Restraints: Care of the Patient at Risk for or Requiring Restraint

*** Please note this DST remains under review pending regional redevelopment. Please direct any questions to local practice leads.*

Quick links

Site Applicability

- Vancouver Acute (VGH, UBCH)
- Acute Mental Health: VGH (PAU, E1, W1, E2), UBCH (1E, 2E, 1W),
- Richmond Hospital
- Coastal Acute (LGH, SGH, Sechelt and Powell River)
- Powell River, and Hope Centre (H4)

Practice Level

- RN, OT, PT, RPN
- LPN with appropriate education & training
- PCA with appropriate education, training & supervision
- OT/PT Rehab Assistant with appropriate direction and supervision from the OT/ PT

Requirements

This policy does not apply to persons in care who are under 19 years of age.

1. **Clinical Decision Making and Ethics**
   The professional 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.

2. **Patient Care**
   When the restraint presents a high-risk for patient injury and/or the patient's behaviour is not stabilized by restraint (mechanical, chemical, and/or environmental), Q 15 minute assessment and constant observation is the clinical standard of care. See Observation levels: Acute Mental Health (D-00-07-30280).

3. **Documentation**
   Specific documentation is required in all instances where a patient is restrained. The Restraint Initiation Record and the Restraint Documentation Record as well as the patient's health record are the documentation standard for sites with paper-based documentation. For sites using Electronic Health Record (EHR), care documentation occurs under the "Restraint and Seclusion" segment of IView.

4. **Safety Considerations**
   Bedding, clothing, washrooms, shower rooms, conference rooms, closets, hallways, and kling/tensor bandages may not be used to restrain patients mechanically or environmentally 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.

5. **Locked and Locked 4-Point Restraints**
   The most restrictive level of physical control is the locked 4-point restraint permitted for use at Vancouver Acute, Lion's Gate Hospital and Richmond Hospital, in the Emergency Department, Psychiatry Assessment Unit, Inpatient MHSU units and following a Code White. Locked 4-point restraint may be used only in extreme situations where the patient presents with imminent physical violence directed at others, self, objects and/or:
   a. Lesser levels of confinement and restraint: have been considered and deemed ineffective
   b. The cause for aggression is not known, or
   c. Assessment and/or treatment of medical, neurological and psychiatric conditions cannot otherwise be conducted.

   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 care plan. An explanation for the alternate location of the key must be documented in the Health Record.
- A key **must** accompany the patient whenever they are transported in locked restraints to another location.

Need to Know

Philosophy:
All patients/clients (hereafter "patients") have the right to optimal freedom of movement and choice as well as the right to make autonomous decisions that may result in living at risk. Vancouver, Coastal, and Richmond Acute Communities of Care support a policy of Least Restraint for all patients. Least Restraint is an approach to care in which the patient's right to optimal freedom of movement is promoted as much as possible within the clinical situation. Rather than restriction, the goal of Least Restraint is to:

- Optimize the patient's ability to interact with other people and/or the environment, and
- Acknowledge and support the patient's autonomy and decision-making capability within the clinical situation.

Restraints are considered an unusual, temporary, short-term measure and used after all other reasonable alternatives have been considered and deemed inappropriate.

Practice Guideline

What is a Restraint?
Restraint is defined as the use of mechanical, chemical, and/or environmental means to prevent a patient from harming him/herself, others and/or damaging property.

What a Restraint is Not
Restraints do not include orthopedically prescribed devices, surgical dressings or bandages, protective helmets, methods that involve the physical holding of a patient for conducting physical examination or tests, or assisting the patient to participate in activities without the risk of physical harm. Some mechanical devices used for positioning are not considered a restraint (e.g. chest straps post high spinal cord injury; lap tray post-stroke). Security access systems that limit patient movement within a geographical area are not considered a restraint. Wandering alert systems that limit patient movement within a geographical area and prevent access to hazards (e.g. stairwells, elevators) are interventions that enhance Maximum Freedom and patient safety.

Types of Restraint:

1. **Mechanical**
   Mechanical restraint refers to the application of a device to or adjacent to the patient's body that limits and restricts movement. Mechanical restraint also includes raising all 4-side rails on the bed. Restraints must be applied according to the recommendations found in Health Canada's Notice to Hospitals.

2. **Chemical**
   Chemical restraint refers to the use of medications to manage behaviours that do not respond to environmental and/or interpersonal interventions.

Therapeutic Use of Medications

Psychoactive medications are used as a pharmacological intervention to target specific behaviours that present a risk for injury to self, others, or property. During an acute behavioural disturbance, the therapeutic use of medications aims to reduce aggressive, agitated, or disruptive behaviour. In a non-emergency situation, pharmacological intervention is used to limit adverse outcomes of symptoms such as aggression, psychosis, mania, self-harm and insomnia. Medications used to treat a behavioural disturbance include antipsychotic, anxiolytic and other sedative drugs. A psychiatric consultation is highly recommended whenever psychoactive medications are under consideration for an acute behavioural disturbance or ongoing mental health problem. Psychoactive medications used for procedural sedation, neurological or mental health problems are not a restraint.

