London Health Sciences Centre

Policy:	Use of Restraints		
Policy Owner:	System Innovation & Business Development Executive		
SLT Sponsor:	Corporate Nursing Executive & VP, Medicine, Critical Care & Professional Practice		
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POLICY

London Health Sciences Centre (LHSC) is committed to respecting the dignity, rights and independence of patients to the greatest extent possible while providing a safe environment for patients, visitors, staff and affiliates.

The use of restraint may be required to prevent bodily harm to the patient or others, or to maintain treatment, when alternative measures have been assessed as ineffective. (Refer to Appendix A for alternatives to using restraints.) Restraint is not to be used as a substitute for professional observation and care.

In accordance with the Patient Restraints Minimization Act and the Mental Health Act, LHSC supports a philosophy of minimal restraint. The use of restraint is exceptional and temporary and should allow for as much autonomy as possible while providing for the safety of the patient and others. Where restraint is deemed necessary, the duration should be as short a period of time as possible and measures chosen which provide the least restraint necessary to control the behaviour of the patient.

The consideration of restraint will involve discussions with the patient/substitute decision maker (SDM) and health care team (HCT) where possible. When there are reasonable grounds to believe that there is an immediate risk of harm to the patient or others, the use of minimum restraint may be initiated, without patient/SDM consent. (An order is required for chemical restraint.) Restraint may be used where necessary to detain an involuntary patient under the Mental Health Act.

While restraints are in use, the condition of the patient and need for restraint must be assessed, monitored, documented and re-evaluated in accordance with this policy and governing legislation and professional standards.

Only approved restraint devices are utilized at LHSC.

This policy does not apply to the use of restraints applied by law enforcement.

PROCEDURE

Refer to Appendix B for restraint use process map.

1. **Urgent Situations**
   - 1.1. When there is an immediate risk of harm to the patient or others, authorized staff/affiliates will:
     - 1.1.1. Assess the behaviour of the patient to determine which type of restraint is appropriate to manage the behaviour. (Refer to Appendix C for criteria for selecting the appropriate physical restraint.)
     - 1.1.2. Activate Code White Procedure if necessary.
     - 1.1.3. Initiate the method of least restraint. Consent is not required when immediate intervention is deemed necessary.
   - 1.2. After the use of restraint has been initiated, the regulated health professional (RHP) will:
     - 1.2.1.1. Initiate documentation of restraint use and assessment. (Refer to Section 7 for documentation requirements.)
     - 1.2.1.2. Initiate Violent Patient Identification Process, as appropriate, in accordance with Managing Abusive Behaviours: Patients, Family and Visitors Policy.
     - 1.2.1.3. Ensure care is taken to meet the patient's health care needs and safety requirements while restrained. (Refer to Section 8 for observation requirements.)

1.2.1.4. Notify the SDM, if applicable.
1.2.1.5. When the need for urgent restraint ends, follow the procedure for non-urgent intervention.

2. **Non-Urgent Situations**
   2.1. When there is a potential for risk of harm to the patient or others and the situation is non-urgent, the regulated health professional (RHP) will:
      2.1.1. Consider psychological or medical basis for behaviour and provide appropriate treatment.
      2.1.2. Collaborate with the patient/SDM to develop a plan of care. Discussions must be documented in the patient's health record.
         2.1.2.1. Discuss alternatives to the use of restraint (Appendix A) with the patient/SDM to determine appropriate interventions with consideration of the patient's needs and preferences.
         2.1.2.2. Where appropriate, discuss with the patient/SDM how the use of restraints may need to be part of the patient's plan of care. Patient Safety and the Use of Restraints brochure (Appendix E) may be provided to patient/SDM to facilitate discussion/consideration of the use of restraint.
      2.1.3. Implement alternative measures according to the plan of care.
      2.1.4. If alternative measures are evaluated to be ineffective and/or inadequate:
         2.1.4.1. Obtain patient/SDM consent for the use of restraint and document consent on the Restraint Flowsheet (Appendix D). (Refer to Section 5 for consent requirements.) If the patient/SDM does not consent to the use of restraint, follow the procedure outlined in Section 6 – Refusal of Restraint.
         2.1.4.2. Initiate restraint use based on the plan of care.
         2.1.4.3. Document restraint use and assessment. (Refer to Section 7 for documentation requirements.)
         2.1.4.4. Ensure care is taken to meet the patient's health care needs and safety requirements while restrained. (Refer to Section 8 for observation requirements.)

