Title: Least Restraint

Number: CC 05-030

Section: Safety/Risk Management

Source: Professional Practice, Least Restraint Advisory Committee & Subcommittee, Department of Bioethics, Dalhousie University

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List of CDHA Approved Restraints – See Appendix A

PREAMBLE

Capital District Health Authority respects the patients’ dignity, rights, values, preferences and expressed needs through provision of patient and family centered care. Patient and family centered care is an approach to planning, delivery and evaluation of health care grounded in mutually beneficial partnerships among health care providers, families and patients. In so doing, health care is situated within a broader, more humanistic context. Health professionals within Capital Health provide care that exemplifies collaboration, accountability, respect and excellence to meet these needs without compromising patient safety or the safety of others.

POLICY

1. The concepts and practices of least restraint apply to all practice areas.
   1.1. Due to specific patient care needs, staff of Mental Health Services are to refer to the policies developed specifically for this patient population regarding the use of restraints. (See Related Capital Health Documents - page 6).

2. Restraints are used only in extenuating circumstances, considered a temporary measure and when all other possible alternative measures have proven ineffective.

3. A hospital or facility may restrain or confine a patient or use a monitoring device on him or her, if:
   3.1. It is necessary to prevent serious bodily harm to him or her or to another person, and;
3.2. Placing the patient under restraint (physical, chemical, environmental) or using a monitoring device, is authorized by a plan of care to which the patient or substitute decision-maker (SDM) has consented. Consent is to be obtained by the RN/physician, with risks and benefits discussed with the patient or SDM, with the discussion and outcome documented in the progress notes.

**Note:** In emergency situations, maintain the safety of the patient and/or staff first and obtain consent within 12 hours or as soon as possible.

3.3. Restraints are implemented for the shortest time possible.
3.4. The least restrictive form of restraint is used first. If this is unsuccessful, progression from least to most restrictive restraint is implemented.

4. The Registered Nurse (RN) is accountable for development of the plan of care

5. The RN/LPN (Licensed Practical Nurse) is responsible for assessment, ongoing care and documentation within their scope of practice. The frequency of assessment and observation following the initiation of physical restraints (see Appendix A for CDHA Approved Restraints) is as follows:

5.1. Every 15 minutes initially for the first hour and when patient behavior is unstable
5.2. Every 30 minutes for one hour
5.3. Every hour until restraint is discontinued
5.4. **Constant observation for 3 or 4 point restraints.**

6. The use of physical restraints requires:
   6.1. The RN initiating the restraint to complete the assessment and to initiate documentation on the restraint checklist.
   6.2. A physician’s order for all 3 or 4 point restraints and for all chemical restraints.

7. Every 24 hours, the use of physical restraints is to be reassessed, and documented on the restraint checklist if still required.

   **Exception:** Intermittent long term use of a restraining device.

8. Patient transfer information is to include restraint information.

9. Staff is to receive education on the correct application of unit specific CDHA approved physical restraints including manufacturer’s recommendations.

**EXPECTED OUTCOMES AND QUALITY**

1. Outcomes
   1.1. Creation of a safe environment for patients, visitors and employees
   1.2. Implementation of restraints in accordance with policy
GUIDING PRINCIPLES

1. The goal of CDHA is to maintain a philosophy of least restraint and encourage the use of alternative measures consistent with respect for and preservation of the patient’s dignity, rights, values and preferences.

2. The protection of independence and self-determination of the patient is a priority in decision-making.

3. The decision to use restraints is made as a result of collaboration with members of the interdisciplinary health care team, the patient, and the patient’s family or SDM when possible.

4. All members of the interdisciplinary health care team need to maintain awareness of the potential risks associated with the use of restraints.

5. Each patient and his/her situation are to be considered on an individual basis with an assessment and evaluation to guide understanding and direct management of that case.

6. The intent of the application of a device will determine the necessity of an order and the initiation of a restraint checklist. Consent is to be obtained.
   
   6.1. A gerichair/wheelchair used solely to confine patient movement is a restraint.
   
   6.2. A gerichair/wheelchair when used to enhance positioning, increase mobilization or improve quality of life would not be considered a restraint.
   
   6.3. A device to provide positioning, seating or mechanical aid to assist in ambulating to which the patient agrees or can be removed by self is not considered a restraint.
   
