INTERDISCIPLINARY CLINICAL

Policy and Procedure

TITLE:	Use of Pinel Restraints for Rapid Physical Restraint - Approved areas	**NUMBER:**	CL-SR-001
Sponsor:	Director – Mental Health and Addictions (Central Zone)	Page:	**1** of **22**
Approved by:	Senior Director – Mental Health and Addictions	Approval Date: Effective Date:	March 21, 2016 March 31, 2016
Applies To:	Central Zone and Northern Zone (Colchester Hospital) - Units/services where Pinel Restraints have been approved for use		

Please refer to existing former DHA policies currently in effect addressing Least Restraint, Code White, Seclusion, Close/Constant observation

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POLICY

1. This policy refers to the use of the Pinel restraints approved for use within designated areas for the purposes of Emergency Rapid Restraint for inpatients who pose an imminent risk of serious physical harm to self or others.

> **Note:** If other restraint or restraint products are required, refer to *existing former DHA Restraint policies*

2. All Health Care Providers (HCPs) and First Responders work collaboratively to provide safety and security and only use rapid physical restraint when necessary *(refer to existing former DHA Code White policies)*
3. Restraints are used as a last resort and only in those emergency circumstances in which all other less restrictive/intrusive interventions (e.g. environmental changes, medication, seclusion) have failed or are considered to be inadequate or inappropriate to effectively reduce the risk of serious physical harm to self or others.
4. Restraints are considered a temporary measure, used for the least amount of time necessary to decrease the threat of imminent serious physical harm to self or others and are to be removed as soon as the threat can be managed in a less restrictive manner.

5. Use of Pinel restraints requires a physician order, a plan of care and communication with the patient and family (where the patient has consented) or substitute decision maker (SDM).
6. Upon hire and annually, First Responders (see definitions) in designated areas where Pinel restraints used, will maintain their skills though:
    6.1.1. review the Pinel manual, Pinel videos, and related Policies
    6.1.2. review procedures with educator or designated staff
    6.1.3. participate in a hands on training practice session

    (Refer to Appendix B)
7. Use of seven point restraint is recommended for rapid restraint. Based on clinical judgment, there may be situations where fewer restraints are required for safe control.
8. Chemical restraints should be considered as an adjunct as needed while in pinel restraints.

GUIDING PRINCIPLES AND VALUES

1. NSHA is committed to a philosophy of least restraint, and use of alternative interventions consistent with respect for and preservation of the patient's dignity, rights, values and preference.
2. NSHA is committed to providing a safe and healthy environment for all patients, visitors, volunteers, employees, physicians and learners.
3. Every patient has the right to freedom/liberty/choice as long as this does not interfere with the safety of self or others. When this occurs, HCPs are expected to make a reasonable and proportionate response which both maintains safety, privacy and dignity.
4. The decision to use restraints is made as a result of collaboration with physician, nurse and health team members. Where possible involve the patient, and the patient's family (where the patient has consented) or SDM. The degree of family involvement is based on the patient's wishes.
5. Use of restraints or the threat of their use, will never be used for convenience, coercion or punishment.
6. Every patient has a right to make choices, and have input into their care and treatment. Throughout their hospital stay, HCPs engage with the patient to discuss their understanding of their situation, their needs and planning of their care, including periods of imminent risk of physical harm to self or others.

7. All members of the interdisciplinary health care team need to understand the risks associated with the use of restraints.
8. Each patient and his/her situation are to be considered on an individual basis with an assessment to guide understanding and direct management of their care.
9. 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.
10. Every patient has the right to access advocacy services in a timely manner throughout their stay in hospital. Employees provide contact information of the Patient Representative.

PROCEDURE

1. **Equipment**

- Pinel De-Restraint System: (here in referred to as Restraints)
- **For Rapid Emergency Restraints (7 Point)**: Use 4 Limb cuffs, shoulder strap and joining the short ends of limb restraints (see diagram in Appendix C)
    - **For additional restraint and the De-restraint process**: may use the Waist belt, Pelvic Strap, Extenders

2. **Assessment**

2.1. The RN, in collaboration with the physician, HCP's and security, assesses the patient, the factors influencing the patient's behavior, any physical / psychological risks and all available options for safe management prior to the use of restraints.

