Introduction

Each Health PEI facility had a least restraint policy. The Directors of Nursing in Acute Care and the Chief Nursing Officer in Long Term Care determined the need to standardize the policy across the province. The revised Health PEI least restraint policy is applicable to all nursing staff and members of the nursing care team in acute care, long term care and in patient mental health. It is recognized that team consultation is required when least restraint initiation is being considered. Therefore, appropriate stakeholders were invited to disseminate among their staff for comment and provide feedback on the policy throughout the revision process. The policy has had many drafts and much discussion among stakeholders and is now ready for publishing.

This self-directed resource guide on least restraint is provided to enhance and refresh your knowledge of least restraint. It is available on the Health PEI Nursing Education web site. www.healthpei.ca/nursingeducation

Revisions to the policy include the need for a comprehensive assessment of the client and team collaboration prior to initiating the least restrictive restraint. A physician/nurse practitioner order may be obtained to initiate the least restrictive restraint. However, the registered nurse carrying out the comprehensive assessment that determines there is a serious risk to the client's safety, or the safety of those around the client can order the least restrictive restraint. If the physician/NP has not been part of the discussion they should be informed as soon as possible after initiation. [This is an overarching policy, specialty programs (e.g. psychiatry, critical care, pediatrics) may have program specific procedures/clinical standards; however, these must be congruent with the intent of this provincial policy].

There is no consent to restraint form to be signed. Rather, a conversation between the family, the client and health care team members involved when least restraint is being considered. Details of the conversation shall be documented. The rationale and clinical judgment behind consideration for least restraint use shall be discussed with the client and their family. Likewise if a family is insisting their family member be restrained this resource guide and policy will assist the health care provider explain why they are not initiating a restraint. A decision tree to assist the health care provider through the process is provided. Alternative interventions and

de escalation techniques (if appropriate) are to be implemented and utilized prior to initiating the least restrictive restraint. When the restraint is initiated the client must be monitored every 15 minutes until stable and then every 30 - 60 minutes until the restraint is discontinued (assessment dependant).

Documentation forms specific to restraint use have been enhanced in the electronic documentation system to reflect the revised policy. Practice settings that remain on paper will use Appendix D of the policy to document appropriately. This will also serve as the downtime form should the electronic system be down for any reason. This paper / down time form can be accessed through usual printing sources.

Clinical educators and /or resource nurses at your individual sites may review the document with health care providers using an associated power point presentation. The presentation can be delivered in conjunction with the self-directed resource guide during a brown bag lunch sessions/ unit/facility education session etc. Once you have completed the self-directed resource guide on least restraint, please inform your manager/clinical educator /resource nurse and they will provide you with a certificate of completion for your professional portfolio if applicable.

If the learning has been self directed, please contact the clinical educator/resource nurse, manager/charge nurse at your site with any comments, questions, and concerns regarding the policy or content of resource guide.

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Learning objectives of self-directed guide:

Health Care Providers will understand;

- The revised “least restraint” policy and be able to discuss it with peers.
- The risks of initiating least restraint.
- The decision making process associated with least restraint prevention or initiation through the use of a decision tree.
- Be knowledgeable of the alternatives/ interventions to be instigated to prevent an episode of restraint.
- The importance of documentation when assessing their client with the option to prevent / initiate an episode of least restraint.
- Be knowledgeable of the electronic documentation required for completion should it be required.
- Will increase/update their knowledge of “least restraint”.

Self-Assessment: Myths and Beliefs [21] **Circle the Answer**

a. Restraints prevent injury. T or F

b. Properly applied restraints will not harm clients. T or F

c. Clients do not mind being restrained, especially if they are confused. T or F

d. Restraints will decrease resistant behaviour, for example, agitation. T or F

e. Restraints are appropriate when clients cannot be closely monitored. T or F

f. Practical alternatives to restraints do not exist. T or F

g. Medication is a good alternative to physical restraints. T or F

h. Clients cannot refuse restraints. T or F

i. Restraints save time. T or F

j. Restraint reduction efforts are costly. T or F

All of the above questions are false. If you answered true, please read the following:

a. Restraints prevent injury: *False*

Is there any evidence to support the use of or identify the effectiveness of restraints?

There are no studies that demonstrate that the use of restraints results in increased client safety.[7] The benefit or effectiveness of physical restraints is not supported by the literature [10].

b. Properly applied restraints will not harm clients: *False*

There is no literature that supports this statement. Adverse client outcomes, including death, can result even with safe restraint practices. Use of alternatives (e.g. hip guards) has been shown to reduce serious injury related to falls. Reducing restraints use has resulted in a decrease in serious injuries. There is a growing body of research that indicates an increase in injury related to the use of a restraint[21].

Dangers of Restraint use:

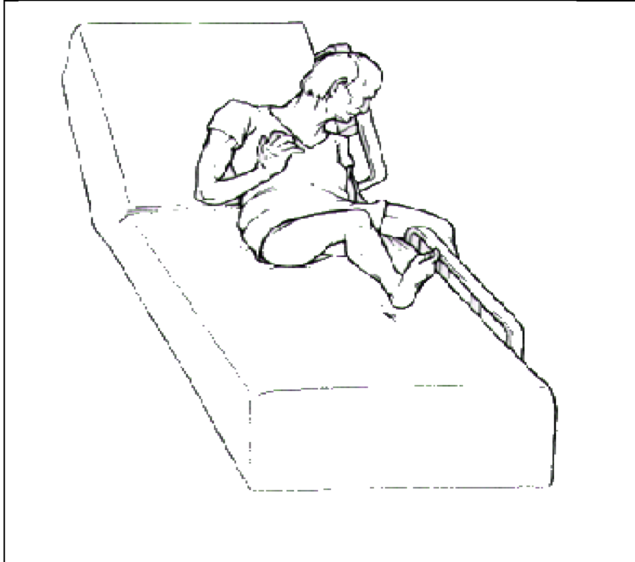
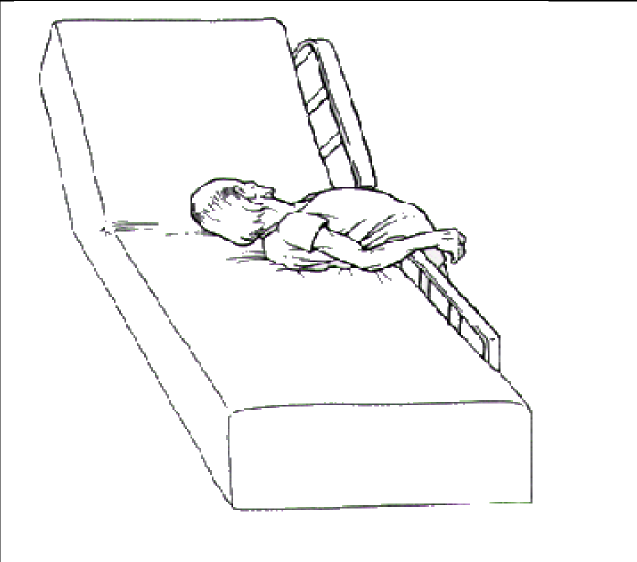
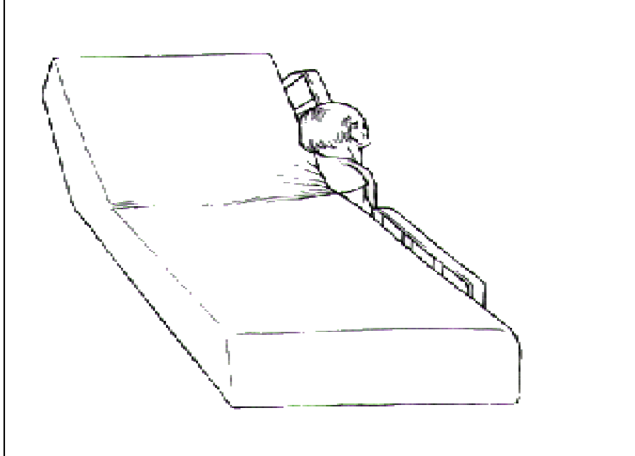
The dangers of restraints are well documented, including longer length of stay, confusion, discomfort, pressure ulcers, nosocomial infections, and even death by strangulation and asphyxiation [9, 17,10] . The Food and Drug Administration (FDA) 2003 has estimated that at least 100 deaths per year are caused by physical restraints[10]. Restraint use raised concerns of client dignity, muscle wasting and weakness; bone loss and increased risk of fracture; and increased risk of development of pressure sores, urinary and fecal incontinence, and infection. More serious were the risks of severe injury and death from strangulation and asphyxiation when restrained persons attempted to remove restraints or ambulate while restrained[6].

