Least Restraint: Guideline for Maximizing Independence (in Residential Care)

Site Applicability

All VCH Residential Care Sites

Practice Level

Basic Skills for all disciplines working in residential care within the competencies of their scope of practice:

- RN, RPN, LPN, NP
- OT, PT
- RD
- Physician

Unregulated healthcare workers – under the supervision and direction of a regulated health care professional:

- Resident Care Assistants
- Rehab Assistants and Activity Workers

Policy Statement

- Facilities are responsible to ensure staff receive training and understand the Residential Care Regulation (Appendix A) and VCH policy on the use of least restraints
- Facilities are responsible to ensure staff have the knowledge and skills to use restraints properly, using alternatives to restraints as much as possible with the end goal of making a restraint unnecessary when caring for a resident.
- Decisions around use of restraints / positioning devices that have restraint effect must be resident-centered. Ensure the decision-making process and care outcome maintain the dignity and independence of the residents.
- The use of restraints must include resident-specific assessment, person-centered care-planning and evaluation to ensure the interventions are effective for the residents.
- Restraint use exceeding 24 hours requires the initiation of an ongoing problem solving and discussion with resident and/or their Substitute Decision Maker (SDM) and MD/NP, followed by their signatures on the Written Agreement (Appendix B)
  - If restraint(s) is in use, the written agreement requires minimum an annual update
- Reevaluation of any restraint is required (at minimum) on admission, quarterly with RAI-RC (MDS) assessments, and annually for care conference.

Need to Know

- A Restraint is defined as “any chemical, electronic, mechanical, physical or other means of controlling or restricting a person in care’s freedom of movement in a community care facility, including accommodating the person in care in a secure unit” *(British Columbia Residential Care Regulation, p. 5, 2009).*
- References to restraints include all positioning devices that have restraint effect
  - Positioning devices are often used therapeutically following a clinical and functional evaluation. Although the intent may not be to restrict free movement, some positioning devices have a restraining effect and therefore are subject to practice standards for use of a restraint. Refer to Appendix E for a list of commonly prescribed positioning devices that are identified as a restraint with some contraindications and considerations for usage
  - Side rails do act as restraints. Refer to Appendix F for the assessment and implementation guide for side rails. An upper bed side rail can act as a positioning, mobility support device. However, as demonstrated in Appendix F, an upper side rail has risks. Therefore it is subject to this practice standard for use of a restraint

- The inappropriate use of restraints are known to negatively impact physical, psychological and social well-being.
- With any restraint use, residents must be systematically monitored to compensate for negative effects of the restraints, to adjust care to ensure the resident's needs and comforts are attended, as well as to evaluate the effectiveness in managing the problem (the reason for the restraint).
- Decision-making involving the use of restraints requires consideration of the specific needs of the resident, collaboration with the resident and/or their SDM and multidisciplinary team members, and in compliance with the British Columbia Residential Care Regulation (Appendix A).
- The written agreement must be signed by the Resident/SDM and MD/NP. The signatures signify that they acknowledge the negative effects of restraints, that effective alternatives to restraint will continue to be used and they agree to the use of restraints at this time (Appendix B: SBAR & Agreement for Restraint).
  - A verbal agreement over the telephone can be obtained and must be documented in the Progress/ Interdisciplinary Notes. Subsequently, the written agreement must be signed at the earliest opportunity.
- Refer to Appendix D for definitions

Please Note: When coding RAI-RC (MDS) assessment, only physical restraints are included. Please note also, for coding, that a physical restraint used for a quadriplegic or comatose resident including a chair that prevent rising is NOT CONSIDERED A RESTRAINT

Equipment & Supplies

A variety of equipment options can be used as non-restraint alternatives. See Appendix C for recommendations.

Practice Guideline

See Decision Guide for Restraint Use. It is a summary of this guideline – Appendix G

Assess/Analyze

1. **Does the resident's behaviour pose imminent danger to the resident or others?**
   De-escalate the situation as appropriate. Refer to VCH Workplace Violence Prevention Program resources.
2. **Is the situation manageable with staff members?**
   a. If the situation is NOT manageable, follow site-specific protocol and procedure on response to emergency/violent situations. For example: Code White, 911
   b. While waiting a response for assistance and if the situation is manageable, continue assessing:
      - Is it delirium? Screen using Confusion Assessment Method (CAM) to screen for delirium and treat a positive CAM score if possible
      - Has the situation occurred in the past? Consult Care Plan for strategies that worked before
   c. Use a restraint as an emergency only to prevent injury to resident or others, and allow essential medical treatment to proceed
      - Use non-restraint strategies first if possible (Refer to Appendix C for examples of non-restraint strategies)
   d. If an emergency restraint is used
      - Implement 24-hour close observation to assess resident's response, identify risks associated with the restraint used and to determine appropriateness of the selected intervention (See Appendix H)
      - Although use of emergency restraints does not require consent from physician/ NP / resident / SDM, involve them in the decision-making process if possible.
      - Always debrief incident of emergency restraint use with resident, family/SDM and staff and add lesson learned to the care plan to assist future decision making

3. **Does the resident require a non-emergency restraint?**
   a. Is it delirium? Screen using Confusion Assessment Method (CAM) to screen for delirium and treat a positive CAM score
   b. If it is not delirium, assess to develop understanding of resident's needs and the situation
      - Review chart to understand resident's condition and history
      - Interview those involved to understand (residents/family, team members) to identify behaviours for which restraints are proposed
      - Initiate 24-hour close observation and review findings with interdisciplinary team to better understand the resident's needs, habits and concerns
      - Review strategies already in use, rationale and outcomes
      - Develop interventions. Likely there will be more than one intervention proposed. Use Residential Care SBAR and Agreement for Restraint (Appendix B) as a worksheet.
      - Set up a plan to systematically test interventions.

4. **Is one of the proposed interventions a restraint?**
   a. Help the resident/SDM understand the situation and plan using the Residential Care SBAR and Agreement For Restraint (Appendix B) to guide the conversation
   b. Obtain agreement from resident or SDM by telephone if necessary
   c. Obtain agreement from physician/NP using the Residential Care SBAR and Agreement for Restraint (Appendix B) if necessary
   d. Initiate 24-hour observation to monitor response to restraint to determine if resident's safety is at risk due to restraint

Care-Planning

1. In setting up a systematic plan to test interventions
   a. Use 24-hour observation cycles to help further understand resident's needs/concerns and response to the selected interventions
   b. Review 24-hour close observation findings and decide:
      - Is the resident's behavior settled?
      - What more have we learned about the resident's values, wishes, habits and concerns? Are there changes or additional information that need to be updated on the care plan?
      - Did the new intervention help to address resident's needs?
      - Do we need another 24-hours of observation to achieve results? Do we need to test another intervention?
   c. How does the resident respond to the restraint(s) and/or non-restraint alternatives?
   d. What new information learned and collected

2. Continue to test interventions until behaviour settled and resident/SDM satisfied with the care outcome.
   a. The behaviour is settling with new interventions and
   b. That the negative effects of restraint are compensated as per care plan, or
   c. The restraint is no longer needed

