QUINTE HEALTHCARE CORPORATION

Nursing – Restraint Minimization

Title: Nursing – Restraint Minimization		**Policy No:**	**3.16.6**
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Approved By:	**Nursing Practice Committee**		

1. POLICY

i. Restraints shall be viewed as "last resorts". Restraints are to be used only in circumstances where there exists an "imminent risk" of harm to the patient or others, only after careful assessment by a regulated health professional, and only after determining that available alternatives would prove inadequate. The use of restraints for convenience or discipline is prohibited at Quinte Healthcare Corporation (QHC).

ii. In all cases, when a restraint is required to meet the patient needs, only the least restrictive restraint shall be used on a patient. Use of restraints is a temporary measure and discontinued as soon as possible.

iii. Informed consent is required for the use of any device that restricts a patient's freedom of movement. In situations of imminent risk, consent must be obtained within 12 hours after the application of the restraint.

iv. A physician's order for restraints is required. In the case of an emergency, when imminent risk of harm to the patient or others exists, the selection and application of restraints may be completed by the nursing staff; however, the physician is to be informed as soon as possible (within 12 hours) and an order received or the restraint is to be discontinued.

v. Orders for restraints must indicate purpose (anticipated reason) and timing.

vi. Patients requiring restraints for transfer (between units, hospitals and/or care facilities) must be accompanied by the appropriate regulated health care professional. The most responsible physician will write an order indicating the need for restraints.

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

viii. The application of restraints is carried out with the minimal use of such force as is necessary while maintaining dignity and respect for the patient.

ix. Under the Mental Health Act (MHA) involuntary/formal patients (certificate under the MHA) may be restrained without their consent or the consent of their Substitute Decision Maker (SDM) should the patient be assessed as a risk to themselves or others.

x. Mental Health patients who are voluntary/ informal cannot be restrained without consent. However, the hospital has a duty under common law to restrain the patient when immediate action is necessary to prevent serious bodily harm to the patient and others in the hospital environment. The restraint of a voluntary patient requires reassessment by the physician as soon as possible regarding certificate status.

2. DEFINITIONS (see Appendix A)

3. PURPOSE

The purpose of the least restraint policy is to respect a patient's autonomy and promote decision making within the context of patient-centred care, with involvement of the patient, family and/or substitute decision maker and information sharing with the health care team.

The use of a restraining device, regardless of the intended purpose, carries a potential risk to the physical safety and psychological wellbeing of the patient to whom the restraint is applied. Limiting a patient's freedom of movement in any way carries with it a responsibility on the part of the health care providers to exercise a high degree of caution and care. Alternatives to restraints are always to be considered first.

4. PROCEDURE

The following procedures outline the decision to restrain, assessment and reassessment requirements, approaches to minimize restraint use, consent, the appropriate application and use of restraints, special precautions and instructions for monitoring a restrained patient's safety (monitoring, repositioning, and release of restraints, and additional interventions), documentation, and required education for staff related to least restraints.

4.1. Making the Decision to Restrain

First conduct an interprofessional patient assessment and consider alternative to restraints. A comprehensive assessment of the patient includes:

- Cognitive Status (level of confusion)
- Physical Assessment
- Risk for falls
- Risk for wandering
- A review of the patient's history in relation to prior application of restraints
- Identify reasons or condition(s) that led the patient to current behaviour (for example, pharmaceutical, cognitive, emotional, pain and physical assessment)

In an emergency situation, the full patient assessment is performed as soon as possible (i.e. once the situation is no longer critical).