   6.4. If intermittent long-term use is necessary as assessed by the interdisciplinary health care team, and if patient’s behavior has been unchanged for 7 days, then the restraint checklist may be discontinued. The long term use of any restraint is to be reassessed on a monthly basis.

7. Patient behaviour which presents a danger to self or others may be sufficient justification for the use of restraints. The goal of the use of restraints is to allow for maximum freedom of movement and self-control by the patient while maintaining the safety of the patient and/or others.
DEFINITIONS

Least restraint: Places a person under control through the minimal use of physical or chemical means, monitoring devices or confining measures, as is reasonable taking into account the person’s physical and mental condition.

Physical restraint: The use of any physical or mechanical device to involuntarily restrain the movement of the whole or portion of a patient’s body as a means of controlling his/her physical activities.

Chemical restraint: The use of a drug to control behaviour or to restrict the patient’s freedom of movement that is not a standard treatment for a patient’s medical or psychiatric condition. Medications are considered ‘chemical restraints’ because of their intent and not because of their name or type of medication

Exclusion: Medications that are “standard treatment” for the patient’s medical or psychiatric condition (including PRNs).

Environmental restraint: 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.

Emergency situations: An emergency situation is defined as one where immediate action is necessary to prevent serious bodily harm to the patient or others.

Substitute Decision-Maker (SDM): For the purposes of this policy, and consistent with Nova Scotia’s Medical Consent Act, Hospitals Act and Vital Statistics Act, is defined as:

- the legally appointed guardian, or if none,
- the person appointed as proxy decision-maker in a valid proxy advance directive, or if none,
- the patient’s legally married partner, or person with whom he or she has cohabitated in a common law relationship for at least two years, or person with whom he or she has filed a domestic-partner declaration may consent on behalf of the partner who lacks capacity, or if none
- next-of-kin, designated by the patient on the patient’s health record, or if none
- the Public Trustee
EQUIPMENT

Only restraints approved for use by Capital District Health Authority are used and only for the purpose of preventing serious bodily harm. They are applied following the manufacturer and hospital guidelines. (See List of CDHA Approved Restraints, Appendix A).

PROCEDURE

Assessment

1. The RN performs a comprehensive assessment of the patient including a description of behaviour and the risk involved (see CC 05-030 Learning Module), identifies alternative interventions and documents the decision to restrain.

   **Indications for use of restraints:**
   1.1. Individual is at risk of harm to self or others
   1.2. Alternative interventions non-effective
   1.3. Plan of care to which the family/SDM has consented

Implementation

1. **Physical restraints:** Consider potential complications (refer to CC 05-030 Learning Module).

   **Emergency situations:**
   1.1. The RN initiates physical restraints (except 3 or 4 point restraints)

   **Non-emergency situations:**
   1.2. Consider restraints **only** after alternatives have been tried and proven unsuccessful. (refer to CC 05-030 Learning Module).

   1.3. Develop an interdisciplinary care plan for the use of restraints or monitoring device.

   1.4. Initiate restraint with specific device identified. Re-assess the use of restraints every 24 hours.

   1.5. The RN/physician obtains and documents informed consent.

   **Patients admitted with restraint device or monitoring device:**

   1.6. Assess for need (see **Restraint Use Algorithm**, Appendix B) and if deemed necessary, implement as per policy.
2. **Chemical restraints:**
   2.1. Obtain a physician’s order.
   2.2. Choose the lowest possible dose.
   2.3. If vascular access is not available, use an intramuscular injection site as the preferred route in an emergency situation. Alternatively, oral medication may be used.
   2.4. Where deemed medically appropriate, staff should continue to prescribe and offer oral medication first even in emergency situations.

3. **Environmental restraints:**
   3.1. Consider the potential implications.