2.2. The RN and physician:

2.2.1. Decide to initiate use of restraints when imminent risk of serious physical harm to self or others is assessed and all other options for intervention have been unsuccessful.

Exception: Where the physician is not present at the time, the RN initiates restraints and immediately contacts the Physician for an order and to assess the patient face to face.

2.2.2. Document the assessment, and relevant information in the health record.

2.3. Initiation of restraints constitutes a serious change in a patient's status. Inform the Substitute Decision makers (SDM) and family members (where the patient has consented) within a reasonable timeframe.

3. Order For Restraints

3.1. Initial orders

3.1.1. The physician writes an order for no more than **12 hours**.

3.1.1.1. If the physician is not present at the time, the RN initiates restraints and immediately obtains a telephone order for the restraints.

3.1.1.2. Within one hour the physician assesses the patient face to face, reviews legal status, signs the order and documents the assessment and reason for restraints.

3.2. Reordering

3.2.1. At a minimum of **every 12 hours** the physician, RN and other team members (as available):

3.2.1.1. Reviews the patient's clinical needs and response to restraints.

3.2.1.2. If the decision is made to continue restraints, the physician provides a new order for no more than 12 hrs. (After regular working hours, the on-call physician may authorize/renew by telephone)

3.2.1.3. The RN determines whether a face to face assessment by physician is required.

> **Note:** The physician performs a face to face assessment at a minimum of once every 24 hours (daily).

3.3. De-Restraining/Discontinuation

3.3.1. As soon as the patient's condition improves, the RN (in collaboration with others) begins the de-restraining process and may discontinue the restraints at any time without a Physician's Order.

3.4. Trial Out Of Restraints

3.4.1. If the time out of the restraints is less than two hours, and further restraint is required, re-apply restraints based on previous order.

3.4.2. If the time out of restraints is more than two hours, and restraints need to be reapplied, consider this a new episode. Obtain a new order and face to face assessment with the Physician.

3.4.3. The RN updates the plan of care and documents assessment in the health record.

4. Documentation Requirements

4.1. Initiating Restraint Documentation

4.1.1. Document the assessment and reason for restraints as follows:

- Description of behaviour (prior to and during application)
- Precipitating factors to behaviour
- Specific physiological and psychological risks
- Interventions tried or deemed inappropriate
- Response to interventions
- Decision and rationale to initiate restraint
- Specific behavioral criteria for discontinuation of restraints
- Plan and reason for restraints discussed with the patient
- Date and time initiated
- Notification (or any attempts to notify) and subsequent discussions with the patient or SDM and family (where the patient consented) regarding the need for restraint, response to restraint use and other supports available.
- Any patient injuries sustained during procedure.

4.1.2. Report application of restraints in *existing former DHA applicable patient safety incident reporting systems.*

4.1.3. Report Staff injuries to *existing former DHA applicable reporting systems.*

4.2. Ongoing Documentation

4.2.1. **Every 30 minutes** the RN/LPN documents all clinical observations, patient monitoring, interventions and care provided using the *Physical Restraint Monitoring Record (CD2471 MR)*.

4.2.1.1. Provide a corresponding progress note of all status changes and/or significant findings in the health record.

4.2.2. In the progress notes, the RN/LPN documents an assessment, plan of care and decisions **every hour for the first 2 hours** and then every **2 hours after or sooner** if monitoring indicates an improvement or worsening of the patient's status, including:

- Any exceptions to monitoring guidelines based on clinical assessment

- De-restraining assessments and activities
- Any communication with the SDM

4.3. **De-Restraining/Discontinuation of Restraints Documentation**

4.3.1. Document the following information:

- Description of the De-restraining process and patient response.
- Response to the trial out of restraints
- Decision about level of observation and monitoring required after restraints discontinued.
- Date and time
- IRRS assessment (where applicable) *or other DHA respective aggression /violence assessment tool)*
- Debriefing Process

5. **Restraint Application**

> **Note:** Any direct care measure that involves release of a limb cuff restraint should be performed with at least two HCPs present.