Bed Rails when used as a restraint

Health Canada has received, between 1980 and April 2006, 51 reported incidents of life threatening bed entrapments in Canada, 26 of which led to deaths. The term "entrapment" describes an event in which a patient/resident is caught, trapped, or entangled in the space in or about the bed rail, mattress, or hospital bed frame [23].

From 2008 to 2013, Health Canada received reports of 26 Canadian incidents involving hospital bed entrapment. Between 2001 and 2005 RIDDOR statistics showed at least 10 fatal accidents and a significant number of 'major injury' incidents where bed rails were implicated [15]. **The federal agency noted in its August 2012 advisory, incidents were continuing to be reported despite the warnings it issued in 2008 and 2009.** In the cases reported to Health Canada since 2009, about two-thirds happened in nursing homes while the remainder happened in hospitals or at home [3].

Pictures of Fatal Client Bedrail Entrapment.

1	2
	
1. The client's leg is moving off the bed into the space between the upper and lower bedrails	2. The client is sliding into the space between the upper and lower bedrails
3 	3, The client is suspended with the thorax lodged and compressed in a 6-inch gap between the upper bedrail and the mattress frame. *Miles & Parker (1998)*

c. Clients do not mind being restrained, especially if they are confused: *False*

Clients report negative psychological effects such as fear, anger, feeling degraded, even when confused [2, 21, 13, 22]. According to Sequeira and Halstead, "all restraint, even if used appropriately, can result in psychological and/or physical trauma to service users" [as cited by 18].

d. Restraints will decrease resistant behaviour, for example, agitation: *False*

Literature indicates restraints may increase agitation. Gorski (1995) stated that "restraints can actually trigger resistance and agitation in the elderly. Attempting to restrain a disoriented, fearful client may increase his panic and make him combative."

e. Restraints are appropriate when clients cannot be closely monitored: *False*

Restraint use must not be a substitute for inadequate staffing[21].

f. Practical interventions to prevent an episode of least restraint do not exist: *False*

Interventions do exist. Interventions are contained within the least restraint policy and the CIS documentation. (Included in appendices at the end of this document)

g. Medication is a good alternative to physical restraints : *False*

This is a clinical decision and relates to the presenting behaviour and the therapeutic use of a drug.

h. Clients cannot refuse restraints: *False*

Clients / SDM can refuse restraints when they are not at serious risk of injury to self or others. A discussion between the client, family/SDM and members of the health care team is important throughout the decision making process. Documentation of this conversation(s) is imperative with a client centred plan of care being established. (See Appendix E, Documentation)

i. Restraints save time : *False*

The Health PEI policy states that initially the person will be observed every 15 minutes for the first hour, until stable and then every 30 - 60 minutes until they are discontinued.

Why do health care provider(s) initiate restraints? – What research tells us.

According to Berzlanovich, Schöpfer, & Keil, (2012), "danger of falling and psychomotor unrest is the most common indications" (p.30). According to McCabe, Alvarez, McNulty, & Fitzpatrick, 2011, "nursing staff identify interference with therapeutic devices as the most important reason for using physical restraints" (p. 43). According to Benbenbishty, Adam, & Endacott, (2010) "restraint is most commonly used in intensive care units (ICUs) to protect the patient from the risks associated with untimely patient-initiated removal of indwelling devices such as endotracheal tubes" (p.242) [24]. Although physical restraint use is not associated with a decrease in falls or fall-related injuries, these devices continue to be used to prevent falls. Because physical restraint use can contribute to problems with balance and coordination, as well as falls, the question arises as to why there remains a persistent perception of physical restraints as "safety measures" (Gulpers et al. 2011). Staff in the emergency department (ED) did not identify therapy disruption as the most important perceived reason for restraint. "ED staff identified health care provider protection from physical abusiveness or combativeness as their most frequent reason to use restraint" (McCabe et al. 2011, p.43).

When should restraints be initiated?

According to the Canadian Nurses Protective Society (2004), "client restraints can be used if it is necessary to prevent serious bodily harm to the client or to another person. They may be applied in an emergency situation where danger is imminent" (para.2).

The PEI Consent to Treatment and Health Care Directives Act "does not affect any authority at common law to restrain or confine a person or take other remedial action when immediate action **is necessary to prevent serious bodily harm to the person or to others" (p.2).**

Prevalence rate of restraint use: Prevalence rates in the United States and Canada range from 6% to 25% in acute care settings, with even higher prevalence for some types of units, such as ICU's [10].

Health PEI Revised Policy of Least Restraint

Philosophy: Least Restraint Policy

Health PEI maintains a philosophy of least restraint and encourages the use of alternative measures/interventions consistent with the respect for and preservation of the client's dignity, rights, values, and preferences. Health PEI strives to uphold the ethical and legal responsibilities to create a safe environment for clients, visitors, and employees.

- Decisions regarding the use of physical, chemical, or environmental restraints must involve the client, substitute decision-maker (SDM), and health care team members.
- Capable clients and their substitute decision makers (SDMs) have the right to personal risk and to refuse a restraint when it does not involve serious harm to self or others.
- A restraint is always a **temporary** and **unusual measure**.
- A restraint is considered an **intervention**, not a treatment.