**Documentation and Ongoing Assessment**
1. Document in the patient’s healthcare record the assessment, decision and rationale to restrain.
2. Document the plan of care to address the use of restraints specific to the needs of the patient.
3. The RN/LPN assesses the physical behavior and psychological status of the patient. (See Policy Statement #5 for frequency of assessment). Document the assessment using the restraint checklist.
4. Every 2 hours remove restraints for 10 minutes and provide opportunities for ambulating, toileting, exercises and other care.
   **Exception:** when patient is sleeping or is able to move from side to side in bed.
   **Exception:** Mental Health areas - see Mechanical Restraints policy

**RELATED CAPITAL HEALTH DOCUMENTS**

**Policies**
Patient Attendants, Use of by the Nursing Units CC 01-065
Consent to Treatment CH 70-045
Therapeutic Quiet: Policy Number 2104 Nova Scotia Hospital (NSH) and East Coast Forensic Hospital (ECFH)
Use of Time Out: Policy Number 2103 NSH and ECFH
Mechanical Restraints/Supports Number 2105 NSH and ECFH
Mechanical Restraints-Psychiatry NC-50-50-40 Abbie J. Lane Hospital (AJL)
Seclusion –Psychiatry NC-50-50-50 AJL
Non-violent crisis intervention (under review)
CC 05-030LM Learning Module– Least Restraint
Forms/Documents
Restraint Checklist  (CD0766MR)

Restraint Considerations for Patients and Families {Available from printing - WT85-0599 (08/2006)}

Application and Laundering Information (Available soon on the CDHA Intranet – ‘Least Restraint Resources’ – accessed from the ‘For Employees’ page, ‘For Managers’ page, or the ‘Education’ page

Appendixes
Appendix A – List of CDHA Approved Restraints
Appendix B – Restraint Use Algorithm

REFERENCES


Clinical Services (2000). CDHA Administrative Policy and Procedure: Least Restraint, Q40-120.000

Dufresne, D & Blevins, J. (2001). Physical and Chemical Restraints for Non-behavioral Health Nursing Staff: an independent study learning supplement. Restraint Task Force Quality Management Department (Eds.) Pitt County Memorial Hospital, Greenville, NC


Hamilton Health Sciences (2000). *Clinical Patient Care: Least Restraint Protocol*


Ontario Ministry of Health (2001) Patient Restraints Minimization Act


**HISTORICAL DATES**

Integrated – June 2007 (Replaces:

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<th>Site</th>
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APPENDIX A

Approved Restraints Product List

The only physical restraint devices approved at Capital Health are listed below. This information provides you with guidelines only. The decision to use a restraint must always first start with an assessment and requires a consent. Patients must always be monitored as per Capital Health policy.

More detailed product information can be obtained at www.posey.com

Vendor: Can Med Surgical

**Security Mitts**

As per Infection Control all security mitts are single patient use and are not to be laundered.

Indication: For patients who disrupt medical treatment, or are prone to self injury or injury to others. Double hook and loop closure for added security. Connecting straps are included to limit range of motion.

- **Posey # 2819- Double padded**, padded on both sides for additional protection (1 pr / package, no mesh back)

- **Posey # 2815 & 2816 Posey Finger Control Mitts –**

Separates fingers for maximum finger control. Mitts secure with hook and loop. Connecting straps are included to limit range of motion, if necessary. One size fits most adults. Open end version (# 2815) accommodates pulse oximeter probes. The closed end version (# 2816) is covered with mesh back to facilitate skin checks.

- **Posey # 2550 Quilted Limb holders**

(*Due to Universal Precautions there will be no future purchasing of leather restraints)
Posey quick release quilted limb holders
Quilted limb holders secure with hook and loop and a quick release buckle.

Indication: For patients who disrupt medical treatment, or are prone to self injury or injury to others.

Posey # 2790Q Posey Quick Release Twice as Tough restraint:

Indication: For the combative, agitated patient: to prevent disruption of IVs, catheters lines or self injury.

Twice-As-Tough wrist restraint cuffs has quick-release buckles, making the cuffs easier to apply. Restraint Cuffs have double connecting straps for the greatest limitation of movement as well as extra strength. Machine washable and sterilizable. One pair per package.

<table>
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<th>Catalog Number</th>
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<th>Cuff Dimensions</th>
<th>Strap Length</th>
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<td>2790Q</td>
<td>Quick-release cuff, wrist</td>
<td>12&quot;L x 2 1/2&quot;W</td>
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<td>2791Q</td>
<td>Quick-release cuff, ankle</td>
<td>14 1/2&quot;L x 2 1/2&quot;W</td>
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Contraindications include but are not limited to the following conditions:

Do not use limb restraints on patients with dislocations, fractures or open wounds to the affected limb.