3. **Environmental**
   Environmental restraint is the confinement, usually involuntarily, of a patient in a room from which they are unable to physically exit. Removal of personal clothing may also be considered an environmental restraint when the intent is to confine the patient to a physical space. Additional examples include:

   a. ***Seclusion:***
      Seclusion is the involuntary placement of a patient in a locked room from which they cannot exit. All patients in seclusion should be certifiable under the Mental Health Act of British Columbia, or present an immediate safety risk to themselves or others. Seclusion may be done in the Emergency Department for assessment only and in Acute Mental Health for both assessment and treatment. Seclusion is part of the overall treatment plan for patients at risk for aggression or elopement and for those whose behaviour causes a significant disruption to the unit milieu. For details on seclusion, see Guideline: Care of the Patient Requiring Seclusion (D-00-07-30283).

   b. ***Private Room (applies to Richmond Hospital only):***
      A Private Room may be used for the restriction of a patient with challenging behaviours that disrupt the unit and present safety risks. If the patient is unable to independently exit and/or the entrance door is closed/latched, a psychiatric consultation is highly recommended. For safety, the standard of care is constant, observation, especially when the patient is exhibiting aggressive, violent or suicidal behaviours. See Private Rooms for Challenging Behaviours.

Protocol

A. Non-Emergency Assessment and Care Planning:

1. Identifying Behaviors/States Increasing Risk for Restraint

Behavior/states that raise the issue of restraint should first trigger an assessment and intervention aimed at understanding and eliminating the underlying cause. Examples of behaviors/states that increase the potential for restraint include:

a. Risk to Self

- Attempting to remove invasive lines/artificial airway
- Wandering and elopement risk when safety is an issue
- Unsteady balance or gait with increased fall risk
- Severe sensory impairment
- Significant threats or attempts at self-injury

Risk to Others

- Physical aggression towards staff, visitors, or other patients
- Combative, violent behavior
- Escalating verbal abuses and threats of violence, when the risk of follow-through is high

b. Risk to Property

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

2. Assessment / Clinical Justification and Care Planning

The professional team considering restraint must justify the decision and document a rationale based on clinical and ethical considerations (Interdisciplinary Restraint Decision-Making Guide)

a. Assess and clearly document in the patient's Health Record, the behaviour/state that demonstrates that the patient is at risk of injury to self, others, or property.
   - What factors are contributing to the problem?
   - When/how often does this behaviour occur?
   - What is the patient's cognitive ability? Is his/her insight and judgment impaired?

b. Complete the Alert System for Aggressive/Violent Behaviours for patients with identified risks to self/others/property.

c. Identify interventions aimed at reducing risk factors, modifying behaviours and maximizing freedom.

d. Invite the patient and/or family to make suggestions about strategies that will increase his/her personal control within the clinical environment.

e. Develop a plan of care that maximizes freedom through psychosocial and physiological approaches as well as environmental modifications. Use Alternatives to Restraint to assist with care planning.

f. Document in patient's Health Record the effectiveness of alternate interventions.

3. Initiation of Restraint

Initiate restraint 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.

In Acute Mental Health, a MD must write an order prior to non-emergency initiation of restraint

a. Patient Without Decision-Making Capability

When possible the decision to restrain the patient without decision-making capability will be made after consulting with the patient and family/Substitute Decision Maker (SDM). If the family/SDM is unavailable, a restraint may be used as a temporary short-term measure, until the interdisciplinary team assesses the patient and an updated plan of care is developed.

If the family/SDM has not been involved, they must be notified within 24 hours and, when appropriate, provided with the rationale for restraints and information about the plan of care.

When the patient is certified under the Mental Health Act of B.C., discussion and explanations about restraint is still required.

b. Patient With Decision-Making Capability

Patients with decision-making capability may decline restraints and choose to live at risk to themselves. This decision should trigger further interdisciplinary assessment and, when possible, a patient and/or family meeting to discuss risks and benefits of living at risk. The outcome of these discussions must be documented.

A patient may be restrained to prevent harm to others whether or not they have decision-making capability.

c. Accountability/Responsibilities within the Team

The RN/ RPN/OT/PT/MD/Nurse Practitioner (NP) initiates the restraint process.

The RN/ RPN/OT/PT/MD/Nurse Practitioner (NP), internal security or outside security/law enforcement personnel applies a restraint.

The LPN applies restraints in collaboration with the RN /RPN/NP. The LPN documents the collaboration with the RN/RPN.

The PCA (Patient Care Aide) and PW/MHW (Psychiatric Worker/Mental Health Worker) may apply restraints only under the direction of the RN/RPN. The RN/RPN supervises the PCA/PW in the care of a restrained patient.

The Rehab Assistant may apply restraints under the direction and supervision of the OT/PT.

The MD/NP may order medications for therapeutic management of behavioural symptoms as well as chemical restraint when needed.

d. Documentation

When restraint is initiated, documentation must include the decision-making process and who was involved. (e.g. interdisciplinary team discussion, SDM, patient), the specific behaviours necessitating restraint, the restraint type, and who initiated the restraint and their designation.

For sites using EHR, documentation occurs in the Restraint Prevention, Restraint Initiation and Restraint Information sections of the Restraints and Seclusion segment in iView, using free text boxes for additional descriptors related to the decision making process as necessary.

For sites using paper-based documentation, the Restraint Initiation Record and Guidelines for Use may be used to record the nursing decision to initiate mechanical restraints. Otherwise, the nursing decision may be documented on the patient's health record. This documentation is required whether or not a MD/NP has ordered a restraint.

e. Notification

In a non-emergency situation, the MD/NP must be notified of the patient's behaviour and need for restraint within 24 hours.

Note: In Acute Mental Health, a physician's order is required for all patients who are placed in any form of mechanical restraint.

4. Care of the Restraint Patient

a. Assessment for mechanical restraints

The patient should be assessed:

- Every 15 minutes until behaviour stabilizes and then
- Every 30 minutes for one hour and then

- Every 60 minutes until the restraints are discontinued.
- Every 24 hours for ongoing need for restraints.