3. Once satisfied with the current plan, update care plan and other relevant documents to ensure all staff have enough information about the care and to make subsequent care decisions

Evaluation

4. Continually review and document in progress note and on care plan: Can the restraint(s) be reduced or removed? Minimally review occur
   a. with every RAI-RC (MDS)
   b. with condition changes
   c. with resident/family at annual care conference

Expected Client/Family Outcomes

- Resident/SDM understand the risks and dangers of restraint proposed
- Resident/SDM understand the care plan proposed, potential and expected outcomes for the resident
- Resident/SDM participate in decision making for the proposed use of both restraint and non restraint alternatives, and provide informed consent
- Resident expresses signs of safety, comfort and contentment

Patient/Client/Resident Education

- Interdisciplinary team members inform the Resident/SDM about restraints, alternatives to restraints, regulations and best practice guidelines for the use of restraints
- May use Family/Resident Education pamphlets as a resource

Evaluation/Audit

- Consider accreditation as a process evaluation strategy to ensure compliance to practice standards
- **Audit Tool:** Least Restraint CPD Audit Tool (Appendix I): Recommend to complete regularly to evaluate compliance with best practice process
- **Quality Indicators:** Baseline Restraint Audit (Appendix J): Complete to identify and track restraint use on the unit and/or the whole care home

Site Specific Practices

Coastal CoC: The following tools apply only to the Coastal CoC. Please order directly from Printing Services:

- Least Restraint Process Algorithm #VCH.CO.0028
- Alternative Non-Restraint Intervention worksheet #VCH.CO.0022
- Behaviour Pattern Record #VCH.CO.0026
- Least Restraint Referral Form #VCH.CO.0031
- Restraint Use Care Plan #VCH.CO.0034
- Restraint use Monitoring Record #VCH.CO.0029
- Restraint use Tracking Record #VCH.CO.0024
- Least Restraint Audit Tool #VCH.CO.0025

Related Documents

VCH:

- BD-00-07-40005: Atypical Antipsychotic Agents - Guideline for use as part of the management strategy of behavioural and psychological symptoms of dementia (BPSD)
- VA: Delirium/Acute Confusion: Assessment and Care for Older Adults
- Identification of Agitated & Excessive Behaviours & Client-Centered Interventions in Residential Care
- D-00-07-30014: Continence: Promotion and Maintenance
- D-00-07-30003: Bowel Function: Promotion and Maintenance in Residential Care
- BD-00-07-40028: Falls & Injury Prevention in Residential Care
- D-00-07-30067: Basic Pain Assessment & Management of the Older Adult in Residential Care

Regulations

1. Community Care and Assisted Living Act. Residential Care Regulation. Division 5 — Use of Restraints (2009) (See Appendix A).
2. Director of Licensing Standard of Practice (2009). Agreement in Writing to the Use of Restraints.
3. Community Care and Assisted Living Act. Community Care and Assisted Living Act. Bill 17 Section 7 – Health Statutes (Residents' Bill of Rights) Amendment Act (2009).

VCH Healthcare Technology Management

Biomedical Engineering

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19. VCH-PHC Capability and Consent Tool BC edition (2009). Available through VCH or email VCH and quote catalogue number 18.100.C33
20. Talerico, Karen. 2001. "Myths and Facts about Side Rails". American Journal of Nursing, 101(7).
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Developed/Revised by

CPD Developer Lead: Clinical Practice Leader, Residential Care, Vancouver

Revision Group Members:	**Original Team Members 2010**:
Care Licensing, Vancouver	BioMed, Regional
Clinical Resource Nurse, Minoru Residence, Richmond	Clincal Practice Leader, Vancouver
CNS, Residential Care, Youville, PHC	CNS, Seniors Program, Coastal
Coordinator of Residential Pharmacy, UBCH	Educator, Coastal
DOC, Windermere Care Centre, Vancouver	Falls Lead, Regional
Educator, Evergreen House, Coastal	Licensing, Vancouver
Educator, Residential Practice, Vancouver	OT Practice Lead, Vancouver
Medical Director, Residential & Transitional Care, Vancouver	Pharmacy, Vancouver
Professional Practice Leader, OT, PHC	RAI Educator, Regional
PT, Residential Practice, Vancouver	RN, Vancouver
Regional CRT, OT, VCH	

Endorsed by

(Regional SharePoint 2nd Reading)
Health Authority Medical Advisory Council (HAMAC)
Health Authority & Area Specific Interprofessional Advisory Council Chairs (HAIAC)
Health Authority Profession Specific Advisory Council Chairs (HAPSAC)
Operations Directors
Professional Practice Directors
Regional Residential Quality Practice Council
Complex Residential Care Working Group

Final Sign-off & Approved for Posting by

Chief Nursing Officer & Executive Lead Professional Practice, VCH

Date of Approval/Review/Revision

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Appendix A: Section 1 - British Columbia Residential Care Legislation, Division 5

B.C. Reg. 96/2009 O.C. 225/2009	Deposited March 13, 2009 effective October 1, 2009

Community Care and Assisted Living Act: Residential Care Regulation [includes amendments up to B.C. Reg. 96/2009, October 1, 2009]

Division 5 — Use of Restraints

Restrictions on use of restraints

73 (1) A licensee must ensure that a restraint is not used unless
(a) the restraint is necessary to protect the person in care or others from serious physical harm,
(b) the restraint is as minimal as possible, taking into consideration both the nature of the restraint and the duration for which it is used, and
(c) the safety and physical and emotional dignity of the person in care is monitored throughout the use of the restraint, and assessed after the use of the restraint.

(2) In addition to the requirements under subsection (1), the following conditions apply to the use of a restraint under section 74 (1) (b) *[when restraints may be used]*:
(a) all alternatives to the use of the restraint must have been considered and either implemented or rejected;
(b) the employees administering the restraint must
(i) have received training in alternatives to the use of restraints and determining when alternatives are most appropriate, and the use and monitoring of restraints, and
(ii) follow any instructions in the care plan of the person in care respecting the use of restraints;
(c) the use of the restraint, its type and the duration for which it is used must be documented in the care plan of the person in care.

(3) Following the use of a restraint in an emergency, the licensee or a person authorized for this purpose by the licensee must
(a) provide, in a manner appropriate to the person's skills and abilities, information and advice in respect of the use of the restraint to
(i) the person in care who was restrained,
(ii) each person who witnessed the use of the restraint, and
(iii) each employee involved in the use of the restraint, and
(b) document in the care plan of the person in care the information and advice given.

When restraints may be used

74 (1) Subject to subsection (2), a licensee may restrain a person in care
(a) in an emergency, or
(b) if there is agreement to the use of a restraint given in writing by both
(i) the person in care, the parent or representative of the person in care or the relative who is closest to and actively involved in the life of the person in care, and
(ii) the medical practitioner or nurse practitioner responsible for the health of the person in care.

(2) A licensee must ensure that a person in care is not restrained
(a) for the purpose of punishment or discipline, or
(b) for the convenience of employees.

