NOTE: The first appearance of terms in bold in the body of this document (except titles) are defined terms – please refer to the Definitions section.

Purpose

- To provide evidence-informed practices intended to promote a culture of least restraint.
- To promote consistency in the decision-making processes regarding restraints.
- To provide direction on the use of physical, mechanical, environmental and/or pharmacological restraints based on the principle of 'least restraint', intended to minimize risk and to guide safety-related care decisions.
- To support a balance between the safety of the patient/resident/client and others and the limitation imposed on the patient's personal liberty when decisions are made regarding restraint.

Policy Statement

Covenant Health is committed to the principle and practice of least restraint. Restraints shall be used only after assessment deems that it is the safest clinical option and that alternative strategies have been deemed unsafe, ineffective or inappropriate for the set of circumstances. If restraint is indicated, the least restrictive restraint suitable shall be used, for the least amount of time to be effective.

Staff education and training on alternatives to restraint use, appropriate application, risk, use, and monitoring of patients in restraints shall be completed in new hire orientation and thereafter per program requirements and standards.

Applicability

This policy and procedure applies to all Covenant Health facilities, staff, medical staff, students and any other persons acting on behalf of Covenant Health.

This policy does not apply to restraints used by corrections authorities for purposes of custody, detention, and public safety reasons.

Responsibility

It is the responsibility of health care professionals to be knowledgeable regarding alternatives to restraints, risks associated with restraint use, the application and discontinuation of the specific restraint being used, and the care needs of the patient being restrained. Health care teams shall apply the principles of this policy consistently across health service settings.

1 Hereafter, all references to 'patients' includes residents and clients.
In emergent situations, Protective Services may assist with application of restraints. Note, this does not limit Protective Services Peace Officers who are acting under their Peace Officer authority to engage their powers of detention, apprehension, or arrest.

**Principles**

Health care providers will work toward identifying and eliminating behavioural triggers and minimizing the adverse consequences of these behaviours, while maintaining a safe environment for all patients, staff and visitors.

The use of restraints, whether physical, mechanical, pharmacological or environmental, should always seek the person’s greater freedom and functioning and be done with scrupulous observance of due legal process.²

Principles that guide the use of restraint(s) are:

1. The patient’s dignity shall be respected at all times and under all circumstances.

2. Covenant shall adhere to the principles to patient and family-centred care.

3. Informed consent is required for all non-emergent restraint use.

4. All reasonable efforts shall be made to identify and employ a non-restraint strategy. Refer to Appendix A - Alternative Interventions.

5. Ongoing documentation of assessments, rationale, consent and plan of care - including patient response to restraint - is required in accordance with applicable program/department requirement.

6. Non-emergent restraints shall be applied as a result of collaborative decision-making following a comprehensive assessment, case review, and documented attempts at alternative interventions. Ongoing communication is a shared responsibility within the interdisciplinary health care team and requires active participation and discussion regarding assessment, documentation and plan of care. Communication and partnership with the patient, family and/or alternate decision-maker is essential.

7. Restraints shall not be used:
   - as a substitute for inadequate levels of staffing;
   - as a means of coercion;
   - for convenience; or
   - for punishment

8. Any application of restraints shall be done only by staff who have received education and training on appropriate restraint use.

9. Only commercially manufactured restraint devices shall be used. The devices shall be used and maintained in accordance with manufacturer guidelines.

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10. Patients in restraints shall be monitored, at minimum, as per Appendix E, *Least Restraint: Monitoring, Assessment and Documentation Requirements*; however, in all situations, each patient shall be assessed on an individual basis to determine if more frequent monitoring is appropriate.

