POLICY TITLE: **Least Restraint Policy**

POLICY #: SJ 03-07-11
SECTION: Health Care Delivery
ISSUING AUTHORITY: Interprofessional Advisory Committee and Medical Advisory Committee
REVIEWED BY: Mental Health and Addictions Clinical Operations Committee March 2020, Nursing Practice Council May 2020, Interprofessional Advisory Committee May 2020, Medical Advisory Committee May 2020
NETWORK APPROVED: August 3, 2017
SUBSEQUENT APPROVAL: May 2020

APPLICABLE SITES: ☐ **Network** ☐ **Providence** ☑ **St. Joseph's** ☐ **St. Michael's**

PURPOSE: To ensure the safe and ethical treatment and care of all patients using the least restrictive approach in accordance with the Patient Restraints Minimization Act (PRMA, 2001). The purpose of this policy is to ensure staff members provide consistent, evidence based care to ensure the safety of staff and patients.

POLICY: In accordance with the Patient Restraints Minimization Act (PRMA, 2001), the criteria for the use of restraints are:

1. To prevent serious bodily harm to self or to another person;
2. To enhance freedom or enjoyment of life; and
3. To conform to the authorized treatment plan to which the patient, or substitute decision maker (SDM) has consented.

PHILOSOPHY:

St. Joseph's Health Centre supports a philosophy of least restraint that recognizes the individuality of the patient, the patient's right to freedom of movement, and the patient's right to self-determination. Where situations arise when the emergency use of restraints may be necessary to prevent serious bodily harm, de-escalation and other behaviour modification techniques must first be considered and attempted.

This policy recognizes the prevalence of patients with a history of trauma and emphasizes the fact that any form of restraint use may be re-traumatizing to patients. When restraints are used, the most appropriate, least restrictive restraint will be selected and used for the shortest duration of time. When a device or medication is used to treat specific medical or psychiatric symptoms, and is part of the treatment plan to which the patient or SDM consented to, it is not considered a restraint.

TYPES OF RESTRAINTS:

Restraint is a mechanical, chemical, seclusion or environmental measure used to control the physical or behavioural activity of a person or a portion of their body (CNO, 2016). (See **Appendix A** for a list of approved restraint devices.)

Environmental Restraint is any barrier or device that limits the locomotion of an individual, and thereby confines an individual to a specific geographical area or location (e.g., Wanderguard, bed rails) (PRMA, 2001).
Note: In Mental Health areas, the use of environmental restraints refers to specific locations within the unit (e.g. seclusion room) and not the unit itself.

Chemical Restraint is a pharmacological agent given to control sudden aggressive or violent behaviour that presents a serious risk of harm to self or others. When a drug is used to treat specific medical or psychiatric symptoms and is part of a treatment plan, it is not considered a restraint (Doyle, Priff, & Walker, 2003).

Full Bed Rails: A bedrail may be considered a restraint when the intent is to limit movement. Half rails, which allow the patient to exit the bed easily, are not considered restraints and do not require consent. (Cornwall Community Hospital, 2012)

Mechanical Restraint is a method of physical intervention involving the use of authorized SJHC equipment. A mechanical restraint restricts the freedom of movement or access to one's own body that is attached to, adjacent to, or worn by the patient and that the patient cannot remove (e.g., lap belt, lap top trays, limb holders, 4 or 5 point Pinel restraints) (Humber River Regional Hospital, 2009; NICE, 2015).

Seclusion is the confinement of a patient in a locked room designated as a seclusion room to restrict movement from one location to another (Doyle, Priff, & Walker, 2003).

DEFINITIONS:

Emergency Situation: An emergency situation is defined as one where immediate action is necessary to prevent serious bodily harm to the individual/patient or others and/or when other measures have been unsuccessful. In an emergency situation, the health care staff uses professional judgment to make a decision to apply/use a restraint. Restraints used in an emergency situations are, chemical, seclusion and Pinel restraints. Emergency situations are time limited; once the situation is no longer critical, patient/SDM consent is required (Health Care Consent Act, 1996; CNO, 2017; RNAO, 2012).

Constant Observation: The assigned nurse or delegate (regulated or unregulated health care provider) will observe patients 1:1 via **direct uninterrupted visual observation** of a single patient.

Intensive Observation: The assigned nurse or delegate will observe and assess patients **more frequently than every 15 minutes**, which requires the continuous physical presence of the nurse in the same environmental vicinity as the patient. This level of observation may include occasional assistance from devices such as security cameras.

Note: This level of observation is only to be used to observe patients admitted on designated Mental Health Units (e.g. PICU).

Debrief: A post event check-in which occurs with all persons who were present and who participated in a code, restraint, near miss, or significantly stressful event in order to provide support and ensure psychological safety.

Non-Emergency Situation: A non-emergency situation is defined as one where an individual/patient is not in imminent risk of causing bodily harm to self or others. In non-emergency situations, the Most Responsible Provider (MRP)/delegate or another clinician acting under a Medical Directive will obtain consent from the patient/SDM prior to initiation of a restraint (See "**Consent**" section below). Patient/SDM consent is required with any change to treatment plan/care plan, dose, etc. (Health Care Consent Act, 1996; CNO, 2017; RNAO, 2012). Examples of restraints used in non-emergent situations include seat belts, lap trays, geri-chairs or tilt wheelchairs.

PRN (pro re nata): When needed. PRN refers to the use of treatments (such as medication) as part of the standard treatment/care plan that is consented to by the patient. The patient or SDM(s) consent may be withdrawn at any time (NICE, 2015).

Responsive Behaviours: Behaviours exhibited by people who are experiencing an altered cognitive state or impairment, as they respond to internal or external factors (TAHSN, 2016).