Reassessment

75 (1) If a person in care has been restrained, a licensee must reassess the need for the restraint at least once within 24 hours after the first use of the restraint.

(2) If a restraint is used in an emergency and the use of the restraint continues, either continuously or intermittently, for more than 24 hours, a licensee must
(a) get agreement in writing to the continued use of the restraint by both
(i) a person described in section 74 (1) (i) *[when restraints may be used]*, and
(ii) the medical practitioner or nurse practitioner responsible for the health of the person in care, and
(b) comply with the conditions set out in section 73 (2) *[restrictions on use of restraints]*.

(3) If a restraint is used under section 74 (1) (b) and the use of the restraint continues either continuously or intermittently for more than 24 hours, a licensee must
(a) reassess the need for the restraint on the earlier of
(i) the time specified in the care plan of the person in care, and
(ii) the time specified by the persons who agreed, and
(b) as part of the reassessment, consult, to the extent reasonably practical, with the persons who agreed to the use of the restraint.

Use of restraints to be recorded in care plan

84 If a person in care is restrained, a licensee must ensure that the following information is recorded in the care plan of the person in care:
(a) the type or nature of the restraint used;
(b) the reason for the use of the restraint;
(c) the alternatives that were considered to the use of the restraint, and which, if any, were implemented or rejected;
(d) the duration of the restraint and the monitoring of the person in care during the restraint;
(e) the result of any reassessment of the use of the restraint;
(f) employee compliance with the requirements of Division 5 *[Use of Restraints]* of Part 5.

Agreement in Writing to the Use of Restraints (Licensing Standard of Practice)

AGREEMENT IN WRITING TO THE USE OF RESTRAINTS
Number: 01/09 Effective: October 1, 2009 Revised: October 1, 2009

This Standard of Practice is made under the authority of section 4(1)(e) of the *Community Care and Assisted Living Act* (the "CCALA"), which permits the Director of Licensing to "...specify policies and standards of practice for all community care facilities or a class of community care facilities...."

Section 74 of the Residential Care Regulation, which is made under the CCALA, provides as follows:

(1) Subject to subsection (2), a licensee may restrain a person in care
- (a) in an emergency, or
- (b) if there is **agreement** to the use of a restraint **given in writing** by both
  - (i) the person in care, the parent or representative of the person in care or the relative who is closest to and actively involved in the life of the person in care, and
  - (ii) the medical practitioner or nurse practitioner responsible for the health of the person in care.

(2) A licensee must ensure that a person in care is not restrained
- (a) for the purpose of punishment or discipline, or
- (b) for the convenience of employees.

This standard of practice is made to clarify what is meant by "agreement in writing" with respect to any adult person in care who is mentally capable but is physically unable to write or is not literate.

The *Adult Guardianship Act* provides, in section 3:

(1) Until the contrary is demonstrated, every adult is presumed to be capable of making decisions about personal care, health care, legal matters or about the adult's financial affairs, business or assets.

(2) An adult's way of communicating with others is not grounds for deciding that he or she is incapable of making decisions about anything referred to in subsection (1).

Similar provisions are also included in the *Health Care (Consent) and Care Facility (Admission) Act* and the *Representation Agreement Act*. These should be read together with section 74 of the Residential Care Regulation. The result is that if an adult in care is mentally capable but physically unable to write, or not literate, s/he may demonstrate agreement to the use of restraints in a manner other than a signature. For example, if the person is not literate, his/her "X" is sufficient if this is the person's standard means of executing legal documents. If a person is physically unable to write, then similarly, his/her standard means of executing a legal document is sufficient.

In both situations, a caregiver must document the facts concerning the person's inability to write in facility records and in the file of the person in care. A notation describing how agreement to the use of restraints was discussed with, and obtained from, the person in care should also be made on the consent form used by the facility.

Director of Licensing Standard of Practice
Ministry of Healthy Living and Sport October 1, 2009

Appendix B: SBAR and Agreement for Restraint

Providence HEALTH CARE

Vancouver CoastalHealth

RESIDENTIAL CARE
SBAR and AGREEMENT FOR RESTRAINT

Sample only

Residential site: _____
Contact number(s): _____

SITUATION: Considering u… …y:
Behavioural issue, resident/others … of:
Is this a change? ☐ Yes ☐ N… **…uspect delirium?** ☐ No ☐ Yes→CAM/PRISME/24 hr observation, explain to resident/family

Usual cognitive status: ☐ Intact ☐ Sometimes impaired ☐ Very impaired CPS/MMSE if known _____
∗OR∗ Other relevant information (example: Lewy body dementia): _____

Behaviour concerns: ☐ Physical aggression ☐ Verbal aggression ☐ Elopement risk ☐ Safety risk to self or others
Other/details: _____

Positioning details: ☐ **Positioning device:** Because a positioning device can act as a restraint (despite our best intentions), we must treat them with the same caution. Use this SBAR to assist you.

BACKGROUND: Alternatives to restraint tried/still in use. Other considerations:
_____ ☐ Still in use ☐ Discarded date: _____
_____ ☐ Still in use ☐ Discarded date: _____
_____ ☐ Still in use ☐ Discarded date: _____
Interdisciplinary Care Team members involved: _____

ASSESSMENT: Emergency restraint used already? - 24 hours max ☐ Yes ☐ No **Type:** _____
Describe resident's response to restraint used: _____

RECOMMENDATION/PLAN:
Ongoing restraint proposed: _____
Adjustments are being made to daily bedside Care Plan or Interdisciplinary Care Plan to:
☐ Specify when to use restraint
☐ Account for toileting needs
☐ Ensure daily care provides regular position changes
☐ Account for adequate fluid/food intake
☐ Account for social needs
☐ Compensate for negative effects of restraints
☐ Add special considerations as necessary

SBAR COMPLETED BY:
Signature _____ Printed name _____ Date _____

RESIDENT AND/OR SUBSITUTE DECISION MAKER: ☐ Agree
Comments: _____
Signature _____ Printed name _____ Date _____

PHYSICIAN/ NURSE PRACTITIONER: ☐ Agree
Comments: _____
Signature _____ Printed name _____ College ID _____ Date _____

DATE FOR FOLLOW UP: _____

Form No. PHC-EL100(T) (Jan 30-13)