### Procedure

1. **Restraints shall be used only in circumstances where:**

   1.1 There is an immediate threat to the safety of the patient, caregivers, or others and immediate action is necessary to prevent serious bodily harm to the person or to another person;

   1.2 Emergency treatments must be provided;

   1.3 An approved treatment regimen, safety plan, or care plan must be followed because the patient is unable to cooperate in the care setting (eg. ICU, NICU, severe cognitive impairment);

2. **Clinical Assessment**

   A comprehensive clinical assessment will be performed for evaluation of each individual patient situation to:

   2.1 Assess if there is risk for harm to self, or others.

   2.2 Determine if there are modifiable factors that may be causing the behavior.

      2.2.1 Consider unmet needs and explore interventions that are alternatives to restraint. Refer to Appendix A - Alternative Interventions.

   2.3 Determine if restraint is the most appropriate clinical option;

      2.3.1 Consult with members of the multidisciplinary team;

      2.3.2 Involve family/support person.

3. **Consent**

   3.1 Consent is not required in an emergency situation where there is an immediate threat to safety or emergency treatment is required.

      3.1.1 Indication for the use of restraint shall be communicated to the patient/alternate decision maker.

   3.2 Consent for restraint is required in all other situations.
3.2.1 Informed consent shall be obtained in accordance with applicable Covenant Health 'Consent to Treatment' policy and procedure(s) available @ http://www.compassionnet.ca/Page433.aspx and documented on form #09741, "Consent to Treatment Plan or Procedure" or on the patient's health record.

3.2.2 If at any time consent is withdrawn by the patient/alternate decision-maker, this is documented on the original consent form.

3.2.3 When the patient/alternate decision-maker does not consent to restraint, the most responsible health practitioner/designate shall engage the patient/alternate decision-maker in conversation to ensure that they are aware of the possible consequences of their decision. In the acute care setting, these discussions will be documented on the patient care record. In continuing care settings, discussions will be documented per Covenant Health policy #VII-B-50, Managed Risk Agreement (MRA).

4. Orders

4.1 An order must be obtained for all restraints.

4.1.1 In a behavioural emergency, a health care professional may apply a non-pharmacological restraint without an order; however, the order must be obtained as soon as possible from an authorized prescriber. In the acute care setting the order must be obtained within 24 hours; in the continuing care setting the order must be obtained within 72 hours (per the Continuing Health Care Service Standards).

4.2 Non-emergent restraints shall not be applied without an order in advance of application.

4.3 The order should indicate:

4.3.1 Type of restraint (eg. mechanical, pharmacological [per Covenant Health policy #VII-B-125, Medication Orders, and manufacturer recommendations], environmental); including date and time of order.

4.4 Pro re nata (PRN) orders shall not be used for restraint without prior discussion and consent of the patient, family and/or alternate decision-maker and shall serve as an appropriate component of the patient’s plan of care.
5. Monitoring Requirements – refer to Appendix E, Least Restraint: Monitoring, Assessment and Documentation Requirements

5.1 Use of restraint increases the need for patient monitoring.

5.2 Restrained patients shall be monitored with sufficient frequency to minimize risk of potential harm. Frequency varies depending on the patient care area and circumstances requiring restraint use. See Appendix E.

5.3 Monitor the restrained patient and provide patient care as required (toileting, hygiene, hydration).

6. Discontinuation or Reduction of Restraint

6.1 Once any restraint is applied it must be decreased, or discontinued, at the earliest and safest opportunity.

6.2 Patients must be assessed prior to reduction or discontinuation of restraint.

6.3 The charge nurse/delegate shall assess restraint use and determine the continued need for restraint (excluding pharmacological restraints).

6.3.1 Pharmacological restraints may not be discontinued without an order.

6.3.2 The most responsible health practitioner/delegate shall be notified when a restraint has been discontinued as soon as reasonably possible.

6.4 Restraints shall be used in a manner that allows for quick release in an emergency situation (e.g., codes).

6.5 When pharmacological restraint is no longer required, the most responsible health practitioner will document instructions regarding the process for gradual dose reduction and discontinuation.

7. Care Planning

7.1 Health care professionals shall develop an individualized care plan with the patient, family and/or alternate decision maker. Refer to Appendix A, Alternate Interventions.

