Least Restraint: Care of the Patient at Risk for or Requiring Restraint (Acute and Sub Acute Care)

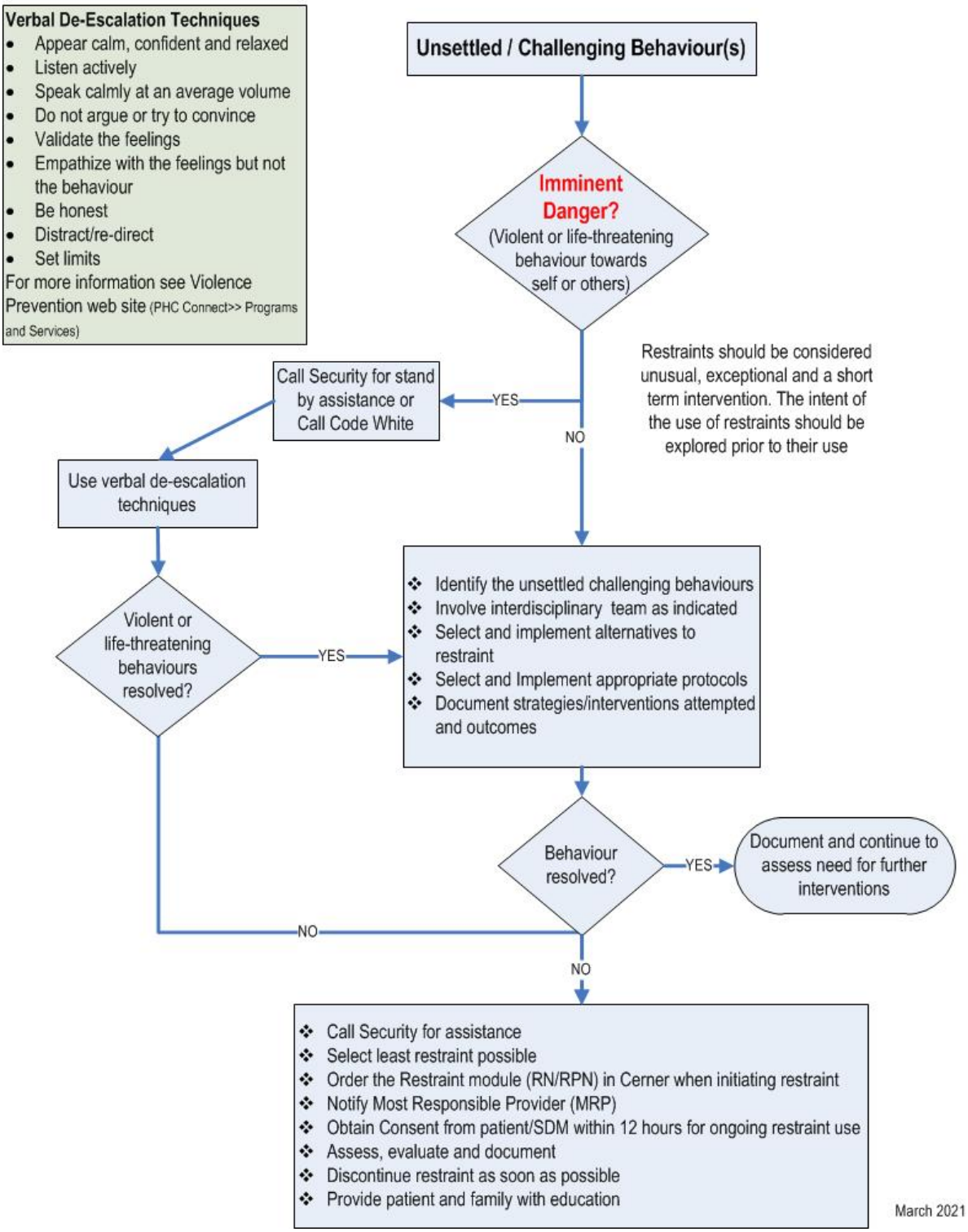
Site Applicability:

PHC Emergency Departments, Critical Care, Acute Care and Sub-acute Inpatient Units

Practice Level:

Profession	Basic Skill	Knowledge and Skills
Physician/NP	• Ordering restraints and discontinuing the order for restraints • Assessing the need for certification under the Mental Health Act and completing the appropriate Mental Health Act forms	Members of the health care team are accountable for obtaining and maintaining knowledge, skills and competencies related to alternative approaches, use of restraints, and the risks involved when caring for patients with potential or active risk behaviour. Education on the application of restraints as per the manufacturer guidelines is required before use.
RNs and RPN	• Ordering restraints (following this DST) • Obtaining, applying, and managing restraints • Obtaining order for continued use of restraints • Physician notification & obtaining order for Secure Room (seclusion) • Discontinuing an order for restraints	
LPNs	• Applying and managing restraints when an order from an authorized health professional is in place • Discontinuing the use of restraints with an order	
OT, PT	• Consulting on alternative interventions • Equipment recommendations	
PCA	• Observing, documenting, providing personal care and safety for a patient at risk for or requiring restraint • Removal of restraints in an emergency situation	
Security	• Assisting with the application, repositioning, and removal of restraints at the direction of the clinical team.	

Least Restraint Approach: Patient at Risk for or Requiring Restraint



Need to Know:

PHC supports care providers in respecting a patient's right to freedom of movement and the right to make autonomous decisions while ensuring the safety of everyone.

Protocol Purpose:

- To protect the safety and autonomy of Providence Health Care patients, staff and volunteers by providing direction for the provision of patient centered care that minimizes the need for restraints.
- To ensure the least restrictive form of restraint is used for the shortest possible duration when restraint is necessary for the safety of patients and/or others.
- To ensure the use of restraints complies with legislation, professional standards, and evidence informed practices.
- To ensure that the principles of consent are applied appropriately and consistently in practice.

Clinical Decision Making and Ethics

The interdisciplinary team considering restraint must justify the decision to restrain the patient and document the rationale based on clinical and ethical considerations. Whenever possible, the patient and/or substitute decision maker must be involved in the decision-making process. Restraint may be initiated only when the patient's behaviour or actions could result in harm to self or others, and interventions that maximize freedom have been attempted and deemed unsuccessful, and should be the least restricting means possible. In an **Emergency Situation,** a restraint can be implemented before obtaining informed consent.

Behavioural Emergency

A behavioural emergency occurs when a patient's behaviour conveys imminent, substantial and probable risk of serious injury to self or others. In a behavioural emergency, the least restrictive and most appropriate form of restraint may be initiated without interdisciplinary assessment. The decision to initiate a restraint during a behavioural emergency is a clinical decision that is made by the MD, NP or RN/RPN.