Appendix C: Non-Restraint Strategies

BEHAVIOUR	UNDERLYING REASON	POSSIBLE INTERVENTIONS
1. Seeking an exit from a unit or facility	• Dementia process • Looking for home/ family/familiar surroundings • Following staff or visitors who are leaving the unit • Boredom • Exploring/moving about/restlessness	• Camouflage doorway/doorknob/elevator/flooring to alter perception of environment • Explore and validate the resident's feelings • Avoid insisting on reality orientation • Use distraction or redirection techniques • Engage resident in a meaningful conversation/activity from previous life experiences • Consider impact of noisy environment • Use simple signs and way-finding cues (e.g. words/pictures) • Personalize rooms with resident's important belongings • Reassure resident to feel safe and secure • Provide rummage boxes or space and activity aprons • Consider use of wanderguard system
2. Entering into other resident's rooms uninvited	• Fatigue • Bed seeking • Inability to recognize their room • Looking for the bathroom • Seeking human contact	• Assess resident for unmet physical need, e.g., hunger, thirst, bathroom, fatigue • Provide assistance to help resident make social connections • Use of visual cues to help resident find their room • As above in #1
3. Verbal and/physical aggression toward others	• Dis-inhibition due to dementia • Behaviour of other residents • Not understanding actions of caregivers • Approach of caregiver (body language, voice tone)	• Be vigilant and proactive to maintain personal safety and safety for other residents • Immediately: o Stop task o Increase resident's personal space o Be aware of your surrounding environment • De-escalate the situation by: o Responding calmly; use non-threatening body posture o Don't react: argue, give a defensive response, rationalize o Validate: acknowledge their feelings o Give directions/instructions o Keep it short and simple o Recognize the difference between venting and abusive language • After the resident has de-escalated: o Seek clarification for the behaviour o Allow time and try another approach o Redirect o Check for triggers: ▪ Check for unmet needs ▪ Check your approach ▪ Check the environment
4. Grabbing / pinching staff during personal care	• Grasp reflex when hand is touched • Depression, Anger • Pain/discomfort • Approach of caregiver (body language, tone) • Fear	• Place washcloth or other type of soft object in hand prior to care • If resident is lying on side, encourage them to grab side rail • Refer to OT/PT for optimal positioning during care • Manage pain by giving analgesics prior to care • Use personal safety techniques to minimize harm

BEHAVIOUR	UNDERLYING REASON	POSSIBLE INTERVENTIONS
5. Standing Up from Wheelchair or Other Type of Chair	• Needing to use the bathroom • Lack of insights and safety awareness • Unmet personal needs: o Pain/discomfort o Need for attention o Hunger/thirst • Tired of sitting	• Investigate possible underlying unmet needs • Develop regular schedule for using bathroom • Assist resident with re-positioning; offer to take resident for a walk or other activity • Use chair alarm • Refer to OT for assessment to ensure selected equipment is appropriate and comfortable for resident • Distraction/involve in activity • 1:1 or companion
6. Leaning Forward/ Sliding in chair	• Lack of decreased body awareness • Poor mobility in chair • Lack of upper body strength • Uncomfortable • Fatigue/tired of sitting • Altered sense of balance and perception • Reaching for objects	• Investigate possible underlying unmet needs • Assist resident to bed if fatigue • Ensure support of the pelvis, feet, trunk and shoulders • Offer long handled reacher • Refer to OT for assessment for appropriate seating, positioning and chair mobility • Provide a non-slip seating surface • Assist to change position
7. Climbing or falling out of Bed	• Not tired • Bored/lonely • Loss of insight to personal safety • Pain • Needing to use the bathroom • Hunger/thirst	• Delay bedtime or bed where staff can observe • Distraction - music, TV, books • Develop regular schedule for using bathroom • Assess for pain and give analgesic • Reposition pillows for comfort • Consider equipment: lower bed height, mattress or foam on floor, hip protectors, commode/ urinal by bed • Offer food and fluids • Provide appropriate lighting for bathroom use • Discuss tolerable risks with family
8. Pulling Out Feeding Tubes / Catheters or IVs	• Pain/Discomfort • Delirium • Dementia process • Anxiety and fear toward unfamiliar objects	• Investigate possible underlying unmet needs • Keep feeding bag, catheter and IV pole out of resident's field of vision, i.e., hide with clothing • Secure feeding tube, catheter / IV • Distract and involve resident in meaningful activities • Re-evaluate appropriateness of tube feeds / catheters / IV therapy. Consult ethics as needed
9. Falling	• Vision changes • Postural hypotension • Musculo-skeletal weakness • Medications • Environmental factors • Cognitive Impairment • Sleep/Wake reversal • Chronic disease • Safety unawareness • Perceptual impairment • UTI or Incontinence • Unsteady gait • Language barrier	• Assess resident for underlying causes for falls, i.e., delirium, fatigue, mobility challenges, weakness • Develop regular schedule for using bathroom • Provide objects to increase orientation • Ensure mobility aide is within reach • Refer to PT for mobility assessment and exercise program • Refer to OT for equipment needs • Provide and encourage resident to use safety equipments (i.e. high protectors, non-skid socks, mobility aide, raised toilet seat) • Ensure call ball within reach • Consider using bed/chair alarms • Review careplan to ensure resident has sufficient rest periods between activities

Appendix D: Definitions

Care plan: Written documentation that reflects the individualized care approaches based on assessed resident needs.

Chemical (Pharmacological) restraint: "Chemical restraints are medications used with the specific intent to reduce a patient's mobility, or promote sedation beyond that required to establish a normal sleep cycle. This should not be confused with medications, whether on a scheduled or as needed basis, used to treat drug responsive behavioural/neuropsychiatric symptoms associated with specific medical and psychiatric diagnoses" (Ward, Carol & Dagg, Paul, Island Health Authority, 2012).

Electronic devices: Bed /chair alarms /wander guards and perimeter security are not considered restraints but alternatives to restraint (Licensing Officer, 2009). Wander guards are typically a feature of the building and this feature with the bed alarms are talked about prior to admission as alternatives with the person in care or their decision maker.

Emergency restraint: means any use of a restraint that does not have written agreement by both the resident / representative/relative and medical/nurse practitioner. Written agreement to the use of the restraint must be obtained after 24 hours intermittent or continuous use of the restraint. (British Columbia Residential Care Regulation, 2009)

Environmental restraint: "The extent to which the environment both minimizes threats to resident safety and maximizes sense of security of residents, staff, and family members." (Weisman, G., Lawton, P., Calkins, M., and Sloane, P. (1996). Professional Environmental Assessment Protocol, Institute on Aging and Environment). Perimeter security is not considered a form of environmental restraint (Licensing Officer, 2009).

Medical practitioner: Is a reserved title of an individual who is authorized to practice medicine under the Health Professions Act

Nurse practitioner: means a person who is authorized to practice nursing as a nurse practitioner under the Health Professions Act

Physical/mechanical restraint: the use of a device or an appliance that restricts or limits freedom of movement; for example, vest restraints, lap belts, pelvic restraints, mittens, geriatric chairs with locked trays and sheets.

- The following situations are not included in this definition:
  - Immobilization of a part of the body as required for medical treatment, such as splints and casts;
  - Temporary immobilization of a part of the body while a procedure is being performed
  - Temporary immobilization during transportation, such as car seats, car seat belts and belts on stretchers

  (College & Association of Registered Nurses of Alberta, 2009)

Physical Restraint – RAI MDS 2.0
"A physical restraint is defined as any manual method, or any physical or mechanical device, material or equipment that is attached or adjacent to the resident's body, that the resident cannot remove easily, and that restricts the resident's freedom of movement or normal access to his or her body.

- "What is important is the effect the device has on the person, not the purpose for which the device was placed on the person" (p. 31, CIHI 2008).