7.1.1 If applicable, ask family to participate in strategies aimed at preventing the use of restraints (frequent visits, staying during the night if the patient becomes agitated, etc.)
8. Documentation – refer to Appendix E, Least Restraint: Monitoring, Assessment and Documentation Requirements

8.1 Document assessment, rationale, alternatives considered, consent, plan, and evaluation.

9. Post Restraint Debriefing

9.1 When restraint or seclusion has been used in a behavioural emergency, post-restraint debriefings shall be conducted with the patient/family alternate decision maker and appropriate members of the multidisciplinary team.

9.2 Post restraint debriefings are to be held as soon as practical after restraint use. The discussion shall include the patient and family as appropriate and include:

9.2.1 Circumstances leading to the restraint application.

9.2.2 To provide the patient/family opportunity to ask questions and provide insight on the restraint use and to provide reassurance

9.2.3 Ongoing restraint requirements will require consent and need to be included as part of the care plan.

9.2.4 Message of support to patient/family that staff are there to support and provide assistance to the patient so that restraint use may be reduced or eliminated in the future.

10. Quality Improvement

10.1 The unit/program manager shall ensure ongoing review of restraint use is conducted with the multidisciplinary team. The process is to emphasize learnings from restraint use and decrease the use of restraints in Covenant Health facilities.

10.2 When restraints are applied without informed consent or when restraints are not identified in the plan of care staff shall report in the Reporting and Learning System, per Covenant Health policy #III-45, Responding to Adverse Events, Close Calls and Hazards.

Definitions

Alternate decision maker means a person who is authorized to make decisions with or on behalf of the patient. These may include, specific decision-maker, a minor’s legal representative, a guardian, a ‘nearest relative’ in accordance with the Mental Health Act [Alberta], an agent in accordance with a Personal Directive, or a person designated in accordance with the Human Tissue and Organ Donation Act [Alberta].
**Care Plan** in Continuing Care health care settings refers to a written working document developed by the interdisciplinary team and includes a client’s assessed unmet health care needs, related health care goals and interventions.

**Family** means one or more individuals identified by the patient as an important support, and who the patient wishes to be included in any encounters with the health care system, including, but not limited to, family members, legal guardians, friends and informal caregivers.

**Locomotion** means the movement of an individual from place to place/room to room.

**Most responsible health practitioner** means the health care professional who has responsibility and accountability for the specific treatment/procedure(s) provided to a patient and who is authorized by Covenant Health to perform the duties required to fulfill the delivery of such a treatment/procedure(s) within the scope of his/her practice.

**Order** means a direction given by a regulated health care professional to carry out specific activity(-ies) as part of the diagnostic and/or therapeutic care and treatment to the benefit of a patient. An order may be written (including handwritten and or electronic), verbal, by telephone or facsimile.

**Patient and family-centred** care means care provided working in partnership with patients and families by encouraging active participation of patients and families in all aspects of care, as integral members of the patient’s care and support team, and as partners in planning and improving facilities and services. Patient- and family-centred care applies to patients of all ages and to all areas of health care.

**Protective Services Officer** means Protective Services Officers with Community Peace Officer appointments pursuant to the **Peace Officer Act** and Covenant Health officers scheduled for Peace Officer training.

**Restraint** means any mechanical, pharmacological, environmental or physical measures used to limit the activity or control the behaviour of a person or a portion of their body. (College and Association of Registered Nurses of Alberta)

Covenant Health recognizes the use of the following types of restraint:

**Environmental**: Any barrier or device that limits the locomotion of an individual and thereby confines an individual to a specific geographic area or location.

**Mechanical**: Any device, material, or equipment attached to or near a patient which cannot be controlled or easily removed by the patient and prevents a patient's free body movement and/or a patient's normal access to their body.