Restraint

Restraints are devices, environments, or medications used to restrict a person's behaviour, movement, or normal access to their own body. Restraints may be used to prevent a patient from harming themself or to restrict their freedom of movement. It is the *intent* for which a device is used that determines whether it is a restraint. The use of restraints is considered to be an *unusual, exceptional,* and a *short- term therapeutic intervention* that is used only after other reasonable alternatives have been identified, trialed, and proven unsuccessful.

Restraints are to be discontinued as soon as possible.

Least Restraint

The least restraint approach implies that all possible alternative interventions to restraint are explored and have been unsuccessful in the reduction of harm to patient and/or staff.

Alternatives to restraints include de-escalation, redirection, setting limits, the use of medication to manage symptoms (not as a control measure), psychosocial interventions, and or the involvement of security personnel, family or friends.

When such alternatives are deployed early enough, the patient may respond positively to these less restrictive options. If restraints are required, the least restrictive restraint should be used for the shortest duration of time.

Types of Restraints

There are three types of restraints: *Physical/Mechanical, Environmental and Chemical*.

Physical/Mechanical Restraint

Physical/Mechanical restraints are defined as devices that are not removable by the patient and that restrict freedom of movement. Physical/Mechanical restraints are an intervention of last resort when the person's behaviour cannot be managed by any other means. Extreme caution is needed in their application to prevent injury.

See Appendix A for a complete list of approved physical/Mechanical restraint products.

Considerations:

- **Side rails:** Full side rails when used against patient's wishes (either expressed or implied) are considered a restraint. Full side rails, when used to prevent exiting bed, are considered a restraint. An alternative is to use split side rails, with 1 or 2 rails down for safe exiting and used in conjunction with a bed alarm.
- **Geri-chairs:** If a geri-chair is used solely to confine patient movement, it is considered a restraint and is *not* approved for use as a stand-alone device. If it is used to enhance positioning and comfort, it is not considered a restraint.
- **Lap belts/waist belts:** If a patient can not release a self-release lap belt or waist belt, because it is unreachable, or because the patient does not have the physical or cognitive ability to release it, it is considered a restraint.

Locked Restraints and Safety Considerations:

- All patients in locked restraint **must** have the key taped to the head of the bed at all times.
- If taping the key to the head of the bed is unsafe, the location of the key must be clearly documented in the Situational Awareness and Planning section of the Handoff Tool in the Power Chart.
- If transporting the patient in locked restraint is necessary, security personnel and the key must accompany the patient.

Environmental Restraint

Environmental restraint is defined as any barrier or device that limits the movement of an individual and thereby confines an individual to a specific geographic area or location. This includes, wander guards, locked doors/units/half doors and seclusion (secure rooms).

Seclusion is the involuntary confinement of a person alone in a room which the person is prevented from leaving. Refer to B- 00-13-10061: Secure Room: Care of the Patient

Note: Security access systems and wandering alert systems that limit patient movement within a geographical area and prevent access to hazards (e.g. stairwells, elevators) are interventions that are considered restraints, however these interventions can enhance maximum freedom and patient safety.

Chemical Restraint

A chemical restraint is the use of a psychoactive medication administered with the intent of of inhibiting responsive behaviours or movements. Responsive behaviours are a form of communication and are often the last means of expression for unmet needs e.g. toileting, pain, or fear. Responsive behaviours are often misinterpreted as agitation, aggression, disruption, and resistance to care. Psychotropic and sedating medications may be used to target specific unsettled behaviour in order to achieve a therapeutic goal. Use of psychotropic medications to treat behavioural symptoms of dementia should be limited to cases where non-pharmacologic measures have failed.

Chemical restraints can have adverse effects, including but not limited to sedation, confusion, hypotension, cardiorespiratory compromise, decreased gastric motility, parkinsonism, bradycardia, increased risk for falls with harm, and mortality.

A psychiatric consultation is highly recommended whenever psychotropic medications are under consideration for an acute behavioural disturbance or an ongoing mental health condition. Use of psychotropic medication should include thorough assessment of the desired effect of the medication as well as its side effects. These medications should be discontinued as soon as possible when the person's behaviour is not posing risk of harm to self or others, or can be managed through non-pharmacological approaches.

Risks of Restraint Use

Restraint use puts patients at increased risk of medical, psychological, and functional complications. Restraints used without a comprehensive approach to assessment, intervention and evaluation may lead to the following negative consequences:

- Pneumonia
- Aspiration
- Nerve Injury

- Muscle Atrophy
- Urinary and or bowel Incontinence
- Strangulation/asphyxiation
- Onset of pressure injuries
- Decreased peripheral circulation
- Cardiovascular Stress
- Infections
- Asphyxiation
- Falls
- Increased confusion and agitation
- Delirium
- Psychological, emotional or spiritual trauma
- Regression
- Withdrawal
- Loss of self-image
- Sensory deprivation
- Increased length of stay
- Death

Consent

Obtaining consent for the use of restraint is important. However, where the adult is incapable of giving or refusing consent, and no substitute decision maker is immediately available, section 12 of the Health Care Consent Act allows a health care provider to provide health care to an adult without consent if it is necessary to preserve the adult's life, to prevent serious physical or mental harm or to alleviate severe pain. Therefore, **in emergency situations, nurses may apply restraints without the consent** of the patient or Substitute Decision Maker.

- Discuss the application of restraint with the capable patient as soon as the emergency situation is settled. Provide information and attempt to get consent. A patient who is capable has the right to personal risk and to refuse a restraint when their unsettled/challenging behaviour does *not* pose imminent danger.
- Discuss the application of restraint with the patient's Substitute Decision Maker (SDM), if the patient is unable to make their own decision. The Substitute Decision Maker may be a Committee of Person appointed by the Court, or Representative as appointed in a Representation Agreement or, if neither of these exists, the most responsible care provider will appoint a Temporary Substitute Decision Maker ([TSDM] - FORM FAST ID 2706). See B-00-11-10110 Consent and BC legislation

When a patient is certified under the *Mental Health Act* of British Columbia, i.e. the patient has been examined by a physician who is of the opinion that the patient meets the criteria

for certification, make sure FORM 5 Mental Health Act Consent for Treatment is completed. Discussion should still occur with the patient at the time of initiating the restraint and be documented.

Consent for ongoing use of restraints

- Ensure consent discussion for ongoing use of restraint occurs **within 12 hours of initiating the restraint.**
- Ensure that consent for **ongoing** restraint use is maintained as follows:
    - Consent obtained from a SDM/TSDM must be renewed in 21 days.
    - Consent obtained for an involuntary patient under the Mental Health Act remains current as long as the certificates are valid:
        - Form 4, 4.1 and 4.2 : Mental Health Act Medical Certificate (Involuntary Admission)
        - Form 5: Mental Health Act Consent for Treatment (Involuntary patient)
        - Form 6: Mental Health Act Medical Report on Examination of Involuntary Patient (Renewal Certificate)
    - When the certification period ends and if it's not renewed, or if the patient is decertified from the Mental Health Act (e.g. no longer involuntary), or if the patient is deemed capable, then consent would be required for the continued use of restraints.
- Discussion with Patient/Family/SDM should include:
    - the reason for the restraints
    - the alternatives that have been attempted or considered
    - the type of restraints to be used
    - the associated risks
    - the plan to review the need for the restraint
    - verbal consent

Equipment and Supplies

Only the devices/products named in the Approved Products section (Appendix A) of this protocol are considered to be approved physical/mechanical restraints and restraint alternatives for use at PHC.