A restraint should be used **only as a last resort** and when all alternative measures/interventions have been exhausted.

Definitions:

Least restraint: Means all possible interventions are exhausted before deciding to use a restraint.

Restraint: Is defined as the involuntary immobilization or restriction of a person's movement. There is a general consensus that restraints can be classified into three main categories;

Environmental Restraint (Seclusion): Refers to any barrier or device that limits the locomotion of an individual, and thereby confines an individual to a specific geographic area or location. (E.g. secured units, safe and secure rooms). Seclusion has been defined as the temporary placement of a client, alone, in a specially designed, unfurnished, and securely locked room.

Physical/Mechanical Restraint: The use of any technique or device to manually prevent, restrict or subdue the free physical movement of a client; or of a portion of the body. Physical restraint sometimes refers to the immobilization of a client where one or more health care provider members make bodily contact (e.g., manual hold); however, physical restraint also has been commonly used as a synonym for mechanical restraint. Mechanical restraint involves the implementation of devices or appliances to restrain the client (e.g., body vests, calming blankets, and multiple-point ligatures). Safety devices that can be removed by the client without assistance (e.g., wheelchair belt) were not considered a restraint.

Chemical Restraint: The use of pharmaceuticals specifically administered for the sole purpose of temporary behavior management or control. Medication prescribed as standard treatment of a client's physical/medical condition or psychiatric disorders are excluded from this definition. Chemical restraint is sometimes called "rapid tranquilization" or "urgent sedation". Drugs commonly used as chemical restraints include benzodiazepines and antipsychotics.

Step by Step Guide through the Process

In emergency situations, maintain the safety of the client and/or health care provider first.

Section 1: Assess and describe the Clients behaviour

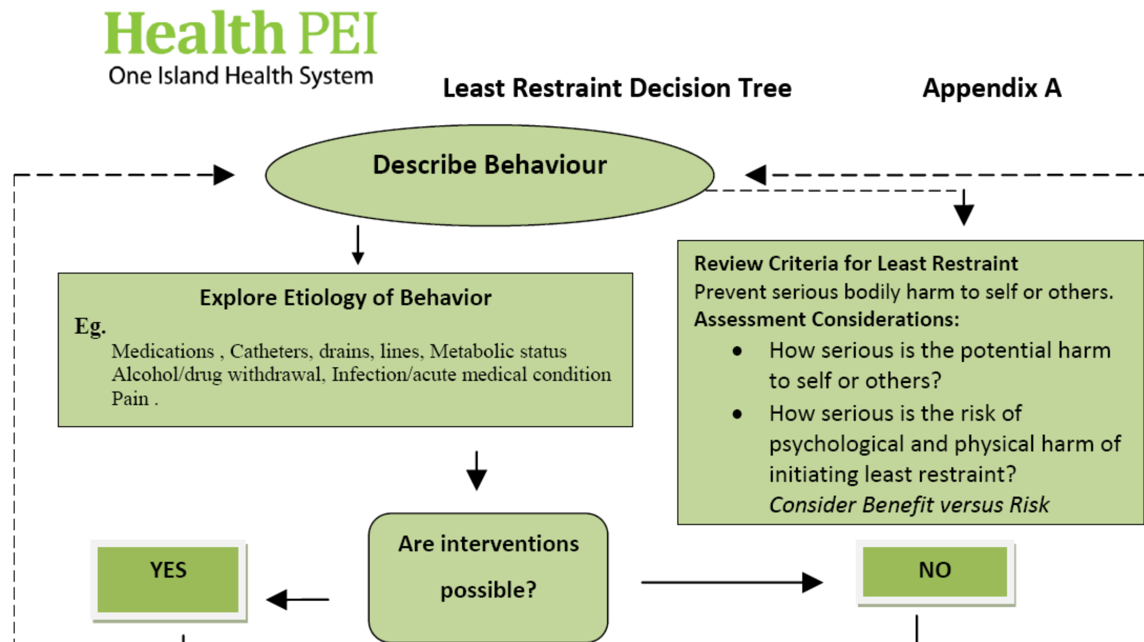
Behaviour!

"All human behaviours have meanings and there is a reason behind the action. The health care provider must ask themselves why my client is acting this way. If we spent as much time on trying to understand behaviour as we spend trying to or control it, we might discover that what lies behind it is a genuine attempt to communicate" [21]

(Goldsmith, 1996)

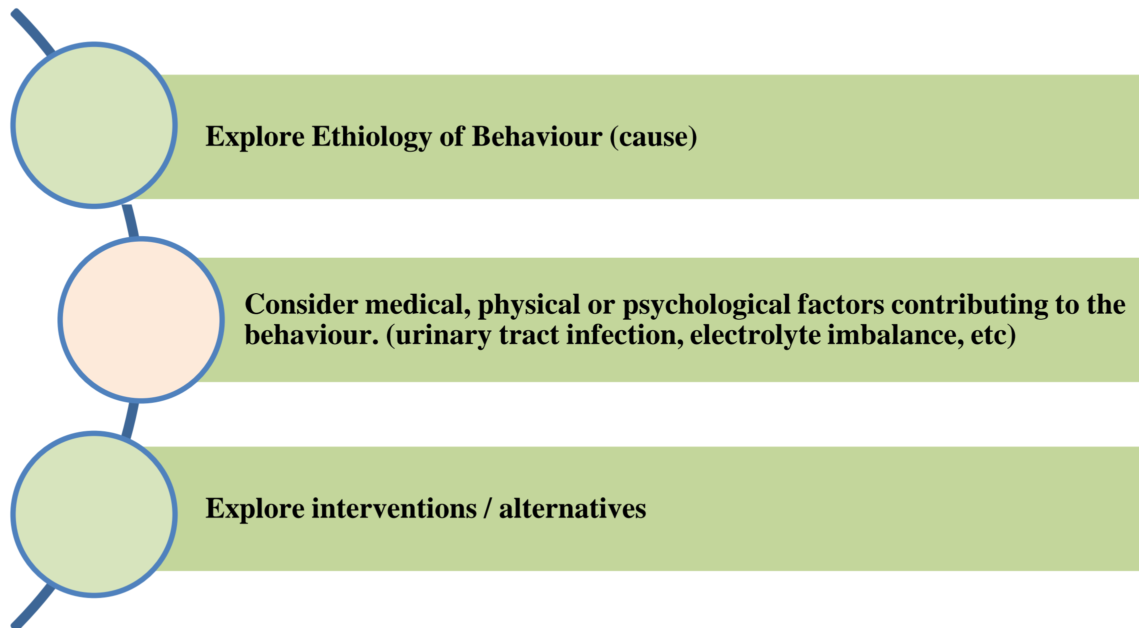
When the reason for the behaviour is identified, alternatives/interventions can be planned to resolve whatever difficulty the client is having that contributes to the consideration of restraint use. For example," if a client has poor balance or is frequently

falling, an intervention, such as providing the client a walker, can be implemented to help protect the client's safety while allowing freedom of mobility" (CNO, 2009, p. 4).