Assessment includes observation to determine if the behaviour necessitating restraint is escalating, decreasing, or has resolved. Restrained limbs are to be assessed for color, warmth, sensation and movement. Respirations are to be assessed to determine if they are satisfactory or altered. For additional guidelines, see Restraint Documentation Record and Guidelines for Use.

b. Interventions for restraint

Interventions are to be completed every two hours while the patient is awake unless otherwise indicated

c. Updating the Plan of Care

The plan of care includes the desired outcome as well as the frequency for review of the decision to use a restraint. The plan of care should be updated every shift and whenever the patient's situation changes. The plan of care includes:

- Time intervals for limb restraint removal and skin check
- Time interval for repositioning/turning
- Positioning of head of bed
- Toileting
- Offering fluid and food
- Periods of time that a restraint will be removed (e.g. bathing, eating)
- A plan for trialing out of restraints. The duration of trial is at the discretion of the professional team member directly involved in patient care.

d. Discussion with Patient/Family/SDM

During the period of restraint and/or when restraint is discontinued, the patient and family/SDM, as appropriate, must be given the opportunity to discuss the experience of restraint. Document significant interaction in the patient's Health Record.

e. **Accountability/Responsibilities within the Team**

The RN /RPN/LPN assesses the patient at regular intervals and communicates with the PCA/PW according to patient status.

f. Documentation

For sites with paper-based documentation, the Restraint Documentation Record may be used for documenting care of the patient in mechanical restraints. See Restraint Documentation Record and Guidelines for Use

For sites using EHR:

- The Restraint Monitoring, Evaluation, Education and Debrief sections are completed within the Restraints and Seclusion segment of iView
- The Behaviour log is completed under Quick View

- Vital signs, neurovascular checks, extremities assessment, integumentary and pain assessments should also be conducted and documented in the electronic record.

g. Incident Report

A Patient Safety & Learning System (PSLS) report must be completed when there are untoward effects of restraint such as positional compromise, skin breakdown or bruising or missing keys to locked restraints. In addition to documentation in the patient's Health Record, an Incident Report Form should be completed whenever a patient releases him/herself from a restraint or a friend/family releases the patient without discussion with the RN/RPN/LPN. The MD/NP is to be notified as necessary.

B. Emergency Assessment and Care Planning:

1. Definition

A behavioral emergency occurs when a patient's behavior/state conveys imminent, substantial and probable risk of serious injury to self, others, or property.

2. Assessment/Clinical Justification and Care Planning

a. During a behavioral emergency, the least restrictive and most appropriate form of restraint may be initiated without interdisciplinary assessment.

b. Consistent with non-emergency situations and as soon as possible, the patient must have a comprehensive interdisciplinary assessment of the behavior/state leading to the emergency initiation of restraint.

c. The professional team member must justify the emergency restraint and document a rationale based on clinical and ethical considerations (e.g. Maximum Freedom).

3. Initiation of Restraint

The decision to initiate a restraint during a behavioral emergency is a clinical decision that is made by the MD, NP or RN/RPN.

a. *Code* White*/Behavioral Emergency*

Using site-specific communication procedures, a Code White (Emergency Response: Code White) may be called to assist the RN/RPN/LPN during a behavioral emergency.

i. During a Code White, the RN/RPN will provide patient information and recommendations for the management of the behavioral emergency to the Code White Team Leader. The information includes:
   - Events preceding the arrival of the Code White Team
   - Patient history as applicable to this situation
   - Potential use of weapons (if known)
   - Infection control issues, and
   - Anticipated outcome of Code White Team intervention.

ii. The decision to initiate any type of restraint is a clinical decision as determined by the RN/RPN and is presented as a recommendation to the Code White Team

Leader

b. *Locked* Restraints

Only the Code White Team **may** apply locking restraints. The key to the locking restraint **must** be available at all times. See Restraints: Four Point Locking Restraint Application

In all areas of Vancouver Acute, the following steps must be taken:

1. A written medical order for locked restraints is required either before application or within ONE hour following application of locked restraint
2. A locked restraint order cannot exceed 24 hours and generally should not exceed 8 hours (or lesser period as clinically indicated)
3. To continue restraint beyond emergency application, the physician must:
   - Examine and certify the patient under the Mental Health Act of B.C. &
   - Seek consultation from a second physician, preferably a psychiatrist, for a second medical certificate if certification is required beyond 48 hours.
4. Patients in locked restraints longer than 24 hours must be reviewed by the Unit Medical Manger and Patient Services Manager
5. **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 on the Health Record
   - Security and the key must accompany patients who are transported in locked restraints

For Richmond Hospital and Lion's Gate Hospital Emergency Departments, please refer to DST Restraints: Use of Four Point Locking Restraints in the ED (Richmond Hospital) - (D-00-07-30307)

c. Accountability/Responsibility within the Team

The RN/RPN is responsible for ongoing patient assessment and care including monitoring of the patient's response to the intervention, during a Code White or other behavioural emergency requiring restraint.

It is recommended that the

- MD/NP assesses the patient within ONE HOUR or as soon as possible to address medical and/or psychiatric issues contributing to the first behavioural emergency.
- Interdisciplinary team and a physician assess a patient in locked 4 point restraints at least every 8 hours to determine continuation of a locked restraint
- Assessment following repeated behavioural emergencies is at the discretion of the MD/NP.

- A psychiatric consultation is highly recommended whenever there is an actual/potential for a behavioural emergency.
- The LPN collaborates with the RN/RPN prior to administering the first dose of a psychoactive medication especially following a behavioural emergency.
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d. Documentation

When restraint is initiated, documentation must include the decision-making process and who was involved (e.g. interdisciplinary team discussion, SDM, patient, Security), the specific behaviours necessitating restraint, the restraint type, and who initiated the restraint and their designation.