If the resident has no voluntary movement, specifically is comatose or he/she is quadriplegic, code sections P4c (Trunk restraint), P4d (Limb restraint), and P4e (Chair prevents rising) as 0 (Not used)." (CIHI, 2010)

Restraint: any chemical, electronic, mechanical, physical or other means of controlling or restricting a person in care's freedom of movement in a community care facility, including accommodating the person in care in a secure unit (Residential Care Regulation, 2009, http://www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/96_2009#section1)

Special Care Unit: A Special Care Unit (SCU) for people with dementia can be defined as a designated section of a building or a free-standing unit that has the following characteristics: a) secured exits, b) physical environment supportive of movement and functioning with physical and psychological security, c) familiar and appropriate behavioural and affective cues, and d) staff trained in dementia behaviour management and therapeutic activities. (Email correspondence Feb 22, 2010 - Chaudhury, H. PhD, Aging and Environment Area, Department of Gerontology, Simon Fraser University).

Substitute Decision Maker (SDM): "is a capable person with the authority to make health care treatment decisions on behalf of an incapable adult, and includes a personal guardian (committee of the person, representative and/ or temporary substitute decision maker" (Advance Care Planning Guide, Feb 2012, p. 24)

Appendix E: Evidence Table for use of Positioning Devices

Following a clinical and functional evaluation to determine mobility and positioning needs, a therapist may consider using a positioning device for therapeutic purposes. Although the intent may not be to restrain free movement, some positioning devices have that effect and therefore are subject to identified practice standards for use of a restraint. Identifying and addressing possible causes for a position may eliminate the need for a restraint. For example, a resident may be sliding forward in the wheelchair for a number of reason including: The resident not properly positioned in wheelchair, hip flexion ROM is limited or hamstring tightness, marked extensor tone/spasticity, or contoured seat cushion is put in backwards. Additionally, effective support of the pelvis, feet, trunk and shoulders and the use of tilt may eliminate the need for an anterior trunk support.

The following table offers a list of commonly prescribed positioning devices that are identified as a restraint with some contraindications and considerations for usage.

Positioning Devices Identified as Restraints	Precautions	Common Therapeutic Usages	Considerations for Use
Seat Belt (Positioning belt, pelvic belt, pelvic strap)	1. Can cause mechanical asphyxiation or strangulation. 2. Prolonged immobility associated with loss of muscle strength and leading to increased risk for falls. 3. Development of pressure sores, incontinence, joint contractures, and thromboses 4. Higher risk for aspiration, restricted breathing, fractures, and chafing	1. Resident exhibits weakness or absent core muscle groups. Belt is used to stabilize the pelvis to promote upright sitting posture and to maintain body alignment and pelvic position. 2. Prevent forward sliding on the seat and reduce risk of ejection from the seat 3. Prevent lower extremity extensor thrust.	• Use in conjunction with a contoured seat cushion • Avoid abdominal placement. If belt is at the level of the umbilicus the resident may be able to “do the limbo” and slide underneath the seatbelt. • Place high across the thighs with a downward and slightly backward pull to prevent the pelvis from sliding forward. • The angle of the seatbelt should be ideally between 60 and 90 degrees from the seating surface • Choose a fastener that can be easily operated by the patient
W/C harness (Anterior Trunk support)	1. Can cause mechanical asphyxiation or strangulation due to: • Harness riding up • Person sliding down • Too tight application • Inappropriate prescription for person • Faulty design or wear and tear • Incorrect application (i.e. harness is applied upside down or straps are not correctly tightened)	1. Resident exhibits weakness or absent core muscle groups. Harness is used to assist in supporting a person to remain in optimal sitting position 2. Prevents the trunk and shoulder from falling forward 3. Assists in keeping shoulders from protracting and prevents them from elevating.	• Used as part of the overall seating system along with other postural supports such as lap belts, foot supports, trunk supports thigh straps, tilt-in space and reclining backrests. • A firm fitting pelvic strap is used every time a harness is used. • Select design which reduces risk of strangulation such as: o Upper straps that join at a central anterior point which is low down ▪ Ability to unclip at central anterior point ▪ Lower straps at fixed length

Positioning Devices Identified as Restraints	Precautions	Common Therapeutic Usages	Considerations for Use
	2. If support is too tightly secured over the chest, it may interfere with reaching and breathing.		▪ Adjustable upper straps ▪ Harness secured with buckles in preference to Velcro or D-ring ▪ Horizontal strap lower than ribcage secured to upper straps ▪ Design of vest harness and butterfly harness pose an increased risk
Lap board (lap tray, upper extremity support surface)	May interfere with resident's ability to propel the wheelchair, reach for brakes and transfer out of the wheelchair. The board can cause pressure to the trunk if the patient slides forward into it.	Working area on wheelchair Support surface for feeding Surface for communication board Surface to mount sensors for power wheelchair controls Weight-bearing surface for the arms to assist in upper extremity support Protects arm from falling for patients with sensory neglect Increases awareness of an arm for patients with sensory neglect.	• Consider a clear board so that residents can view their lower limbs • Ensure positioned at optimal height for activities • 1" gap between abdomen and the inside of board to prevent arm from sliding between • Stabilize pelvis to prevent sliding
Tilt-in-space w/c	Decreased maneuverability compared with conventional wheelchairs	Resident exhibits weakness or absent core muscle groups. Tilt-in space systems reduce the effect of gravity in seated position thus: • improve pressure redistribution, • offer postural support, • manage increased extensor tone in lower extremities • delays the occurrence of fatigue • aids in pelvic stabilization and seating stability • improved comfort • offers a position of rest sitting out of bed	

Appendix F: Side Rails – Assessment and Implementation Guide

1. The use of any side rail is a restraint and the CPD for least restraint will be followed, including completing the *Residential Care SBAR and Agreement for Restraint and Initial (and Emergency) 24 hour Restraint Monitoring Record*.
2. Avoid the automatic use of bed rails of any size or shape.
3. If a bedrail is to be used with a resident who is vulnerable to entrapment, use a bed that is compliant* with the dimensional guidelines given in the Heath Canada Guidance, "Adult Hospital Beds: Patient entrapment hazards, side rail latching reliability, and other hazards."
4. Use compatible side-rails and mattresses for the bed frame to prevent gaps that may place the resident at risk for entrapment. *(See Diagram on next page)*.
5. If the bed is equipped with split rails, the side rails at the head of the bed can be raised with the foot side rails down for a least restrictive approach.
6. If upper side rails are used, it should be based on the following functional criteria:
    - Aiding in turning and repositioning within the bed.
    - Providing a hand-hold for getting into or out of bed.
    - Providing easy access to bed controls and personal care items.
7. The use of any bed rails should be based on a documented assessment in the progress notes of the benefits to the resident versus risks for entrapment by the RN with input from team members.
8. Keep the bed in the lowest position with the wheels locked if resident is at risk of climbing or falling out of bed. For residents who are able to get out of bed independently, bed height should be individually assessed for safe transfer. Beds are usually adjusted at or slightly above knee level for safe and independent transfer.
9. If the resident is at risk for falling out of bed, use Falls Prevention strategies to minimize risk for injury. (See Falls & Injury Prevention Guideline)
10. An incident of entrapment or near miss should be reported within your facility and also to Health Canada. .