Consider alternatives to restraint use (see Appendix B for an inventory of alternatives to restraints). Furthermore, explore alternatives to restraints with patient/family/substitute decision maker, these may include:

- identifying measures used at home to ensure patient's safety and well being
- the family's availability to assist with patient's care in hospital (for example, sitting with the patient)

General considerations to implement (or consider) include:

- A location change (moving the patient closer to the nursing station, moving the patient to a more or less simulating environment dependent on patients' needs assessment)
- For restless patients, consider consultation with an occupational therapist for a seat assessment. Note: A seat assessment may help reduce the need for restraints in patients with reduced mobility due to physical or cognitive behaviour
- Keeping the bed in the lowest position
- Rearranging furniture in the room to clear obstacles
- Post signs to help the patient find his/her room
- Keep the call bell within easy reach; remove hazardous objects (for example, sharp containers)
- Regular toileting of the patient (at a minimum of every 3 hours or according to patient's individual requirements)
- Review patient medications, with consultation of pharmacy to check side effects, paradoxical effects, and appropriateness of medications ordered

4.2. Application of Restraints

If the decision is made by the (multidisciplinary) interprofessional team to restrain the patient (see Appendix C – Decision Making Tree for Least Restraint):

- Define the condition for which the restraints are used, the type of restraint, and monitoring requirements
- Select the least restrictive restraint to meet the patient's needs
- The application of the restraints is the responsibility of a regulated health professional as it requires an assessment of the patient. Unregulated health care providers may assist the regulated professional in the application of the restraint only
- See Appendix D for safe application of pinel restraint checklist
- Always examine restraints before application to ensure they are in good working condition, and replace as required
- Only attach the restraint straps to the moveable portion of the bed frame that supports the mattress not to the bed frame that supports the bed wheels
- Only restraints approved for use by QHC are to be used (Appendix E). Please note, commercially manufactured restraints must be used as intended by the manufacturer and are not to be modified or adapted in any way. Staff must receive orientation to all restraint products used at QHC before applying any device.

4.2.1 Physical Restraints as an Emergency Intervention

The Most Responsible Physician (MRP) may order restraints on a patient. However, the nurse may physically restrain, without an order or consent, a patient in an emergency situation to prevent harm to the patient or others.

4.2.2 Chemical Restraint

The attending physician on call may prescribe a chemical restraint. A chemical restraint is ordered STAT to prevent harm to the patient or others in their environment. The chemical restraint may be given without the patient's consent.
Recent and clear documentation supporting the continued belief that the patient may imminently cause serious bodily harm to self or to others must be evident on the chart when PRN chemical restraint is given. The patient will be observed and the effect of the chemical restraint will be documented in the patient's chart by nursing staff.

4.3 Consent

Whenever a restraint is considered necessary the patient and/or substitute decision-maker must be informed within 12 hours regarding the reason for the restraint, alternatives considered, the type of restraint chosen, risks and benefits of restraint use, and when it will be re-evaluated. Provide the family with the Restraint Information for Patients and Family Form (Appendix F).

Consent must be obtained from the patient and/or substitute decision-maker within 12 hours. The patient and/or their substitute decision maker must sign the QHC Request/Refusal for Restraint Form (Appendix G). Individuals declared incompetent to manage their own affairs legally or financially might still exhibit sufficient understanding of direct care issues and therefore, be capable of evaluating the risks of refusing restraint. It is important for the health care team to carefully evaluate the patient's ability to contribute to decision-making with respect to restraints and to ensure that his/her contributions are taken into account.

The onus remains on the health care provider to ensure that the patient and family are aware of the plans for restraint and have sufficient information regarding the use and effects of the restraints to ensure their full participation. Always remember, patients and their substitute decision makers have the right to personal risk and have the right to refuse a restraint when it does not involve serious harm to self or others.

Restraints cannot be used without decision maker consent. The exception is in emergency situations or when the patient is under a certificate of the Mental Health Act where there exists a serious threat of harm to the individual or others and all other measures have been unsuccessful. Emergency situations are time limited. The patient's substitute decision maker must be informed within 12 hours of restraint use.

