Policy & Procedure

Policy Title:	Restraint as a Last Resort	
Applies To:	All Health Team Members	
Approved: September 13, 2022	**Effective:** March 1, 2023	**Next Review:** March 1, 2026
Sponsor:	Senior Director, Interprofessional Practice & Learning	
Approval Authority:	Clinical Operations Council	
Number: CL-SR-005	**Manual:** Interdisciplinary Clinical	

TABLE OF CONTENTS

Purpose....2
Policy Statements....2
EQUIPMENT....4
Principles and Values....4
Procedure....4
References....12
Related Documents....13
Policies....13
Forms....14
Relevant Subject Guides....14
Appendices....14
Appendix A: Definitions....15
Version History....18

This is a CONTROLLED document for internal use only. Any documents appearing in paper form are not controlled and should be checked against the electronic file version prior to use.

PURPOSE

This policy provides guidance for Restraint prevention, decision-making, application, ongoing assessment, and documentation where Restraints are required as a last resort. For direction on the use of Seclusion, High Observation Rooms, and Pinel Restraints, follow appropriate Nova Scotia Health and relevant local policies (see Related Documents).

This policy does not apply to the means used to prevent patients from leaving a facility (for example: a locked unit or someone guarding the door) when patients are detained under legislation.

POLICY STATEMENTS

***Definition Change Alert*:**

1. **Physical Restraint**: any action or procedure that prevents a person's free body movement to a position of choice and/or normal access to their body by the use of any method, attached or adjacent to a person's body that they cannot control or remove easily (Bleijlevens, 2016).

   There are two subcategories of physical Restraint:

   1.1 **Mechanical Device**: Restraint by physical devices (for example: wrist Restraint).

   1.2 **Physical Intervention**: Restraint using safe physical holding by another person (for example: holding hand during a blood draw to keep arm still).

2. **Pharmacological (Chemical) Restraint**: A sedative or tranquilizer given to a patient to reduce agitation or potentially hazardous behavior (Taber's, 2017).
3. **Environmental Restraint**: Method predominantly used to prevent free movement of a person in a building/area, controlling a patient's mobility (for example: a secure unit or garden, Patient's room, seclusion or a time-out room) (RNAO, 2012).

1. The Health Care Team takes a **preventative approach** by identifying individual patients at risk for the use of Restraint and designing a care plan with **alternative interventions/approaches** to avoid the use of Restraint.
2. Restraint is used only when other strategies have been deemed ineffective or inappropriate in the **current circumstances,** and there is a risk of **Harm to self, Team Members, or others**.
3. Restraints, or the threat of Restraints, must never be used for convenience, coercion, or punishment.
4. The **least restrictive Restraint** suitable to achieve the intended outcome must be used for the **shortest time possible**, as indicated for that individual patient.
5. An Authorized Prescriber **order is required** for all Restraints (Physical [includes Mechanical Device and Physical Intervention], Pharmacological and Environmental).

This is a CONTROLLED document for internal use only. Any documents appearing in paper form are not controlled and should be checked against the electronic file version prior to use.

   5.1. **Exception**: In Perioperative settings (OR, post-procedural settings [for example: PACU] or Day Surgery), an Authorized Order is not required for Physical Restraint (Mechanical Device or Physical Intervention) and is required for Pharmacological Restraint.

6. **Informed consent** must be obtained and documented for use of Restraints. Refusal of consent for use of Restraints should also be documented.
7. A competent patient or Substitute Decision Maker (SDM) may choose to take the risk of Harm to self rather than be restrained (for example: accept fall risk versus wearing a pelvic holder).

Emergency Situation: Where an imminent risk of Harm to self, Team Members, or others requires immediate action to prevent Harm to the person or to another person.