5.1. Apply Pinel restraints according to the manufacturer's recommended use and in such a manner as to allow some restricted movement.

5.2. Restraint application is a collaborative process. The Response Coordinator directs the application and ensures that the first responders have designated roles and responsibilities.

5.3. To achieve rapid restraint, use 7 point restraint as recommended. (I.e.: Use of four limb restraints, shoulder strap and joining the short ends of limb restraints)

5.4. Attach restraints to the designated bed /Stretcher frame. (Do **not** attach directly to a side rail)

5.5. Restrain the patient in a supine or side lying position. Never place the patient in a face down (prone) position.

5.6. Search the patient's clothing for items deemed dangerous. Remove such items and document in the progress note. Leave the patient in their own clothing.

5.7. Assess the patient's comfort. Ensure that the clothing does not interfere with the patient's comfort and restraint application.

6. Engagement/Monitoring/Interventions

6.1. The RN /LPN communicates to the patient the reasons for restraint use, including:

6.1.1. that it is a temporary intervention for protection

6.1.2. what they can expect in terms of the frequency of monitoring/engagement and

6.1.3. the specific behavioral criteria for its discontinuation

6.2. Each intervention requires consideration of the safety and therapeutic value based on the patient's current mental and physical status. Document any exceptions to the monitoring guidelines.

6.3. Due to specific monitoring requirements, assign an RN or LPN to provide constant observation and monitoring. Where there are specific unit guidelines, the RN/LPN may assign other designated Health Care providers to work collaboratively with the RN/LPN to assist with Constant Observation.

> **Note:** All observation is continuous, unobstructed direct visual and not via camera

6.4. Report any changes to the assigned RN immediately.

6.4.1. Loosen/remove restraints immediately if circulation is impaired or other forms of physical injury are detected.

6.4.2. Record on the *Physical Restraint Monitoring Record (CD2471 MR)*.

6.4.3. Monitor behaviors and response to interventions.

6.4.4. Provide calming strategies, ongoing support and comfort measures.

6.4.5. **Circulation and skin Integrity:**

6.4.5.1. **RN/LPN**

- Assess circulation (colour, temperature, sensation, movement and capillary refill), skin integrity and pressure areas, **every 30 minutes** or sooner if it is safe to do so or based on clinical observation.
- Respond to any patient concerns related to restraint tightness or positioning. (Assess for any swelling, redness, broken skin, decreased sensation, diminished pulses, tingling, discomfort)

6.4.6. **Limb release/repositioning/range of motion (ROM):**

6.4.6.1. When both safe and unless contraindicated due to patients agitation, **every hour** while awake, repositioning with the release and passive range of motion and skin care of each limb, in sequence with **only one limb unsecured at a time**. **Ensure that at least 2 HCPs are present when releasing limb cuffs.**

6.4.7. **Vital Signs**:

6.4.7.1. **RN/LPN**

- Assess vital signs (B/P, Pulse, Resp, O_2 sats and Temp) soon after initiation of restraints where it is safe and feasible to do so.
- If not possible, due to safety concerns (ie. not prudent or safe to physically touch or disturb the patient), assess their respirations and color and obtain a full set of vital signs as soon as possible (including O_2 sats).
- Assess vital signs as clinically indicated and at a **minimum of Q 1 hourly.**

> **Note:** If asleep, maximum time between vital signs is four hours.

6.4.8. **Physical care**:

6.4.8.1. Assess and provide care for personal needs (nutrition, hydration, elimination, skin integrity and mouth care) at a minimum of once **every 2 hours** or as required.