Mechanical restraints do not include positioning devices that are used as mechanical supports – that is, items that provide postural support; stability; pressure distribution and/or pressure relief; or those that promote healing and prevents contracture or reduces the risk of other complications (e.g., skin sheering/breakdown); or items whose intent is to enable occupation or promote function and achieve proper body position, balance, or alignment so as to allow greater freedom of mobility than would be possible without the use of such an
item. Mechanical supports are not intended to limit movement or manage responsive behavior (e.g., aggression).

**Pharmacological**: The use of pharmaceutical products to control behaviours, actions, and/or restrict freedom of movement, but which purpose in the situation is not to treat an identified medical or psychiatric condition.

**Physical**: The direct application of physical holding techniques to a patient that involuntarily restricts their movement.

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**Related Documents**

- Appendix A – Alternative Interventions
- Appendix B – Restraints – Pediatric Patient Population
- Appendix C – Restraints – Emergency Department
- Appendix D – Restraints - Continuing Care
- Appendix E - Least Restraint: Monitoring, Assessment & Documentation Requirements

**Covenant Health Policies**

- III-45, Responding to Adverse Events, Close Calls and Hazards
- VII-C-55, Managed Risk Agreement

**References**

- Alberta Health Continuing Care Health Service Standards, Alberta Government Continuing Care Branch (amended 2018)
- Alberta Health, Policy HCS-176, Restraint as a Last Resort, effective February 2018

**Previous Version Date(s)**

- September 21, 2011 (titled *Physical Restraints*)
## ALTERNATIVE INTERVENTIONS

### POSSIBLE CAUSES FOR AGITATED BEHAVIOUR

<table>
<thead>
<tr>
<th>Cognitive Impairments</th>
<th>Alternative Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>• anxiety</td>
<td>✓ introduce yourself (NOD)</td>
</tr>
<tr>
<td>• delirium / confusion</td>
<td>✓ take time to listen</td>
</tr>
<tr>
<td>• depression</td>
<td>✓ provide reassurance with a calm approach</td>
</tr>
<tr>
<td>• emotional distress</td>
<td>✓ allow patient appropriate control and offer choices</td>
</tr>
<tr>
<td>• fear</td>
<td>✓ provide call bell</td>
</tr>
<tr>
<td>• lack of mobility</td>
<td>✓ encourage family visits and involvement</td>
</tr>
<tr>
<td>• sensory impairment or loss</td>
<td>✓ attend regularly to the needs of nutrition and hydration</td>
</tr>
<tr>
<td></td>
<td>✓ establish toileting schedule</td>
</tr>
<tr>
<td></td>
<td>✓ re-orientate to environment as required and place familiar objects in room (eg. clock, calendar, family pictures)</td>
</tr>
<tr>
<td></td>
<td>✓ use sensory items to distract the patient; eg. soft cloth dolls to keep hands occupied, a sensory blanket for dementia care (known as 'fidget quilt'), music, etc.</td>
</tr>
<tr>
<td></td>
<td>✓ ensure patient has his/her eye glasses, hearing aids, and dentures</td>
</tr>
<tr>
<td></td>
<td>✓ provide environment conducive to sleep to establish sleep / wake cycle</td>
</tr>
<tr>
<td></td>
<td>✓ assessment of medications</td>
</tr>
<tr>
<td></td>
<td>✓ administer medication as ordered to treat delirium</td>
</tr>
<tr>
<td></td>
<td>✓ mobilize whenever possible</td>
</tr>
<tr>
<td></td>
<td>✓ refer to Falls Risk Management resource page on compassionNET @ <a href="http://www.compassionnet.ca/page3154.aspx">http://www.compassionnet.ca/page3154.aspx</a> for assessment tools</td>
</tr>
<tr>
<td></td>
<td>✓ physio therapist and/or occupational therapist assessment</td>
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<tr>
<td></td>
<td>✓ walk with the person</td>
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<tr>
<td></td>
<td>✓ balance rest and activity.</td>
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<td></td>
<td>✓ redirect in a positive manner (i.e. come with me instead of don’t go there)</td>
</tr>
</tbody>
</table>