8. In an Emergency Situation:
   8.1. The Registered Nurse (RN) or Paramedic can implement an Environmental Restraint, Mechanical Device, or Physical Intervention and obtain an order from an Authorized Prescriber immediately following the application/use of Restraint.
   8.2. A Restraint can be implemented before gaining informed consent.
9. In situations where refusal of a Restraint creates an imminent risk of Harm, the Emergency Situation operates to allow implementation of a Restraint before obtaining informed consent or an Authorized Prescriber Order.
   - For example, emergency treatment such as a physical examination is required of a motor vehicle accident patient who is delirious and combative.
10. Nova Scotia Health recognizes the need to balance the safety of Health Team Members, patients, and others with its obligation to provide health care services to those in need.
11. A Safety Improvement Management System (SIMS) report must be entered:
    11.1. If the policy and procedure were not followed as outlined, **OR**
    11.2. If the implementation of a Restraint resulted in a patient safety incident (Harm to the patient).
    11.3. If the implementation of a Restraint resulted in a Team Member safety incident (resulted in Harm/injury or act of violence towards a Team Member).
       11.3.1. Central and Eastern Zones refer to zone-based reporting procedures instead of SIMS.
12. Monthly unit reports must be completed documenting the initiation of all Restraints, including additions (another type of pharmacological Restraint and/or mechanical Restraint) for individual patients.

This is a CONTROLLED document for internal use only. Any documents appearing in paper form are not controlled and should be checked against the electronic file version prior to use.

13. Team Members are accountable for obtaining/maintaining knowledge, skills, and competencies related to alternative approaches, use of Restraints, and the risks involved **when caring for** patients at risk for the use of Restraints (for all patients with potential or active risk behaviour).
    13.1. Program areas identify training requirements for Team Members.

EQUIPMENT

1. Nova Scotia Health approves Mechanical Restraints by meeting the following criteria:
   - Procurement Services awards contract to vendor(s). Criteria include that the product meets Health Canada standards.
   - Infection Prevention and Control (IPAC) services have analyzed approved Restraints to verify single use or proper cleaning and disinfection.
   - Products do not show signs of broken stitches or parts; torn, cut or frayed material; or locks, buckles, or hoops and hook fasteners that do not hold securely that would compromise the integrity of the product. If equipment is as described, do not use.
2. If a different product/Restraint device required for patient care has not been assessed, the product must:
   - Be analyzed by IPAC services to verify single use and/or proper cleaning and disinfection.
   - Have quick release buckle(s) whenever available.
3. Previously approved vendor products in use are to be evaluated for wear and recommended IPAC recommendations.

PRINCIPLES AND VALUES

- Nova Scotia Health is committed to a philosophy of the least restrictive Restraint as a Last Resort.
- The protection of independence, self-determination, and safety of the patient is a priority in decision-making.
- Each patient and their situation are considered on an individual basis with an assessment and evaluation to guide understanding and care planning.
- Nova Scotia Health strives to balance personal freedom and choice with the potential risk of Harm.
- The least intrusive, least restrictive care refers to providing safe, competent, and ethical care with respect to individual rights, dignity, and autonomy.

PROCEDURE

1. Assessment/Decision: Applies to all types of Restraints.

This is a CONTROLLED document for internal use only. Any documents appearing in paper form are not controlled and should be checked against the electronic file version prior to use.

1.1. The RN collaborates with the Health Care Team, where available, to perform a comprehensive assessment of the patient identified as being at risk for possible Restraint use:

- □ Factors contributing to actions or behaviours that are perceived to require Restraint.
- □ Acting where reasonably possible to eliminate or reduce these factors.
- □ Immediate situational assessment of patient status and their ability and/or willingness to control their actions and/or behaviours perceived to require Restraint.
- □ Identify any potential risks to the patient, Team Member, others, and the environment.
- □ Evaluate the potential risks of Restraint (linked to adverse health outcomes) and non-restraint.

Note: *In practice settings that do not have 24-hour RN coverage, the LPN will collaborate with the designated RN linked with the unit, or Authorized Prescriber.

1.2. The RN, in collaboration with the Health Care Team where available, identifies alternative approaches and interventions, develops a care plan and documents in the health record.

1.3. The patient, family, SDM (where applicable), and/or Circle of Support are an essential part of the care planning process and are included whenever possible.