Review Criteria for least restraint: Remember the criteria for least restraint is to prevent serious bodily harm to self or others. When carrying out your assessment consider how serious the potential harm to self or others is. Consider benefits versus risks of restraint.

Explore Ethiology of Behaviour:



Interventions/alternatives

Interventions are already used in practice. Here is one such example.

Mrs. Gaudet is an 82-year-old client admitted with Chronic Obstructive Pulmonary Disease. On your night shift, she is unable to settle and demonstrates agitation and attempts to climb out of bed. On entering the room you find two side rails up. You provide a drink of water and take her to the bathroom. She settles.

Interventions listed

- They are: offering fluids and toileting.

Examples of interventions will depend on your individual client assessment.

Assess the effectiveness of the interventions trialed. If the intervention, alternative you choose does not succeed ***choose another***.

Please view the list of Pre Restraint Alternatives below. These are built in the electronic health record under restraint. (On paper they are Appendix B – attached at the end of this resource guide).

Appendix B (paper) identifies the behaviour and the suggested interventions to prevent an episode of restraint. Review this information and select the most appropriate when completing documentation. Review this information and select the most appropriate when completing documentation.

The CIS documentation has split the behaviour into an acute medical/surgical intervention listed in Figure 1 and behavioral restraint initiation in Figure 2.

Review this information and select the most appropriate when completing documentation.

Figure 1

Acute Medical/Surgical Restraint Initiation

Restraint Initiation Time

Reason/Behavior Necessitating the Use of Restraints

- ☐ Cognitive impairment that interferes with medical care
- ☐ Interference with medical devices, tubes and dressings
- ☐ Medically approved mechanical ventilation protocol
- ☐ Wandering that interferes with medical care
- ☐ Other medically approved protocol
- ☐ Other:

Pre-Restraint Alternatives Attempted

- ☐ Assess for cold, heat, hunger
- ☐ Assess past coping strategies
- ☐ Assistive devices easily available
- ☐ Consult other memebers of health care team
- ☐ Diversional activities
- ☐ Enhanced observation
- ☐ Environmental changes
- ☐ Family involved in planning care
- ☐ Gentle touch
- ☐ Increase social interaction
- ☐ Medication review
- ☐ Pain relief/comfort measures
- ☐ Presence of family/visitors
- ☐ Reality orientation
- ☐ Redirect with simple commands
- ☐ Regular ambulation
- ☐ Sitter at bedside
- ☐ Toileting needs addressed
- ☐ Use of alarm devices, bed, chair,door,watchmate
- ☐ Other:

Figure 2

Behavioral Restraint Initiation

Restraint Initiation Time

Behavior Necessitating the Use of Restraints

- ☐ Physical abuse to others
- ☐ Self injurious behavior
- ☐ Verbal aggression with potential harm to self or others
- ☐ Other:

Behavior Description

Pre-Restraint Alternatives Attempted

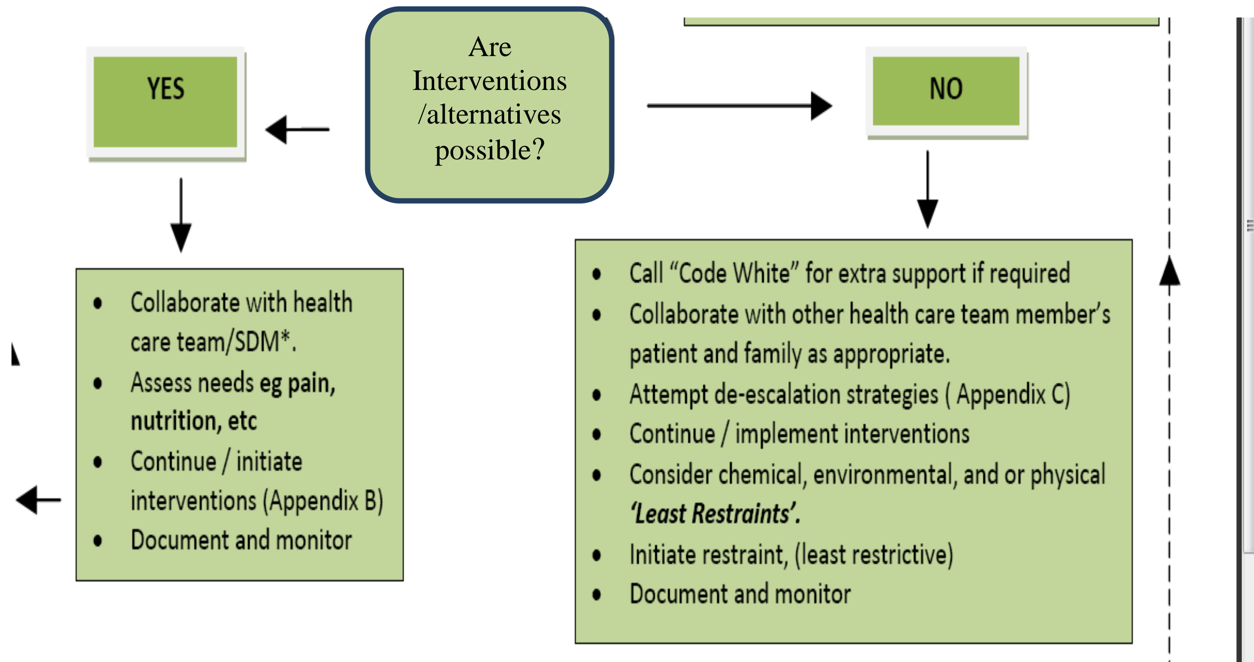
- ☐ Ask others to leave area
- ☐ Assess for cold, heat, hunger
- ☐ Assess past coping strategies
- ☐ Consult other memebers of health care team
- ☐ Crisis team
- ☐ Diversional activities
- ☐ Enhanced observation
- ☐ Environmental changes
- ☐ Family involved in planning care
- ☐ Limiting visitors
- ☐ Medication review
- ☐ Negotiation
- ☐ Pain relief/comfort measures
- ☐ Redirect with simple commands
- ☐ Relaxation/Exercise activities
- ☐ Toileting needs addressed
- ☐ Verbal limi
- ☐ Other:

- Explore and implement interventions to prevent an episode of restraint after consultation with the client, family and the other health care team members.

Some of the suggested Interventions/Alternatives built in the CIS system/in Appendix B - (paper) are as follows

- Consult appropriate team members (including MD, PT, OT, RN, Pharmacist, LPN, PCW/RCW
- Glasses, hearing aids, walking aids easily available
- Redirect with simple commands
- Alarm devices
- Pain relief/comfort measures
- Normal schedule/ routine
- Toileting regularly
- Assess for hunger, pain, heat, cold
- Medication review
- Quad exercise: mobility/ambulation
- Limit visitors
- Increase social interactions
- Reality orientation
- Client /family involvement
- Diversional activities
- Routine positioning (Q2H)
- Regular ambulation
- Relaxation/ exercise

Step 2: Are the interventions/alternatives attempted successful? YES or NO?