Non-restraint devices such as bedding, clothing, kling/tensor bandages, laptrays, and transfer belts are never to be used to restrain patients under any circumstances. The use of physical force (e.g. holding down the patient) except to intervene or apply restraints in an emergency is not supported due to concerns for the safety of both staff and patient.

Protocol

Imminent danger

Assessment

Decide if the unsettled/challenging behaviour poses an **imminent danger**, defined as violent or life-threatening behaviour towards self or others. Nurses need to assess the risk of the behaviour that is involved in the use of restraints. Risks can be divided into the following categories:

i. ***Risk to Self***

1. Attempting to remove invasive lines, artificial airway, tubes or drains
2. Wandering and elopement risk when safety is an issue
3. Severe sensory impairment
4. Significant threats or attempts at self-injury

ii. ***Risk to Others***

1. Physical aggression towards staff, visitors, or other patients (signs of a behavioural emergency)
2. Escalating verbal abuse (signs of an emotional crisis) and threats of violence, when the risk of follow-through is high

iii. ***Risk to Property***

1. Destructive behavior such as property damage (e.g. punching walls, throwing TVs, breaking equipment)

Interventions

When there is an imminent danger, team members will take steps to protect the patient and others. In such a situation the RN/RPN:

- Calls for Security Standby or a Code White. Placing the call can be delegated to any available staff. Refer to # B-00-11-10190 - Code White Emergency Response Policy. A Code White is always a clinically led intervention.
- Selects and implements appropriate type of restraint. As soon as possible following the administration/application of restraints, informed consent is sought for the use of restraints.
- Informs the physician about the use of the restraint
- Administers any ordered PRN medications as treatment for underlying delirium/agitation to the patient. Note: A prescriber's order is required prior to the administration of medication for the purpose of chemical restraint.
- Implement Violence Risk Alert and Care Plan and the appropriate signage if patient's behaviour meets the criteria for a Violence Risk Alert, Refer to policy: B-00-11-10178: Violence Risk Alert.
- Inform and debriefs with patient, family, and/or Substitute Decision Maker

Restraints are to be discontinued as soon as possible

No Imminent Danger

Assessment

- Identify the frequency, pattern, and timing of the behaviour e.g. after lunch, in the evening.
- Consider the patient's cognitive ability, insight, and judgment.
- Assess for unmet needs, e.g. hunger, toileting needs, pain, especially when the person has limitations in the ability to communicate needs, including cognitive impairment.
- Screen patients for delirium on admission, and routinely using the Confusion Assessment Method, and implement appropriate interventions. Refer to
  - B-00-13-10065 - Delirium Assessment and Care
  - B-00-10-10001 - Delirium Risk Care Plan
- Actively involve the patient, patient's family, substitute decision maker and the interdiciplinary health care team. Invite them to make suggestions about strategies that will increase the patient's personal control within the clinical environment.

Interventions

- Consider calling Security for stand by assistance
- Develop a plan of care that maximizes freedom through psychosocial and physiological approaches as well as environmental modifications.
- If a person's behaviour meets the criteria for a Violence Risk Alert, a Violence Risk Alert and Care Plan must be implemented, and the appropriate signage applied. Refer to policy: B-00-11-10178: Violence Risk Alert.
- Select and implement alternatives to restraint aimed at reducing risk factors and modifying behaviours. See table below for some alternative interventions.
- Attempt an individualized approach, involving interdisciplinary team members (OT, PT) as appropriate.
- Make the plan of care available to all staff encountering the patient.

All Scenarios (Imminent or no imminent danger):

Select and implement as appropriate the following alternative interventions to restraints

Interventions to Establish Therapeutic Rapport
• Introduce and identify yourself each time you speak to the individual • Face patient at the same level; try making eye contact • Speak in a low-key friendly tone and use a calm manner • Consider the patient's culture, age and personal preferences in planning care. If acceptable to the individual, use gentle physical touch techniques (e.g. foot stroking, hand massage) • Consider using a translator or the remote video language service, to ensure patient understands information being shared • Approach and move slowly, no sudden gestures

- Explain procedures clearly and concisely, in language that patient understands and re-state any clarification in words or phrases that the individual uses
- Respond to request for assistance in a timely manner so that trust can be built
- Use both verbal and non-verbal communication strategies
- Involve family members/caregivers, as appropriate and as available, to stay with the patient
- Recognize communication deficits and provide aids as appropriate (voice amplifiers, communication boards). Ensure that sensory aids, such as glasses and hearing aids, are functional and in use

Other Interventions

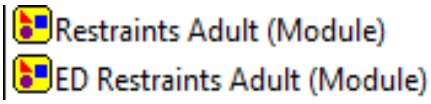
- Toilet regularly
- Maintain adequate pain control
- Remove unnecessary irritants (such as Foley catheters, IV lines) as soon as possible. If unable to discontinue irritants provide comfort to the site, e.g. proper securement or padding
- Attempt to camaflouge devices or irritants, e.g. with long sleeved clothing
- Help to regularly re-orientate the patient using such tools as wall clocks or calendars if this intervention does not cause distress to the patient
- Provide diversionary activities
- Provide something to hold e.g. soft toy
- Initiate oral feedings (versus intravenous or nasogastric) as soon as condition indicates
- Review medications that may be contributing to challenging behaviors and collaborate with physician/pharmacist for medication adjustments as necessary
- Request further assessment//treatment of sensory deficits if necessary
- Involve Occupational therapy and Physiotherapy in providing supportive devices to enhance positioning, increase mobilization or improve quality of life e.g. customized wheelchair seating, specialized walkers
- Involve Speech Language Pathology or Occupational therapy to implement or enhance communication strategies
- Involve team members as appropriate and as available to engage patients in meaningful activities, including family caregivers
- Involve the Addictions Consult Team to assist with any existing substance use issues or potential experience of withdrawal via harm reduction strategies
- Involve Psychiatry Liaison Consult Nurse to help with care planning for patients with complex and challenging behaviours
- **Consider the need for close or constant care**

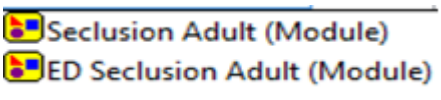
Environmental Interventions
Adjust the stimulation in the environment, as able: • Light and noise • Proximity to nursing station • Number of contacts • Roommate selection • Consider using a private room

If the behaviour of concern is resolved with the support of alternative interventions continue using those interventions until the behaviour is completely eliminated and care plan is updated.

