Lakeridge Health ☑ Harmonized	**Least Restraint: Prevention, Initiation and Management – Policy and Procedures**	
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	Document Applies to: Lakeridge Health (LH) Interprofessional Team, Security Staff with education in restraint application and preventing and managing responsive behaviours	
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Introduction

This policy and procedures includes the safe and appropriate use of least restraints in emergent situations and non-emergent situations guided by the *Patient Restraint Minimization Act (2001)*, *Health Care Consent Act (1996), Mental Health Act (1990)* and in alignment with evidenced-based care and in alignment with evidenced-based care and recognizes that restraints are an exceptional and temporary measure and should be used as a last resort, in the least restrictive form, to meet the patient's need and for the shortest duration possible.

Policy

Lakeridge Health (LH) follows a policy of least restraint. The use of alternative approaches (Appendix A) prior to initiating any restraint ensures respect for and preservation of the patient's dignity, rights, values and preferences. Restraints are to only be used as measure to restrict patient movement/behaviour when there is a clinical situation that involves:

- risk of harm to self
- risk of harm to others.

Restraints should not be considered for use for punitive reasons, or as a means of convenience for staff and should not be used as a falls prevention strategy.

Devices used to promote normal body positioning, increase their freedom of movement and/or enhance a patient's enjoyment of life would not be considered restraints such as a seatbelt for positioning or a secure unit to enable a patient to mobilize if they are not actively exit seeking.

Efforts to avoid the use of restraints should be exhausted prior to considering their use, as the use of restraints can cause serious negative, physical, social and psychological effects on those involved. This aligns with a trauma-informed approach to care, which acknowledges the high prevalence of trauma in all patient populations and provides care that minimizes unintentional traumatization/re-traumatization of patients/families/staff.

The *Patient Restraint Minimization Act, 2001*, prohibits the writing of PRN ("as needed") orders for any form of chemical, environmental or physical restraints which is to be practiced at LH.

LH supports and values a safe and healthy workplace environment and is committed to ensuring the safety of LH Colleagues as outlined in the *Workplace Violence Prevention – Policy and Procedure.* A point of care risk assessment is required prior to the initiation of a restraint to ensure appropriate resources and supports are available. To safely manage responsive or unpredictable behaviour, calling a Code White may be required to support staff and patient safety. If indicated when implementing a restraint, personal protective equipment (PPE) is to be worn to ensure protection based on hazard and risk.

All clinical staff are expected to maintain competence and complete the appropriate mandatory education annually (as clinically indicated per area of employment) in:
- application of least restraints, and
- preventing and managing escalating or responsive behaviour(s)

The decision to initiate restraints (Appendix B), the proper application and clinical monitoring during restraint use, is the responsibility of regulated health care providers (RHCP), regardless of the patient population, type or reason for the restraint.

The application of physical or environmental restraints may be supported by security and other staff trained in restraint application. When unregulated healthcare providers assist with the application and/or removal of restraints, this must be done in collaboration with a RHCP.

The process of discontinuing an emergent use of restraint includes a debriefing process with the interprofessional team, including the patient and/or substitute decision maker (SDM) as appropriate, to ensure that alternatives to restraint use are discussed and to contribute to a plan of care should restraints be indicated again in the future (RNAO, 2012).

The use of restraints at LH is classified by the urgency of the situation in which it is needed:
- Emergent
- Non-Emergent

And the type of restraint:
- Physical
- Chemical
- Environmental

The use of more than one type of restraint may be required, however **physical restraint and seclusion are not permitted to be used at the same time**.

Physical Restraints*:*
Only LH approved physical restraints will be used (Appendix C). These physical restraint devices must be used as intended by the manufacturer and are not to be modified or adapted in any way. Non-approved or "make-shift" equipment must not be used to restrain patients

Pinel restraints are the only physical limb holder restraints permitted at LH with the exception of Critical Care, Post Anesthetic Care Unit (PACU), Acute Cardiac Unit (ACU) and the Emergency Department when patients have received procedural sedation. In this case soft limb holders may be used.

Designated units/departments are stocked with a minimum of one Pinel Restraint Kit. Extra Pinel Restraint Kits, herein referred to as Pinel, can be obtained by calling Laundry Services or Environmental Services via Locating or, if needed urgently and after hours, by contacting Security.

Other approved physical restraints include protective mitts, lap trays, seatbelts, all bed rails up, chairs tilted back etc. listed in (Appendix C) if used to prevent the patient from harming themselves or others.

Chemical Restraints:
All chemical restraints are to be ordered as a STAT, one-time order only and are only used as an emergent restraint. When a pharmacological intervention 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). If a chemical restraint is ordered and the patient has de-escalated or is accepting of oral PRN medication prior to IM administration, use clinical judgement to support least restraint. If an ordered chemical (STAT) restraint is not required, clearly document in the health record, the reason it was not provided and what alternative intervention occurred to mitigate the need for the restraint.

Environmental Restraints:
Secure units and seclusion rooms are considered environmental restraints. At LH a secure unit would be considered a restraint if the patient is actively trying to leave the unit and they do not meet the conditions for detainment under the Mental Health Act (1990). Seclusion will only be supported at LH in areas that have designated seclusion rooms, such as on the Mental Health unit and in the Emergency Department.

Custodial Restraints:
In the case of patients arriving to LH in custodial restraints (i.e. handcuffs or shackles) related to a criminal offence under the custody of Corrections Canada and/or police officer(s), it is the responsibility of the custodial officer(s) to provide constant observation and management of their restraint devices as per their regulations. In addition to custodial restraints, health care team members may apply additional restraints based on patient safety needs according to this policy and will be responsible for their maintenance and use accordingly. The health care team member may request that custodial restraints be removed for a period of time if they interfere with treatment (e.g. physiotherapy). The custodial officers must approve the request and if approved, must remain with the patient during treatment. If the request is not approved, treatment plans will be modified to support best patient care. A Physician order is not required for custodial restraints. Custodial restraints should be included in routine documentation but do not require restraint specific documentation.