Standard Monitoring Parameters (SMP) are criteria for the standard assessment of a patient in restraints. The frequency that SMP are assessed is identified according to the specific restraint (See **Appendix B: Monitoring and Care of Patients in Restraints** section below).

Substitute Decision Maker (SDM) is defined under the Health Care Consent Act as the person(s) authorized to give or refuse consent to treatment on behalf of a person who is incapable with respect to that treatment. Section 20 of the Health Care Consent Act outlines a list of persons that are appropriate to act as a SDM(s). (See **Appendix C** for the SDM rankings.)

Trauma Informed Care: An approach to engage people with histories of trauma which recognizes the presence of trauma symptoms, acknowledges the role that trauma has played in their lives and resists doing further harm (SAMHSA, 2017).

Trial Release: A trial release is defined as a period of time where a patient is completely de-restrained or is removed from seclusion. A trial release lasting two hours is deemed successful (CAMH, 2016).

A. PROCEDURE FOR NON-EMERGENT RESTRAINT USE:

1. Assess the Patient

a. Patient's behaviour and source of behaviour;
b. Medical condition;
c. Psychiatric condition;
d. Pain;
e. Environmental factors;
f. Functional impairments- vision, hearing, physical, speech;
g. Cognitive status; and
h. Previous experience of restraint use and de-escalation strategies.

2. Explore Alternatives to Restraints

a. Orient patient to the environment, person, place and time;
b. Divert or redirect attention; engage in social activities, if patient condition allows;
c. Provide distraction and calming techniques (e.g., play music, therapeutic touch, and/or change of environment);
d. Engage in active listening, provide reassurance, validation and emotional support;
e. Decrease stimuli, such as to offer a quiet area;
f. Use products and devices that protect the patient without restricting movement (e.g. skin sleeve to protect IV/wound sites);
g. Implement walking or exercise schedule for wandering or restless patients;
h. Consider consult with physiotherapy and occupational therapy;
i. Consider consult with pharmacy – review medications, side effects, paradoxical effects, appropriateness, medication timings;
j. Consider the use of a constant observer;
k. Leave a light on at night if requested/needed;
l. Remove unnecessary equipment to keep a clear path to the washroom and exit;
m. Assess for appropriate footwear;
n. Consider the use of a floor mat;
o. Keep bed in lowest position;
p. Consider a toileting/commode routine;
q. Ensure glasses/hearing aids are in use, or immediately accessible;
r. Ensure that the patient has access to the call bell and is informed how to use it; and
s. Collaborate with the family/SDM regarding visiting, measures used at home to ensure patient safety, a plan of care regarding restraints.

3. Consent

In non-emergency situations, the Most Responsible Provider (MRP)/delegate or another clinician acting under a Medical Directive will obtain consent from the patient/SDM prior to initiation of a restraint.

4. Restraint Order and Initiation

a. After a patient is assessed as requiring restraints, the least restrictive restraint will be applied
b. The order is placed under a Medical Directive (Med02; Med03; Med04);
c. If a restraint device Medical Directive is enacted, the initiator will document, at minimum, that the procedure/treatment indicated is "per medical directive" and the name, signature and designation of the initiator. The initiator may also indicate the name or number of the directive
d. Only devices specifically manufactured for the purpose of physical intervention are permitted. (See **Appendix A** for a List of Approved Restraint Devices);
e. The initiator will document the application in the appropriate section of the patient's health record. (See "**Documentation**" section below);
f. Discuss the rationale and explain the procedure to the patient/SDM(s);
g. Prepare the environment to maximize safety;
h. If Security Services staff is directed to apply restraints, a member of the health care team must be present during application and lead the care delivery;
i. Simultaneous restraint of all four limbs is implemented only in emergent situations. See "**Procedures for Emergency Restraint Use**" below.

5. Other Considerations

Patient/SDM(s) opposes restraint use

In a non-emergent situation, if the patient or SDM(s) does not consent to the restraint, the team will:

a. Withhold the restraint (unless an emergency situation develops);
b. Document that the patient/SDM(s) did not consent to the use of restraints after the benefits and risks were explained (See Appendix C for the SDM rankings);
c. Inform the MRP/delegate and Patient Care Manager (PCM) or designate;
d. Negotiate an acceptable plan of action to manage the safety risk and document the plan of action developed, as well as associated risks;
e. Document all events, decisions, actions taken and patient response; and
f. Consult Ethics and/or Risk Management, as needed.

See Section C, Paragraph 9 for next steps.

B. PROCEDURE FOR EMERGENCY RESTRAINT USE:

6. Assess the Patient

Assess for early signs of escalating behaviour, such as conflict with others, verbal abuse, pacing, agitation, anger, and distress. Assess underlying cause (e.g., physical illness, medication, and stressors) and do not threaten to use restraints or take patient's behaviour personally. (Crisis Prevention Institute, 2012).

7. Explore Alternatives to Restraints

a. Identify your intent to help and explain actions;
b. Provide an opportunity for the patient to work through feelings in a non- threatening manner;
c. Offer choices to help the patient regain control. For example, provide/encourage quiet time in room to decrease stimuli, relaxation exercises, offer PRN medication or stay with the patient until they settle (if appropriate);
d. Modify routine care as needed (e.g., delay bathing routine);
e. Consider changing patient's current observation level (e.g., use of constant observation);
f. Ensure physical comfort and privacy;
g. Reduce level of environmental stimuli (if appropriate);
h. Remove sharp objects or objects that could be used as weapons;
i. Place at risk patients closer to the nursing station;
j. Consult pharmacy;
k. Consult security; and
l. Perform and complete environmental safety checklist, as outlined in the Inpatient Mental Health Routine Standards of Care.