Ordering Restraints

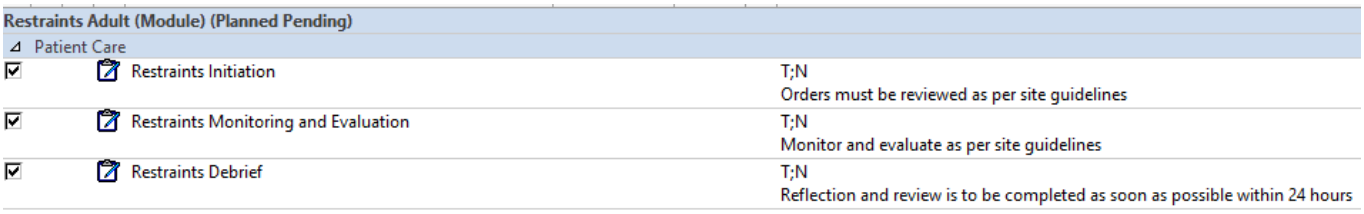
The same order and documentation processes are required for all types of restraints. In the Cerner Electronic Health Record (EHR) a restraint order is placed as *Restraints Adult (Module)* or *ED Restraints Adult (Module)*. Seclusion is ordered separately as *Seclusion Adult (Module) or ED Seclusion Adult (Module).*





All modules contain three components:

- Restraints initiation
- Restraints monitoring and evaluation
- Restraints debrief



All 3 order components fire tasks to the CareCompass Task List as well as the Single Patient Task List for nurses. The restraints monitoring and evaluation order fires a continuous/PRN task.

Restraint Initiation	The order and documentation process begins with the nurse contacting the provider about the behaviour and the use of restraints. Nurses can initiate and order the restraint module in emergency situations. Enter the order as a "No co-signature required" and inform the physician or NP verbally or by telephone about the behaviour and the use of restraints. ● *For Seclusion:* Inform physician **and** request to place an order for "Seclusion Adult (Module)" or "ED Seclusion Adult (Module)" **within 1 (one) hour.** Avoid PRN orders. (See B-00-13-10061 Secure Room protocol) ● *For 4- Limb Restraints:* Inform physician **within 1 (one) hour** ● For *all other restraints*: Inform physician as soon as possible; **within 8 hours** In emergency situations when restraints are initiated for the first time, it is recommended Security personnel be present to assist with applying restraints When restraints are initiated for the first time without a physician order, the physician will assess the patient in person, document clinical findings and plan of care as soon as possible following the application of restraints. When the order is initiated, the Cerner EHR provides a pop-up restraint alert when opening the chart indicating that the patient has active restraint orders. The alert will remain in place until the restraint orders are discontinued. **RESTRAINT ALERT** : has active restraint orders. Review and re-evaluate if restraints are · to your site policy/guideline for reordering and documentation.
Plan of care	While the patient is restrained, a comprehensive assessment and a plan of care are required to ensure safety of the patient. The plan of care should be updated every shift and whenever the patient's situation changes. The nurse in collaboration with the appropriate team members, including family caregivers will formulate a plan of care.

Restraint Monitoring and Evaluation (also see Appendix B)**:**

All Restraints

- Monitor for changes in LOC and respiratory status.

Physical restraints

- Monitor colour, circulation, sensation, motion and skin condition of all restrained limbs according to the parameters below.

Chemical restraints

- Monitor vital signs and the effectiveness of chemical restraints in managing the behaviour.

Environmental Restraints (Refer to B-00-13-100061 for Secure Room monitoring)

- Monitor patients behaviour, response to and effectiveness of environmental restraints

Restraint Type	Criteria	Initial Assessments – until behaviour stable	Ongoing assessment
Physical / Chemical Restraints	• **Level of consciousness** • **Respiratory status**	• Assess every 15 minutes x 1 hour • Continue every 15 minutes if/while patient behaviour remains unstable, then • Then assess every 30 minutes x 1 hour	• Q1h until restraints are discontinued
	• **BP, HR, Temp**	• Monitor as per orders, unit routine and PRN	
Physical Restraints	**CWMS restrained limbs**	• Assess every 15 minutes x 1 hour • Continue every 15 minutes if/while patient behaviour remains unstable, then • Then assess every 30 minutes x 1 hour	Every two hours and PRN: ○ Remove restraints to assess skin integrity ○ Reposition the patient ○ Perform range of motion exercises ○ Re-apply restraints, if still needed
Environmental Restraints	• Assess individually according to patient's level of risk, as per orders, unit routine and PRN (Secure Rooms – see B-00-13-10061)		

A full patient assessment, including head to toe assessment and VS are completed as per unit routine or prescriber orders **and** at the discretion of the nurse with any other restraint monitoring. Consider the need for close or constant care.

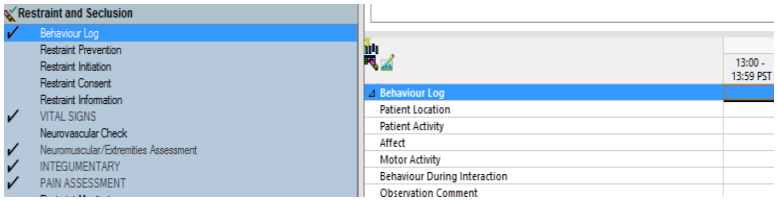
Removal of Restraints:

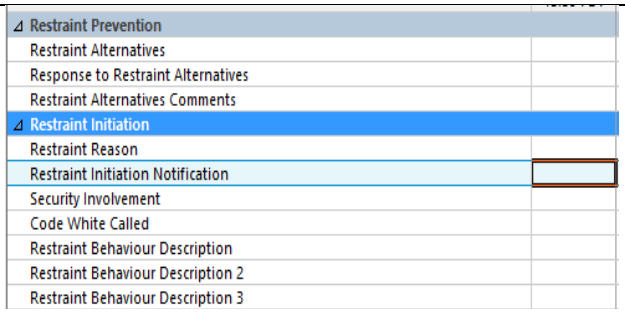
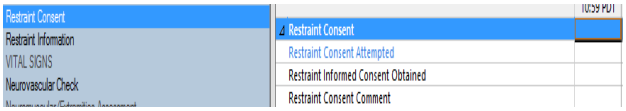
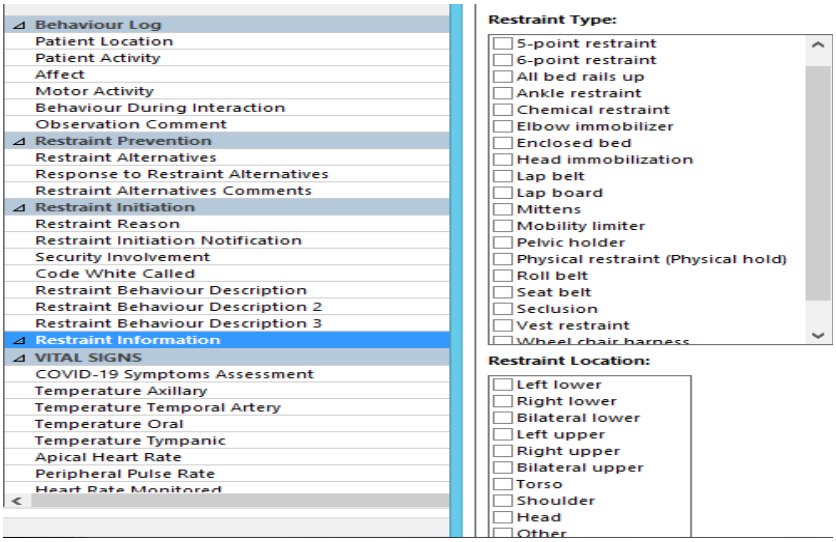
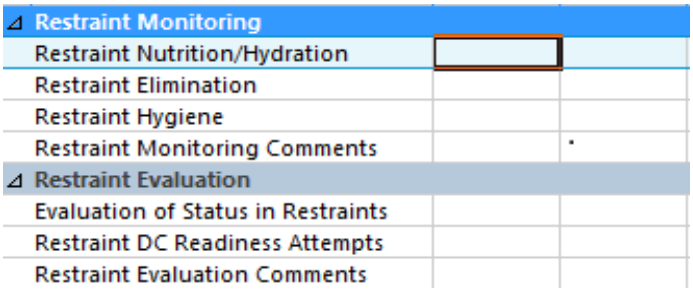
If the patient has demonstrated a risk of violence, ensure security personnel is present prior to removal of restraints. In patients with more than 2 points of restraints applied, any direct care measure that involves release of a limb or limbs should be performed with the support of at least 2 staff members. The sequence of removal and reapplication of physical restraints will depend on the assessment of patient safety (i.e. behaviour escalating) and staff safety. For example, staff may remove and reapply wrist restraints one at a time to safely assess skin/ circulation and allow for ROM.

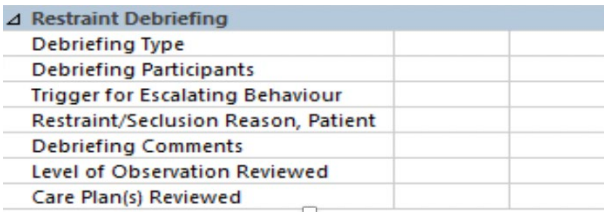
A trial period out of restraints or partial restraints is recommended before discontinuation. The duration of trial without restraint is at the discretion of the care team members directly involved in the patient's care. The discontinuation of restraint is based upon team review and in consultation with the patient/SDM.

Documentation

Documentation occurs as close as possible to the time of the event or care provided. This includes all assessment, planning, intervention, and evaluation. Providers and Allied Health professionals document their assessment and any alternative interventions or equipment recommendations made in the appropriate sections of the Cerner EHR

Restraint and Seclusion	In the Cerner EHR document the use of restraints using the restraint tasks from CareCompass and in iView under the Restraint and Seclusion Band.
Behaviour Log	Document the details of behaviour under Behaviour Log 
Restraint Prevention	Document restraint alternatives trialed prior to the application of restraints and patient's response to restraint alternatives.
Restraint Initiation	Document the reason to use the restraint when the clinical decision to apply a restraint device is made. Document the notification to provider per usual process; and patient and family or substitute decision maker after having the discussion with them about the use of the restraints and consent.

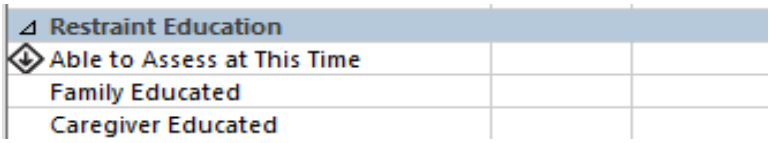
	
Under *Restraint Consent*	Document the attempts to obtain consent and if consent is obtained or not. 
Under *Restraint Information*	Create a dynamic group for each physical restraint device in use and for seclusion. Document the restraint type and location of its use. Additionally, a narrative note may be created documenting the events leading up to, and the decision making behind initiating a restraint where more detail is required. 
Restraint Monitoring and Restraint Evaluation	Document ongoing care and outcomes with each assessment (continuing restraints, releasing and reapplying restraints, trialing off, or discontinuing). 

Incident Reports	A PSLS must be completed when there are untoward effects of restraint such as skin breakdown or bruising. The MD/NP is to be notified. If staff are injured as a result of violent incident, they must report the incident to the Provincial Workplace Health Call Centre 1-866-922-9464.
Discontinuation of Restraint	Once the patient no longer requires any restraint device, an RN/RPN/provider can discontinue the order for restraints module, and deactivate the dynamic group created for the restraint device. For periods of trialling off, or trying an alternate restraint, document this in the "Restraint Activity" section, and do not discontinue the order.
Restraints Debrief	Research has shown that debriefing with clients, families, SDMs and staff has been helpful in preventing future restraint episodes. Debriefing needs to be completed as soon as possible within 24 hours of applying the restraints and should include the health-care team and the patient/family/SDM. The debriefing should include a review of the triggers, the restraint alternatives, the care provided, type of restraint, timeframe of the removal of the restraint, the family involvement, and the consent and feedback from the patient. Debriefing can also 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. The Restraints Debriefing order can remain on the chart until debrief is completed. Once debrief is complete, document this in the Restraints Debriefing task in the Scheduled/Unscheduled tab of the Care Compass Task List. Update the patient's violence risk alerts and care plan. If necessary, collaborate with the Violence Prevention Advisor (violenceprevention@providencehealth.bc.ca).  Restraint Debriefing Debriefing Type Debriefing Participants Trigger for Escalating Behaviour Restraint/Seclusion Reason, Patient Debriefing Comments Level of Observation Reviewed Care Plan(s) Reviewed

Patient and Family Education

Provide patients, as appropriate, and family members/temporary substitute decision- makers with education about restraint as a last resort, alternative approaches trialled, and plan of care with the use of restraints.

Provide the information brochure entitled "*Recovering in a Least Restraint Environment*" (Appendix C). Document education provided.