Do not use limb restraints if the IV site could be compromised
Aggressive, combative restless or suicidal patients should not be put into a restrictive product unless they will receive constant monitoring.

**Posey # 2796 Twice as Tough Restraints for Stretcher (4 point)**

*Approved for Mental Health & Emergency areas only

**Indication:** For the combative, agitated patient: to prevent disruption of IVs, catheters lines or self injury.

Connected T-A-T ankle and wrist restraint cuffs are designed to be left in place so they are ready for use when needed. For stretcher use, choose #2796 Connected Wrist Cuffs or #2797 Connected Ankle Cuffs. Machine washable. One complete set (cuffs and connecting strap) per package.

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<td>Adjusts from 46&quot; to 86&quot;</td>
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<td>2797</td>
<td>Connected ankle cuffs for the stretcher (pair)</td>
<td>14 1/2&quot;L x 2 1/2&quot;W</td>
<td>Adjusts from 40&quot; to 86&quot;</td>
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Contraindications include but are not limited to the following conditions:

Do not use limb restraints on patients with dislocations, fractures or open wounds to the affected limb.

Do not use limb restraints if the IV site could be compromised

Aggressive, combative restless or suicidal patients should not be put into a restrictive product unless they will receive constant monitoring.
Posey # 1231 Posey Roll Belt

A less restrictive restraint, that allows the patient to sit up or roll from side to side in bed. Helps the patient from falling, or getting out of bed unassisted. Straps attach to bed frame out of patients reach.

Indication:

Unassisted bed exit
Patients at risk of a fall
Patients who require a positioning product to assist medical treatment
Patients who need the freedom to roll from side to side or sit up in bed.

Contraindications include but are not limited to:

Aggressive, combative, agitated or suicidal patients

Patients with ostomy, colostomy, G-tubes, hernias, severe COPD, those with post surgery incisions that may be compromised by the pressure from a restrictive product, or those with monitoring equipment, tubes or lines that might be compromised by rubbing against a restraint.

Discontinue use immediately if the patient is able to slide forward or down underneath the device.
Posey # 4427 Posey Breezeline Pelvic Holder

Indication: Helps prevent the patient from forward sliding in wheelchair or geri-chairs. Breezeline mesh helps keep patient cool and comfortable. # 4427 Straps secure to wheelchair tilt bars or geri-chair with quick release buckles. Available in three sizes. Machine washable. One per package.

<table>
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<td>4427L</td>
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<td>Pelvic Holder - 60 1/2&quot;, Attachment Straps - 56&quot;</td>
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Contraindications include but are not limited to:

Aggressive, combative, agitated or suicidal patients

Patients with ostomy, colostomy, G-tubes, hernias, severe COPD, those with post surgery incisions that may be compromised by the pressure from a restrictive product, or those with monitoring equipment, tubes or lines that might be compromised by rubbing against a restraint.

Discontinue use immediately if the patient is able to slide forward or down underneath the device.
APPENDIX B

Restraint Use Algorithm

Describe Behavior

Explore etiology of behavior e.g.
- Medications
- Catheters, drains, lines
- Metabolic status
- Alcohol/drug withdrawal
- Infection/acute medical condition
- pain

- How serious is the potential harm and to whom?
- How serious are the detrimental physical and psychosocial effects of the restraint?
- Does potential benefit outweigh the risk?

ARE ALTERNATIVES POSSIBLE?

YES

- Collaborate with team
- Initiate alternatives (see list)
- Assess needs (e.g. pain, nutrition)
- Document and monitor

INTERVENTIONS EFFECTIVE?

YES

Continue with intervention

NO

Meets criteria for restraints?
Alternatives ineffective
Prevent serious bodily harm
Plan of care is authorized/consented to

- Code white if immediate support required
- Assess need for immediate use of restraint
- Assess need for patient attendant versus restraint
- Collaborate with team ASAP
- Initiate restraint and obtain consent within 12

When to use a patient attendant:
- Restraints increase agitation
- Wandering continues despite controls
- Suicide risk

When to use Restraints:
- Violent/aggressive behavior*
- Maintain integrity of interventions (e.g. pulling out lines, tubes, IVs, etc.
- behavior that places the individual and/or others at immediate risk for physical harm

Least Restraint CC 0