Definitions

Refer to Appendix D for a list of definitions.

Procedures

Initiating Restraints

- Prior to the use of any form of restraint, the team will exhaust all alternative approaches and interventions as clinically appropriate, using Appendix A as a guide.

- If alternatives are not successful and restraint use is required, the least amount of restraint to ensure safety of the patient and others is to be used. (Appendix C)

Physician's Orders and Assessment

- All restraints require a physician's order which is to include:
  - Type of restraint
  - Reason for the restraint
  - Duration of the order (based on situation and type)

- If the patient continues to require restraints beyond the duration of the order, a new physician order must be provided.

- In an **Emergent** situation, an RHCP can initiate physical or environmental restraint with or without the consent of the patient/SDM or a physician order, however an order for the restraint must be obtained **within 2 hours of application/use**. In addition:
  - A Physician face-to-face assessment must occur within 16 hours of application/use of physical, chemical or seclusion restraint (exception for Paediatrics is within one hour).
  - Within 24 hours from an emergent restraint order, a face-to-face Physician assessment is required to reassess and re-order the restraint.
  - If during the 24 hour restraint order period de-restraining efforts are not successful, a new order is not required to reapply the restraints or re-initiate seclusion
  - If the patient has been in mechanical restraints or seclusion for three continuous 24 hour periods (72 hours), the unit Physician must arrange to have another Physician perform an in-person consultation to assess if the restraint or seclusion is still warranted and provide a second opinion to promote least restrictive care.

- All **Non-Emergent** restraint orders must be written/received **prior to restraint use and with the consent of the patient/SDM**. Restraint re-orders require a Physician face-to-face assessment of ongoing need of the restraint and re-orders are necessary:
  - Within 24 hours of initial application
  - 72 hours after re-order
  - Weekly thereafter

- If a non-emergent restraint is used greater than 1 month, a reorder and review of the restraint necessity is required and at least monthly thereafter. An interprofessional team meeting with the patient/SDM and unit leadership will be conducted at least once per month for the duration of the restraint use to review and update the plan of care.

- In addition the following will occur **before** non-emergent restraint use:
  - Members of the Interprofessional team (1 or more) are responsible for the comprehensive assessments of the patient's need for a restraint. (Appendix B).
  - The therapeutic reason(s) for using a restraint must be explained to the patient and/or SDM, including requirements for discontinuation of the restraint, how behaviours can be modified and/or changed. The patient is encouraged to express thoughts, feelings, and discuss alternatives to use of the restraint.
  - A plan of care which includes the decision to use the restraint must be made in collaboration with the patient and/or SDM and members of the Interprofessional team and be documented in the patient health record.
  - If the patient and/or SDM declines the use of the restraint:
    - The device must not be used in a non-emergent situation.
    - Education will be provided regarding the rationale for using restraint.
    - Risk versus benefits will be explained.
    - Consultation will be sought with the Interprofessional team and the patient and/or SDM regarding alternatives.
    - Discussion and outcome must be documented in the patient's health record

Restraint Device Initiation Procedures

Procedures Prior to Administration

- Promote the patient's dignity and safety by:
  - Making all reasonable efforts to establish a therapeutic relationship and gain the patient's cooperation to proceed with least restrictive options
  - Providing the patient with a choice of options to enable the patient to gain control
  - Communicating and explaining clearly to the patient behavioural expectations, reason for restraint, and necessary behaviour for restraint discontinuation
  - Using de-escalation techniques
  - Calling a Code White if required to manage the situation

Application of Restraints

Physical Restraints - Pinel

- Pinel restraints are the only physical limb restraints permitted. Exception Critical Care, PACU, ACU and Emergency Department for patients who have received procedural sedation.
- Staff must ensure to safely hold and secure patient's limbs during the application of the restraints. At no point should a patient's head, neck or chest be physically/ manually restrained.
- Pinel restraints must not be applied to high-low beds (excludes Mental Health beds), as they have the potential to break the bed mechanics. If Pinel restraints are required, change the high low bed to a non-high-low bed.
- Ensure education for application of restraints has been completed before applying Pinel restraints.
- Pinel restraints are to be applied on the patient in accordance with the manufacturer's instructions. Refer to the education materials on the Least Restraint WAVE page for correct application of Pinel restraints on various surfaces.

- The waist restraint system (waist restraint, pelvic restraint (beaver tail), and side straps) is required whenever using a Pinel restraint in emergent and non-emergent situations.
  - If during the initial moment of emergent restraint application the waist restraint system is not able to be applied, it is expected that it is applied as soon as clinically appropriate and safe to apply should the patient continue to require the use Pinel restraints.
- Use clinical judgment when deciding on the number of limb restraints, as well as the length of slack on the restraint, to enable the least restrictive restraint as clinically indicated.
  - Do not restrain opposite limbs unless required to manage the situation i.e. if the left wrist need to be restrained due to line integrity, the right (or left) ankle do not also need to be restrained.
- The location of the Pinel Unlocking Key should be known/readily accessible to all staff on the unit. The key should not be accessible to the patient.
- Continue on-going point of care risk assessments throughout the restraining process.
- The number of required staff necessary for restraining a patient is dependent upon the regulated health care provider's assessment and patient presentation to maintain the safety of the patient and staff. In emergent situations ensure an appropriate number of trained staff are present when initiating restraints. This could mean a person to hold each limb, a person to apply the restraints, and an additional person acting as the patient supporter, explaining what is occurring and supporting the patient.
- Prior to applying restraints remove items impacted by the application of the restraint as able i.e. socks, jewelry, belts and watches.
- Unless contraindicated, when the patient is in supine position, it is expected that the head of the bed is elevated 15 to 30 degrees.
- Additional configurations of Pinel restraint application can be used in special circumstances to support patient care. Any configuration not mentioned above must follow recommended manufacture instructions and used if proper in-person education has been received by the health care team i.e. walking restraints.