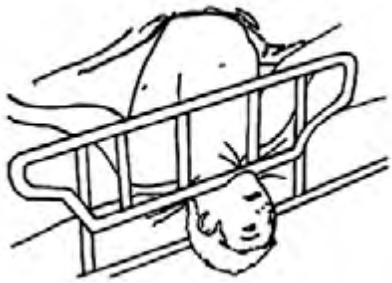
Harm Related to Use of Bedrails:

- Strangling, suffocation, serious bodily injury, or death when residents are caught between rails, the openings of the rails, or between the bed rails and mattress.
- Impede resident's ability to safely get out of bed because residents may crawl over rails or footboard and fall from greater heights increasing the risk for serious injury.
- May confine residents unnecessarily to their beds, creating a barrier to performing routine activities such as going to the bathroom.
- Can create negative psychological effects such as poor personal image, lower self-esteem, contribute to isolation and increase risk for incontinence.

* "Compliant" means that the dimensions of gaps and openings in the bed system (bed and mattress) are within acceptable range as defined in the Health Canada documents. The gaps and openings can be assessed with the "cone and cylinder tool" described in these documents. The tool and an instructional video are available from the VCH Healthcare Technology Department. HTM personnel can assess the bed/mattress system.

Appendix F (cont'd): Side Rails – Assessment and Implementation Guide

Zone 1



Zone 2

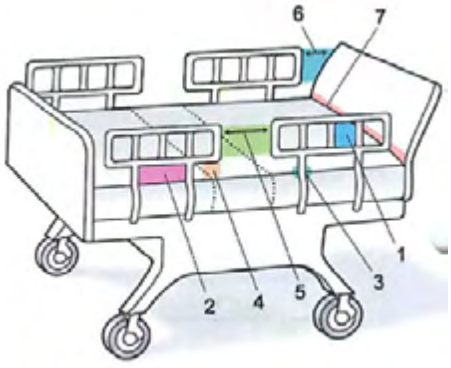
Zone 3

Zone 4

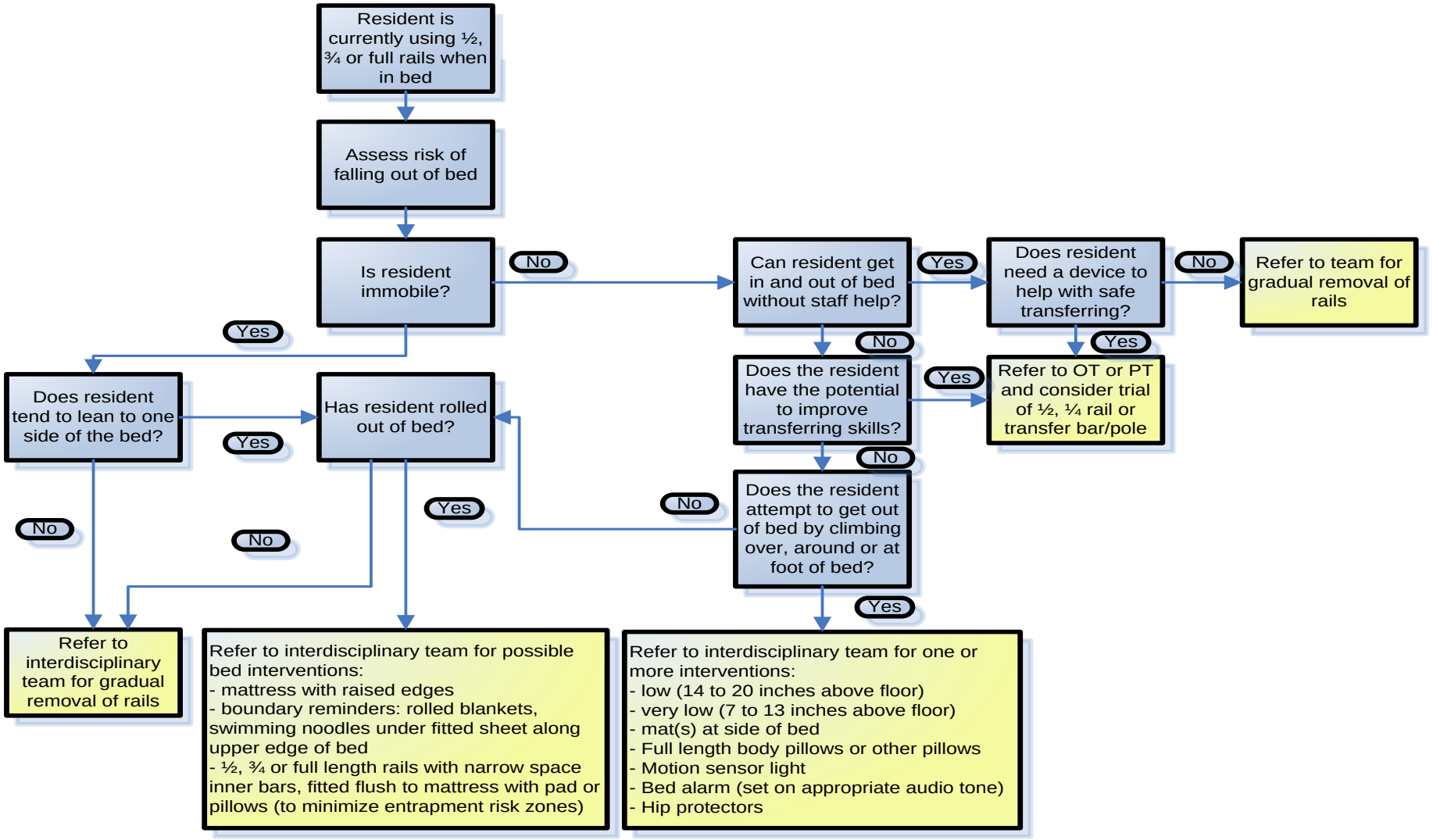
Zone 5

Zone 6

Zone 7

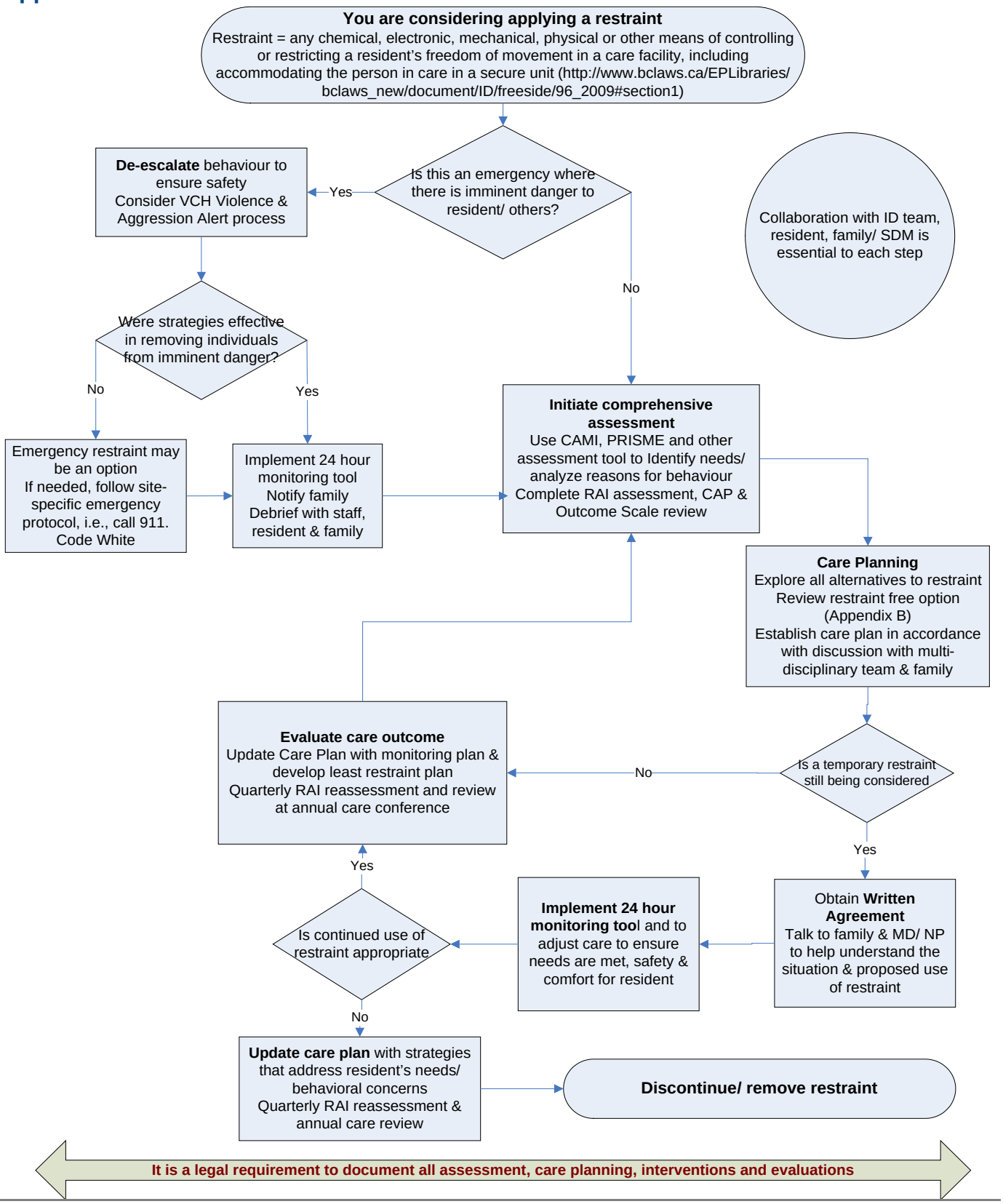


Algorithm for the Removal of Side Rails



Adapted from: Talerico, KA & Capezuti, E (2001). Myths and facts about side rails. American Journal of Nursing, 101:43-48.

Appendix G: Decision Guide for Restraint Use



Appendix H:

RESIDENTIAL CARE: 24 HOUR CLOSE OBSERVATION RECORD
Getting to Know You Better

Date: _____

Rationale: (tick all appropriate)

- ☐ Delirium
- ☐ **Newly Moved-in**
- ☐ Falls risk
- ☐ Behaviour symptoms
- ☐ Potential for self injury
- ☐ Suicide risk
- ☐ Other: _____

Relevant Information/Strategies to test:

_____

_____

_____

_____

Use codes from legends at right

Time	Behaviours	Underlying cause	Interventions	Initial	Action & Evaluation / Outcome / Most [illegible] Response	Initial
1400						
1500						
1600						
1700						
1800						
1900						
2000						
2100						
2200						
2300						
2400						
0100						
0200						
0300						
0400						
0500						