8. Restraint Orders

a. After a patient is assessed as requiring restraint, the least restrictive restraint will be applied;
b. The attending physician will be contacted as soon as is safely possible for an order for chemical, seclusion or mechanical restraint. The order should include:
    i. The reason for the restraint;
    ii. Type of restraint (See **Appendix A** for list of approved restraint devices); and
    iii. Duration of use.
c. Note: Seclusion and mechanical restraints are **not** to be ordered simultaneously. All chemical and seclusion restraints are to be ordered as a STAT, one time order only. There are to be **no PRN** orders for **any kind of restraint**. The only devices used for emergency restraints are 4 point or 5 point Pinels.
d. When 4 point or 5 point restraints are initiated, a physician must complete a face-to-face assessment as soon as possible (within 12 hrs). All other physical or environmental restraints (restraints covered under the Medical Directives) will be monitored for appropriateness and continuation re-ordered every 24 hours in person and as needed; and
e. The nurse will document the initiation and application of restraints in the appropriate section of the patient's health record. (See "**Documentation**" section below).

9. Consent

a. In an emergency situation, in order to prevent serious bodily harm to a patient or to another person, the health care staff uses professional judgment to make a decision to apply a physical restraint. A nurse is authorized under the Health Care Consent Act and common law to apply a mechanical or environmental restraint. Emergency situations are time limited; once the situation is no longer critical, either patient/SDM consent or removal of the restraint is required.

b. SDM(s) request use of restraints against medical advice:

i. If the SDM(s) insists that the patient be restrained despite professional assessment that deems restraint is not in the patient's best interests, inform the MRP/delegate and PCM, or designate;
ii. Document all events, decisions, action taken and patient response; and
iii. Consult Ethics and/or Risk Management.

C. PROCEDURE FOR ALL RESTRAINT USE:

10. Reordering of Restraints

When a patient is in 4 point or 5 point Pinel restraints for emergency situations:

a. An order from a physician must be entered and is required for the continued use of seclusion or 4 point and 5 point Pinels, twice a day;
b. An order for the continuation of 4 point or 5 point Pinels cannot be signed by a physician who has not previously seen the patient;
c. A physician who provides medical care (not psychiatric care) is required to complete a face to face assessment of the patient every 24 hours;
d. External consultation/peer review by an MD (not from the unit) is to take place every 72 hours at a minimum. The assessment is to ensure that there are no consequences of prolonged restraint or consequences due to the decrease in physical activity;
e. All restraints covered under Medical Directives will be monitored for appropriateness and continuation every 24 hours in person and as needed; and
f. A physician's order is not required to remove restraints or to remove a patient from seclusion. A nurse may remove a patient from restraints, but the order may only be discontinued by a physician.

11. Application of Restraint

a. When the need for restraint has been determined,
    i. the patient will be told the reason for the restraint and what is necessary to be released from the restraint (i.e, when the patient is calmer, speaking respectively, isn't exhibiting responsive behaviours);
    ii. a personal search will be conducted by assigned staff or delegate
b. Discuss the rationale and explain the procedure to the patient/SDM(s);
c. Prepare the environment to maximize safety;
d. If Security Services staff is directed to apply mechanical restraints, a member of the health care team must be present during application and lead the care delivery (See **Appendix D** for Restraint Application Process);
e. Simultaneous restraint of all four limbs is implemented in emergency situations and only 4 point or 5 point Pinels will be used (e.g., do not use limb holders/soft restraints as 4 point restraints);
f. Patients in 4 point or 5 point Pinel restraints must have the appropriate level of observation as per the Observation of Patients Policy; and

g. When using 4 point or 5 point Pinel restraints, all four limbs must be secured, except during the process for restraint removal.

12. Monitoring of Patients In Restraints

Appendix B outlines the monitoring and care of patients in restraints

13. Monitoring of Corrections Patients or Patients Under Police Custody

If a patient is under police custody, immediately institute the Caring for Corrections Patients and Patients under Police Custody Policy (SJ 03-01-40). Restricted patients are to have one custodial restraint on at all times. Custodial restraints are to be maintained by officers. Staff and physicians may apply clinical restraints based on patient clinical / safety needs according to the Least Restraints Policy. Clinical restraints are maintained by staff and physicians and follow observation as per the policy. Officers will assist staff, as required, with the application of SJHC restraints.

The health care professional may request that custodial restraints be removed if they interfere with treatment (e.g., physiotherapy). The officer must approve the request and when approved, the police/correctional officer will remove the custodial restraints and must remain with the patient. In the event that custodial restraints cannot be removed safely, the inability to treat is to be documented, and further medical advice is required.

14. Restraint Removal

a. A physician's order is not required to remove restraints or remove a patient from seclusion. A nurse may remove a patient from restraints regardless of the time remaining on the order, but the order may only be discontinued by a physician;
b. An order for seclusion or 4 point or 5 point Pinels will be in effect for a period no greater than 12 hours. During this 12 hour period, restraints may be reapplied if the trial period was unsuccessful and patient behaviour warrants it. If the order is not current (i.e., within 12 hours) a new order is required;
c. A trial release should be attempted as soon as the goals for discontinuation are met. If the trial release was successful, the discontinuation time of restraints should be the start time of the trial release. A trial release that lasts 2 hours is deemed successful;
d. If the trial period is unsuccessful and the order is current (i.e., within 12 hours), another physician's order is not required and restraints may be reapplied;
e. If seclusion or mechanical restraint is initiated after the 2 hour trial release, it is considered a new episode and requires a new initiation order. An in person (face-to-face) assessment by the physician is required as soon as possible (within 12hrs) where 4 point or 5 point Pinels are involved;
f. Remove the first restraint. After 15 minutes, if the nurse assesses the patient's behaviour to be safe towards him/herself and/or others, then the remaining restraints can be removed, as per the flow chart in **Appendix E**;