Examples of Alternative Approaches:

Environmental changes, distraction, Positioning Device, long sleeves to camouflage an intravenous therapy line (IV), de-escalation communication techniques, Comfort Positioning, topical anesthetics.

1.4. The care plan includes:

- □ Specific behaviour/unmet need.
- □ Patient-centred information to support the care plan (likes, dislikes, triggers, strategies that work.)
- □ Interventions and when they are to be used.
- □ Time frames for reassessment/review of the effectiveness of interventions.
- □ Level of involvement with family/SDM/Circle of Support.

1.5. When alternative approaches/interventions are ineffective, the RN collaborates with the Health Care Team in the decision to use Restraints, choosing **the least restrictive form** as assessed for **that individual patient** for the **shortest time possible.**

Examples:

A patient displaying occasional harmful behaviours requires an uncomfortable, necessary procedure. The Health Care Provider establishes a care plan that involves providing the lowest effective dose of sedative (Pharmacological Intervention) and supportive, therapeutic communication during the procedure instead of wrist restraint (Mechanical Device), or holding arms in place (Physical Intervention).

Security mitts only when intermittent IV medications are being administered.

1.6. Consider the following indications for the decision to use Restraints:

- An Individual's behaviour poses a risk of Harm to self, Team Members, or others.
- Alternative interventions have been unsuccessful in reducing risk.
- The potential benefits outweigh the risks and complications of using a Restraint.

Examples of Inappropriate Restraint Use:

Health Care Provider uses a Restraint (for example: medication, pelvic holder, Dutch ½ door) for a confused patient who is wandering into other patients' rooms who does not pose a risk for Harm to self, Team Members, or others.

Pharmacological Restraint given to a patient who is yelling profanities at Team Members and other patients who are upset by what they are saying and who does not pose a risk for Harm.

2. Initiating Restraints

2.1. The RN/Authorized Prescriber/Appropriate Health Care Team member(s):

2.1.1. Obtains **informed consent** from the patient or SDM and documents:

- The nature and purpose of the Restraint.
- The intended benefits.
- Material or probable risks or complications.
- The consequences of foregoing Restraint.
- Any alternatives available.

2.1.2. Obtains an **order** from the Authorized Prescriber for all types of Restraints (Physical, Pharmacological or Environmental.)

Exception: In Perioperative settings, an order is not required for Physical Restraint.

2.1.3. Develops a **plan of care** with specific direction regarding:

- When and what type of Restraint will be used (circumstances).
- Level of monitoring/observation required and by whom.

- Clear direction of any Delegation by RN in the care plan (for example: CTA application of pelvic belt holder).
- Care needs frequency (such as toileting, nutrition, hygiene).
- How to minimize potential risks (for example: skin breakdown, venous thromboembolism (VTE), deconditioning, anxiety, distrust of health care providers, etc.).
- Documentation required (for example: Restraint checklist, behaviour tracking).
- Reassessment by whom and timeframes (specifics required).
- When to discontinue (for example: intermittent IV infusion of medication completed, ½ Dutch door opened with de-escalation).

2.1.4. Provides patients, families, and caregivers with education about Restraint as a Last Resort, alternative approaches trialed and Restraint usage plan of care, documenting the same.

2.1.5. Include as part of the transfer of health information the decision-making, application, ongoing assessment, and document of Restraint use. Reassess the need for Restraint among Patients who have been admitted/transferred with a Restraint and, if still required, obtain consent, a new order and implement or document refusal as per policy (see Information Transfer at Care Transitions - Policy & Procedure - NSHA CL-SR-015).

> **NOTE**: In an **Emergency Situation** where an **imminent** risk of Harm to self, Team Members, or others requires **immediate action** to prevent Harm to the person or to another person, the RN or Paramedic may:
>
> - Implement a Restraint before gaining informed consent and an Authorized Prescriber order (except Pharmacological Restraint)**.** A Pharmacological Restraint requires an Authorized Prescriber order prior to administration.
> - As soon as possible following the administration/application of Restraints, informed consent is sought for continued use and future use.
>   - Obtain an order immediately following the application/use of Restraint (which may require physician assessment).
>
> Once the Emergency Situation has passed, Restraint **cannot be used** without consent (no longer considered an emergency). The RN, Paramedic or Physician informs/debriefs the patient/SDM, explains what happened and documents the results of the discussion.
>
> Refer to facility policy/protocol if security assistance is required (Code White) if applicable.