YES - Successful

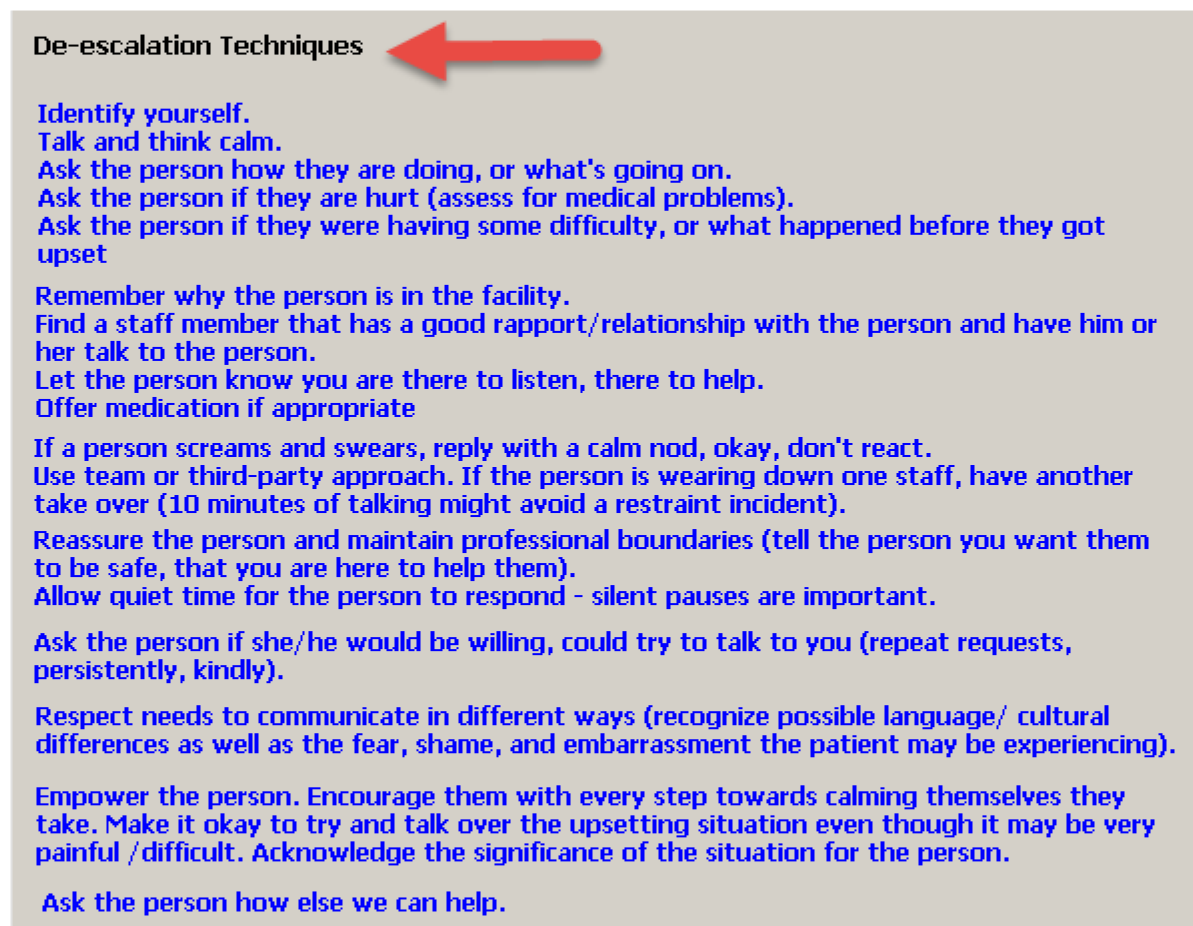
If the interventions/alternatives were successful continue to collaborate with the team members present, continue to assess the client's needs, pain, elimination, nutrition, mobility, and continue to document and monitor**.**

No Unsuccessful

- Call a "Code White" if extra support is required (remember maintain the safety of the client and/or health care provider first).
- Continue to collaborate with other team members.
- Attempt de-escalation techniques (Figure 3 , Appendix C) and appropriate interventions / alternatives.

- Initiate the most appropriate least restrictive restraint, (physical or chemical) after the de-escalation attempts, alternatives / interventions and following consultation with health care team members and family has been unsuccessful and the client is at risk of serious harm to self or others.

Figure 3- CIS-De-escalation techniques (Appendix C - Paper)



"The decision to initiate a restraint is a team decision"

A physician/NP order may be obtained but the registered nurse completing the client assessment can order the least restraint if the client is at risk of serious harm to self or others.

In order to initiate a restraint;

- the registered nurse must complete a comprehensive assessment of their client;
- the client must meet the criteria for initiating least restraint [prevent serious bodily harm to self or others]
- the registered nurse must collaborate with and seek assistance from other health care team members (client and family, physician, pharmacy, physiotherapy, occupational therapy and other members of the nursing care team)
- the registered nurse will review the least restraint decision tree
- the registered nurse will attempt de-escalation techniques and exhaust alternatives and interventions with the assistance of other team members as available.
- a team decision is made, interventions/alternatives and de-escalation have proved unsuccessful and the client is in serious danger to self or others, the least restrictive form of restraint is used first. If this is unsuccessful, progression from least to most restrictive restraint is implemented.
- Inform physician/NP as soon as possible if they have not been part of the decision making process.
- Continue to document and monitor client.

Restraint use must be assessed and reevaluated at least every 24 hours.

The order to restrain is only effective for 24 hours. After 24 hours a comprehensive re assessment shall be completed and if the client continues to meet the criteria for restraint it is re ordered.

