London Health Sciences Centre

Policy Administration Console

Policy:	Use Of Restraint		
Policy Owner:	Director, Nursing & Allied Health, Professional Scholarly Practice		
SLT Sponsor:	Chief Nursing Executive, Patient Safety & Quality Officer, Professional Scholarly Practice		
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This policy applies to: ☑ LHSC

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.

LHSC supports a philosophy of minimal use of 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. Information for patients and families about this philosophy is found in the Patient Safety and the Use of Restraints Brochure (Appendix F).

Restraint use is limited to those situations where alternative measures have been assessed as ineffective. (See Appendix A) The consideration of restraints will involve discussions with the patient/Substitute Decision Maker (SDM) and health care team (HCT) where possible. The condition of the patient must be assessed, monitored, documented and re-evaluated on a specific schedule while restraints are in use.

Restraints may be required in the following situations:

- When circumstances related to the patient's psychological or physical condition necessitates immediate intervention, and when there are reasonable grounds to expect there will be self-injury or injury to others;
- While investigating and treating psychological and physiological causes of agitation and/or confusion;
- When other alternative measures (Appendix A) have been used or considered and are judged to be ineffective.

Requirements for the Use of Physical, Chemical and Environmental Restraint

Physical Restraint

- The Most Responsible Provider's (MRP) order is not required for physical restraint but may be initiated by personnel authorized by the regulation.
- The physical health of the patient must be assessed at least every 24 hours.

Chemical Restraint

- A physician's order is required (Refer to Controlled Drugs and Substances Act).
- The MRP must be informed by members of the HCT of changes in the patient's behaviour that

warrants the initiation or discontinuation of restraints.

- The patient must be assessed for release from chemical restraint at least every 24 hours.
- An order for continuation of restraint can only be signed if the patient has been seen within 2 hours.
- External consultation by a physician not from the unit where the patient is restrained must take place every 72 hours or sooner.

Environmental Restraint

- The MRP's order is not required for environmental restraint but may be initiated by personnel authorized by the regulation.
- The physical health of the patient must be assessed at least every 24 hours.
- Maintain patient safety by preventing patient from moving from one location to another.

In accordance with the Patient Restraints Minimization Act, the use of restraint on a voluntary patient at LHSC will be ordered by the MRP or by personnel authorized by the regulation in order to prevent serious harm to the patient or to others. The Mental Health Act applies to all involuntary patients at LHSC. Refer to Appendix E for additional requirements for mental health patients.

Only approved restraint devices are utilized at LHSC.

PROCEDURE

1. Determining the Need for Restraint Use

1.1. A regulated health professional (RHP) will assess the situation and determine if the situation is urgent or non–urgent.

1.2. When the situation is **urgent**, the RHP will:

a. Assess the behaviour of the patient and consider which type of restraint is appropriate to manage the behaviour. (Refer to Appendix D - Criteria for Selecting the Appropriate Physical Restraint)
b. Activate Code White emergency procedures if necessary.
c. Initiate the use of restraint where immediate action is necessary to prevent serious harm to the patient or others.
   i. Consent is not required when immediate intervention is deemed necessary.
d. Apply physical restraints by following instructions provided by the manufacturer.
e. Notify the SDM if restraints were applied.
f. Initiate the Restraint Flow Sheet (Appendix C).
g. Develop a Plan of Care as soon as possible.
h. Determine when the need for urgent restraint use ends and inform the patient/SDM what behaviour is required to be restraint free or what alternative measure will be instituted to manage the behaviour.
i. When the situation is no longer critical for restraint use, follow the procedure for non-urgent intervention. (See Section 1.3.)

1.3. When the situation is **non-urgent**, the RHP will:

a. Consider psychological or medical basis for behaviour and provide appropriate treatment.
b. Consider and implement alternative measures to the use of restraints (Appendix A).
c. Assess and monitor alternative measures to evaluate effectiveness.
d. Consider the use of restraints after alternative measures have been assessed, evaluated, and deemed unsuccessful and/or inadequate.
e. Provide a Patient Safety and the Use of Restraints Brochure (Appendix F) to the patient/SDM to facilitate discussion/consideration of all methods for managing behaviour. **The use of restraints is NOT to be used as a substitute for professional observation and care.**
f. Develop a Safety Care Plan with the patient/SDM to allow for:
   i. Early discontinuation of restraint;
   ii. Planned intermittent mobilization;

iii. Description of target behaviours for release of restraints;
iv. Preventative strategies following the discontinuation of the restraint.

g. Obtain consent for restraint from the patient/SDM. (Refer to Section 2.)

1.4. When the situation is **non-urgent** and the **SDM/family requests** patient to be restrained, the RHP will:

a. Complete and document assessment.
b. Discuss assessment with the HCT.
c. Communicate with SDM/family the assessment findings and reason for not using restraints.
d. Discuss alternative measures to the use of restraints (Appendix A) with the SDM/family.
e. Document discussion with the SDM/family on the patient's health record.

2. Consent for Restraint

2.1. A regulated health professional (RHP) will:

a. Obtain informed verbal consent from the patient/SDM after the assessment for restraint use has been discussed with the patient/SDM, including:
i. Alternatives that have been attempted/considered;
ii. Reason(s) for restraint use;
iii. Type of restraint recommended by HCT;
iv. Risks associated with not restraining the patient;
v. Response of the HCT when the situation is urgent.
b. Inform the patient/SDM that the duration for restraint use will be for as short a period of time as possible.
c. Allow patient/SDM to weigh the benefits and risks of recommended restraint.