3. Ongoing Assessment and Documentation for all Restraints

This is a CONTROLLED document for internal use only. Any documents appearing in paper form are not controlled and should be checked against the electronic file version prior to use.

3.1. The RN/Appropriate Health Care Team member(s)/Authorized Prescriber documents (use the Restraint monitoring checklist, progress notes, unit-specific flow sheet or electronic documentation):

- □ Behaviours indicating the need for continued or discontinued use of Restraint.
- □ Patient assessment (for example: altered circulation, sensation, movement and respirations, pain, skin integrity, crying, etc.)
- □ Evaluation of intervention (effectiveness or ineffectiveness), including if the behaviour is unchanged, escalating, de-escalating, or the patient has settled/sleeping.
- □ Times initiated/removed for care or intermittent use.
- □ Care interventions provided (for example: toileting, nutrition, repositioning, hygiene, etc.)
- □ Addition of any alternative interventions (for example: bed alarm, distraction, de-escalation techniques, etc.) utilized to discontinue Restraint.

3.2. The RN reassesses the clinical situation, with input from the Authorized Prescriber and Health Care Team, where available, at a minimum of every **24 hours**, to determine whether to continue, change, reduce, or discontinue Restraints and documents in the health record.

3.3. The RN/Appropriate Health Care Team member(s)/Authorized Prescriber documents the **plan of care** specific to the needs of the patient, including:

- □ Evaluation of the effectiveness or ineffectiveness of the plan of care.
- □ Revisions made to the plan of care and when it is discontinued.

3.4. The RN/LPN ensures the monitoring and observation **at a minimum**, as follows:

- □ Every 15 minutes for the first hour, then
- □ Every 30 minutes for one hour, then
- □ Every hour until the Restraint is discontinued (may be Delegated to Health Care Provider [HCP] if deemed appropriate.)

3.5. Monitoring/observation is increased based on the therapeutic response and the patient's physical/mental condition.

3.6. Where an Authorized Prescriber has ordered observation levels (for example: constant observation), these remain in place until the order is reviewed by an Authorized Prescriber and a new observation order is written.

3.7. Constant Observation by an RN/LPN for 3-4-Point Restraints may not be Delegated to non-licensed staff (for example: bilateral wrist and ankle Restraints).

3.8. Where any Restraint is required for more than seven days, the RN, and Authorized Prescriber, in collaboration with the Health Care Team, determine and document the

This is a CONTROLLED document for internal use only. Any documents appearing in paper form are not controlled and should be checked against the electronic file version prior to use.

ongoing frequency of monitoring and reassessment. It may be decided to discontinue the Restraint checklist and document the rationale.

3.8.1. Reassess and document the following monthly or more frequently as the situation changes:

- The effectiveness of the Restraint.
- Need for Restraint.
- If the type currently being used is the least restrictive Restraint necessary.

3.8.2. The Patient/SDM is informed of the plan of care.

3.8.3. Document in the care plan the specific reason for intermittent use, expected outcomes and frequency of monitoring.

3.8.4. If the specific reason for intermittent use changes (care plan), the Restraint checklist must be restarted, and effectiveness reassessed.

4. Implementation of Specific Types of Restraints: Additional Requirements

4.1. Mechanical Device (Physical Restraint):

- □ Education on applying the Mechanical Device as per manufacturer guidelines is required before use.
- □ The Mechanical Device used allows for quick release in emergency care (for example: cardiac arrest.)
- □ All Mechanical Restraints are to be removed every 2 hours for at least 10 minutes to allow for skin/circulation assessment, ambulation, toileting, and other care as needed. The sequence of removal and reapplication of Mechanical Restraints will depend on assessing patient safety (behaviour escalating) and Team Member safety. For example, may remove and reapply wrist Restraints one at a time to assess skin/circulation safely and allow for range of motion (ROM.)
- □ Follow IPAC recommendations for the Mechanical Device chosen.