Step 3: Monitoring and Care delivered when least restraint is initiated (CIS)

Restraint Monitoring

Restraint

	Activity	Type
Upper Extremity	<Alpha>	<Alpha>
Lower Extremity	<Alpha>	<Alpha>
Torso	<Alpha>	<Alpha>
Systemic	<Alpha>	<Alpha>

Circulation/Skin

- ☐ Skin intact
- ☐ Pulses intact
- ☐ Broken
- ☐ Cyanotic
- ☐ Reddened
- ☐ Other:

Range of Motion/Positioning

- ☐ Active range of motion
- ☐ Passive range of motion
- ☐ Repositioned
- ☐ Other:

Nutrition/Hydration

- ☐ Offered
- ☐ Offer declined
- ☐ IV fluid
- ☐ Tube feeding
- ☐ NPO
- ☐ Other:

Hygiene/Elimination

- ☐ Diaper change
- ☐ Offered
- ☐ Offer declined
- ☐ Incontinent
- ☐ Urinary catheter
- ☐ Other:

Bed Safety

- ☐ Bed alert on
- ☐ Bed in low position
- ☐ Side rail in use
- ☐ Wheels locked
- ☐ Other:

Safety

- ☐ Call device within reach
- ☐ ID band check
- ☐ Night light
- ☐ Non-Slip footwear
- ☐ Other:

Affect/Behavior

- ☐ Appropriate
- ☐ Calm
- ☐ Cooperative
- ☐ Agitated
- ☐ Anxious
- ☐ Appears depressed
- ☐ Combative
- ☐ Crying
- ☐ Fearful
- ☐ Flat
- ☐ Hostile
- ☐ Inappropriate
- ☐ Restless
- ☐ Uncooperative
- ☐ Other:

Restraint Discontinuation Readiness Attempts

- ☐ Comfort measures
- ☐ Diversional activities
- ☐ Enhanced observation
- ☐ Environmental changes
- ☐ Family/Visitors at bedside
- ☐ Frequent toileting
- ☐ Negotiation
- ☐ Reality orientation
- ☐ Verbal limit setting
- ☐ Other:

Any member of the client's care team can release or remove a restraint for opportunities of care delivery (e.g. hygiene, family present).

- Toilet every 2-4 hours (dependant on individual assessment)
- Check the client:
  - (1) Every 15 minutes initially for the first hour and until client behavior is stable
  - (2) Every 30 – 60 minutes until restraint is discontinued

<u>An order is not being sent to the nursing task list every 15 OR 30 – 60 minutes.</u>

Nursing if initiating least restraint will order same "Restraint"

This sends a communication order to the Patient Care Summary tab under Assessments

Within this order is the reference text containing the Decision Tree.

When the physician / NP orders a restraint the decision tree will also be contained within the reference text.

In long term care facilities and during down time for the CIS electronic documentation system (planned or unplanned) your documentation form is Appendix D.

Paper copies can be obtained via internal printing.

Step 4: Discontinuation of Least Restraint (CIS)

Acute Medical/Surgical Restraint Discontinuation

Restraint Initiation Time

Restraint Discontinuation Time

Total Restraint Time

Behavior Criteria for Release

- ☐ Cognitive status improved and no longer interferes with medical care
- ☐ Medical devices, tubes, and dressings removed
- ☐ Other:

Behavioral Restraint Discontinuation

Restraint Initiation Time

Restraint Discontinuation Time

Total Restraint Time

Behavior Criteria for Release

- ☐ No longer exhibits physical abuse to others
- ☐ No longer exhibits self injurious behavior
- ☐ Other:

Discontinue Restraint

- Suggestions to discontinue restraint should be reviewed by the health care team members.
- Discontinue restraint when client no longer meets criteria for restraint use.
- Document removal of restraint on client’s health record.
- An order is **not** required to discontinue a physical restrain

Documentation (Appendix E of policy)

Documentation: Least restraint

"Accurate and complete documentation of the use of restraints is essential and is mandated in some legislation. Nurses have been disciplined by their licensing body when they failed to document the use of client restraints" (CNPS 2004).

CIS: Restraints Form (Located under IV Therapy / Procedure / POC section)

Paper : Appendix D

The use of any restraint is to be fully documented in the client's record and plan of care.

Documentation must include if applicable:

- Decision tree used to assist decision making process
- Description of the behavior that initiated the restraint use or its continued usage.
- A detailed assessment and documentation of any underlying etiology (cause) that contributed to the behavior.
- Steps taken to correct the underlying etiology. (e.g. Treatment for a urinary tract infection or electrolytes corrected)
- What interventions/alternatives and de-escalation tips were attempted?
- Client and family/SDM involvement in the decision-making process, any discussions and outcomes.
- Team members involved in decision to initiate least restraint and discussion.
- Documentation that the family / SDM have been informed about the least restrictive restraint initiation if they were not part of the discussion (Emergency)
- Type of restraint used (lap, vest, limb etc)
- Date and time of restraint application and health care provider(s) involved.
- Documentation of reassessment and monitoring, ongoing use of alternatives and de-escalation strategies.
- A detailed skin assessment

- When client is restrained : Check the client:
  (1) Every 15 minutes initially for the first hour and until client behavior is stable
  (2) Every 30 – 60 minutes until restraint is discontinued

- Discontinuation of least restraint, by whom, date and time.
- Client Care Plan should describe client's response and/or outcome of restraint.

Documentation of conversation between family/SDM and health care provider.

An individual assessment of the client will identify the risks they pose to themselves or others.

The following information may help you communicate with the family/SDM and assist with documentation.

Risks if restraint <u>is not</u> initiated:

- A restraint has been initiated as the client is in danger of hurting themselves**.**
  (Health care provider: Explain your reasoning due to your assessment / team assessment to the family/client)
- Client's behavior may harm another client, family member or health care provider.
  (Health care provider: Explain your reasoning due to your assessment / team assessment to the family/client)

Physical risks of r<u>estraint</u> include the following

a) Asphyxiation

b) Aspiration

c) Abrasions, other skin injuries

d) Impeded circulation

e) Decreased mobility which:

- impacts on movement, muscle strength, and energy
- contributes to constipation/impaction and urinary retention
- inhibits full lung expansion
- contributes to pressure areas
- contributes to osteoporosis

f) Increased possibility of incontinence in mobile clients

g) Resistance may lead to unsafe acts (e.g. tipping wheelchairs, banging people and

objects, climbing over bedrails)

h) Decreased functional ability

Psychological Risks of restraint use include the following:

a) The basic need for freedom is denied…loss of self-esteem and dignity.

b) A person may lose the will to live, initially fighting the restraint, and then gradually resigning him/herself to this state.

c) Over protectiveness can rob a person of excitement regarding life.

d) A person may become frustrated and angry at being restricted/controlled and react in an agitated or aggressive manner.

e) Consistent use of restraint can lead to dependence on its use.