Special Circumstances with Pinel Restraint Use

Pregnancy

- It is preferred to use seclusion with constant observation instead of Pinel restraints with patients who are pregnant or in the 6 week postpartum period unless they are at risk of self-harm (to self and/or fetus)
- If the patient is at risk of self-harm, the Pinel limb restraints should be used WITHOUT the waist restraint system and constant observation of the patient is required. Ensuring the restraint is used for the least amount of time as possible
- If the patient is beyond the first trimester and has not delivered the baby, the patient is not to be placed on their back due to possible blood flow restrictions to the heart. The patient will need to either be:
  - restrained on their side or propped up using a wedge under their hip (preferably positioned laying on the left side, requiring alternating sides for pressure relief and comfort) with their knees bent with pillow placed between knees or
  - restrained on their back with limb restraints applied ensuring the head of bed is elevated greater then 45 degrees to avoid blood flow restriction
- Consider padding the bed rails to avoid injury to the abdomen and other areas if the patient is moving aggressively in bed

NOTE: Regardless of position, the patient will need constant observation to ensure safety

- If restraints are required in the postpartum period, they should allow for the mother's safe handling of her infant as required for feeding and bonding as clinically appropriate

Abdominal Surgery

- The use of the Pinel waist restraint system for patients within 6 weeks post-operative from abdominal surgery is contraindicated
- Constant observation using a 1:1 observer is recommended
- If the patient is at significant risk of self or harm to others which cannot be otherwise managed, the Pinel limb restraints should be used WITHOUT the waist restraint system with constant monitoring for safety. Ensure the Pinel restraints are used for the least amount of time as possible
- Consider padding the bed rails to avoid injury to the abdomen and other areas if the patient is moving aggressively in bed

Other Physical Restraints

Other measures considered physical restraints include protective mitts, soft restraints (only for patients receiving procedural sedation), lap trays, seatbelts, all bed rails up, chairs tilted back etc. (Appendix C) if used to prevent the patient from harming themselves or others.

- These items must be used as intended by the manufacturer and not modified or adapted in any way.
- Staff must have knowledge, skill and judgment to use these devices prior to applying these devices on patients.
- Position the patient comfortably or as intended before applying the restraint.
- Follow the manufacturer instructions for cleaning, disposal and/or maintenance of the restraint.
- In the event that a patient is sleeping in a restraint, the staff will use clinical judgment and assessment skills to determine whether the restraint should be removed.
- Consent is required from the patient and/or SDM for any changes to the planned use of the restraint.

Chemical Restraints

Only to be used in emergent situations.

- The STAT medication must be ordered and administered at the time of an emergent situation
- The administration of a chemical restraint may be initiated in conjunction with the use of physical restraints or seclusion.
- Chemical restraint medication should always be administered via the least invasive and safest route possible.
- If possible, obtain verbal consent from the patient before the administration of the chemical restraint, including explaining what the medication is for.
- Advise staff of planned intervention prior to approaching patient. For safety, staff members should remove articles from their person which may cause injury to patient or staff member, e.g. watch, glasses, rings, wallet, lanyards, stethoscope or pen/pencil.
- Provide patient privacy and use PPE as indicated.
- Offer the patient a choice of prepared medication a second time. If the patient refuses again, instruct staff to restrain body and extremities and administer medication as ordered i.e. intramuscular injection.

- The administration of a chemical restraints may or may not require the use of physical restraints to support safe administration, this is to be determined based on the clinical situation. Of note physical restraints used in this situation must be removed as clinically appropriate.

Environmental Restraints

- Explain to the patient what behaviours are necessary in order to be released from seclusion/the secure unit
- Remove all safety hazards from the patient when feasible and applicable such as: sharps, drug paraphernalia, matches, lighters, jewelry, belts/cords.
- If clinically required, based on an identified risk, the patient should be wearing hospital attire.
- For the purpose of providing physical care and for a trial of decreasing seclusion, a regulated health care provider's assessment, in collaboration with the interprofessional team, (including risk related behaviours and behaviours indicative of behavioural control) will determine if release from seclusion or secure unit can be safely attempted.
- Routine assessments for the need for seclusion or secure unit is required.

Monitoring, Assessment and Clinical Care of Patients in Restraints

The monitoring, assessment and required interventions for patients during restraint use is determined by the reason for restraint, the length of time the restraint is required, patient's current presentation, cognitive status, physical status and safety.

Appendix E lists the minimum requirements for monitoring, assessment and intervention during restraint use.

Post-Initiation of Restraints

- Acknowledge to the patient and/or SDM the impact the event has had on the therapeutic relationship.
- Keep an open dialogue with the patient through the period of restraining, including asking the patient about what type of interaction would be most comfortable to them while restrained.
- Conduct a debrief with staff and the patient and/or SDM for all emergent restraint uses. (Refer to Debrief section for process).
- Initiate de-restraining efforts as soon as possible, as clinically indicated. (Refer to De-restraining Procedures section).

Documentation Requirements

In addition to the Physician's orders and documentation, each Interprofessional team member providing care documents all assessments and care provided including the following as applicable:

- Prior to initiation of restraint:
  - Observed behaviours leading to restraint
  - Alternative strategies attempted and outcomes
  - If restraints were initiated because of a Code White

- Discussions, education and consent process with patient and/or SDM (as applicable)

A significant event note must be completed to document that a restraint has been initiated which will minimally include the type of restraint initiated, if consent and/or an order was obtained and what alternative strategies were attempted prior to restraint use.

- The Restraint flowsheet/intervention must be added to the care plan. Documentation for constant observation is every 15 minutes and every 30 minutes for close observation. For non-emergent situations, documentation should be captured minimally every 2 hours in the Restraint flowsheet/intervention documentation.