4.1.1. **Exception**: The decision to remove Restraints while the patient is sleeping is at the discretion of the RN/LPN based on the current assessment of the patient. Given that the patient has deescalated, it may be appropriate to remove at that time or wait and continue to monitor as per policy.

4.1.2. Support or stabilization of a body part (for example: motion reduction devices) to facilitate diagnostic imaging, procedures, and/or treatments is not a Restraint.

4.1.3. Devices that are part of safety restraints used in the everyday care of children (for example: appropriate use of crib rails, arm boards) and that are part of products such as highchairs, swings, strollers, car seats would not be considered a Restraint.

This is a CONTROLLED document for internal use only. Any documents appearing in paper form are not controlled and should be checked against the electronic file version prior to use.

4.1.4. Products that comply with legislation (for example: vehicle seatbelts) are not Restraints.

4.1.5. Bedrails for sedated or unconscious patients are not considered a Restraint.

Mechanical Restraint vs Positioning Device

Seating and mobility interventions are often used to support the patient's body in a very specific position or posture and may limit body and/or limb movement.

For example, a person in a wheelchair requires a hand strapped to the wheelchair arm to be able to maintain contact with control.

Movement may be limited, but the intent is to provide postural support, stability, pressure distribution, and pressure relief.

- Documentation must justify the clinical indicators for the positioning device.
- Monitoring of potential risk determined by the clinical situation and plan to reduce/avoid in place (occupation therapist discussion with nursing possible risk such as risk to skin integrity)

Note: Restraint checklist monitoring is not required for a positioning device.

Resource: http://www.atilange.com/resources.html

Exception: A Positioning Device is considered a form of Restraint if the main intent is to prevent a person's free body movement to a position of choice and/or normal access to their body using any method, attached or adjacent to a person's body that they cannot control or remove easily. When a positioning device in used in this way, treat as a Restraint, and implement the policy.

4.2. Physical Intervention (Physical Restraint):

- □ The direct application of physical holding techniques to a patient that involuntarily restricts their movement.
- □ Recommended when all less restrictive intervention methods have been tried and are unsuccessful.
- □ Use a manner that continues to support the patient in calming and assist in re-establishing the therapeutic relationship.
- □ Follow unit-specific prevention plan, Non-violent Crisis Intervention (NVCI) and de-escalation techniques and the Code White policy.

4.2.1. Therapeutic care approaches (for example: gentle hand holding with reassurance, diversion strategies) and Comfort Positions (pediatric, toddlers) are not Restraints.

4.3. 4.2.2 Support or stabilization of a body part to facilitate procedures and/or treatments (for example: stabilize arm when giving an injection, intravenous insertion) is not a Restraint. Pharmacological Restraints:

4.3.1. Where there is a dose range, start with the lowest possible dose (if deemed appropriate by the Authorized Prescriber).

4.3.2. Select the least restrictive/invasive route to provide the medication safely to obtain the most efficient and effective results.

4.3.3. In Emergency Situations, when vascular access is unavailable, the preferred route is an intramuscular injection.

4.3.4. The RN/LPN assesses, administers, monitors, and documents the administration, effectiveness, and side effect(s) of medications after every administration and during each shift.

4.3.5. Medications ordered to treat a specific condition, which can be regularly scheduled or as needed, are not considered a restraint. For example, antipsychotic medication to treat a chronic mental health diagnosis or antipsychotics (Haldol) ordered to reduce the imminent risk for physical harm to self and staff because of acute delirium, enabling a consistent drug level to become effective management.

4.3.6. Medications routinely given during a procedure to all patients (sedation before a colonoscopy) would not be considered a restraint.

- If specifically given to an individual to reduce the risk of harm to self or others and alternative approaches have not been successful, it would be considered a restraint (for example: sedation of child before accessing port-a-cath because of previous negative attempts).