4.4 Documentation

The use of any restraint is to be fully documented in the patient's health care record and plan of care. Documentation must include:

- Reason for restraint
- What alternatives were tried
- Type of Restraint
- Description of the behaviour that required the patient to be restrained or continue to be restrained
- Patient Involvement in decision making in regards to personal care
- Documentation of reassessment, monitoring and other alternatives tried
- Consent

When a chemical restraint is used, documentation must include the behaviour displayed requiring chemical restraint, chemical used, dose and method of administration (on medication administration record), and the effect of the medication given.

4.5 Monitoring and Repositioning of Restraints

Restraining all four limbs (4 points restraints) simultaneously is considered an extraordinary measure and is used only when all other measures of least restraint have been considered and/or exhausted and deemed to be ineffective or not appropriate. The application of such extraordinary measures of restraints must be accompanied by constant observation. **Please refer to QHC policy *3.18.11 Patient – Enhanced Levels of Observation and Use of Sitters*.**

Other situations may exist which would also require constant or close observation; these may include 3-point restraint and/or the restraints of both arms/wrists limiting the patient from protecting him/herself and/or seeking help. An assessment by the regulated health care provider, in consultation with the team leaders and/or manager is required. Arrange for constant or close observation by an appropriate member of the health care team (refer to QHC Policy *3.18.11 Patient – Enhanced Levels of Observation and Use of Sitters*). Please note that this requires approval by the department manager (or designate).

Monitoring of all patients in restraints shall be done hourly, or more often, according to the type of restraint used and the needs of the individual patient, and to ensure the correct position of the restraining device (for physical restraints) and the patient's comfort, safety, and well-being.

The following will be monitored, assessed and supported by documentation every 2 hours:

- Hydration, Nutrition and Elimination will be assessed and provided every 2 hours for all patients with restraints
- The restraint must be removed for skin care, repositioning or exercise every two hours if appropriate
- Restraints need to be released for ten minutes q2h if appropriate
- Restraints are not required to be released if the patient is sleeping and is able to turn self from side to side in bed
- Provide an opportunity for patient and/or substitute decision maker to discuss any thoughts, feelings or concerns in regards to the restraint
- Ensure safety standards are in place (i.e. call bell within reach, brakes on bed, bed in lowest position)
- Assess position of restraint and ensure it has not slipped or moved
- Assess any change in condition/behaviour of patient
- Ongoing need for restraint is reassessed every 2 hours
- Use alternatives in place of restraints whenever possible

Strict adherence to these instructions will help to minimize any associated risk to the patient when a restraint is in place. Ongoing reassessment is required to ensure patient safety by reducing or eliminating restraints at the earliest possible point in their care.

Concerns about supply, condition of, and access to the necessary equipment should be brought to the immediate attention of the unit manager.

4.6 Education

- All health care providers at QHC will be made aware of the least restraint policy
- All new nursing staff will be educated on the least restraint policy and restraint devices at QHC during nursing orientation
- Nursing staff working in areas of physical restraint use will complete a mandatory annual learning module on least restraints

4.7 Special Considerations

- **Rail Covers:** Regardless of the type of restraint being used, side rail covers should be in place for all beds with gaps in the rails when restraints are used with the patient in bed.
- **When Using Pinel Restraint System:** In order to reduce risk to our patients, when the **Pinel waist restraint** is used in bed, the following must be in place:
  1) All bed rails must be placed in the UP position
  2) If the bed has split rails (that create a gap), the gap covers (or side rail covers) must be used
  3) Side straps (yellow) must be used to ensure that patient remains centred in bed
  4) The pelvic strap must be used to prevent upward travel of the waist belt

- Each unit should have a consistent location for an extra key in the event of an emergency.

APPENDICES AND REFERENCES

Appendices: Appendix A – Definitions
Appendix B – Alternatives to Restraints
Appendix C – Decision Making Tree for Least Restraint
Appendix D – Safe Application of Pinel Restraints Competency Skills Checklist
Appendix E – Acceptable Restraint List
Appendix F – Restraint Information for Patients and Family
Appendix G – QHC Request/Refusal for Restraint Form

References:

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