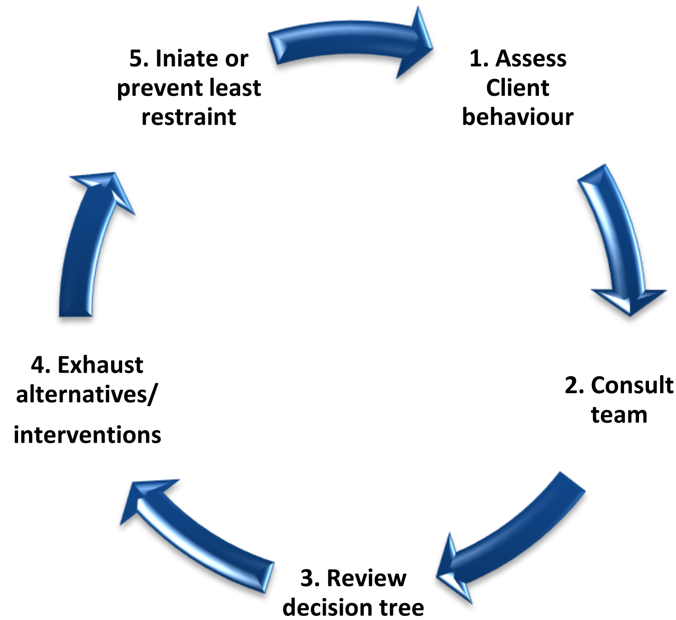
f) Fear of being abandoned;

g) Increased confusion;

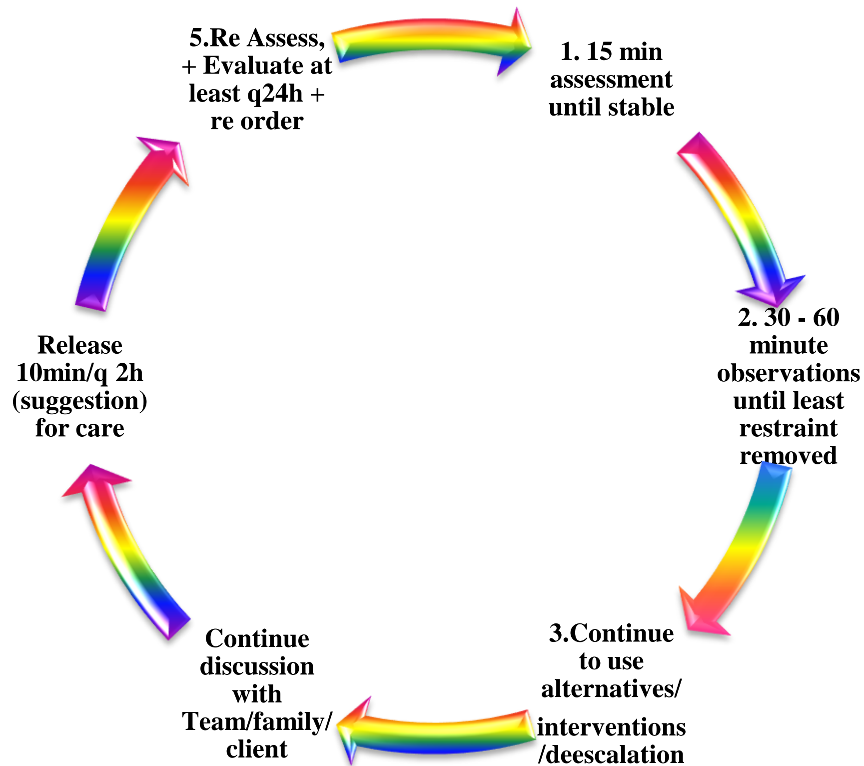
h) Decreased ability to function mentally and emotionally.

"Risks of physical and psychological restraints" Adapted from Parkridge Centre – *"Operational Policies and Procedures: Resident Safety" (1992)*

Simplified summary of process to initiate least restraint



Simplified process after least restraint is initiated



Emergent Situation

In emergent situations, initiate **approved** restraint (where there is immediate serious risk of harm to the client, health care provider or others).

1. Call a Code White for extra support to manage client behavior as per facility/unit emergency codes.

2. Initiate least restraint in an emergency situation to provide safety for clients, health care provider and others,

3. Continue to attempt de-escalation strategies (Appendix C)

4. Consult Health P.E.I. Least Restraint Decision Tree. (Appendix A)

5. Inform physician/nurse practitioner as soon as possible after restraint initiated if they are not aware.

6. Document the rationale for the use of the restraint, include all interventions and de-escalation attempts to prevent restraint use.

7. Revise the clients care plan to reflect the application of restraint.

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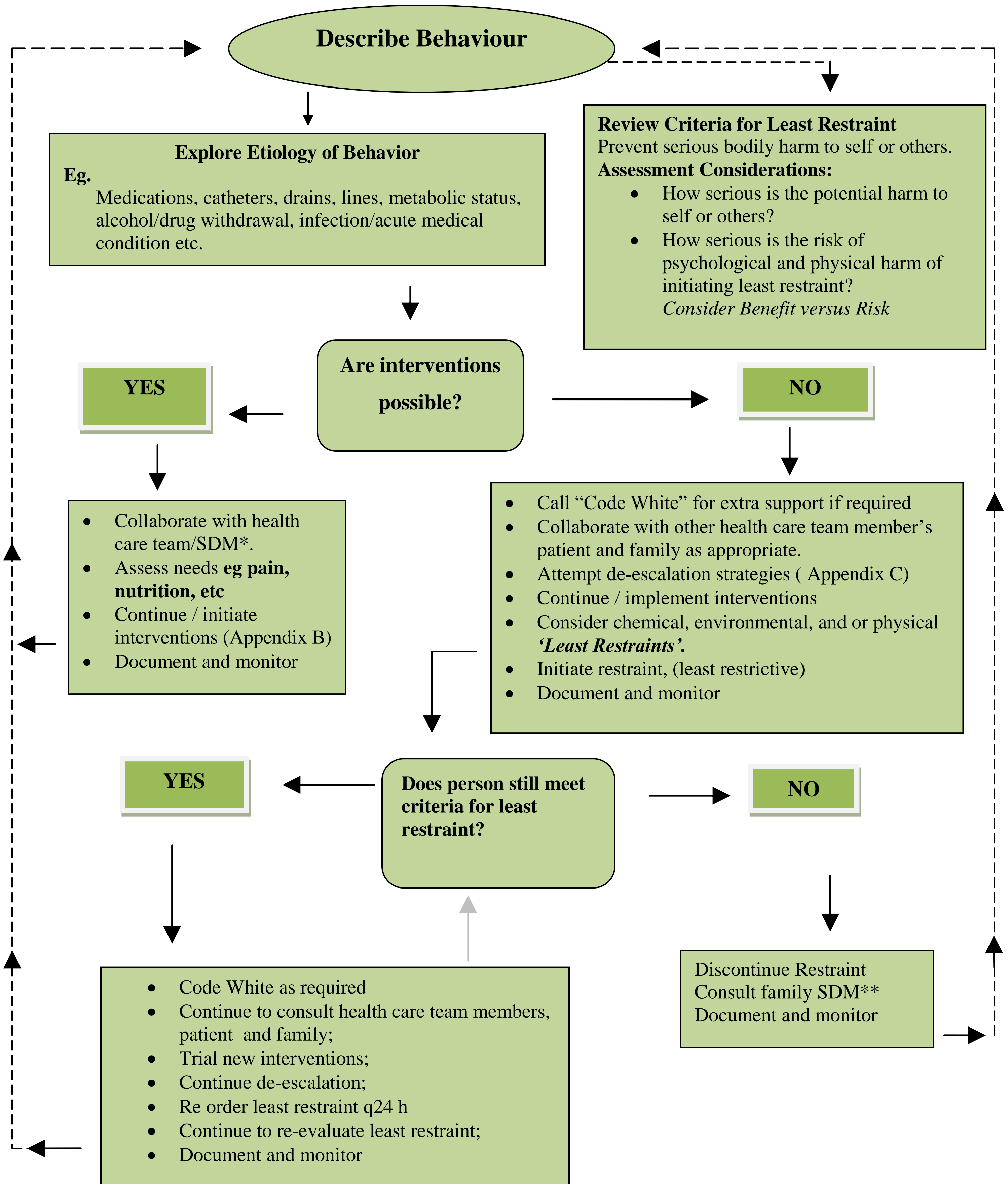
Health PEI
One Island Health System