4.4. Environmental Restraints:

- Half doors/Dutch doors and Access Controlled Egress doors, such as pen access, push-button or push pad code, are considered an Environmental Restraint if the intent is to limit patient movement.
- The Environmental Restraint allows for quick release (unlocking) in emergency situations (for example: code red/fire) either automatically or manually as per unit protocol.
- All doors must meet the Nova Scotia Fire Safety Act, National Fire and Building Codes and Nova Scotia Prevention Act (NSPA). Contact Occupational Health Safety and Wellness for information.

Exception: Features such as doors used for building security, to control access to restricted areas of a building for patient safety or to ensure the privacy of other patients are not considered Environmental Restraints.

Example:

- Access Controlled Egress door is used for building security.

This is a CONTROLLED document for internal use only. Any documents appearing in paper form are not controlled and should be checked against the electronic file version prior to use.

- Limited access to areas on the unit for patient safety, food safety, etc. (for example: locked kitchen, utility room).
- Removal barriers (for example: Velcro©) to deter patients from wandering into another patient's room is considered an alternative approach.

REFERENCES

Alberta Health Services. (2023). Restraint as a Last Resort. Retrieved from: https://extranet.ahsnet.ca/teams/policydocuments/1/clp-prov-restraint-hcs-176.pdf

Bleijlevens, H.C., Wagner, L.M., Capezuti, E. and Hamers, J.P.H. (2016). Physical restraints: Consensus of a research definition using a modified Delphi technique. *Journal of the American Geriatrics Society 64*: 2307-2310. DOI:10.111/jgs.14435

College of Nurses of Ontario. (2002). Practice standard; Restraints. Retrieved from http://www.cno.org/en/learn-about-standards-guidelines/educational-tools/restraints/

Coskun, H., Kilic, C. & Senture, C. (2016). The evaluation of dorsogluteal and ventrogluteal injection sites: a cadaver study. *Journal of Clinical Nursing*, 25: pp 1112–1119. doi:10.1111/jocn.13171

Crisis Prevention Institute. CPI’s nonviolence crisis intervention instructor guide: Glossary of terms. (2nd edition). https://www.crisisprevention.com/Platform/Sign-In?returnurl=%2fen-CA%2fmedia%2fnci%2fguide%2fPDF_NCI_2_IG_InstructorGuide.pdf

Nova Scotia Department of Health and Wellness (DHW) Policy: Long Term Care Program Requirements: Nursing Homes & Residential Care Facilities (2019). Retrieved from https://novascotia.ca/dhw/ccs/policies/Long-Term-Care-Facility-Program-Requirements.pdf

Nova Scotia College of Nursing (2019). Assignment and delegation to unregulated care providers. https://cdn1.nscn.ca/sites/default/files/documents/resources/AssignmentAndDelegationUCP.pdf

Registered Nurses Association of Ontario RNAO: Clinical best practice guideline: Promoting Safety: Alternative Approaches to the Use of Restraints. (Feb 2012)

Taber Cyclopedic Medical Dictionary 23rd Edition (2017). D. Venes (Eds). Retrieved from http://online.statref.com/Document.aspx?FxId=57&SessionID=2C6FA2CHLOTDOXVW

Legislative Acts

Involuntary Psychiatric Treatment Act, *Revised Statutes of Nova Scotia* (2005, c 42, s 1). Retrieved from: https://novascotia.ca/dhw/mental-health/involuntary-psychiatric-treatment-act.asp

Nova Scotia Hospital Act, *Revised Statutes of Nova Scotia* (1989, c 313, s 1). Retrieved from: https://nslegislature.ca/legc/bills/60th_2nd/3rd_read/b027.htm

Personal Directives Act, *Revised Statutes of Nova Scotia* (2008, c. 8, s. 1). Retrieved from: https://novascotia.ca/just/regulations/regs/pdpersdir.htm