a) In 5 point Pinel restraints:

i. Remove the upper torso restraint first
ii. Separate central limb connections
iii. Remove the dominant hand first, then remainder of restraints

b) In 4 point Pinel restraints:

i. Separate central limb connections
ii. Remove the dominant hand first, then remainder of restraints

g. All members of Security Services will have a restraint key;
h. Every patient care area (e.g., inpatient and appropriate outpatient areas, diagnostic imaging, etc.) will have a minimum of two restraint keys available on the unit/area at all times;
i. Patients should continue to be monitored closely for aggressive behaviour; and
j. All non-disposable restraints will be cleaned between patients and disposable restraints will be disposed of after patient use. (**See Appendix E**.)

15. Debrief

a. The STAFF debrief is done as a team. The purpose of which is:
   i. To ensure staff's physical and emotional well-being
   ii. To strategize on prevention and next steps
b. The OPEN tool has been developed to support staff in completing the debrief process with both staff and patients (See **Appendix F**). The OPEN tool serves as a guide to facilitate the debrief process and does not become part of the patient's chart;
c. The PATIENT debrief may begin as soon as the patient is able to communicate rationally with staff and it MUST BE COMPLETED within 24 hours of the removal of restraints;
d. The assigned nurse, or delegate, will complete the debrief process with the patient post restraint removal; and
e. Documentation of the debrief will cover the following:
   i. Reason for restraint discussed
   ii. Plan for restraint alternatives developed with patient
   iii. Therapeutic rapport re-established

16. Documentation

a. Documentation of restraint events are completed in:
   i. The Vital Signs/Screening Flowsheet. On medical/surgical units, the Least Restraint Flowsheet Parameter must be added
   - Right Click on the Flowsheet and select Add Parameter
   - Select the appropriate required parameter under Least Restraint and Click Add

   ii. The paper Restraint Monitoring Flowsheet for units that do not use electronic documentation and/or when electronic documentation downtime processes are in effect.

b. Complete Documentation includes, but is not limited to, the following:
    i. Date and time of initiation and by whom
    ii. Behaviour that triggered restraint use
    iii. Alternatives to restraints considered or tried prior to initiation
    iv. Discussion of consent
    v. Application of restraint, including the type of restraint and the date and time of application or administration
    vi. Patient response
    vii. Periods out of restraints or seclusion
    viii. Rationale for continuing, which includes re-assessment;
    ix. Removal of restraints
    x. Review and revisions to the patient's plan of care
    xi. Any adverse events (e.g., injury, dislodging of IV, or development of skin breakdown)
    xii. Discussion and education of the use of restraints with patient and/or SDM(s)
c. For the documentation of prolonged non-emergency restraint use, the nurse will complete the above documentation for the restraint initiation. Continuous monitoring and observation flowsheets will be documented every shift while the restraint is in use;
d. Ongoing restraint monitoring is documented on the paper Restraint Monitoring Flowsheet (See **Appendix G**);
e. Ongoing constant observation is documented on the Constant Observation Sheet and the Mental Health Observation Checklist as per the Observation of Patients Policy; and
f. A Safety First report is entered each time 4 point or 5 point Pinel restraints, a chemical restraint or seclusion are used.

17. Evaluation of Restraint Use

a. The PCM will review the Safety First reports entered for 4 point or 5 point Pinel restraints, chemical restraint and seclusion use on their unit(s) as per the Safety Reporting and Event Management Policy (SJ-03-02-01);
b. The PCM will be notified when a patient is restrained, unit specifications are outlined below:
    i. On Medicine/Surgical units, the PCM will be notified when limb holders or 4 point or 5 point Pinels are applied
    ii. In the Emergency Department, the PCM will be notified when 4 point or 5 point Pinels are applied
    iii. On Mental Health units, the PCM will be notified when seclusion, chemical or 4 point or 5 point Pinels are applied
c. The PCM or delegate will review the Restraint Chart Audit following each incident of 4 point or 5 point Pinels or seclusion restraints are used to ensure all required documentation is documented on the chart (see **Appendix H** - Restraint Audit Tool); and
d. The PCM, nurse or delegate will complete the debrief process with the patient to review the occurrence from the patient's experience and explore alternatives to prevent similar occurrence in future (See "**Debrief**" section above).

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CROSS REFERENCE: Consent to Treatment Policy (SJ-04-06-01), Prevention and Management of Falls and Fall-Related Injury (SJ 04-02-18), Inpatient Mental Health Routine Standards of Care, Observation of Patients Policy (SJ-03-07-10), Application of an Electronic Restraint by a Nurse Medical Directive (MED 02), Initiation of a Soft Lap Belt or a Lap Top Tray Restraint by a Nurse Medical Directive (MED 03), Initiation of a Soft Restraint Medical Directive (MED 04), Safety Reporting and Event Management Policy (SJ-03-02-01),Caring For Corrections Patients and Patients Under Police Custody (SJ 03-01-40).