6.4.9. **Ambulation:**

6.4.9.1. Ambulate for at least 15 minutes **every 8 hours**.

6.4.10. Monitor **intake and output** each shift.

6.4.11. When safe and feasible, staff may lengthen restraints attached to the bed while the patient is asleep to allow for comfort and greater range of movement. (limb cuffs stay intact)

6.5. Engage with the patient and provide verbal support unless considered counter-therapeutic.

7. De-restraining/Discontinuing

7.1. The RN, in collaboration with HCP's, assesses whether to continue with restraints or begin the process of incremental de-restraint.

7.1.1. Negotiate and plan with the patient the de-restraining process (refer to Pinel manual).

7.1.2. Consider a trial period (for up to 2 hours) to assess the patient's ability to manage behavior without restraint.

> **Note:** This is a collaborative process between HCPs and the patient; maintain constant observation during trial out of restraints.

7.2. If restraints are removed for more than two hours, consider this event discontinued. Should the patient's behavior require further restraint, obtain a new order.

7.3. The RN and/ or physician determine the level of patient monitoring required after restraints.

7.4. Upon discontinuation, ensure that the restraints are cleaned / disinfected. (Appendix E)

8. Debriefing

8.1. **Patient/SDM:**

8.1.1. The RN in collaboration with the physician debriefs with the patient as soon as the patient is able to participate and to the extent that the patient is willing to participate. Record the patient's perspective of the event. (See Appendix D for Debriefing guidelines)

8.1.2. The RN and/or physician debriefs the SDM, or family (with consent), at a reasonable time.

8.2. **Team Debrief:**

8.2.1. The Response Coordinator organizes an initial debrief with all First Responders and HCPs involved following the incident.

8.2.2. Following the use of restraints the team updates the patient's plan of care appropriately after considering:

8.2.2.1. The reasons for use of restraints

8.2.2.2. If it achieved effective outcome

8.2.2.3. Other alternatives considered

8.2.2.4. Areas for improvement

8.3. **Other Patients:**

8.3.1. Assess impact of incident on other patients and the unit milieu.

8.3.2. Provide support to other patients and debrief as necessary and appropriate while maintaining confidentiality.

8.3.3. Provide reassurance of unit safety and security.

9. **Reporting/Consultation**

9.1. Notify the Health Services Manager (HSM) during regular working hours.

(Exception: Emergency services)

9.2. Inform the Physician and Health Service Manager when restraints are discontinued.

(Exception: Emergency Departments)

9.3. If restraints extend beyond 24 hours, the Physician reports the clinical situation to the Clinical Director.

9.4. Should a patient remain continuously in restraints for a period of 72 hours, the treating Physician obtains a consult from another Physician.

9.4.1. The physician providing the consult completes a face to face assessment of the patient and sends the consultation summary to the attending psychiatrist within the next business day of receiving the request.

9.4.2. The attending Physician documents that he/she reviewed the consultation.

9.5. Report the restraint application and any restraint related issues on the existing former DHA applicable patient safety incident reporting system.

9.6. Report any employee injuries to the existing former DHA reporting system.

10. **Quality Review**

10.1. During regular working days, the Health Services Manager (HSM) reviews any situation where restraint were used, provides follow-up as necessary and post-incident review

10.2. Collects the following data on each episode of restraint:

- Unit/service
- Date and time initiated and discontinued
- Reason for restraints

- Age and gender of the patient
- Whether injuries were sustained by patient or employee

11. **Care of Equipment**

11.1. After each application and at the end of each month, nurses:

11.1.1. check the Pinel equipment and kit (inspect restraints for wear/defects, check pin/button, key magnets, expiry dates, velcro)

11.1.2. document on the Pinel Equipment Checklist

11.2. Following each use ensure the equipment is cleaned and washed (See Appendix E for washing instructions)

REFERENCES

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Policies

Alberta Health:

Policy: Restraint Use (March 2015)

Policy: All Limb and Body restraints (Oct 2008)

BC Mental Health and Substance Use Services:

Policy :Use of Mechanical restraints (Feb 2012)

Calgary Health Region: Policy: Restraints- physical (2013)