RELATED DOCUMENTS

Policies

Falls and Injury Reduction - Policy and Procedure - NSHA CL-SR-010

Use of Patient Attendants - Policy and Guidelines - NSHA CL-AP-045

Use of Pinel Restraints for Rapid Physical Restraint - Policy and Procedure - NSHA CL-SR-001

Authorized Leave (Pass) - Policy and Procedure - NSHA MA-IS-001

Patient Safety Incident Management - Policy - NSHA AD-QR-015

Venous Thromboembolism (VTE) Prophylaxis in Adults - Policy and Procedure - NSHA CL-SR-020

Violence in the Workplace - Policy - NSHA AD-OHS-010

Managing Potential for Violence and Aggression in the Emergency Department - Protocol - NSHA CL-EC-070

Abuse Prevention and Response - Policy and Procedure - NSHA AD-QR-001

CDHA

CC 65-030 Use of Seclusion on Mental Health Inpatient services

CDHA CC 65-038 Close Patient Monitoring and Constant Observation on Mental Health Inpatient Units

Protocol # 551 Dutch Doors Veterans Services Camp Hill Veterans Memorial Building

Emergency Chair Restraint (for Emerald Hall and Transition Hall, Nova Scotia Hospital only)

AVH

Close Observation: 500.004

Constant Observation: 500.005

Code White Team Response: 200.072

Locked High Observation Room: 500.009

Cumberland

Aggressive Agitated Residents 210-002

Cape Breton

CBDHA MA (Inpatient MH) 5-60 Constant Observation

Colchester East Hants

CEHHA 109-008 Aggressive Person Management and Code White

Pictou

PCHA - Code White 11-c-11

Forms

NSRLR Restraint as a Last Resort

Relevant Subject Guides

Elder Care in Hospital

Dignity Risk and Choice

Diversity and Inclusion

Fall and Injury Prevention

Informed Choice

Restraint

Mental Health and Addictions Education in the Emergency Department

Appendices

Appendix A: Definitions

* * *

Appendix A: Definitions

Access Controlled Egress door	A pen access, push-button, or push pad code access door, considered an Environmental Restraint.
Authorized Prescriber	A health care professional permitted by legislation, their regulatory college, Nova Scotia Health, and practice setting (where applicable) to prescribe medications and treatments. The authority to order medications is not linked to any particular health profession and may differ within that health care profession depending upon specific competencies and skills. Examples of an authorized prescriber may include but are not limited to, a physician, medical resident, nurse practitioner, pharmacist, midwives, or a registered dietician approved to order parenteral nutrition (NSHA).
Circle of Support	Friends and family whom the patient consents to share information with and be involved in their care.
Comfort Positioning	Facilitates safe access to the part of the body required for a medical procedure without removing the child's right to freedom of movement. Comfort positioning utilizes comfort items and the accompanying support person in the positioning of a patient to ensure proper interventions. (IWK)
Constant Observation	One-on- one observation.
Delegation	Delegation is an active process whereby the responsibility for the performance of an intervention is transferred to an individual (delegatee) whose scope of practice or employment does not authorize the performance of that intervention. Education of the delegatee is always required for delegation because the intervention is not within their scope of practice or employment (Nova Scotia College of Nursing, 2019). Nova Scotia College of Nursing (2019) Delegation: *This is client specific, usually, delegation applies to a specific intervention for a specific client in a specific context. This is because the decision to delegate an intervention is based on the overall needs of an individual client at a given point in time. No two clients are identical, so each one is to be assessed to determine the appropriateness of the delegation of a specific intervention. One of the underlying principles of delegation is that an individual Unlicensed Care Provider's (UCP) authority to perform a delegated intervention with one client does not automatically transfer to other clients.*
Emergency Situations	An imminent risk of Harm to self, Team Members, or others and immediate action is necessary to prevent Harm to the person or another person.

This is a CONTROLLED document for internal use only. Any documents appearing in paper form are not controlled and should be checked against the electronic file version prior to use.