2.2. If consent is obtained, the RHP will document consent on the Restraint Flow Sheet (Appendix C). (Refer to Consent to Treatment Policy)

2.3. If the patient/SDM does not provide consent, refer to Section 3.

3. Refusal of Restraint

3.1. A regulated health professional (RHP) will:

a. Complete the Consent for Refusal of Physical Restraints (Appendix G) when a patient/SDM refuses the use of restraint.
b. Document the refusal on the Restraint Flow Sheet (Appendix C).
c. Continue with alternative measures for managing behaviour.
d. If the risk of harm to the patient, staff or to others continues follow the urgent situation process. (Refer to Section 1.2)

3.2. When the need for restraint is deemed necessary, and the situation is Non-Urgent, other strategies may include:

a. Family/friends staying with the patient
b. Observational care (Family may be responsible for costs associated with this service. Refer to Observational Care Policy)
c. Consultation with the hospital Ethicist
d. Placing the patient on a Form 1, if appropriate, and initiating a psychiatric consultation for assessment under the guidelines of the Mental Health Act.
i. The use of restraints under the Mental Health Act applies where the intent of the restraint is to prevent the patient from attempting to cause bodily harm to themselves or another person.
e. Discharging the patient.

4. Documentation

4.1. A regulated health professional (RHP) will:

a. Document restraint use, assessments and care provided on the Restraint Flow Sheet (Appendix C), including:
i. The rationale for the use or discontinuation of restraint and the behavior that required restraint management;

ii. Initials of the member of the HCT during initiation, observation, reassessment, monitoring and discontinued use of restraint;
iii. The date and time of the initial application and the removal/discontinuation of the restraint mechanism used;
iv. Documentation of informed verbal consent for restraint or Consent for Refusal of Physical Restraints (Appendix G);
v. Changes in the Plan of Care and the condition of the patient.

b. Document observations regarding the effects of the restraint on the patient on the Restraint Flow Sheet (Appendix C), Bedside Record or Clinical Progress Record, including assessment of the following factors:
i. Ability to cope emotionally with the restraint;
ii. Level of alertness and orientation;
iii. Positioning of restraint;
iv. Physical effects of restraint, including skin condition at point of contact, skin condition where reduced ability to change positions could be a factor, circulation to extremities, pain and discomfort;
v. Response to restraint (i.e. whether restraint achieving the desired result);
vi. Need for care, including hygiene, toileting and nutrition.

c. Where a chemical restraint is used, the entry shall include a statement of the chemical employed, the method of administration and the dosage to be documented on the Medication Administration Record.

5. Observation

5.1. The health care team (HCT) will ensure care is taken to meet patient's health care needs and safety requirements while restrained.

5.2. On initial application, a member of the HCT will:
a. Observe patient in restraints every 15 minutes for the period of 1 hour.

5.3. After one hour of restraint use, a member of the HCT will:
a. Observe patient every 15 to 60 minutes as indicated by their condition.
b. Observe patient a minimum of every 60 minutes for any type of restraint for the duration of time restraint is in use. (Refer to Standards of Nursing Care, Restraints for details of requisite care)

6. Education and Training

6.1. Unit specific training will be provided for staff regarding restraint use and assessment of alternative measures when applicable.

6.2. Unit leadership will ensure that training for staff includes review of this policy as well as monitoring and documentation required for the use of restraint.

7. Maintenance of Restraint Devices

7.1. London Hospital Linen Service (LHLS) manages the inventory, cleaning, inspection and distribution of approved physical restraint devices.

7.2. For identified areas, Mobile Work Centres will be provided to 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.

7.3. 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.

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

7.5. When restraints are not in use metal pin/magnet/key can be cleaned according to the Standard

Wiping Protocol and placed back into Mobile Work Centres for next use.

DEFINITIONS

Authorized Personnel –Individuals at LHSC that are authorized by the Patient Restraints Minimization Act, including nurses, security personnel and orderlies.

Form 1 –An application for psychiatric assessment completed by a physician. Once a person has been brought to a psychiatric facility to be assessed, the physician may hold them there for up to 72 hours on a Form 1. This form allows the person to be held at a psychiatric facility for assessment, but does not itself permit any treatment without the persons consent.

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.

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, including waist restraint belts, lap belts, wrist or ankle cuffs and mitts. 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 locked doors, Geri-chairs or bed rails. All four bed rails up is **not** an approved restraint at LHSC.

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. This object cannot be removed by the patient without effort.
- Limiting a person's movement to keep them in a certain area.
- Using medication to manage a person's behaviour

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

REFERENCES

Corporate Policies

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

Applicable Legislation & Standards

Mental Health Act, 1990
Substitute Decisions Act, 1992
Health Care Consent Act, 1996
Patient Restraints Minimization Act, 2001
Occupational Health and Safety Act
College of Nurses of Ontario Practice Standard (2009) Restraints

APPENDICES

Appendix A – Alternatives to Using Restraints
Appendix B – Restraint Minimization Decision-Making Process
Appendix C – Restraint Flow Sheet
Appendix D – Criteria for Selecting the Appropriate Physical Restraint
Appendix E – Additional Requirement for Mental Health Patients
Appendix F – Patient Safety and Use of Restraints Brochure
Appendix G – Consent for Refusal of Physical Restraints