Related Documents:

1. B-00-13-10013 – Alcohol Withdrawal
2. B-00-13-10081 – Close or Constant Care: Decision Making Process
3. B-00-13-10135 Close or Constant Care: Providing
4. B-00-11-10110 – Corporate Policy: Consent
5. B-00-13-10065 – Delirium: Assessment and Care (Acute Care)
6. BD-00-07-40081 - Delirium: Screening, Assessment and Management (Long Term Care at PHC)
7. B-00-07-10011 - Falls Injury Prevention and Management
8. Occupational Health and Safety Violence Prevention policies
9. B-00-11-10190 - Code White Emergency Response
10. B-00-13-10061 - Secure room: Care of the Patient
11. Mental Health Act

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Persons/Groups Consulted:

Director Clinical Supplies and Equipment, PHC

Corporate Director, Quality, Patient Safety, Risk Management, Patient Relations & Infection Prevention and Control

PHC Nurse Educator Group

PHC Nurse Practitioners

PHC Clinical Nurse Specialists

PHC Practice Consultants

PHC Clinical Informatics Specialists

Medicine Quality and Safety Committee

Mental Health CNS's

Violence Prevention Advisor

Occupational Therapy Professional Practice Lead

Physiotherapy Research, Education and Practice Co-ordinator PHC

Tertiary Mental Health

Security Leads; Co-ordinator Protection Operations, Paladin Security

Developed By:

Clinical Nurse Specialist Medicine

Nurse Educator MSJ Medicine and Senior's Care

Practice Consultant, Professional Practice

Initial Effective Date:	August 2003
Posted Date:	18-APR-2023
Last Revised:	18-APR-2023 (minor edits)
Last Reviewed:	18-APR-2023
Approved By:	PHC
	Professional Practice Standards Committee
Owners:	PHC
	Professional Practice, Mental Health, Medicine

Appendix A Approved RESTRAINT & NON-RESTRAINT PRODUCTS (Acute)

Refer to - B-00-13-10059 Least Restraint: Care of the Patient at Risk for or Requiring Restraint

1) Each unit is responsible for the ordering and management of the products required for the department, to be stored in an accessible location.
2) **Mark all items with a permanent marker** identifying unit location for linen services to return to the unit linen cart.

NURSING SUPPORT: CNS Medicine Local 66768
CERNER: *Only the products listed below are approved for PHC use.

LIMB	
	**ITEM ID: 00082048 WAREHOUSE INVENTORY** **Disposable Wrist and Ankle Foam Holders with Quick Release Buckles** (VENDOR ITEM ID: Bowers/Posey 2532) ***Quick Reference: B-00-14-10016***
	**ITEM ID: 00090260 VENDOR DIRECT** **Wrist Cuff Blue *Reusable* Non Locking attach with Quick Release buckles** (VENDOR ITEM ID: Bowers/Posey 2790Q) ***Quick Reference: B-00-14-10018***
	**ITEM ID: 00090261 VENDOR DIRECT** **Ankle Cuff Red *Reusable* Non Locking attach with Quick Release buckles** (VENDOR ITEM ID: Bowers/Posey 2791Q) ***Quick Reference: B-00-14-10018***
	**** FOR USE IN EMGERGENCY DEPARTMENT ONLY**** **POSEY TAT (Twice as Tough cuff with D-Rings Non-locking)** **ITEM ID: 00032154 WAREHOUSE INVENTORY** **Wrist Cuff Blue Non Locking Cuffs Reusable attached with D-Rings** (VENDOR ITEM ID: Bowers/Posey 2790) **ITEM ID: 00001326 WAREHOUSE INVENTORY** **Ankle Cuff Red Restraint- Reusable with D rings** (VENDOR ITEM ID: Bowers/Posey 2791) ***Quick Reference: B-00-14-10015***
MITTENS	
	**ITEM ID: 00011537 WAREHOUSE INVENTORY** **MITTENS -Reusable Double padded one size** (VENDOR ITEM ID: Bowers/ Posey 2819) ***Quick Reference: B-00-14-10014***

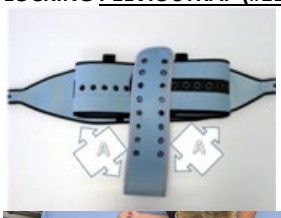
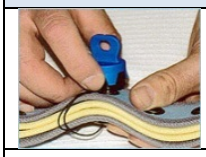
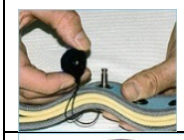
ELBOW IMMOBILIZER/ARM SPLINT

ITEM ID: 00011583 WAREHOUSE INVENTORY
Arm Splint–<u>Medium Size</u> Reusable (limb circumference 6”-17”)
(VENDOR ITEM ID: Bowers/Posey 8168M)
Special Order sizes:
Sizes:
S - (limb circumference 3’’-14’’) (Style #8168S) Direct Order
M - (limb circumference 6’’-17’’) (Style #8168M) ITEM ID # 00011583
L - (limb circumference 8’’-21”) (Style #8168L) Direct Order
Optional Splint Clips
ITEM ID: 00083112 DIRECT TO VENDOR
(VENDOR ITEM ID: Cardinal/ Posey 8161)
*Quick Reference: **B-00-14-10017***

PINEL WAIST BELT

Safety Alert – Waist Restraints

- It is recognized that there are inherent dangers related to the use of patient waist restraints. There have been patients who died from asphyxiation when a waist restraint has been able to slide up over a patient’s chest. The restraints currently in use at Providence Health Care are selected to minimize the risk of harm associated with their use. Some basic reminders will ensure the safety of the patients and residents who require the use of restraints
- Perform a thorough assessment of the patient to determine whether a waist restraint is appropriate, and if so what level of monitoring needed
- Keep the side rails of the bed raised at all times when waist restraints are being used
- Assess whether there is a gap between the split side rails. Ensure that any gaps are blocked with a manufactured solid gap barrier that effectively prevents the patient from sliding through when restraints are being used. If this is not available, determine the level of observation required to safely maintain the patient in restraints
- Ensure that restraints keep the patient centered in bed, and that the waist belt cannot slide up over the patient’s chest
- Ensure that the straps for the waist restraint are attached to the bed frame and not the side rails, and ensure that the part of the bed frame they are attached to moves with the patient as the bed height and angle are adjusted (otherwise tightening or loosening of the restraint may occur as the bed position changes)
- Ensure pelvic straps are used when using the Pinel waist restraint in bed and chair. This will prevent the waist belt sliding up and causing harm to the patient; and
- Ensure routine monitoring is observed as outlined in Least Restraint Decision Support Tool on SHOP