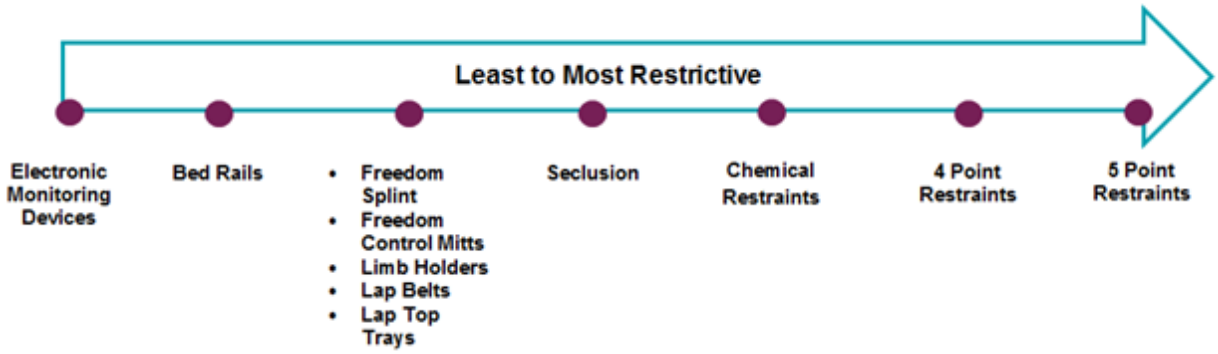
REGULATORY REFERENCE: N/A

REVISED BY: Mental Health and Addictions Program Leadership and Interprofessional Practice.

UPDATED BY: Mental Health and Addictions Program Leadership and Interprofessional Practice.

Appendix A: List of Approved Restraint Devices

Devices are listed in order from least to most restrictive. The least restrictive device must be considered for use before moving to a more restrictive device. The key point to consider is the intent of the device or medication.



Type of Restraint (least to most)	**Specific Restraint Devices**	**Patient Indicators/Behaviour**
Electronic Monitoring Devices	Wandering patient system Chair/Bed exit alarm Infant protection bracelet (anti abduction technology)	Patients at risk of leaving area unattended Patients at risk for harm if leaving the chair/bed unassisted
Bedrails	Full bed rails	Patients at risk for falls
Freedom Splint Freedom Control Mitts Limb Holders	Secure mitts/Freedom control mitts Freedom splint Foam Limb Holder (single use)	Patients at risk for harm to self or others Patients at risk for pulling out tubes Consider using device that is least restrictive to patient *Use with discretion on patients with open wounds on or near the application site or if an IV site could be compromised*
Lap Belts Lap Top Trays	Soft lap belt Lap top tray	Patients at risk for harm from unassisted chair exit
Seclusion	Room seclusion – Mental Health Units only (MHESU, MHSSU, CAIPU, 7M & PICU)	Patients at risk for harm to self or others Patients at risk due to vulnerabilities

Type of Restraint (least to most)	**Specific Restraint Devices**	**Patient Indicators/Behaviour**
	Note: Not to be used in conjunction with 4 or 5 point Pinel restraints	Consider use of chemical restraint, if appropriate, to decrease time spent in seclusion
Chemical Restraints	If a medication is to be used as a chemical restraint, the order for the medication should be **a STAT one time only order** that specifies the purpose. Examples include hypnotics, sedatives, analgesics, neuroleptics, and psychotropics The key point to consider is the intent of the medication	Severe responsive behaviour(s) that puts the patient and/or others at risk for harm Should be used in conjunction with 4 or 5 point Pinel restraints or seclusion to promote restraint minimization
4Point Restraints	Pinel limb restraints	Severe responsive behaviour(s), agitation or aggression that puts the patient and/or others at risk for harm Immediate use of chemical restraints should be considered
5 Point Restraints	Pinel limb restraints and upper torso (shoulder) restraint	Behaviour as noted above and someone who cannot be cared for safely in 4 point Pinel restraints 5 point Pinel restraints must be used in conjunction with 4 point Pinel restraints

Appendix B: Monitoring and Care of Patients in Restraints

Restraint Device	Monitoring for ALL Restraint Devices	Care for ALL Patients in Restraints
All Restraint Devices	A Restraint Monitoring Flowsheet will be used for the duration a patient is in restraints Assess the need for restraint on an ongoing basis **Discontinue or initiate the use of a less restrictive restraint as soon as possible** Re-evaluate the decision to continue to use a restraint and the type of restraint prior to each application/use The nurse will assess the skin by evaluating using the: **Standard Monitoring Parameters (SMP) criteria:** correct position of restraint; pain or discomfort related to the restraint tissue integrity of restrained limb (e.g., circulation, sensation, movement (CSM) respirations The frequency that SMP are assessed is identified according to the specific restraint Ensure that the IV site does not become compromised by the restraint	Oral fluids are easily available (as appropriate) and offered regularly. Offer toileting **q2h** while awake, and as requested Regular provision of mouth care as appropriate The nurse will assess the patient's affect, emotional well-being, and behaviour status [e.g., confusion, agitation/restlessness, intimidation, and tension reduction (demonstrate rational/emotional/physical control) Provide opportunities to discuss thoughts and feelings (as appropriate) Ambulate the patient for **at least 15 minutes every 8 hours** where the interprofessional team (including Security) feels it can be accomplished safely During daily unit rounds, the plan of care of patients in all forms of restraints will be reviewed
Electronic Monitoring Devices	Test that the device is functional prior to each patient use On-going testing as per manufacturers' recommendations and/or Medical Directive MED02 application of electronic restraint by a nurse (i.e. Wanderguard or BabyWatch)	As per manufacturers' guidelines