Least Restraint Decision Tree

Appendix A



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* SDM = Substitute Decision Maker

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Appendix B
Observed Behaviour and Suggested Interventions to prevent an episode of restraint

Behaviour	Suggested Interventions to prevent an episode of restraint
1. Falls	• Consult appropriate team members (including MD, PT, OT, Pharmacist, RN in Charge) • Medication review • Toileting regularly • Quad exercise: mobility/ambulation • Routine positioning (Q2H) • Increased participation in ADL • Pain relief/comfort measures • Normal schedule/individual routine • Assess for hunger, pain, heat, cold • Glasses, hearing aids, walking aids easily available • Hip protectors, helmet • Increase social interactions • Redirect with simple commands • Call bell demonstration • Involve family in planning care • Diversional activities: pets, music, puzzles, crafts, cards, snacks • Scheduling daily naps • Alarm devices – bed/chair/door • Clutter free rooms • Mattress on floor/lower bed/Posey floor mat • Non-slip strips on floor • Night light • Acceptance of risk
2. Cognitive Impairment - dementia	• Consult appropriate team members (including MD, PT, OT, Pharmacist, RN in Charge) • Toileting regularly • Normal schedule/individual routine • Assess for hunger, pain, heat, cold • Label environment, e.g., bathroom door • Increase social interactions • Redirect with simple commands • Gentle touch • Assess past coping strategies • Involve family in planning care • Diversional activities: pets, music, puzzles, crafts, cards, snacks • Reminiscence • Scheduling daily naps • Pacing permitted • Alarm devices – bed/chair/door • Clutter free rooms • Night light • Glasses, hearing aids, walking aids easily available

Appendix B

Behaviour	Suggested Interventions to prevent an episode of restraint
3. Acute Confusion - delirium	• Consult appropriate team members (including MD, PT, OT, Pharmacist, RN in Charge) • Medication review • Assess for electrolyte imbalance, infections and constipation • Assess for hunger, pain, heat, cold • Pain relief/comfort measures • Toileting regularly • Normal schedule/individual routine • Label environment, e.g., bathroom door • Increase social interactions • Redirect with simple commands • Gentle touch • Assess past coping strategies • Involve family in planning care • Scheduling daily naps • Alarm devices – bed/chair/door • Clutter free rooms • Night light • Glasses, hearing aids, walking aids easily available
4. Agitation	• Consult appropriate team members (including MD, PT, OT, Pharmacist, RN in Charge) • Mobility/ambulation/exercise routine • Routine positioning (Q2H) • Medication review • Pain relief/comfort measures • Toileting regularly • Normal schedule/individual routine • Assess for hunger, pain, heat, cold • Increase social interactions • Redirect with simple commands • Relaxation techniques • Gentle touch • Assess past coping strategies • Involve family in planning care • Diversional activities: pets, music, puzzles, crafts, cards, snacks • Scheduling daily naps • Pacing permitted
5. Wandering	• Assess for hunger, pain, heat, cold • Buddy system among staff/consistency • Label environment, e.g., bathroom door • Increase social interactions • Assess past coping strategies • Involve family in planning care • Diversional activities: pets, music, puzzles, crafts, cards, snacks • Tape (stop) line on floor • Alarm devices – bed/chair/door • Clutter free rooms

Appendix B

Behaviour	Suggested Interventions to prevent an episode of restraint
	• Night light • Room close to nursing station • Glasses, hearing aids, walking aids easily available
6. Sliding	• Routine positioning (Q2H) • Pain relief/comfort measures • Call bell demonstration • Wedge cushions/tilt wheelchairs (consult OT/PT) • Non slip cushion (consult OT)
7. Aggression	• Consult appropriate team members (including MD, PT, OT, Pharmacist, RN in Charge) • Medication review • Pain relief/comfort measures • Normal schedule/individual routine • Assess for hunger, pain, heat, cold • Increase/Decrease social interactions • Relaxation techniques • Assess past coping strategies • Involve family in planning care • Pacing permitted • Soothing music
8. Pulling out invasives/tubes	• Pain relief/comfort measures • Increase social interactions • Redirect with simple commands • Call bell demonstration • Stimulation/meaningful distraction • Explain procedures/treatments • Gentle touch • Involve family in planning care • Camouflage tubing on IV • Abdominal binder over PEG • Change IV to intermittent asap • Arm splint (prevent elbow bending)
9. Unsteadiness	• Consult appropriate team members (including MD, PT, OT, Pharmacist, RN in Charge) • Mobility/ambulation/exercise routine • Medication review • Increase social interactions • Call bell demonstration • Scheduling daily naps • Clutter free rooms • Mattress on floor/lower bed • Non-slip strips on floor • Night light • Acceptance of injuries • Glasses, hearing aids, walking aids easily available

Health PEI
One Island Health System

Appendix C

De-escalation Tips and Interventions to Assist Persons to Cope

1. Always identify yourself.
2. Talk and think calm.
3. Ask the person how they are doing, or what's going on.
4. Ask the person if they are hurt (assess for medical problems).
5. Ask the person if they were having some difficulty or what happened before they got upset.
6. Remember why the person is in the facility.
7. Find a staff member that has a good rapport/relationship with the person and have him or her talk to the person.
8. Let the person know you are there to ***listen*.**
9. Offer medication if appropriate.
10. If a person screams and swears, reply with a calm nod, okay, don't react.
11. Use team or third-party approach. If the person is wearing down one staff, have another take over (10 minutes of talking might avoid a restraint incident).
12. Reassure the person and maintain professional boundaries (tell the person you want them to be safe, that you are here to help them).
13. Allow quiet time for the person to respond – silent pauses are important.
14. Ask the person if she/he would be willing, could try to talk to you (repeat requests, persistently, kindly).
15. Respect needs to communicate in different ways (recognize possible language/ cultural differences as well as the fear, shame, and embarrassment the patient may be experiencing).
16. Empower the person. Encourage them with every step towards calming themselves they take.
17. Make it okay to try and talk over the upsetting situation even though it may be very painful or difficult.
18. Acknowledge the significance of the situation for the person.
19. Ask the person how else we can help.

Milwaukee County Mental Health Division

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