3. **Transferring Patients in Restraints**
   3.1. When transferring a patient in restraints to another unit/department for any purpose:
      3.1.1. A nurse familiar with the patient's medical condition and understanding of why the patient was placed in the restraints must accompany the patient with Portering.
      3.1.2. At transfer of care, the receiving health care responsible must be competent to remove and reapply restraints. The receiving area leader will alter assignment as required to ensure safe transfer of care.

4. **SDM Requests for Patient Restraint**
   4.1. If the HCT determines that alternative measures are adequate/effective but the SDM requests that the patient be restrained, the regulated health professional (RHP) will:
      4.1.1. Discuss the HCT's assessment findings and reason for not using restraints.
      4.1.2. Discuss alternative measures to the use of restraints (Appendix A) with the SDM.
      4.1.3. Document discussion with the SDM on the patient's health record.

5. **Consent for Restraint**
   5.1. Patient/SDM consent is not required in urgent situations. When the need for urgent restraint ends, consent must be obtained in accordance with the procedure for non-urgent intervention.

   5.2. In non-urgent situations, the RHP will:
      5.2.1. Obtain informed verbal consent from the patient/SDM after the assessment for restraint use has been discussed with the patient/SDM, including:
         5.2.1.1. Alternatives that have been attempted/considered,
         5.2.1.2. Reason(s) for restraint use,
         5.2.1.3. Type of restraint recommended by the HCT,
         5.2.1.4. Risks associated with not restraining the patient, and
         5.2.1.5. Response of the HCT when the situation is urgent.
      5.2.2. Inform the patient/SDM that the duration for restraint use will be for as short a period of time as possible.

   5.3. If consent is obtained, the RHP will document consent on the Restraint Flowsheet (Appendix D).

   5.4. If the patient/SDM does not provide consent, refer to Section 6 – Refusal of Restraint.

6. **Refusal of Restraint**
   6.1. In non-urgent situations where the patient/SDM does not provide consent for the use of restraint, the RHP will:

6.1.1. Document refusal on the Restraint Flowsheet (Appendix D), if already initiated, and in the patient's health record.
6.1.2. Continue alternative measures according to the plan of care.
6.1.3. Continue to collaborate with the patient/SDM regarding the plan of care as the patient's condition evolves.

6.2. When there is an immediate risk of harm to the patient or others follow the procedure for urgent situations (Section 1).

7. **Documentation**

7.1. The RHP will:

7.1.1. Document the plan of care, including discussions with the patient/SDM, in the patient's health record.
7.1.2. Document initiation and discontinuation of restraint on the Restraint Flowsheet (Appendix D).
7.1.3. Document restraint use, assessments and care provided on the Restraint Flowsheet (Appendix D).

7.2. If patient/SDM does not provide consent for the use of restraint, the RHP will document refusal on the Restraint Flowsheet (Appendix D), if already initiated, and in the patient's health record.

8. **Observation**

8.1. A member of the HCT will monitor patient in accordance with Restraint Flowsheet (Appendix D).

8.1.1. Constant observation is required for soft limb restraints.
8.1.2. For all other restraints, minimum observation is every 15 minutes in the first hour, and every 60 minutes after the first hour.

9. **Education**

9.1. The following staff require restraint education upon hire and then annually:

9.1.1. Nurses,
9.1.2. Medical Imaging Technologists,
9.1.3. Security Guards,
9.1.4. Mental Health Orderlies,
9.1.5. Emergency Department Technicians, and
9.1.6. Personal Support Workers (PSW). PSWs are not authorized to initiate restraints but may assist in application. PSW education will encompass restraint maintenance and care of patients in restraints.

9.2. Clinical leadership will ensure staff education is completed as required.

10. **Maintenance of Physical Restraint Devices**

10.1. London Hospital Linen Service (LHLS) manages the cleaning and distribution of approved physical restraint devices.

10.2. Mobile work centres will be provided for identified patient care units. Clinical leadership will be responsible for designating an appropriate location for storage and access. Work centres will contain a variety of Pinel restraint components that have unit names and bar codes to facilitate return of the devices post-laundering by LHLS.

10.3. Pinel restraints (except metal pin/magnet/key) are placed into the soiled linen hampers after use. Once laundered, the restraints will be returned to the respective units by LHLS staff.

10.4. Clinical Leadership will be responsible for maintaining and adequate supply of restraints in good condition

10.5. Clinical leadership will identify a common location within each designated patient care unit to store metal pin/magnet/key during times of restraint.

10.6. When restraints are not in use metal pin/magnet/key will be cleaned according to the Standard Wiping Protocol and placed back into mobile work centres for next use.