Restraint Device	Monitoring for ALL Restraint Devices	Care for ALL Patients in Restraints
Full bedrails	The nurse will check the patient and assess SMP hourly	Full bed rails are considered a restraint except in patient safety (e.g., stretchers or other transferring equipment, in treatment rooms, following medical treatment (e.g., administration of sedative), for patients that cannot move (e.g., comatose, spinal injury), or if a cognitively intact patient requests them
Freedom Splint Mitts	The nurse will check the patient and assess SMP hourly	The nurse will check the patient and assess SMP hourly
Lap Belts Lap Top Trays	The nurse will check the patient and assess SMP **hourly**	The nurse will check the patient and assess SMP hourly
Limb Holders	The nurse will check the patient, patient's behaviour and SMP: upon initiation, at minimum **at q15min x 4** then **q30min x 2**, then **q1h** until discontinued	Reposition with release, active/passive ROM if possible, and skin care will be performed **q2h**
Seclusion (Mental Health Units, only: MHESU, MHSSU, CAIPU, 7M & PICU)	Patients in seclusion will be on **constant observation** with the exception of those on designated Mental Health units who may be on **intensive observation**. Assess the patient's affect, emotional well-being, and behaviour status (e.g., confusion, agitation/ restlessness, intimidation, and tension reduction)	Perform and document visual scan of the room prior to placing patient in seclusion. Remove and document patients' valuables and possessions. Patients will have periods out of seclusion based on clinical assessment, but the patient will remain on either intensive (for designated Mental Health Units only) or constant observation during this time

Restraint Device	Monitoring Specific to Each Device	Care Specific for Each Type of Restraint
Chemical	The nurse will monitor the patient **q15min** after desired effect has been achieved; thereafter at minimum, properties of the drug, and patient's clinical status Patient to be monitored for: a. level of alertness b. respirations c. behaviour	Vital signs as ordered by the physician, and performed more frequently according to patient status
4 Point Pinel Restraints	While in 4 point Pinel restraints, the patient will be on **constant observation** with the exception of those on designated Mental Health units who may be on **intensive observation**.. The nurse will check the patient and assess SMP **q15 minute (or more if unit policy)** A nurse and a member of Security Services will accompany patients who are in 4 point Pinel restraints on transfers between units and to diagnostic tests. Staff on the sending unit will reassess the ongoing need for the restraints prior to contacting Security Services	The patient will be in a supine position, HOB at 30 degrees, and full side rails up. **Check vitals at baseline within 30 minutes** After baseline, **q4h OR as ordered by physician.** Reposition with release and active/passive ROM by releasing only one limb from only one limb from the restraint **q2h** while awake, if safe to do so Patients will have periods out of restraint based on clinical assessment, but the patient will remain on either intensive (for designated Mental Health Units only) or constant observation during this time.

Restraint Device	Monitoring Specific to Each Device	Care Specific for Each Type of Restraint
5 Point Pinel Restraints	While in 5 point Pinel restraints, the patient will be on **constant observation** with the exception of those on designated Mental Health units who will be on **intensive observation**. The Nurse will check the patient and assess SMP **q15 minute (or more if unit policy).** A nurse and a member of Security Services will accompany patients who are in 5 point Pinel restraints on transfers between units and to diagnostic tests. Staff on the sending unit will reassess the ongoing need for the restraints prior to contacting Security Services.	The patient will be in a supine position and the head of the bed must be flat **Check vitals at baseline within 30 minutes** After baseline, **q4h OR as ordered by physician.** Reposition with release and active/passive ROM by releasing only one limb from the restraint **q2h** while awake, if safe to do so. Patients will have periods out of restraint based on clinical assessment, but the patient will remain on on either intensive (for designated Mental Health Units only) or constant observation during this time.

Appendix C: Substitute Decision Maker List

According to the Health Care Consent Act 1996, persons who may give or refuse consent in descending order of authority include the incapable person's:

1. Guardian
2. Attorney for personal care
3. A representative by the Consent and Capacity Board
4. Spouse or partner
5. Child (greater than 16 years) or Parent or Children's Aid Society (if applicable)
6. Parent with only right of access
7. Brother or sister; or
8. Any other relative

The SDM(s) must also meet the following criteria:

- Capable to make the treatment decision
- At least 16 years of age
- Not prohibited by court order or separation agreement
- Is available; and
- Is willing to assume the responsibility of giving or refusing consent.

