, spiritual, and cultural factors should be considered in order to identify the underlying cause.