3-4-point restraint	A mechanical restraint used to fix the patient to a location at three to four points (i.e., hands and feet attached to the bed with wrist and ankle restraints, pelvic belt holder and wrist restraints.)
Harm	Physical injury, illness, or adverse effect to health (whether acute or chronic).
Health Care Team	Health Care Providers (HCP) such as Nurses (RN/LPN), Nurse Practitioners (NP), Paramedics, Occupational Therapists (OT), Occupational Therapy Assistants (OTA), Physiotherapist (PT), Social Worker (SW), Recreation Therapist (RT), Recreation Therapy Associates (RTA), Therapeutic Assistants (TA), Continuing Care Assistants (CCA), Care Team Assistants (CTA), Developmental Worker (DW) and others who are involved in the care of the patient.
Monitoring Device	Monitoring is to check by using an electronic device. A device is an apparatus, tool, or machine made for a specific function (Tabers, 2017), (e.g., bed/chair/door alarms or wrist bracelet.)
Positioning Device	Seating and mobility interventions that are used to support the patient's body in a very specific position or posture and may limit body and/ or limb movement. Movement may be limited but the intent is to provide postural support, stability, pressure distribution, and pressure relief. (http://www.atilange.com/resources.html)
Restraint	Anything that is intentionally used to limit the movement or behaviour of a patient and over which the patient has no control. Restraints may be physical, environmental, or chemical. A resident is restrained if they cannot remove a physical device, leave a specific area, or refuse a chemical restraint. NSHW (2019) Long Term Care Program Requirements: Nursing Homes & Residential Care Facilities.
Restraint as a Last Resort	A philosophy of least restrictive measures where all possible alternative interventions are exhausted before deciding to use a Restraint and using the least restrictive form of Restraint allowing for maximum freedom of movement for the shortest duration of time. (RNAO 2012)
Restraint - Chemical	A sedative or tranquillizer given to a patient to reduce agitation or potentially hazardous behaviour (Tabers, 2017)
Restraint - Physical	Any action or procedure that prevents a person's free body movement to a position of choice and/or normal access to their body by the use of any method, attached or adjacent to a person's body that they cannot control or remove easily (Bleijlevens, 2016). There are two subcategories of physical Restraint:

	Mechanical Device: Restraint by physical devices (e.g., wrist restraint). (Tabers, 2017) Physical Intervention: Restraint using non-harmful physical holding (e.g., holding hand during blood draw.)
Restraint - Environmental	Predominantly used to prevent free movement of a person in a building/area, controlling a patient's mobility (e.g., a secure unit or garden, seclusion or a time-out room) (RNAO, 2012).
Risk Behaviour	Behavior that presents an imminent or immediate risk to self or others (Crisis Prevention Institute, 2022)
Substitute Decision Maker (SDM)	The individual with the legal authority to provide or refuse informed consent on a patient's behalf while the patient is incapable (refer to consent to treatment-related policies).
Team Members	Refers to all employees, physicians, learners, volunteers, board members, contractors, contract workers, franchise employees, and those with affiliated appointments and other individuals performing activities within Nova Scotia Health
Trauma Informed Care	Trauma informed care is a universal, systematic approach that is grounded in an understanding of, and responsiveness to, the impact of trauma. Being trauma informed is about using the principles of trauma informed care to create: Safety and trustworthiness through our practices Safe physical and emotional environments Positive social interactions with clients, families, staff, volunteers and physicians. Retrieved from: What is Trauma Informed Care? | Your Experiences Matter

VERSION HISTORY

Version:	Effective:	Approved by:	What's changed:
Original	2023-03-01	Clinical Operations Council	N/A
Minor Revision	2022-10-30	Senior Director, IPPL	Effective date changed
Minor Revision	2022-12	Senior Director, IPPL	Clarification of physical harms
Minor Revision	2023-05-09	Senior Director, IPPL	Modification to definition of some physical restraints Exceptions for Periop Settings In practice settings without 24-hour RN coverage, the LPN will collaborate with the designated RN linked with the unit or Authorized Prescriber
Minor Revision	2023-12-28	Senior Director, IPPL	Exception for Periop settings Clarification regarding support/stabilization as not applicable