- Post-initiation of restraints and ongoing Restraint documentation will include:
  - Observed behaviour and all alternative approaches attempted
  - Type of restraint used and status of the restraint
  - Monitoring for any adverse events due to restraint use (e.g. injury, skin break down etc.)
  - Discussion(s) with patient and/or SDM about the effect of the restraint on the patient, required demonstrated behaviours for restraint removal and therapeutic supports offered to assist
  - Review and revisions to the patient's Restraint care plan

- Discontinuation of restraints:
  - The regulated health care provider who discontinues the restraint must document this in the restraint flowsheet
  - Additionally a significant event note is to be completed, which will include the clinical status of the patient at the time of restraint discontinuation and relative pertinent information to prevent future restraint use.

- Documentation may also include:
  - An assessment of risks for violence
  - Any history of triggers for behaviours and context of such behaviours

Transporting Patients in Physical Restraints

As per the *Transportation (Inter and Intra Facility) of Adult Patients Policy* and the *Workplace Violence Prevention – Policy and Procedure* the use of restraints are included as circumstances where a RHCP or security staff may be required to escort a patient to and from a procedure or LH hospital site. If restraints are required to be removed for a procedure, a RHCP trained in restraints removal/application is required to escort the patient unless the patient is safe to have the restraints discontinued for the transport to, during and from the procedure. Involuntary patients in physical restraints or seclusion, transferred for a diagnostic test, must be accompanied by a RHCP whom will remain with the patient for the duration of the procedure with security as needed. Patients being transported using non-medical transportation services cannot be transported in physical restraints. If restraints are required for intra transport then the patient would fit the emergent/critically ill provisions in the Transportation (Inter and Intra Facility) of Adult Patients Policy.

De-Restraining Procedures

When clinically indicated, and in consultation with the patient and/or SDM, staff must initiate the process of de-restraining. Ensure to keep an open dialogue with the patient through the period of de-restraining. The process of discontinuing restraints should include a debriefing process, an assessment of risk factors, and a behavioural assessment. The interprofessional team and the patient and/or SDM are to be included in the de-restraining process. A period of greater than 2 hours out of restraints or seclusion is considered successful (CAMH, 2016).
Note: When a physical restraint is temporarily removed or decreased to support patient mobility, circulation, ADLs, skin integrity, testing or other direct care, this is not considered a de-restraining trial, however, the patient's ability to remain out of the restraint will be assessed before re-application.

Physical Restraint – Pinel

1. Conduct a risk assessment for each phase of de-restraining.
2. The number of required staff necessary for de-restraining a patient is dependent upon the regulated health care provider's assessment and patient presentation. In emergent situations, ensure at least 2 staff are present when attempting to de-restrain the patient.
3. The decision of how many and which restraints to remove, is determined by the patient's level of readiness, behaviour and mental status. This may range from one restraint at a time, to all restraints removed at once.
4. If unable to remove all restraints at the same time, always remove the limb restraints prior to the waist and pelvic restraint.
5. There is not a required sequence for limb restraint removal, but instead, limbs should be removed as clinically indicated, maintaining patient safety.
6. Maintain continual interaction throughout the de-restraining process to support a therapeutic relationship and reinforce expected behaviour to decrease/prevent further restraint use.
7. Place used Pinel restraints in the unit-designated bag for laundry processing

Other Physical Restraints

1. Conduct a risk assessment for de-restraining
2. Remove restraint on basis of the patient's behaviour and response to de-escalation techniques
3. The number of required staff necessary for de-restraining a patient is dependent upon the regulated health care provider's assessment and patient presentation.
4. Maintain continual interaction throughout the de-restraining process to support a therapeutic relationship.
5. The team should assess or re-asses the appropriateness of continuing the de-restraining process
6. Dispose/clean the restraint/protective device as per manufacturer instructions

Seclusion/Secure Unit

Removal of patient from seclusion or secure unit is based on the patient's behaviour and response to de-escalation techniques:

1. Conduct a risk assessment for removal of patient from seclusion
2. Make patient aware of behaviours required for de-restraining process
3. Document interventions and patient responses

Debrief

Debriefing regarding the use of restraints in emergent situations must be completed following restraint application and based on the discretion of the team for non-emergent situations. Following the debrief for emergent situations, a patient incident report is to be completed. Once an emergent restraint has been removed, a debrief with the patient and/or SDM is recommended as applicable. A debrief needs to be implemented within a non-punitive environment and must utilize a standardized approach to assist in the exploration of what events led up to the use of restraints and a review of what went well, with an exploration of any harmful incidents to determine what actions could have improved or prevented the outcome (RNAO, 2012).

Staff Debrief

Following the initial application of restraints the clinical team lead or delegate in charge of the care for the patient will lead this team debrief process using the tool in Appendix F. The purpose of the debrief is:

- To ensure staff's physical and emotional well-being
- To review prevention, de-escalation and best practice strategies used prior to the use of restraints
- To strategize next steps, including any adjustments to the patient's plan of care
- To review any complications or safety concerns surrounding the restraining event or as direct result of the use of restraints

Note: The debrief tool is not to become part of the patient's health record, rather it is used to guide the team conversation. When complete, it is submitted to the unit/program manager to inform the review of the submitted incident management report. Once this need is met, the document will be discarded in the appropriate shredding receptacle.

Patient and SDM Debrief

Within 24 hours of restraint removal in an emergent situation, the nurse in charge of the care for the patient or another member of the interprofessional team should review the emergent situation with the patient and/or SDM. The goal is to strengthen or re-establish the therapeutic relationship, review the triggers that led to the use of restraints, the alternative approaches attempted prior to using restraints, the care provided while in restraints, the strategies and timeframe for the removal of the restraint, the family involvement in the process, and the consent and feedback from the client (RNAO, 2012). Documentation to be completed as a patient care note.