Within one hour of a behavioural emergency, the initiation of restraint must be documented on:

- Either the Restraint Initiation Record or the Health Record for paper-based documentation(See Restraint Documentation Record and Guidelines for Use), or
- In the Restraint and Seclusion segment under Interactive iView for sites using EHR

e. Notifications

The MD/NP must be notified within ONE HOUR following the first behavioural emergency especially with the use of 4-limb restraint. Ongoing communication with the physician regarding unsettled behaviour and repeated behavioural emergencies is at the discretion of the RN/RPN.

Note: In Acute Mental Health, a physician's order is required for all patients who are placed in any form of mechanical restraint.

The PSM/delegate must be notified and consulted as soon as possible. Issues related to maintaining these standards of practice must be discussed with the PSM or delegate as soon as possible.

4. Care of the Restrained Patient

a. Assessment

Continuous Assessment

Continuous assessment is the standard of care during and after a Code White while the patient's behaviour is unstable. Unstable is defined as continuous, escalating behaviour despite application of restraint and/or positional compromise.

Constant Observation

When the restraint presents a high-risk for patient injury and/or the patient's behaviour is not stabilized by restraint, Q 15 minute assessment and constant observation is the clinical standard of care. Examples include a patient who can remove a restraint, is at risk from environmental hazards (e.g. side rails, exit

seeking), or is found in a compromised position (i.e. between side rails, restraint around the neck).
The RN/RPN must reassess the patient continually to prevent the patient from removing restraints, and document the results of the reassessment as well as the rationale for continuation of the emergency restraint.

b. Interventions

For patients in restraint, interventions are to be completed every two hours while the patient is awake unless otherwise indicated.

c. Updating the Plan of Care

- The plan of care should be updated once restraint is initiated in order to meet the individual needs of the patient.
- The plan of care must include the desired outcome as well as the frequency for review of the decision to use a restraint. The plan of care should be updated every shift and PRN.
- For mechanical restraint, the plan of care should include:
    - Time intervals for rotating limb restraint removal and skin check
    - Time interval for repositioning/turning
    - Positioning of head of bed
    - Individualized interventions for toileting
    - Individualized interventions for offering fluid and food
    - Periods of time that a restraint will be removed (e.g. bathing, eating)
    - Plan for trialing out of restraints. The duration of trial out of restraint is at the discretion of the professional team member directly involved in patient care.

d. Safety Considerations

After a behavioural emergency, when removing a mechanical restraint for care or a trial without restraint, contact Security and request “Security standby for a planned intervention”.

Unless the patient’s safety is in jeopardy, do not remove the restraint without Security present.

Patients in locked restraint must have the key taped to the head of the bed at all times

e. Discussion with Patient/Family/SDM

When the patient’s behaviour has stabilized or when restraint is discontinued, the patient and family/SDM, as appropriate, must be given the opportunity to discuss the experience of restraint. Document significant interaction in the patient’s Health Record.

f. Accountability / Responsibility within the Team

The RN/RPN is responsible and has overall accountability for ongoing patient assessment and care following a Code White or other behavioural emergency

requiring restraint. When the patient has stabilized, nursing care of the restrained patient may be assumed by the LPN or assigned to the PCA/PW.

g. Documentation

For sites that are paper-based, document patient care in the Patient Health Record, or on the Restraint Documentation Record (See Restraint Documentation Record and Guidelines for Use)

For sites using EHR, document patient care within the "Restraint and Seclusion" segment of iView and the Behaviour log under Quick View.

h. Incident Report

A Patient Safety & Learning System (PSLS) report must be completed when there are untoward effects of mechanical restraint such as positional compromise, skin breakdown or bruising. In addition to documentation in the patient's Health Record, an Incident Report Form should be completed whenever a patient releases him/herself from a restraint or a friend/family releases the patient without discussion with the RN/RPN. The MD/NP is to be notified as necessary.

5. Discontinuation of Restraint

- As restraint is considered an unusual, temporary, short-term measure, the goal is to discontinue the restraint as soon as possible.
- A trial out is recommended before discontinuation of any restraint that was initiated due to Code White/behavioural emergency.
- The duration of trial out of restraint is at the discretion of the professional team member directly involved in the patent's care.
- Discontinuation of restraint is based upon the team's review of the assessment and care planning.

Documentation

- Appendix E: Restraint Initiation Record and Guidelines for Use
- Appendix F: Restraint Documentation Record and Guidelines for Use

Appendices

- Appendix A: Recommended Restraint Products (under review)
- Appendix B: Health Canada Notice
- Appendix C: Interdisciplinary Restraint Decision-Making Guide
- Appendix D: Alternatives to Restraint
- Appendix E: Restraint Initiation Record and Guidelines for Use
- Appendix F: Restraint Documentation Record and Guidelines for Use
- Appendix G: Use of Pinel Magnetic Waist Belt *(Lions Gate Neurosciences unit only)*

Related Documents/Resources

- Elsevier/Mosby Clinical Skills: Restraint Application and Monitoring – CE (To best view this document, **copy and paste** link into Google Chrome): http://mns.elsevierperformancemanager.com/SkillsConnect/Default.aspx?Token=549253&SkillID=585
- VCH Emergency Management Plans and Procedures https://my.vch.ca/dept-project/health-emergency-management/emergency-plans-procedures/Pages/default.aspx
- VCH Violence and Aggression ALERT - Acute Care
- VCH Violence Prevention Resource Page
- Falls and Injury Prevention Guideline (in Acute Care) (D-00-07-30033)
- Seclusion: Care of the Patient Requiring Seclusion (D-00-07-30283)
- Restraints: Use of Four Point Locking Restraints in the ED (Richmond Hospital) (D-00-07-30307)
- Observation Levels: Close or Constant Care Provision (Richmond Hospital) SOP (D-00-16-30227)
- Observation Levels: Provision of Close or Constant Care (Richmond Hospitals) (D-00-07-30305)
- Paladin Security Group Ltd, Policy and Procedure, Code White Response, Number PAL 01 HC. August 04, 2003.