0600						
0700						
0800						
0900						
1000						
1100						
1200						
1300						
1400						

CODES

Behaviours observed

1. Awake & cooperative
2. Asleep
3. Calling out
4. Pulling off tubes/clothes
5. Wandering
6. Pacing
7. Not sleeping (at night)
8. Striking out
9. Resisting touch/movement
10. Unsteady
11. Self harm _____
12. Forgetful
13. Seeing things I can't see
14. Suspicious
15. Talking nonstop
16. Unsafe/risky movements
17. Keeps asking the same thing
18. Poor safety awareness
19. Drowsy
20. Other: _____

Potential underlying cause of behaviour

1. Hungry
2. Thirsty
3. Constipated
4. Needs toilet
5. Seems to be _____
6. Seems to be in pain
7. Seems to be afraid
8. Is ill
9. Seems to be angry
10. Bothered by _____
11. Seems lonely
12. Seems to be bored
13. Overwhelmed, can't cope
14. Too much stimulation
15. ↓ family support/contact
16. Disoriented
17. Not enough restful sleep
18. Very sleepy
19. Medications changed
21. Unknown

Interventions attempted

1. Checked in, is OK
2. Toileted
3. Shifted position (SP)
4. Turned – major position change
5. Pain medication
6. Comforted physically
7. Put things within reach
8. Food
9. Fluid
10. Removed unnecessary irritants
11. Oriented, helped find way
12. Oriented to time
13. Diverted, redirected
14. AM care
15. PM care
16. Reassured
17. Provided company
18. Engaged in activity
19. Included socially
20. Behaviour medication

At end of 24 hours: RN/RPN/LPN/ designated clinical leaders review and decision:

I have reviewed this Record and the Progress Notes and feel confident that daily bedside care as noted in the Care Guide / Care Plan **promotes a balance of safety/comfort /contentment.**

- ☐ **Yes** - Discontinue 24 hour observation. Note concerns on Care Plan for regular review
- ☐ **No** - Begin new 24 Hour Close Observation Record

Signature: _____ Printed name: _____ Designation: _____ Date: _____

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Hourly Close Observation is shown by research to help health care workers better minimize falls and associated injuries when residents are at high risk for falls: moving-in, change in condition, after a fall. It also: helps to make care proactive rather than reactive, reduces call bell use, saves walking for the health care worker.