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Appendix A - Alternative Approaches and Strategies

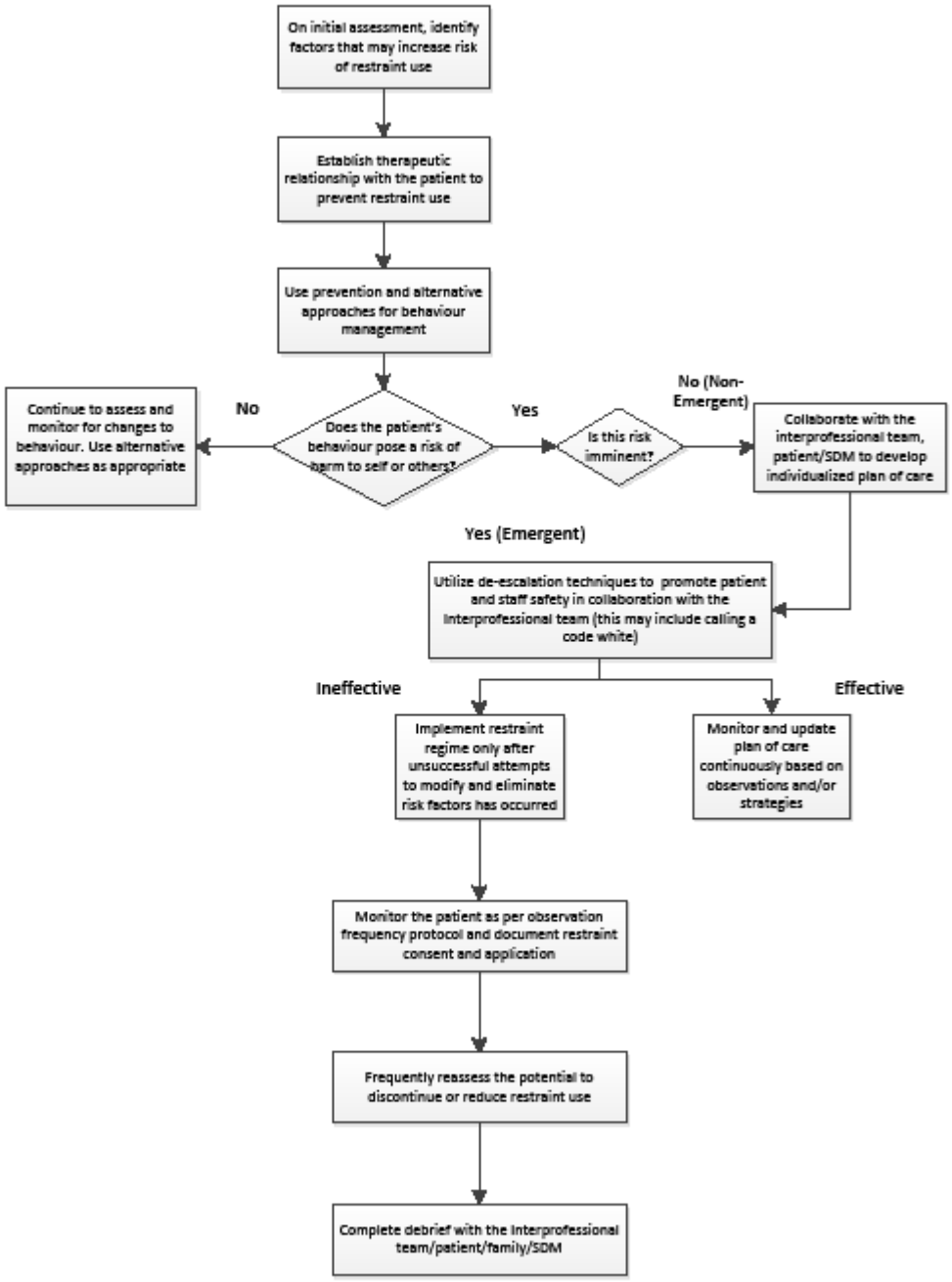
Note: Original located on the WAVE on the Least Restraint: Prevention, Initiation & Management page

Person at Risk for Falls	• Review medications regularly • Reposition every 2 hours • Provide pain relief/comfort measures • Redirect with simple commands • Toilet regularly • Keep personal items and assistive devices within easy reach • Educate on use of call system devise and maintain within easy reach • Encourage participation in activities of daily living (as appropriate) • Assess for basic needs (e.g. hunger, pain, heat, cold) • Encourage mobility/ambulation (as appropriate) • Bed/chair/door alarms	• Involve family in care • Establish individualized routines • Encourage social interactions • Clean, dry floor surfaces • Maintain clutter free environment • Music therapy • Pet therapy • Use distraction (e.g. games, crafts) • Adequate lighting/night light • Bed in low position
Person with Unsteady Gait	• Review medications • Schedule daily naps • Put mattress on floor/lower bed • Educate on use of call system device and maintain easy reach • Establish mobility/ambulation/exercise routine	• Adequate lighting/night light • Increase social interactions • Maintain clutter free environment • Maintain non-slip flooring • Involve family in care
Persons with Cognitive Impairment	• Establish individualized routine • Encourage social interactions • Assess past coping strategies • Distraction (e.g. games, crafts) • Schedule daily naps • Maintain clutter free environment • Toilet regularly • Assess for basic needs (e.g. pain) • Pet therapy	• Redirect with simple commands • Involve family in care • Use reminiscence therapy • Allow pacing • Adequate lighting./nigh light • Label environment (e.g. bathroom) • Use gentle touch • Install bed/chair/door alarm • Music therapy
Persons with Acute Confusion	• Establish individualized routine • Assess past coping strategies • Schedule daily naps • Maintain clutter free environment • Toilet regularly (e.g. every 2 hours) • Redirect with simple commands • Assess for basic needs (e.g., pain) • Increase/decrease social interactions • Keep personal items and assistive devices within easy reach	• Involve family in care • Adequate lighting./nigh light • Label environment (e.g. bathroom) • Use gentle touch • Install bed/chair/door alarm • Review medications • Facilitate diagnostic testing • Provide pain relief/comfort measures
Persons Displaying Agitation	• Review medications • Establish individualized routine • Redirect with simple commands • Assess past coping strategies • Distraction (e.g. games, crafts, pets) • Use relaxation techniques (e.g. music, dark environment) • Establish mobility/ambulation/exercise routine • Toilet regularly (e.g. every 2 hours)	• Increase social interactions • Use gentle touch • Involve family in care • Routine positioning every 2 hours • Provide pain relief/comfort measures • Assess for basic needs (e.g. pain) • Schedule daily naps • Allow pacing
Persons Prone to Wandering	• Redirect with simple commands • Distraction (e.g. games, crafts) • Tape "Stop" line on the floor • Pet therapy • Maintain clutter free environment • Keep personal items and assistive devices within easy reach • Employ "buddy system" among staff (maintain consistency) • Assess for basic needs (e.g. hunger, pain, heat, cold)	• Room close to nursing station • Assess past coping strategies • Music therapy • Install bed/chair/door alarms • Adequate lighting/night light • Label environment (e.g. bathroom) • Increase social interactions • Involve family in care
Persons Prone to Sliding	• Use non-slip/wedge cushions • Educate in use of call system device and maintain within easy reach • Facilitate referral to occupational/physical therapist	• Reposition every 2 hours routinely • Provide pain relief/comfort measures • Use tilt wheelchairs
Persons Displaying Aggression	• Review medications • Establish individualized routine • Assess past coping strategies • Use relaxation techniques (e.g. soothing music, quiet/dark environment)	• Assess for basic needs (e.g. pain) • Provide pain relief/comfort measures • Increase/decrease social interactions • Involve family in care • Allow pacing
Preventing Treatment Interruptions In Adults	• Redirect with simple commands • Explain procedures/treatments • Camouflage intravenous tubing • Educate on use of call bell system device and maintain within easy reach • Apply abdominal binder over feeding tube • Replace with less restrictive/intrusive devise as soon as possible	• Increase social interactions • Use gentle touch • Change intravenous to saline lock • Provide pain relief/comfort measures • Use distraction (e.g. games, crafts) • Involve family in care • Use arm splint