The Royal Mental Health (Ottawa)

Policy: Emergency use of restraints (Jan 2013)

Policy: Minimization of use of restraints (July 2013)

Providence Care (Kingston Ontario_ policy: Emergency restraints (May 2012)

RELATED DOCUMENTS

Policies

Existing Former DHA Policies addressing:

- Code White
- Least Restraint
- Seclusion
- Close and Constant Observation
- Patient Safety Incident Reporting Systmes

Forms

CD2471 MR Physical Restraint Monitoring Record

Pinel Equipment Checklist – (located on each unit)

Appendices

Appendix A - Definitions

Appendix B – Training for Pinel Rapid Restraint

Appendix C – 7 Point Restraint Diagram

Appendix D – Patient Debriefing Guide

Appendix E – Care and Washing Instruction for Pinel Restraints

Other

IRRS The Imminent Risk Rating Scale (IRRS©) developed by Dr. Andrew Starzomski

http://www.pinelmedical.com/uploaded_files/pinelmanual.pdf

http://www.pinelmedical.com/sef/page/id/18.htm

Version History

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Appendix A - Definitions

Constant Observation:	An intensive clinical intervention where a patient at risk of harm to self or others requires direct continuous, unobstructed, visual observation and monitoring by an assigned staff. During use of restraints, a Registered Nurse (RN) or Licensed Practical Nurse (LPN) will provide the constant monitoring due to specific monitoring requirements. As per specific unit guidelines, other designated staff, may provide observation under direction of the RN or LPN (*refer to District related policies on Close and Constant)*
Response Coordinator	The Charge Nurse, or patient's assigned nurse or designated RN who coordinates /directs the crisis event
First Responders	Designated employees such as security, correctional workers, nursing and care team assistants, who respond as a team to crisis situations using the principles and philosophy of Nonviolent Crisis Intervention® (NCI) program. Nursing refer to as: Registered Nurses (RN), Licensed Practical nurses (LPN) Care Team Assistants (CTA) Developmental Workers (DW), Psychiatric Support Workers (PSW), Continuing Care Assistants (CCA)
De-Restraining process:	The process of incremental removal of restraints through cooperative negotiation with the patient.
Emergency Situation	Where a threat of imminent serious physical harm to self or others requires HCPs to take immediate action necessary to prevent serious harm to the patient or others.
Physical Restraint:	The use of any physical or mechanical device to involuntarily restrain the movement of the whole or a portion of a patient's body as a means of controlling his/her physical activities. *(Ontario Hospital Association, 2001)*
Rapid Restraint: (7 point)	The technique of rapidly securing a patient's four limbs and shoulders in order to establish quick safe control of the individual. Includes use of 4

	Limb cuffs, shoulder strap and joining the short ends of limb restraints together.
IRRS	The Imminent Risk Rating Scale (IRRS©) is used to predict an individual's risk for violence in the next few days. The IRRS requires training to administer. It is used in specific areas of the Mental Health and Addictions program.

Appendix B: Training for Pinel Rapid Restraint

All Responds Coordinators, and First Responders in designated areas where Pinel restraints are used will annually review and maintain their skills using Pinel restraints.

This review will include:

1. Read and review the restraint policy, and other *related District polices Code White, Seclusion, Least restraint)*

2. Review the Pinel De-restraint manual (located on each unit). May be accessed at http://www.pinelmedical.com/uploaded_files/pinelmanual.pdf

3. Review the video for the Pinel De-restraint System. May be accessed at http://www.pinelmedical.com/sef/page/id/18.html

4. Attend a PINEL practice training session(s) to increase understanding about the use of restraints and to build practice skills in using the PINEL De-restraint system.

5. Practice using the Pinel De-restraint System to maintain competence and skill in using the Pinel restraints.

Appendix C: Diagram of Pinel 7 Point Restraint

Use 4 Limb cuffs, shoulder strap and joining the short ends of limb restraints

Source: Pinel De-Restraining Instruction manual Page 12

Appendix D - Patient Debriefing Guide

Use of Physical Restraint poses potential psychological and physiological responses that may impact on the person. It is essential that debriefing with the patient occur in a timely manner. Include the SDM or other individuals identified by patient where appropriate.