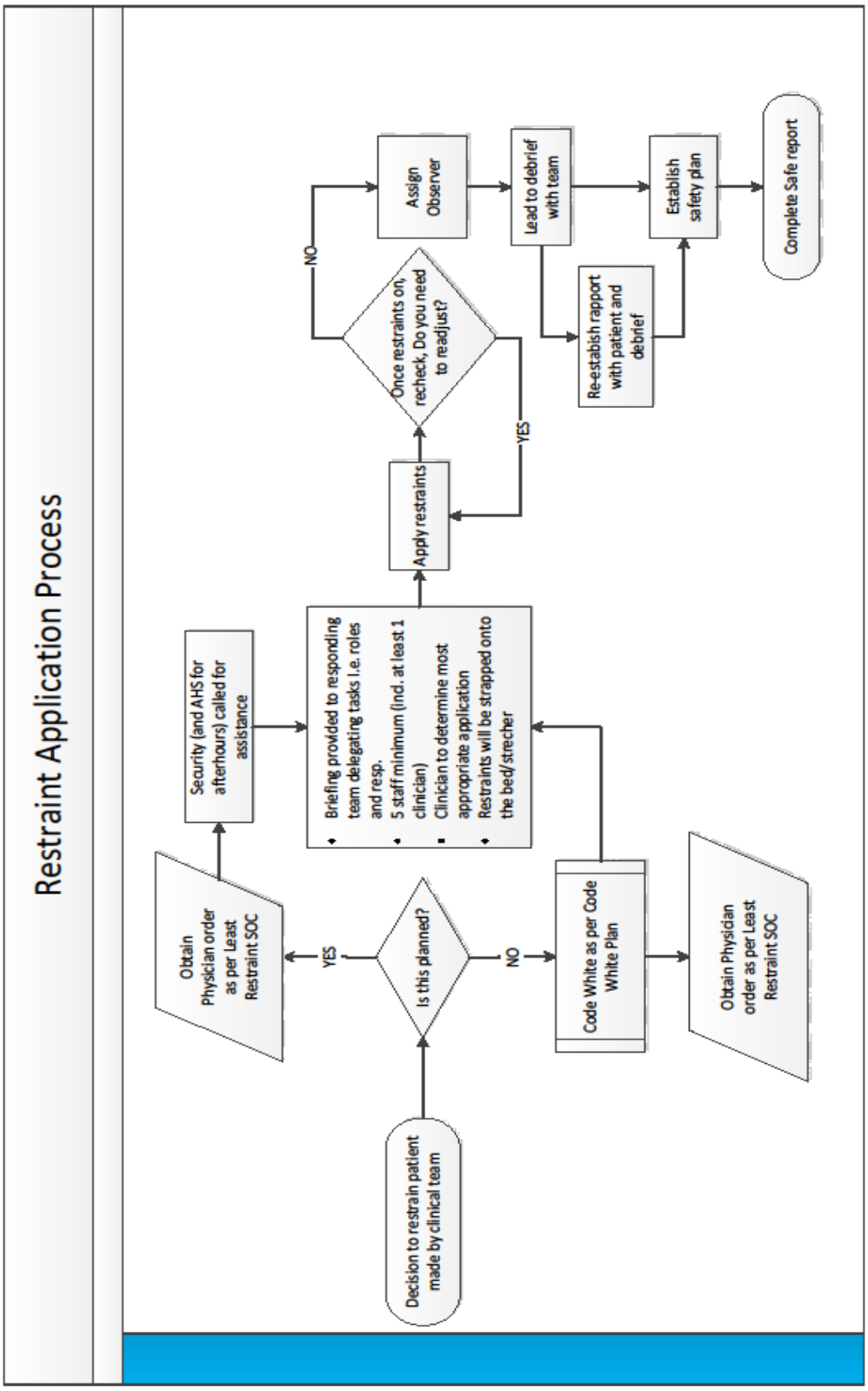
The principles of giving or refusing consent are:

- The previously expressed wishes of the individual (aged 16 or over) that are applicable to the situation; or
- If no previously expressed capable wishes as described above, then best interests of the individual.

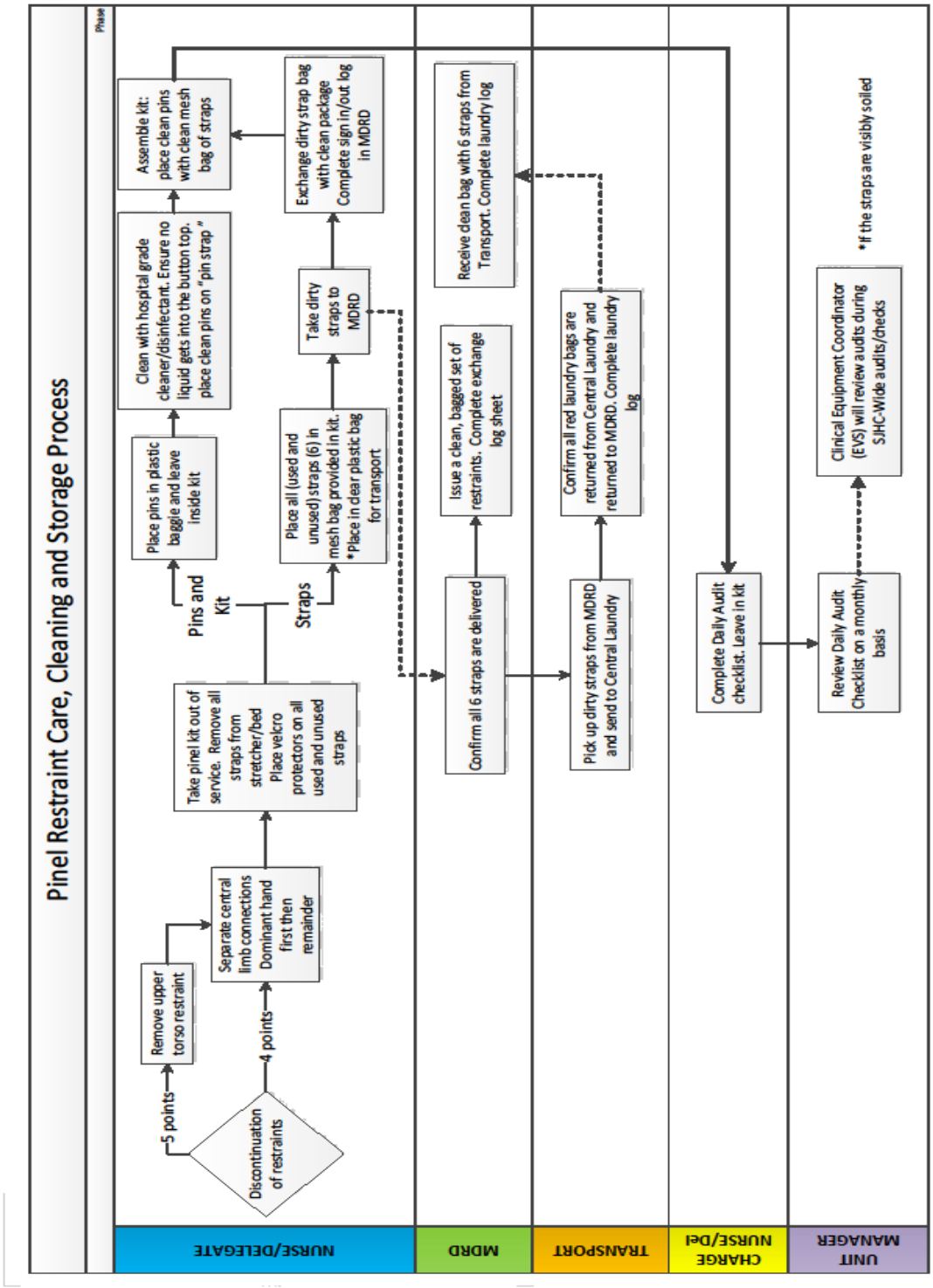
REFERENCE:

Centre for Clinical Ethics (2006). Substitute decision making: A quick guide for health care consumers and healthcare providers. Toronto, ON

Appendix D: Restraint Application Process



Appendix E: Removal and Care, Cleaning & Storage Process of Pinel restraints



OPEN Model

	Tool	Client	Staff
O: orient	Orient self and client to the basic events of the incident utilizing a non-judgmental approach	Describe in your words what happened? How did staff respond? What made staff get involved to assist you?	What did staff observe? Hear? How did staff respond in the crisis?
P: Patterns	Patterns/triggers Identifying patterns in behaviour and identifying triggers may assist in prevention of further incidents of escalation	What triggered the incident? Can you identify any specific patterns? What were the possible triggers prior to the incident? What could you have done differently that may have prevented the incident? What could staff have done differently that may have prevented the event?	Did staff respond in a timely manner? Was intervention(s) in compliance with Least Restraint Standards? Were there any precipitating factors noted? Is there something staff could have done differently to prevent incident?
E: Ensure	Ensure staff and client are back in both physical and emotional controls prior to engaging in debrief process.	Give client back responsibility to control their behaviour. How has the incident affected you? Did you feel staff attempted to support you in preventing escalation (e.g., de-escalation techniques, prn's)? Did the staff allow you to take back control at any point during the incident?	Discuss and address any issues of emotional trauma or physical injury that may have occurred. Ensure staff feel appreciated and supported.
N: Negotiate	Negotiate change/plan of care Engaging the client in discussion on changes to plan of care assists the client in actively participating in strategies that may prevent further incidence.	Re-establish therapeutic rapport. Negotiate appropriate changes to plan of care and document clearly and include in the Transfer of Accountability at handover and inter-departmental transfers.	Give the client an opportunity to discuss their plan of care? What strategies may be helpful in preventing future incidents?

References

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Third edition 2015

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https://www.psychologytoday.com/blog/crimes-and-misdemeanors/201302/critical-incident-stress-debriefing-traumatic-event

ST. JOSEPH'S HEALTH CENTRE TORONTO

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ADDRESSOGRAPH

RESTRAINT MONITORING FLOW SHEET

Type of restraint applied_____

Location of restraint applied_____

* Please use one monitoring flow sheet per restraint*

PAGE # _____

Month/YYYY																								
Day (DD)																								
Time (24h)																								
Type of Restraint Applied																								
Standard Monitoring Parameters																								
Restraint Review																								
Initial																								

Month/YYYY																								
Day (DD)																								
Time (24h)																								
Type of Restraint Applied																								
Standard Monitoring Parameters																								
Restraint Review																								
Initial																								

Type of Restraint Applied	
Electronic Monitoring Devices	E
Bedrails	BR
Freedom Splint	F
Lap Belt	B
Lap Top Tray	T
Mitts	M
Limb Holder	L
Seclusion	S
Chemical	C
4 Point Restraints	**4P**
5 Point Restraints	**5P**

Standard Monitoring Parameters (SMP)

- Correct position of restraint
- No impairment to color, sensation, and movement (CSM)
- No changes to respiratory status
- No impairment to skin integrity
- Mental status: affect, emotional well-being, behavior and tension reduction

✓= Indicates that all of the SMP are met.

✱= Focus Note: complete when the SMP are not met.

PLEASE SEE THE BACK OF THE RESTRAINT MONITORING FLOWSHEET FOR ADDITIONAL SPECIFIC RESTRAINT MONITOIRNG PARAMETERS

Restraint Review	
Agitation/symptoms require continued restraints	O (ongoing)
Level of restraint changed (see Focus Note)	*

Appendix H: Restraint Audit Tool

Restraint Chart Audits	Yes	No	N/A
CHART:	**1**	**2**	**3**
Nursing assessment record			
Nursing documentation related to attempts to de-escalate			
Restraints/Seclusion			
(MD) order is present (written or electronic)?			
(MD) if telephone/verbal orders, signed within one hour?			
(MD) physician assessment to support restraint documented in chart?			
(RN) restraints application and d/c documented as per MH flowsheets?			
(RN) Was a Safety First report submitted?			
Medications			
Medications given?			
Documented as given in the progress note?			
Signed off with time and initials (for not e-care units)?			
Nursing interventions			
Documentation of focused nursing reassessments and/or interventions in the progress note			
Restraint Monitoring Flow Sheet in place and has proper documentation (SMP and interventions)			
Vital signs per guidelines			
Evident of attempts to safely remove restraints as soon as possible			
Documentation of Debrief with patient			
DASA/NGASR updated and Plan of Care updated (if changes needed)			
Mental Health Act compliance for restrained patient			
(Form 1, 3, etc.) Physician seen patient?			
(Form 1, 3, etc.) Same physician signed form?			
(Form 1, 3, etc.) Patient identification on each page?			
(Form 42/30) Original Form 42/30 issued to patient?			
(Form 42/30) Copy of Form 42/30 in chart?			