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Approved By: *(committee or position)*	VCH
	ENDORSED BY: (Regional SharePoint 2nd Reading) Health Authority Profession Specific Advisory Council Chairs (HAPSAC) Health Authority & Area Specific Interprofessional Advisory Council Chairs (HAIAC) Operations Directors Professional Practice Directors • VA Nursing Practice Advisory Council (VANPAC) • VA Interprofessional Advisory Council (VAIAC) • Operations Director, Medical Services - Acute, Sub-Acute, Acute Care for Elders, MAU & Palliative Care • Operations Director, VA - Medical Services - BMT, Cardiac Sciences, Renal & Emergency (Director, Nursing & Allied Health, Vancouver Community) **APPROVED FOR POSTING** • Professional Practice Director, Nursing VA • Director Medicine Services Administration, VCH • Director - Surgical Program, Procedural Care, Emergency, Critical Care and Volunteer Services **Final Sign Off:** Vice President, Professional Practice & Chief Clinical Information Officer, VCH
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PROGRAM/UNIT: Restraint Advisory Committee

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CNS, Gerontology
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(added Richmond Hospital and Coastal CoC)

June 12, 2020 – Initial Revision Posted Date

May/2021 added SGH Pinel Wais Restraint

March 14, 2022 – Post updated document to SHOP. Fixed Header/Footer in Appendices.

October 17, 2023 – Removed appendix C that was only applicable to Richmond Hospital

Appendix B:
Health Canada Notice

(Applies to Richmond Hospital only)

Health Canada / Santé Canada

Health Products and Food Branch
Direction générale des produits de santé et des aliments

The Health Products and Food Branch (HPFB) posts on the Health Canada web site safety alerts, public health advisories, press releases and other notices as a service to health professionals, consumers, and other interested parties. These advisories may be prepared with Directorates in the HPFB which includes pre-market and post-market areas as well as market authorization holders and other stakeholders. Although the HPFB grants market authorizations or licenses for therapeutic products, we do not endorse either the product or the company. Any questions regarding product information should be discussed with your health professional.

NOTICE TO HOSPITALS
Health Canada Issued Important Safety Information on the Use of Waist and Torso Patient Restraints

March 16, 2007

To: Hospital Chief of Medical Staff, Nursing Homes

Please distribute to Departments of Geriatrics, Nursing, and/or other Departments as required and other involved professional staff and **post this NOTICE** in your institution.

Subject: **Risk of fatal asphyxiations resulting from the use of waist or torso patient restraints**

There have been several reports in Europe of fatal asphyxiations involving waist-fixating physical restraints. The European incidents happened predominantly when patients tried to leave the bed. The waist-fixating belt would then slide up over the patient's chest, which led to fatal asphyxiations by compression of the thorax. Some incidents occurred when patients slipped into the gap between split side rails. In most of the incidents, the side straps were not being used and the side rails of the bed were not in the raised position.

Following a review of the information provided by manufacturers and distributors selling waist restraints in Canada, and the incidents in Europe, Health Canada is making several recommendations on the use of waist restraints to prevent the occurrence of such incidents.

Recommendations for the use of waist and torso patient restraints:

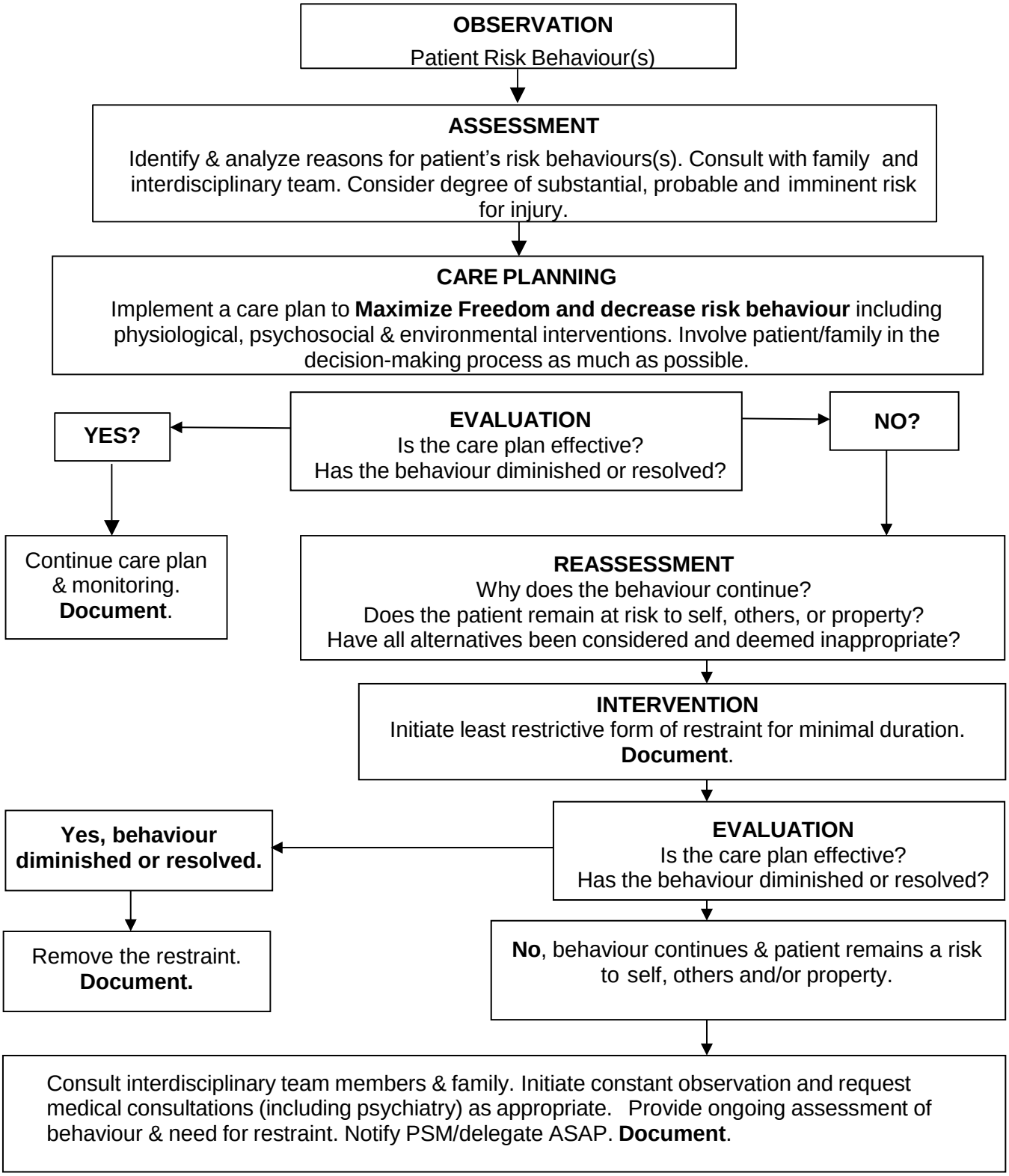
1) Perform a thorough assessment of the patient to determine the degree of restraint, the type of restraint and the appropriate level of patient monitoring needed. Many health care centres have a 'least restraint' policy that requires care givers to use the least restrictive option consistent with the patient's safety and comfort.

2) Keep the side rails of the bed raised at all times when restraints are being used.

3) Ensure that any gaps between split bed rails are blocked with a solid gap barrier that effectively prevents the patient from sliding through when restraints are being used.

4) Ensure that the waist belt cannot slide up over the patient's chest. For those patients deemed at risk, consider using side straps or other accessories to limit patient movement from side to side and to limit "helicoptering" (i.e turning in bed head to toe).

Appendix C:
Interdisciplinary Decision-Making Guide



Adapted from: Fletcher, K. (1996). Use of restraints in the elderly. AACN Clinical Issues, 7(4), 611-620.
St. Boniface General Hospital, (September 2001). Physical Restraints. Nursing Policy Manual.

Appendix D: Alternatives to Restraint Guidelines for Maximum Freedom

BEHAVIOUR	UNDERLYING REASONS	INTERVENTIONS FOR MAXIMUM FREEDOM
1. Fall Risk **See #3, Climbing or Falling Out of Bed**	• Poor vision • Decreased balance • Postural hypotension • Muscle weakness • Unsteady gait • Poorly fitting footwear • Environmental hazards • New or recent increase in medications • Taking contributing meds (i.e., cardiac, oral hypoglycemics, benzodiazepines, laxatives, antihypertensives, diuretics) • Cognitive impairment • Poor safety awareness • Perceptual impairment • Bowel/bladder incontinence • Language barrier • Fear of falling	• Consult PT for assessment of balance, gait, strength, walking aids • Consult OT to assess seating, footwear, assistive devices • Assist patient to use assistive devices such as a cane, walker, grab bars, bath stools, reacher • Monitor blood pressure lying and standing • Remove mobility restrictions such as foley catheters, drains, IV lines as soon as possible • Review medications and consult MD/pharmacist as needed • Toilet regularly or increase frequency while awake • Keep commode or urinal at bedside • Ensure mobility aid and footwear are reachable • Keep bedside and walking paths free from clutter • Ensure appropriate footwear • Ensure glasses & hearing aids are properly placed, clean and in working condition • Use signs (i.e. toilet) to increase orientation • Use side rails sparingly, especially at night • Use bed and/or chair alarms
2. Pulling at Tubes	• Pain/Discomfort • Cognitive impairment • Delirium • Tubing not incorporated into body image	**IV Peripheral/Central** • Assess need & discontinue ASAP • Wrap site with gauze or use Freedom Splint • Use saline lock • Remove equipment from patient's field of vision (i.e. under clothing, behind bed, under a dressing) • Inspect site regularly & treat pain/discomfort • Provide guided exploration of tubing **Urinary Catheter** • Assess need & discontinue ASAP • Ensure urine flows freely • Assess/treat pelvic/urethral pain & bladder spasm • Tape catheter to leg to avoid pulling on urethra • Disguise tubing under clothing/continence