To understand cause of underlying behaviours, ask yourself?	**CONSIDERATIONS**
• Does the resident need to use the bathroom? • When was their last bowel movement? • Is the resident thirsty or hungry? • Does the resident need to go for a walk? • Would the resident benefit from distraction? o TV, food, conversation, walk • Does the resident need medication? • Does the resident have an understanding of where they are and plan of care? • How is your approach influencing the behaviour? • Does the resident smoke, consider smoking cessation? • Are there gender/cultural considerations? • Are there language or other communication barriers?	**Establishing a rapport** • Eye contact • Friendly tone, calm manner • Approach slowly • Listen to verbal and non verbal communication • Establish and maintain consistent care plan • Provide communications aids • Involve family members as appropriate • Ensure appropriate communication tools/aids are present (e.g. hearing aids, corrective lenses, pictogram tools, interpreter etc.) **Environmental stimuli** • Adjust stimuli: lighting, excess noise, • Consider room mate selection, proximity to nursing station
Additional resources: • Local professional staff -OT • POCT team especially for pain/end of life • Geri Psychiatry • Geriatric Medicine Consult Service	**Related Nursing Care Standards** (located on PHC intranet) • Suicidal patients • Delirium • Least Restraint • Managing Unsettled Behaviour

Form No. PHC-EL090(T) (R. Mar 6-12) Back

Appendix I: Audit Tool

Site/Area: **Auditor:**

Reporting Period: From **to**

Number of charts: 10 per area **Key: Met = M, Not Met = N, Not Applicable =N/A,** **Compliance= C**

STANDARD/CRITERIA											# M	# N	# N/A	% C
Assessment Form														
Resident's history with restraint use														
Monitoring Record completed for the first 24 hours of restraint use														
Documentation														
Stated types of alternatives to restraint use were initiated and why														
Stated results of alternative strategies														
Stated why restraints were initiated														
Evidence of completed assessment by two or more disciplines in the individualized care plan development														
Stated who was involved in decision to use a restraint														
Evidence of assessment and reasons to support continued restraint use														
If Emergency Restraint used, rationale for application of restraint reviewed in 24 hrs														
Consent for restraint use														
Written Agreement completed and signed by MD/NP and resident/SDM for non-emergency restraints and restraint use exceeding 24 hours														
Written Agreement reviewed and updated at least annually														
Care Plan														
Type of restraints in use, goals, implementation plan and strategies, and goals clearly stated														
Care plan is current and accurately reflects care provided														
Evidence of minimum quarterly review of restraint use														
% of compliance = (M / M+N) x 100														

Appendix J: Baseline Restraint Audit

NB: This is an administrative worksheet to assist in identifying and tracking restraint use, and is not intended to be part of the residents' records.

Date:_____ Unit:_____

RESIDENT NAME	RESTRAINT TYPE								Reason(s)	Alter-natives	Agreement in writing		Care Plan	Re-assessment date
	Physical					Chemical / Pharmacological	Environmental	Other Type: Specify	Documented	Documented	Physician / Nurse Practitioner	Resident / Representative		
	Bed Rails		Seat Belt	Tilt Chair	Other Physical Specify									
	Upper	Upper & Lower												

Appendix K: PRISME and CAMI Tool

DELIRIUM: SCREENING AND ASSESSMENT

PREDISPOSING RISK FACTORS:

- Cognitive impairment
- Over 80
- Chronic illness
- Multiple co-morbid conditions
- Sensory deficits
- Alcohol abuse
- Immobility
- Insomnia
- 5+ medications

SCREENING TOOL: CAM

Presence of features 1 and 2 & either 3 or 4:

1. **Acute onset & fluctuating course**
2. **Inattention:**
   -difficulty focusing attention
   - easily distracted
3. **Disorganized Thinking:**
   -rambling speech
   - illogical flow of ideas
4. **Altered Level of Consciousness**
   - agitated
   - alert
   - lethargic
   - stuporous
   - comatose

Identification:	Assessment:	Interventions:

P	Pain
	• Regular pain assessment & monitoring
	• Use consistent pain scale
	
	Poor Nutrition
	• Dehydration/malnutrition
	• ↓Albumin or protein levels
	• Swallowing difficulties
	• Electrolyte/glucose imbalance
	• Weight on admission and prn
		Pain
		• Regular scheduled analgesia (not prn)
		• Non-pharmacological support: turning, positioning
		• Document effect of analgesia
		
		Poor Nutrition
		• Fluid intake at least 1500cc/24hrs
		• Dietary consult:
		  • Recent wt loss/gain (>10lbs in last year)
		  • Total protein < 64 g/L and Albumin level < 35 g/L
		• OT Consult for swallowing difficulties

R	Retention • Determine continence ability; bowel pattern • Assess for urinary retention • Palpate abdomen for distention/impaction • Evaluate fluid balance/output Restraints • explore alternatives to restraints whenever possible to maximize functional status and safety	Retention • In/out catheterization if suspect retention • Nurse Continence Advisor consult if in retention • Regular toileting schedule (minimize use of Incontinence pads) • Initiate bowel protocol; refer to CPG on Continence • Ensure person is well hydrated Restraints • Refer to CPG on Maximizing Freedom and Least Restraint • Avoid restraints if possible. Use only if patient a danger to him/herself or others • Involve family members/support persons
I	Infection/Illness (new) • ongoing monitoring for UTI, chest infection, wound infection Immobility • Determine pre-morbid functional abilities	Infection/Illness (new) • Monitor VS & O2 sats; compare to baseline (note as normal process of aging, temperature may remain normal) • ↑↓ BP, postural ↓ BP • Request appropriate diagnostic/lab tests (e.g. C&S, chest x-ray) Immobility • Encourage mobility, sitting up in chair & maintenance of ADLs • OT/PT Consult; refer to CPG on Falls
S	Sleep • Assess for altered sleep/wake cycles • Use Sleep Pattern Record Skin • Assess for areas of skin breakdown • Braden Scale Sensory • Assess for sensory deficits and aides used	Sleep • Document changes in pattern – day/night reversal • Implement non-pharmacological sleep promotion measures • Intersperse activities during the day with planned rest periods Skin • Pressure reducing mattress as indicated, turn q2h • Refer to Wound/Continence Nurse if wound present Sensory • Ensure eyeglasses, hearing aids & dentures are working and used • Use Pocket talker to assist with communication/assessments
M	Mental Status • Monitor for sudden changes in ability or cognition • Other causes of behavior • Grief, loss, emotional trauma Medications • Polypharmacy (>5 meds) • Medication side effects • Withdrawal – alcohol, benzodiazepines, nicotine • Toxicity (digoxin, dilantin) Metabolic • Monitor for abnormal lab results/hemodynamic status	Mental Status • Refer to CPG on Agitated and Excessive Behaviour • Identify self; use a calm/gentle approach; use cues to orient • Acknowledge and validate fears related to changes in cognition • Use interdisciplinary interventions to support restoration of normal activity i.e. Volunteers/family, mobility, activities, familiar objects and photos, routines, clocks/calendar Medication • Review med profile with pharmacist for recent changes, adverse effects, toxicity, drug interactions • Start Low, Go Slow! • Assess psychotropic med response report any side effects (ie. ↑ anxiety/agitation; Parkinson-like symptoms, postural ↓ BP) Metabolic • Evaluate lab results and notify MD of abnormalities
E	Environment • Self-care ADL's ability • Relocation stress (eg. Unfamiliar surroundings/routine)	Environment • Provide calm & safe environment • Promote normal ADL routines; consistent staff • Encourage family/support persons to provide support • Provide adequate lighting and exposure to daylight

CAM: screens for the presence of absence of a delirium
PRISME: an acronym that can assist in identifying and relieving underlying factors are modifiable and can contribute to the onset and perpetuation of delirium

~~PRISME: Adapted from Maureen Shaw, 2006; CAM: Delirium in the Older Person, VIHA 2006~~