Adapted from the Registered Nurses Association of Ontario November 2018 BPG Order Set

Appendix B – Least Restraint Care Pathway

Note: Original located on the WAVE on the Least Restraint: Prevention, Initiation & Management page



Adapted from: RNAO (2018). Promoting Safety: Alternative Approaches to the Use of Restraints Order Set [Care Pathway].

Appendix C – List of Approved Restraints

Before using any restraint please ensure you consider Alternative Approaches (Appendix A) The least restraint device should always be considered first. Consider intent before initiation of any type of restraint. Below is a list of all approved restraints; Physical, Chemical & Environmental.

Least to Most Restrictive

Mitts	Bed rails (all)	Seclusion	2 or 3 Point Pinel	4 or 5 Point Pinel
Soft Limb Holder	Lap Tray	Chemical	Tilt Chairs	
Alarm Seat Belt	Locking Breaks			
Secure Unit	Seat Belt			
	Pinel Waist Restraint			

Types of Restraint (Least to Most)	Restraint Information	Patient Indicators
Mitts	• Soft, fiber-filled mitten with secure closure	• Patients who are prone to self-injury or who may disrupt medical treatment i.e. pull out tubes or lifesaving devices
Soft Limb Holder	• Foam ankle or wrist restraint. • Secures with hook and loop. • Secures to movable portion of the bed with quick-release buckles or ties. • Adjustable size fits pediatric or adult limb.	• Devices to prevent the patient from interfering with medical treatment and equipment **NOTE:** only to be used for critical care patients or in PACU for patients under sedation and at risk of pulling out lines or tubes
Alarm Seat Belt	• Soft lap belt made of high-quality nylon, non-restrictive self-release design. • Alarms attach to back of chair or wheelchair. • Designed to alerts staff *before* patient gets up. An alarm sounds as soon as the patient disengages the fastening buckle. • Device **is** a restraint if patient cannot open independently and not needed for positioning.	• Patients at risk for harm from an unassisted exit from chair • Provides an extra margin of safety for more active wheelchair patients.
Secure Unit	• A unit that is secured by a door lock or closed doors to prevent unwanted exiting or entering • A secure unit **is** a restraint if the patient is actively exit seeking	• Patient at risk of harm if able to leave unit

Types of Restraint (Least to Most)	Restraint Information	Patient Indicators

	• A secure unit is not a restraint if:
	  ○ it enables a patient to mobilize safely on the unit
	  ○ staff would open the door should the patient ask to leave
	  ○ for patients held involuntary under the Mental Health Act	

Bed rails (all up)	• Use of all 4 bedrails • Device **is not** a restraint capable patient requests use • If for an incapable patient the SDM requests all bed rails up this **is** a restraint	• Patients at risk for harm from exiting unassisted from bed
Lap tray	• Hard tray for use with High back chair, Geri-chair or wheelchair • Device **is** a restraint when used to prevent patients from exiting their chair • Device **is not** a restraint when used solely for activity or function such as eating, reading.	• Patients at risk for harm from an unassisted exit or slide from chair
Locking Wheelchair Breaks	• Used to prevent chair from moving from one location to another • Device **is not** a restraint if patient can unlock breaks	• Patients at risk for harm from an unassisted exit from chair
Seat Belt with or without pin lock	• Seat belt made of high-quality nylon with lockable release or a pinlock buckle. • Device **is not** restraint if patient can unfasten it independently or if required for positioning/increasing freedom of movement i.e. enabling patient to foot propel	• Patients at risk for harm from an unassisted exit from chair
Pinel Waist Restraint System	Pinel Waist Restraint System is to be used minimally as a 1 point Pinel restraint • Includes the waist restraint, the pelvic strap (beaver tail) and side straps. • The Pelvic strap is attached to the waist belt and passes between the patient's legs from back to front. • Side straps attach to each side of the belt and fasten on either side of the bed used to control the degree of the patient movement.	• Designed to keep patients mobile and secure in bed, stretcher or chair while preventing aggressive and dangerous escape attempts. • Pelvic strap and side straps are mandated by Health Canada with Pinel Restraint use