		products • Place tubing between the legs and the bag at the foot of the bed • Use a leg bag to promote mobility & prevent falling **Feeding Tube** • Question reason/goals for feeding tube. Refer to Guidelines re Provision of Food & Fluids (N-096) • Hide PEG under abdominal binder/large dressing Remove tube and pump from patient's visual field • Provide guided exploration of tubing • Assess for discomfort with feeding • Provide distraction during feeding times
3. Climbing or Falling Out of Bed **See #1, Fall Risk**	• Toileting needs • Pain/discomfort • Biorhythms incompatible with hospital routine • Bored, lonely, not tired • Cognitive impairment • Decreased safety awareness	• Use side-rails sparingly. Top rails up only in most cases. If climbing, leave one side completely down • Put mattress on the floor • Keep bed in low position • Ensure bedside is well lighted. Night light PRN • Toilet regularly or increase frequency while awake • Commode and urinal at bedside • Shoes on while in bed • Use bed and/or chair alarms • Reposition frequently while awake • Assess & treat acute/chronic pain
4. Leaning Forward or Sideways; Sliding Out of a Chair **See #1, Fall Risk**	• Decreased awareness of body parts • Poor chair mobility • Lack of upper body strength • Uncomfortable chair • Fatigue/tired of sitting • Decreased balance • Reaching for objects • Decreased safety awareness	• Avoid fatigue by getting patient up for short periods • Assess & treat acute/chronic pain • Ask OT to assess seating/positioning/chair mobility • Place pillow on overhead table • Place patient closer to desk for observation • Assist patient to use assistive devices such as a long handled reacher • Toilet regularly or increase frequency while awake • Position patient appropriately for meals to avoid aspiration
5. Wandering	• Cognitive impairment • Inability to recognize a new, strange environment • Looking for home, family, pets, familiar surroundings	• Track patterns of wandering in Nurses Notes • Determine if behaviour occurs at particular times of day & adjust care/investigations to minimize stress. Redirect using a calm, positive, & gentle approach

	• Trying to accomplish a goal (i.e. going to the bank) • Seeking an exit from building • Following staff or visitors who are leaving • Exploring environment • Restlessness	• Toilet regularly or increase frequency while awake • Use distraction & involve in another activity • Acknowledge patient's "agenda" and feelings about need to leave (i.e. worried children will be home alone) • Ask the family their views on the patient's behaviour • Avoid reality orientation. Instead, validate emotions, give reassurance, and problem-solve around leaving the unit • Reduce levels of noise, clutter, & people • Personalize room as much as possible • Use positive phrases to indicate what the patient is to do. Say, "Turn around" rather than "Don't go there." • Activate wandering-alert system
6. Aggression	• Delirium • Cognitive impairment • Psychosis • Impaired communication, vision, hearing • Disinhibition due to illness and medications • Loss of control & independence • Behaviour of other patients, families, visitors • Inability to understand the intentions of caregivers • Approach of caregiver (body language, voice level/tone, touching without permission)	• Track triggers & what time behaviour(s) occur in Nurses Notes or Flowsheet • Assess & treat acute/chronic pain • Identify warning signs of escalating aggression • Minimize fatigue by balancing rest with activity • Encourage pacing to relieve anxiety • Increase interaction and social contact with staff/family • Consider past experiences & coping strategies • Contact the family/facility/other caregivers for clues to understanding behaviour • Establish eye contact as appropriate • Speak slowly and clearly • Use active listening skills • Identify yourself, repeat questions and allow time for response with each contact • Use positive phrases. Tell patient what you would like him/her to do, rather than what not to do • Ask permission to touch the patient. Always explain what is going to happen • Provide increased staff observation with opportunity to talk about concerns • Move patient from stimulating milieu to a quiet area • Administer PRN medications • Move patient to single room with close observation

Appendix E: Restraints Initiation Record and Guidelines for Use

Appendix F: Restraint Documentation Record and Guidelines for Use

Appendix G: Use of Pinel Magnetic Waist Belt *(Lions Gate Hospital Neurosciences Unit & Squamish General Hospital only)*

Need to Know

- Magnetic Belt is NOT used:
  - On patients with respiratory difficulties
  - On patients who have a large abdomen causing the belt to rise upwards
  - On patients too thin for the belt to fit securely
- A blue magnetic key to unlock the pinel magnetic waist belt is always kept at the bedside for emergency release of the patient.
  - A second release key is kept in the code blue box.

Risk of positional asphyxiation

This is due to the belt moving up over the thorax and restricting respirations.

Prevention:

- The pelvic strap must always be in use with the pinel magnetic waist restraint.
- Do not put any pads or bed linens between the belt and the patient. Pads may move and cause the belt to loosen.
- Ensuring that all staff who applies the waist belt are aware of all Pinel instructions.
- Put all three 3 bed rails in the UP position when patient is in the waist belt.
- Lateral straps (inserted side straps) are required to ensure that the patient is centred in bed while still permitting turning on side.
- Ensure the waist restraint keeps the patient centered in the bed.
- Ensure the straps for the waist restraint are attached to the non-moving part of the bed frame and NOT the side rails or any moving parts of the bed.
- Ensure the waist restraint is applied snugly. For obese patient, an optional extender strap is available to extend around the waist.

Hourly visual check of the patient must be performed along with offers of toileting, hydration, food, and keep personal item close to patient. See assessment and documentation for further guidance.