10.7. Clinical leadership is responsible to maintain a sufficient restraint supply for departmental needs and ensure replacement of restraints that show signs of wear/damage.

10.7.1. Every area that houses restraints will assign one or more staff to complete and document weekly audits using the Restraint Audit Tool (Appendix F) and Assessing Condition of Restraints Poster (Appendix G).

10.7.2. Joint Health and Safety Committee will include a review of the audits as part of their inspection checklist. Non-compliance with audit requirements will be reported by the JHSC representative as a workplace hazard.

DEFINITIONS

Authorized Staff/Affiliates – Individuals at LHSC that are trained in the application of restraint, and who may initiate use of restraint. LHSC only supports the following staff/affiliates to apply restraints: Nurses, Medical Imaging Technologists, Security staff, Mental Health Orderlies and Emergency Department Technicians.

Health Care Team – The health care professionals providing care to the patient (e.g. physicians, nurses, health disciplines professionals).

Involuntary Patient – A person who is detained in a psychiatric facility under a Mental Health Act Form.

Most Responsible Provider (MRP) – A physician, dentist or midwife who has the ultimate responsibility for that patient's care at LHSC.

Regulated Health Professional – A member of the College of a health profession as defined in the Regulated Health Professions Act or the Social Work and Social Service Work Act.

Restrain – To place under control when necessary to prevent serious bodily harm to the patient or to another person by the minimal use of such force, mechanical, chemical or environmental means as is reasonable having regard to physical and mental condition of the patient. Restraints are intended to prevent injury or bring under control behaviors or physical movements which could cause bodily harm to patients or others.

Restraint – Something that restricts the patient is some way:

- Placement of an object near or on the person's body to limit their ability to move,
- Limiting a person's movement to keep them in a certain area, or
- Using medication to control a person's behaviour.

Substitute Decision Maker (SDM) – If patient is incapable with respect to a treatment, the Health Care Consent Act lists in order of rank the following deciders:

- The incapable person's guardian of the person, if the guardian has authority to give or refuse consent to the treatment,
- The incapable person's attorney for personal care, if the power of attorney confers authority to give or refuse consent to the treatment,
- The incapable person's representative appointed by the Board under section 33, if the representative has authority to give or refuse consent to the treatment,
- The incapable person's spouse or partner,
- A child or parent of the incapable person, or a children's aid society or other person who is lawfully entitled to give or refuse consent to the treatment in the place of the parent. This paragraph does not include a parent who has only a right of access. If a children's aid society or other person is lawfully entitled to give or refuse consent to the treatment in the place of the parent, this paragraph does not include the parent,
- A parent of the incapable person who has only a right of access,
- A brother or sister of the incapable person,
- Any other relative of the incapable person,
- Public Guardian and Trustee (PGT), if two or more equally ranked substitute deciders disagree about whether to give or refuse consent.

Type of Restraint – The following types of restraints are utilized at LHSC:

- Physical or Mechanical Restraint: Any device which restricts free movement or prevents spitting, including waist restraint belts, lap belts, wrist or ankle cuffs and mitts, approved spit barriers. When devices are used solely for the purposes of positioning, they are not considered as restraints (e.g. lap tray, hemisling, trunk belt).
- Chemical Restraint: Pharmacological interventions used to control sudden outbursts of aggressive or agitated behavior in a patient where there is a potential for injury to self or others in the environment. The goal is to relieve symptoms without affecting the patient's level of consciousness or mobility.
- Environmental Restraint: Any barrier intended to prevent a patient's movement from one location to another such as Geri-chairs or bed rails. All four bed rails up is not an approved restraint at LHSC.

Urgent – When there is an immediate risk of harm to self or others.

REFERENCES

Corporate

Consent to Treatment
Managing Abusive Behaviours: Patients, Family & Visitors
Workplace Violence Prevention
Observational Care
Patient Rights and Responsibilities
Standards of Nursing Care, Restraints

Legislation and Standards

Mental Health Act
Substitute Decisions Act
Health Care Consent Act
Patient Restraints Minimization Act
Occupational Health and Safety Act
College of Nurses of Ontario Practice Standard (2009) Restraints

APPENDICES

Appendix A – Alternatives to Using Restraints
Appendix B – Restraint Use Process Map
Appendix C – Criteria for Selecting the Appropriate Physical Restraint
Appendix D – Restraint Flowsheet (NS4442)
Appendix E – Patient Safety and Use of Restraints Brochure (NS6707)
Appendix F – Restraint Audit Tool
Appendix G – Assessing Condition of Restraints Poster