ROLL BELT: PINEL LOCKING WAIST BELT	*KEYS REQUIRED *MUST BE USED WITH THE PELVIC STRAP *Quick Reference* B-00-14-10013
  **Locking Waist BELT (1PHC)-used with Pelvic strap(#11)**  **cking Extender (2-PHC)** **LOCKING PELVIC STRAP (#11)**  	**ITEM ID: 00023727 WAREHOUSE INVENTORY** **PINEL LOCKING WAIST BELT UNIVERSAL 5"x 42"LONG** (1-waist belt, 2- side straps, **3-keys**, 1-button/pin, 2-button/pin/lanyard sets) (VENDOR ITEM ID: Associated Health/PINEL PIN-1U /PIN-1PHC) **ITEM ID: 00023728 DIRECT TO VENDOR** **PINEL LOCKING WAIST EXTENDER 10" UNIVERSAL 5 X 42"** (VENDOR ITEM ID: Associated Health/PINEL PIN-2PHC Extender PHC Custom 1" wider than standard PIN-2) INCLUDES 1 BUTTON/PIN **ITEM ID: 00089419 VENDOR DIRECT** **PINEL LOCKING PELVIC STRAP PINEL #11 (**NO VELCRO) ***For Bed or Chair use with Pinel Locking waist belt.** (VENDOR ITEM ID: Associated Health/PINEL #11 PIN-11)
PINEL KEYS /ACCESSORIES	***REPLACE LOCKS EVERY TWO YEARS**
	**ITEM ID: 00023730 WAREHOUSE INVENTORY** **PINEL MAGNETIC KEY (PINEL #5)** (VENDOR ITEM ID: Associated Health/PINEL PIN-5)
 	**ITEM ID: 00023731 WAREHOUSE INVENTORY** **PINEL BUTTON / PIN / LANYARD (PINEL #6L)** (VENDOR ITEM ID: Associated Health PINEL PIN-6L)
	**PINEL BUTTON ONLY (PINEL #6A)- Special Order Direct to Vendor** **Special Order #Pinel #6A from Associated Health** USE: Locks material together by inserting Pin in bottom hole of Button. Should be replaced about every two years. COMPONENTS: 1 X Button.
	**PINEL PIN ONLY (PINEL #6B) Special Order Direct to Vendor** **Special Order # Pinel #6B from Associated Health** 1 X Pin. USE: Insert through grommet holes of up to FOUR layers of material.
	**PINEL BUTTON / PIN (PINEL #6)-Special Order Direct to Vendor** **Specials Order # Pinel#6 from Associated Health** 1 X Button; 1 X Pin. USE: Without string. Used normally on center portion of Waist Belt.

NON RESTRAINT ALTERNATIVES	
SOCKS (*ON TOP UP)	**Non Skid Double- Sided Latex Free Disposable** *Quick Reference* ***B-00-14-10011***
	**ITEM ID: 00085378 WAREHOUSE INVENTORY** **SOCKS TAN ADULT SIZE 7.5-10** (VENDOR ITEM ID: MEDICAL MART 721/1097-001)
	**ITEM ID: 00085379 WARHOUSE INVENTORY** **SOCKS GRAY ADULT SIZE XXL 10.5+** (VENDOR ITEM ID: MEDICAL MART 721/ 1098-001)
	**ITEM ID: 00085380 WAREHOUSE INVENTORY** **SOCKS ROYAL BLUE ADULT BARIATRIC /SWELLING SIZE XXXL** (VENDOR ITEM ID: MEDICAL MART 721/1099-001) **Special Order Note**: Transition Thread on cuff that snaps to expand cuff
HIGH FALLS RISK ONLY * USE RED SOCKS	*Quick Reference* ***B-00-14-10011***
	**ITEM ID: 00118000 VENDOR DIRECT** **SOCKS RED PILLOW PAWS DOUBLE SIDED SIZE CHILD/YOUTH** (VENDOR ITEM ID: STEVENS 492-3943-001)
	ITEM ID: 00118001 VENDOR DIRECT **SOCKS RED PILLOW PAWS DOUBLE SIDED SIZE ADULT 5-7** (VENDOR ITEM ID: STEVENS 492-3923-001)
	ITEM ID: 00117190 WAREHOUSE INVENTORY **SOCKS RED PILLOW PAWS DOUBLE SIDED SIZE ADULT XL** (VENDOR ITEM ID: STEVENS 492-3811-001)
	ITEM ID: 00116927 WAREHOUSE INVENTORY **SOCKS RED PILLOW PAWS DOUBLE SIDED SIZE XXL** (VENDOR ITEM ID: STEVENS 492-3802-001)
	ITEM ID: 00116928 WAREHOUSE INVENTORY **SOCKS RED PILLOW PAWS DOUBLE SIDED SIZE XXXL** (VENDOR ITEM ID: STEVENS 492-3807-001)
HIP PROTECTORS	
	✓ *Available through OT/PT ✓ *Requires OT/ PT referral * NOTE: This is a patient-purchase item / not available through Stores. *Quick Reference*: ***B-00-14-10012***

STRYKER INTEGRATED BED ALARM	
	**STRYKER GO-BED** **Model FL28C** *Quick Reference* ***B-00-14-10010***
PROTEKT ADVANCED MAGNET ALARM	
	**PROTEKT ADVANCED MAGNET ALARM** **VENDOR MACDONALD HOME HEALTHCARE ORDER # 10240B** Proactivemedical web site *Quick Reference* *B-00-14-10019*
SENSATEC WIRELESS ALARM	**SENSATEC Special Order from Omega Solutions**
 ***OLDER* MODEL ST320**  **CHAIR SENSOR MAT**  **BED SENSOR MAT**	**1.Sensatec Sensor Unit Fall Alert Control Model ST320** (battery or 110 volt) Order# 10000-0878 2. **Nurse Call Accessory Cord 12Ft, RJ45 to 1/4in** Order# 0460-0055 3. **Nurse Call "Y" Adapter** Order# 0460-0005 4. Pwr Supp, 9VDC 3 prongOrder# 0180-0025 **Extra control unit (3 pieces):** 1. Sensatec sensor unit (battery or 110- volt) 2. Adapter cord for nurse call system 3. "Y" adapter 4. Wireless Transmitter (future add-on) --- **ITEM ID: 00023789 VENDOR DIRECT** **CHAIR SENSOR MAT 90 DAY USE (special Order only)** **Single patient use only** *DATE MAT (VENDOR ITEM ID: Sensatec/Omega1000-1859K) (1000180610k) --- **ITEM ID: 00075548 WAREHOUSE INVENTORY** **BED SENSOR MAT 90 DAY USE** **Single patient use only** *DATE MAT (VENDOR ITEM ID: Sensatec/Omega 2794901849K)(1000-1849k) *Quick Reference* *B-00-14-10019*

<table>
<tr>
<td> 
NEW <u>MODEL ST750</u>

 
<u>CHAIR</u> SENSOR MAT

 
<u>BED</u> SENSOR MAT</td>
<td>SENSATEC MODEL ST750 CONTROLLERS AND ACCESSORIES

SENSATEC ST750 <u>CONTROLLER</u> 10000575 CODE ALERT / W/Boot, Strap, Battery
CABLE 04600150 SENSATEC NURSE CALL ACCESSORY / 700 SERIES
SENSATEC <u>AC POWER SUPPLY</u> 01800068 ST700 SERIES / 5VDC
SENSATEC <u>NURSE CALL 'Y' ADAPTOR</u> 04600005