The following are suggested areas to review for potential follow-up

- Review the patient's perception of the restraint experience. Where appropriate and feasible, provide opportunity for person to write their own response/experience to this event.
- Provide reassurance of the patient's safety
- Provide acceptance and reassurance that staff will continue to work in partnership with the patient
  (i.e. re-establishing therapeutic rapport)
- Review the reasons why the patient was placed in restraints and clarify any possible misperceptions the client may have concerning the incident.
- Address any trauma that may have occurred as a result of the incident.
- Assist the patient to develop an understanding of potential precipitating factors and symptom recognition.
- Explore ways to assist the patient better manage anxiety, aggression, and/or dangerous/harmful behavior.
- Explore coping mechanisms and identify alternative interventions to manage similar situations /behaviors/emotions
- Consider alternative interventions and modify the treatment plan
- Consider the client's willingness to involve family or other caregivers in the debriefing; to discuss and clarify any misperceptions.
- Support the client's re-entry back to the unit milieu and clearly identify what behaviours are expected.
- Provide support and access to the Patient Representative Advocacy service.

COPING Model Guidelines for Debriefing

Confirm the client has regained control	• Orient to facts • Allow time for the person to share their perceptions of events and their concerns • Staff provide their perceptions of the experience
Patterns of behavior	• What are triggers • What have you done in the past • What needs to change

	• Identify connect between thoughts, feelings and actions/behaviors
Investigate alternatives to behavior	• What are new learning's • Brainstorm ideas • choose alternatives
Negotiate plan for next time	• Write a plan or contract • Identify both our role and responsibility and their responsibilities
Give them responsibility for controlling their own behavior	• Give them control over their own decisions and behaviors • Provide dignity, respect empowerment and responsibility for their own behaviors

APPENDIX E - Care and Washing Instructions for PINEL Restraints

****DO NOT USE CHLORINE-BASED COMPOUNDS IN WASH****

General Principles:

- Washer must be cleaned **PRIOR** to use. (VIROX wipes for cleaning the washer, knobs, handles, doors).
- Restraints must be washed by **THEMSELVES** and not with other patient items.
- Hospital standard is to follow the manufacturer's standard for cleaning (i.e. recommended temperature, cleaning product, and duration of time cleaning product).

Procedure:

1. Remove all pins/buttons *before* laundering.
2. Clean all pins/buttons with Virox wipes.
3. For Limb restraints, ensure that white Velcro cover - covers the entire black HOOK portion of the cuff.
4. Use EXEC 120 powder when washing PINEL restraints on units. The Ecolab R&D committee recommends the use of this enzyme detergent with peroxide bleach for optimal performance. Please ask your laundry manager to obtain this item for you.
5. An alternative is Tide with Bleach which does not contain the Chlorine compound that can destroy the Para Arymide.
6. If bleach is required, use a PEROXIDE compound. (Check with Central Laundry). Water temperature 90 degree Celsius / 194 degree Fahrenheit (Warm water wash cycle temperature between 90˚-110˚ Fahrenheit / 43.3˚-32.2˚ Celsius).
7. Drying Instructions:
   - Hang to dry for one hour (preferred method)
   - Machine Dry: Perma-press cycle –30 minutes
8. Washing Machine MUST be cleaned/disinfected after use. Washer surface, buttons, handles, and doors are to be wiped down with Virox wipes.
9. Run an *empty wash* cycle with EXEC 120 powder detergent.

NOTE: All PINEL products may be autoclaved

TORONTO PLANT

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Major Revisions (e.g. Standard 4 year review)	Minor Revisions (e.g. spelling correction, wording changes, etc.)
Transitioned to NSHA policy – Central And Northern (Colchester) – March 31, 2016	2017-10-09 Changed the number from CL-SM-001 to CL-SR-001.