Types of Restraint (Least to Most)	Restraint Information	Patient Indicators
	NOTE: only 3 layers of fabric are permitted on each pin and button can spin when locked.	
Seclusion	• Room Seclusion • Only LH designated seclusion rooms in ED and MH are to be used for patients requiring seclusion.	• Patients who are risk for harm to self or others **NOTE:** Not to be used with physical restraints.
Chemical	• A medication ordered and administered at the time of an emergency situation • This is a STAT one time order only	• Patients who are risk for harm to self or others **NOTE:** chemical restraints require constant observation by health care provider or designate until desired effect achieved
Tilting Chair (Broda, Geri-chair, HTR etc.)	• A chair tilted backwards **is** a restraint if used to prevent patient from exiting their chair • Device **is not** a restraint if used to bring a patient out of their room and/or provide required positioning for skin integrity etc.	• Patients at risk for harm from an unassisted exit from chair
Pinel Limb Restraints	• Limb restraints are to be used with the Pinel waist restraint system as in 1 Point Pinel above unless during an emergent use if unsafe to apply it at that moment. The waist restraint system must be applied when able and if patient continues to need Pinel restraints. • The number of limb restraints are applied as clinically indicated to manage the responsive behaviour or safety concern ***NOTE: only 3 layers of fabric are permitted on each pin and ensure cap can spin when locked.*** **For Extreme emergent situations in the Emergency Department, Child and Adult Inpatient Mental Health Units, the addition of a shoulder restraint can be used to maintain safety of the patient and staff when clinically indicated and staff have the knowledge, skill and judgement to use shoulder restraints.**	• Patients at risk for removal of life saving technology • Patients' who are aggressive, an immediate urgent threat whereby the well-being of others/self is being threatened. • 4 to 5 Points of Pinel restraints are used for select circumstances whereby all limbs must be immobilized due to real and imminent threat to themselves or others. **NOTE:** 4 or more points requires constant observation.

Appendix D – Definitions

Alternative Approaches: Strategies used to resolve behaviours that may result in self-harm or harm to others. Alternative approaches are developed in collaboration with the Interprofessional team, family/SDM and patient (if appropriate) then reflected in the patient's individualized plan of care. Alternative approaches should focus on the client and an individualized approach to care regardless of the client's level of cognition. These interventions must be exhausted prior to the decision to use restraints of any kind.

Constant Observation: The one to one uninterrupted visual observation of one patient by one assigned regulated/unregulated staff member (this can include agency/contract staff such as security) who has no other competing responsibility. If unregulated staff members are providing constant observation, a visual assessment of the patient by a regulated staff member is to be completed every 15 minutes.

Close Observation: Visual assessment of the patient by a designated clinical staff member completed every 15 minutes.

Debrief: An informal review and discussion of a restraint event or events for those involved including staff, patients, family, friends and significant others. This includes review of precipitating factors and the process of restraint including patient and team response and outcome.

De-escalation: The use of techniques (including verbal and non-verbal communication skills) aimed at defusing anger and averting aggression (NICE, 2015).

Emergent Situation: When behaviour or actions of the patient has placed him/herself or others at immediate risk of harm. This situation is defined as one where immediate action is necessary to prevent serious bodily harm to the individual/patient or others and when other approaches have been unsuccessful. In this situation the health care staff uses professional judgment to make a decision to apply/use a restraint. Emergent situations are time limited.

Interprofessional Team: Health care professionals involved in the patient's care and care planning and can include but is not limited to: Nursing, Physiotherapy, Rehabilitation Assistants.

Non-emergent Situation: When the behaviour or actions of the patient indicate a potential risk of harm if not addressed.

Paediatric Patient: A patient less than 18 years of age, up to but not including the 18th birthday.

Responsive Behaviour: A reaction to an unmet need in a person, whether cognitive, physical, emotional, social, environmental or other. It can also be a response to circumstances within the social or physical environment that may be frustrating, frightening or confusing to a person. Room temperature, misplaced items, loss of control, loneliness, hunger, thirst or the need to toilet are some examples of unmet needs

Restrain: To place under control when necessary to prevent serious bodily harm to the patient or another person by the minimal use of such force (which is trauma informed),

mechanical means or chemicals as is reasonable having regard to the physical and mental condition of the patient (CAMH, 2016)

Restraints: Physical, chemical or environmental measures used to control the physical or behavioural activity of a person or a portion of his/her body. (CNO 2017).

- **Chemical Restraint:** A STAT pharmacological intervention which is administered in an emergency situation with or without the patient's consent to help with managing behaviour that constitutes an imminent threat to the safety to the patient and/or others. They can be any form of psychoactive medication used not to treat illness, but to intentionally inhibit a particular behaviour or movement. (CNO, 2017). The use of pharmacological intervention as a restraint is distinct from pharmacological interventions used to treat illness which is governed by the Health Care Consent Act and is not within the scope of this policy.

- **Environmental Restraint:** Used to control a patient's mobility, restrict movement from one location to another and/or decreases stimulation. At LH environmental restraints include secure units or seclusion rooms to manage a patient's undesirable behaviour.
  - **Secure Unit:** Considered a restraint if its purpose is to keep a patient on a unit against their will. Exceptions to this would be as per the conditions established for detaining formed patients under the Mental Health Act (1990).
  - **Seclusion:** An environmental restraint that refers to the confinement of a patient in a locked room designated as a seclusion room to restrict the movement from one location to another. At LH these rooms are located in Mental Health and the Emergency Department.

- **Physical Restraint:** The use of any physical device to involuntarily limit the movement of the whole or a portion of a patient's body used to control his/her behaviours or activity when a patient's behaviour presents and immediate risk of serious bodily harm to self or others. Physical restraints can include Pinel restraints, lap belts, tables fixed to chairs or bed rails that cannot be removed by the patient. (SHS 2016, CNO 2017) Example: a HTR/Geri-chair used to bring a patient out of their room and provide a position change is not a restraint however it would be a physical restraint when used to prevent a patient from standing and wandering.