ORDER # 1000180610K DIRECT TO VENDOR
SENSATEC <u>CHAIR SENSOR PAD</u> 1000180610K 90 DAY WTY / FOLDABLE, DISPOSABLE 10 /PACK
<u>Single patient use only</u> *DATE MAT

ORDER# 1000180210K DIRECT TO VENDOR
SENSATEC <u>BED SENSOR PAD12x 30”</u> 1000180210K 90 DAY WTY / FOLDABLE, DISPOSABLE 10/ PACK
Quick Reference B-00-14-10019
<u>Single patient use only</u> *DATE MAT</td>
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<tr>
<td>IN-SERVICE /VENDOR SUPPORT</td>
<td><u>POSEY</u> via Canadian Hospital Specialties /CHS
CAE Medical Manager Canadian Hospital Specialties Ltd. 2810 Coventry Road, Oakville, Ontario L6H 6R1 Web: www.chsltd.com
---
<u>PINEL</u> via Associated Health https://www.pinelmedical.com/
Territory Manager Associated Health Systems #6 8145-130th Street Surrey, BC V3W 7X4. Toll Free 877-457-8012
www.associatedhealthsystems.com orders@associatedhealthsystems.com
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<u>STRYKER INTEGRATED BED ALARM</u>
Stryker Account Manager, Acute Care

<u>PROTEKT ADVANCED MAGNET ALARM</u>
MACDONALD HOME HEALTHCARE 1B-138 West 6th Ave Vancouver BC V5Y 16K
Phone 604-872-5496 ext 2 Customer Service

<u>SENSATEC</u> via OMEGA Solutions EMAIL: support@omegasolution.ca
President & General Manager Omega Solutions Inc.
#222-1751 Harvey Ave, Kelowna B.C. V1Y 6G4 Toll free 1- 844-666-4275 ext 1000</td>
</tr>
<tr>
<td><u>LAUNDRY OF REUSABLE PRODUCTS</u>

*Ensure items are clearly marked with a permanent marker identifying the unit location for linen services to return to the unit cart.</td>
<td><u>REUSABLE SUPPLIES</u> are sent down to laundry and returned to the unit on the clean laundry cart in a bin, these items are to be removed daily by the Ward Aide to replace in the Restraint box/bin on unit.

*STORAGE OF SUPPLIES ON THE UNIT
It is the responsibility of each unit to manage Restraint/Non Restraint products, whether in a bin or cart set up.</td>
</tr>
<tr>
<td colspan="2">*ANY PRODUCT NOT LISTED - PLEASE DISPOSE</td>
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Appendix B: Restraint Monitoring and Evaluation

All Restraints

- Monitor for changes in LOC and respiratory status.

Physical restraints

- Monitor colour, circulation, sensation, motion and skin condition of all restrained limbs according to the parameters below.

Chemical restraints

- Monitor vital signs and the effectiveness of chemical restraints in managing the behaviour.

Environmental Restraints (Refer to B-00-13-100061 for Secure Room monitoring)

- Monitor patients behaviour, response to and effectiveness of environmental restraints

Restraint Type	Criteria	Initial Assessments – until behaviour stable	Ongoing assessment
Physical / Chemical Restraints	• **Level of consciousness** • **Respiratory status**	• Assess every 15 minutes x 1 hour • Continue every 15 minutes if/while patient behaviour remains unstable, then • Then assess every 30 minutes x 1 hour	• Q1h until restraints are discontinued
	CWMS restrained limbs	• Assess every 15 minutes x 1 hour • Continue every 15 minutes if/while patient behaviour remains unstable, then • Then assess every 30 minutes x 1 hour	Every two hours and PRN: ○ Remove restraints to assess skin integrity ○ Reposition the patient ○ Perform range of motion exercises ○ Re-apply restraints, if still needed
	BP, HR, Temp	• Monitor as per orders, unit routine and PRN	
Environmental Restraints	• Assess individually according to patient's level of risk, as per orders, unit routine and PRN (Secure Rooms – see B-00-13-10061)		

A full patient assessment, including head to toe assessment and VS are completed as per unit routine or prescriber orders **and** at the discretion of the nurse with any other restraint monitoring. Consider the need for close or constant care.

Appendix C – Patient and Family Teaching (IA.200.R245.PHC). Recovering in a Least Restraint Environment

Providence HEALTH CARE
How you want to be treated.

Recovering in a Least Restraint Environment

What is a restraint?

A 'restraint' is a way to limit a person's movement and ability to hurt them self or others. For example; pulling out tubes; or acting in an aggressive or violent way.

There are three types of restraint:

- A **physical restraint** limits a person's ability to move for example; padded mittens, soft wrist restraint or waist belt.
- An **environmental restraint** limits a person's movement within a space, such as a specialized quiet room that patients cannot leave
- A **chemical restraint** is medication given to restrict movement or cause sedation.

Before we use restraints

Except in an emergency,we encourage patients and families to be involved in making decisions about the use of restraints. We will always try to find different ways to help without using a restraint.

Some options we can try:

- Have a family member sit at the bedside.
- Increase activity level with such things as walking more often or exercises.
- Arrange for the patient to listen to their favourite music.
- Have patients wear hip protectors. These protect hips from injury should a fall occur.
- Identify and treat any pain or discomfort.
- Keep to a normal daily routine.
- Review and adjust medications.
- Use a bed or chair alarm. This alerts us if the patient gets out of the bed or chair on their own.
- Use reminders such as signs, calendars, or photos.
- Provide support and reassurance.

Least restraint approach

Restraints are an exceptional and temporary last resort to keep patients, families and staff safe. We want to provide a safe therapeutic environment and respect the dignity, rights and independence of patients.

- Our approach is to always use the least restrictive way that keeps patients and others safe.
- We only use restraints when other ways to help have been tried and do not work.
- If a restraint is needed, it is used for as short a time as possible.
- Unless there is a great risk that the patient might hurt themselves or someone else, they can say "no" to a restraint.

If a restraint is necessary

Restraints are applied by trained professionals and are never used as punishment.

When restraints are used we will:

- try to find out why a restraint might be needed.
- work with everyone on the health care team to find other ways to help.
- always respect the rights of the patient.
- keep patients and families informed.
- use the least restrictive restraint possible.
- watch closely to make sure the patient is safe.
- remove the restraint as soon as possible.
- continue to provide daily care.

If you have concerns or questions about the use of restraints, please ask the nurse or care provider.

IA.200.R245.PHC (2021.03.03)