Equipment and Supplies

1. Pinel magnetic waist belt consisting of
   a. Waist belt with 2 side positioning straps (Epro stock # 00023727)
   b. 4 buttons/pins (Epro stock # 00023731)
   c. 1 magnetic key (E-pro stock # 00023730)
   d. 1 pelvic strap (Epro stock 00089419)
   e. 1 extender (optional for larger patients) (Epro stock # 00023728)

Procedure

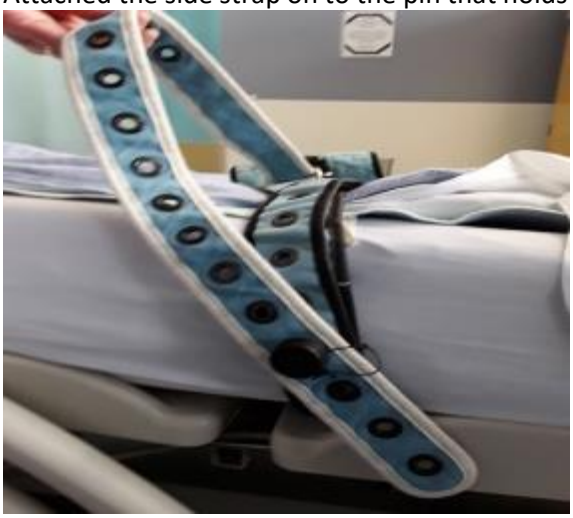
1. Ensure blue magnetic key is placed in a visible area at the bedside.
2. Test the pins/button and magnetic key to ensure the equipment is in proper working order prior to attaching the waist belt to patient.
3. Attach the pelvic strap to waist belt.
4. Attached the long straps of the waist restraint to the flat, non-moving part of the bed.

5. Magnetic waist belt must be snug and centered on the bed.
6. Wrap the wide inner flaps snugly around the patient's waist; bring the pelvic strap up through the legs to the waist. Secure the waist flaps and the pelvic strap together with two magnetic pins.

7. Attach both side straps to prevent the patient from sliding outside the side of the bed.

8. Pass the side strap through the waist buckle and then through its own buckle for a solid lock.

9. Attached the side strap on to the pin that holds the waist strap onto the bed frame



Steps: Pin locking procedure

1. A steel pin is inserted through the grommet holes of the materials to be locked together, layers of the pinel strap material will be held on this pin. The pin is able to accommodate up to 4 layers of pinel material.

2. Insert the black locking button onto the top of the pin. Remove the button from the key first.

3. Tug on the button to ensure lock engagement
4. The materials are now locked together by a force of approximately 1200lbs.
5. Patient should be able to roll side to side without falling out of bed.

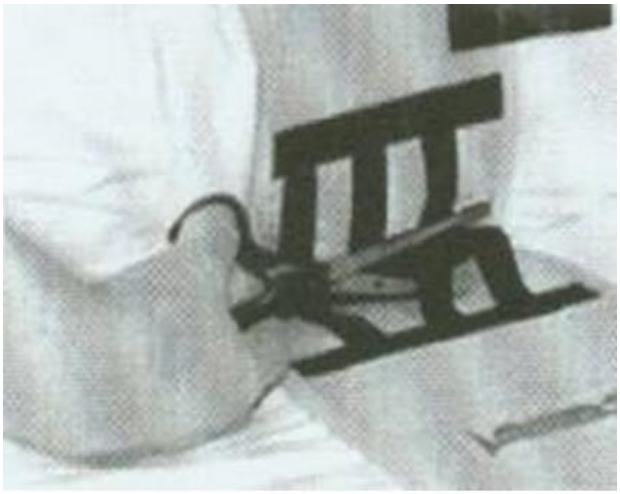
Steps: Pin unlocking procedure

This lock has a unique characteristic – it will not unlock with the key until all pressure is removed from below the black button.

To unlock:

a.) Slide finger under the pin base and press upward.
b.) Simultaneously, press material located near the button downward in a pinching motion.
c.) Insert key onto top of button
d.) Using slight finger pressure on the side of the button to assist lift. Lift off button.
e.) If there is resistance, make sure the pin is aligned straight with the key and restart the procedure.

For emergency escape from the waist belt, cut the interlocking straps connecting the patient portion and the bed portion of the belt only.



Washing instruction:

1. Remove all the pins, buttons, and key. Wipe down with disinfectant wipes and put in a plastic bag and place the bin in the clean utility room.
2. The magnetic belt, straps and pelvic strap are put in the bag labeled “return to 7 east” and delivered to EGH personal laundry for washing and picked up the next day.

Restraints Assessment and Documentation

	Assessment	Documentation
First initiation	1. Consider alternatives to restraints, need for restraint, type of restraints, and restraints behaviour 2. Assess proper placement of restraint, tightness of the restraint to allow for breathing freely, and able to turn side to side, 3. Depending on patient's history consider and assess for increasing ICP, pain, CAM, CIWA-Ar, and COWS whichever is appropriate. 4. Assess and document behaviour Q15min until pt settles, then q30m x 1h	1. **Restraint and Seclusion**: restraint prevention , restraint initiation, restraint information, pain assessment, restraint education, and restraint debriefing 2. create a dynamic group to describe the restraint in use 3. **Quick view**: behaviour log and CAM 4. **Adult systems assessment:** neurological and when appropriate CIWA-Ar, COWS,
On- going monitoring of restraint	1. Hourly assessment and documentation of toileting, hydration, food, and access to safe personal items. 2. Restraint removal? 3. Restraint activity (on or off) 4. Check tightness of restraint and its proper position. Patient should be able to breathe freely 5. Behaviour of patient	1. **Quick View**: behaviour log 2. **Restraint and seclusion**: pain assessment, restraint monitoring, restraint evaluation,
discontinuation of restraint	1. Assess for pain controlled, 2. Stable gait 3. Insight to abilities, 4. Delirium cleared as evidence by CAM negative 5. Alcohol withdrawal complete as evidenced by CIWA score 0 6. Opioid withdrawal complete as evidence by COWS score less than 5	1. **Restraint and Seclusion**: restraint information 2. discontinue restraint order