Staff Member: Any staff employed at LH. Staff member can include Service Associates, Security Personnel, Health Care Professional, etc.

Substitute Decision Maker (SDM): A person who is authorized under the Health Care Consent Act to give or refuse consent to treatment on behalf of a person who is incapable with respect to treatment.

Trauma Informed Approach: A therapeutic approach based on the understanding that many persons have experienced trauma in their lives. This approach is not focused on treatment or disclosure, but rather the approach is applied universally to ensure the persons are not further traumatized in the course of accessing care and that they are able to grow in a positive, relational context (RNAO, 2017)). Care emphasizes physical, psychological and emotional safety through six key principles and aims to help individuals rebuild a sense of control and empowerment, re-gain emotional regulation, create meaningful relationships, and increase sense of self. (Alberta Health Services, 2019; CAMH, 2019; Substance Abuse and Mental Health Services Administration).

Appendix E - Monitoring, Assessment and Clinical Care of Patients in Restraints

General Guidelines:

- The chart below identifies the **minimum monitoring and interventions** when restraints are used. Clinical judgement is required to ensure the level of monitoring matches the level of risk and safety needs at that a higher level of observation is applied as indicated.
- When constant monitoring is through video monitoring or monitoring by a non-regulated staff, a RHCP must remain assigned and visually monitor the patient on close observation.
- If the required assessments or interventions are not conducted, clearly document the rationale for this (i.e. patient refusing)
- Documentation of restraint use, must occur when a restraint is initiated, at a minimum of every two hours while in restraint and when the restraint is discontinued.

Restraint Type	Required Level of Observation	Nursing Assessments & Interventions
Secure Unit	Close observation for **first hour** post initiation	Ongoing assessment of patient presentation and behaviour. Assess need for continued secure unit use and the appropriate level of observation. Provide routine daily care as ordered and based on clinical presentation.
	Then a minimum of hourly, up to close based on clinical need	
Seclusion	Constant observation for the **first hour** by direct monitoring, through the seclusion room window or by staffed video monitoring*.	Ongoing assessment of patient presentation and behaviour. Assess need for continued seclusion and the appropriate level of observation. Provide routine daily care as ordered and based on clinical presentation.
	Based on patient's clinical condition, close observation for the remaining period of locked seclusion unless the clinical condition warrants constant observation as determined by the assigned nurse in consultation with the physician.	
Chemical	Constant observation on initiation, until the behaviours have minimized and/or settled. Or if a second restraint (i.e. pinel, seclusion) is used, monitor based on the other restraint requirements.	Initial and ongoing assessment of vital signs, level of alertness and assessment and management of side effects/adverse effects as clinically indicated and documentation of effectiveness in managing patient behaviour. Provide routine daily care as ordered and based on clinical presentation.

Appendix E - Monitoring, Assessment and Clinical Care of Patients in Restraints (cont'd)

<table>
<tr><th>Restraint Type</th><th>Required Level of Observation</th><th>Nursing Assessments & Interventions</th></tr>
<tr><td>Soft Limb Holder</td><td>Close Observation on Initiation of restraints for the first hour

After the first hour, based on the patients clinical presentation, implement routine hourly checks or maintain close observation</td><td rowspan="3">On initiation assess patient's condition as clinically indicated. Take vital signs, check colour, sensation and movement (CSM).

Every 30 minutes visually assess circulation. If indicated, assess the skin integrity at point of contact of the restraint.

Hourly measure respirations. Assess circulation, sensation, movement and warmth.

Every hour while awake reposition with limb release and encourage full range of motion of the restrained limb as clinically indicated. Document rationale if unable to reposition/release minimally every 2 hours.

Every 2 hours while awake provide opportunity for toileting, nutrition, hydration, mouth and appropriate skin care as required, or more frequently if clinically indicated. Note: oral nutrition and hydration should never be done in a recumbent position

Ongoing assessment of vital signs and mental status as per patient care standard or as clinically indicated

Every 8 hours Mobilize patient for a minimum of 15 minutes. Ambulation is preferred if safe to do so as appropriate. Document rationale if unable to ambulate/mobilize patient.

NOTE: If at high risk for Deep Vein Thrombosis (DVT) or Pulmonary Embolism (PE), consult MRP for prophylactic interventions</td></tr>
<tr><td rowspan="2">Pinel Restraints</td><td>For emergent situations:
Constant observation is required through direct monitoring or by staffed video monitoring*</td></tr>
<tr><td>In non-emergent situations:

Constant Observation is required for
4 or more restraint points or those who display severe agitation/ attempts to exit the restraint

Close observation is required for 3 or less restraint points, then routine observation once the when behaviour has settled.</td></tr>
<tr><td>Other Physical Restraints</td><td>Close observation for the first hour, then a minimum of routine hourly observation based on the patient's clinical presentation and needs.</td><td>Ongoing Assessment of restraint necessity and patient's behaviours.

Provide routine daily care as ordered and based on clinical presentation.</td></tr>
</table>

Appendix F - Staff Restraint Debrief Tool

Note: Original located on the WAVE on the Least Restraint: Prevention, Initiation & Management page

Least Restraints Staff Debrief Overview

Perform Wellness Check	
Introduction	After every incident we like to get together and discuss what happened. No fault, no blame; we want to look at the facts, see the whole picture and where we may have opportunities to improve. Everyone's contribution is important and should be respected.
Timeline	*(Background information, Summary of events, gaps in timeline, perspectives of everyone involved, especially if were in different locations/arrived at different times)*
Successes	*(What went well? Identify effective response strategy/conditions that we would want to replicate in the future; highlight good ideas, decision making and positive outcomes)*
Opportunities	*(What could have gone better? What should have happened? Why didn't it? What are our lessons learned? If this were to happen again, how can we improve our response?)*
Recommendations	*(How can we achieve improvements identified above?)*
Questions	*(Questions to follow up on with area leaders and/or other stakeholders)*
Perform Wellness Check	

Notes submitted to: _____ Date: _____ Time: _____

Follow up required? Y / N _____