### EQUIPMENT:

- interference or tampering with lines and/or tube insertions; e.g. PEG Tubes, Gastric Tubes, Catheters, Intravenous Lines

<table>
<thead>
<tr>
<th>Alternative Options</th>
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</thead>
<tbody>
<tr>
<td>✓ assess for compromise to medical equipment (eg. obstruction of urinary catheter, interstitial peripheral intravenous catheter)</td>
</tr>
<tr>
<td>✓ use abdominal binder or a foam binder to eliminate the sight of the tube</td>
</tr>
<tr>
<td>✓ frequent reorientation and education regarding purpose of medical equipment (eg. urinary catheter, intravenous tubing, etc.)</td>
</tr>
<tr>
<td>✓ place tubing/catheters out of patient view whenever possible</td>
</tr>
<tr>
<td>✓ discontinue lines and catheters at earliest opportunity</td>
</tr>
<tr>
<td>✓ kling wrap the IV site</td>
</tr>
<tr>
<td>✓ convert IVs to saline locks where possible</td>
</tr>
<tr>
<td>Possible Causes for Agitated Behaviour</td>
</tr>
<tr>
<td>--------------------------------------</td>
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<tr>
<td><strong>Medical Issues:</strong></td>
</tr>
<tr>
<td>- gastrointestinal issues</td>
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<tr>
<td>- constipation</td>
</tr>
<tr>
<td>- urge to defecate, incontinence</td>
</tr>
<tr>
<td>- nausea</td>
</tr>
<tr>
<td>- pain / untreated or undertreated</td>
</tr>
<tr>
<td>- fluid overload</td>
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<tr>
<td>- dehydration</td>
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<tr>
<td>- infection</td>
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<tr>
<td>- drug toxicity</td>
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<tr>
<td>- medication side-effects</td>
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<tr>
<td>- abnormal blood work</td>
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</tbody>
</table>

| Physical Environment                  | ✓ modify routine as needed |
|                                      | ✓ don’t take it personally; don’t argue with the patient; don’t threaten |
|                                      | ✓ provide opportunity for patient to work out feelings in a non-threatening manner |
|                                      | ✓ offer choices to help patient regain control |
|                                      | ✓ consider quiet time in a room; 1:1 talk with staff, reduce stimuli; distractions such as a game or activity |
|                                      | ✓ kindly but firmly explain expected behaviour and identify your intent to help and explain your actions |
|                                      | ✓ you may need to walk away |
|                                      | ✓ consider family involvement |
|                                      | ✓ assess for potential triggers |

| Aggression                            | ✓ modify routine as needed |
|                                      | ✓ don’t take it personally; don’t argue with the patient; don’t threaten |
|                                      | ✓ provide opportunity for patient to work out feelings in a non-threatening manner |
|                                      | ✓ offer choices to help patient regain control |
|                                      | ✓ consider quiet time in a room; 1:1 talk with staff, reduce stimuli; distractions such as a game or activity |
|                                      | ✓ kindly but firmly explain expected behaviour and identify your intent to help and explain your actions |
|                                      | ✓ you may need to walk away |
|                                      | ✓ consider family involvement |
|                                      | ✓ assess for potential triggers |
### APPENDIX B

#### Restraints – Pediatric Patient Population

**Note**

This does not apply to safety restraints used in everyday care of children (e.g., appropriate use of crib rails, arm boards, and restraints that are part of products such as highchairs, swings, strollers, car seats, etc.) or to a ‘time-out’ for the purpose of regaining emotional control.

**Orders**

Health care professionals faced with a situation where restraining techniques may be required in excess of what would reasonable be required to safely perform a medically necessary procedure, investigation, or therapy are responsible to obtain an order from an authorized prescriber, consent (per requirements identified in procedure), and initiate a comprehensive assessment of the patient and the patient's behavior prior to the application of restraints.

**Assessment**

In addition to the requirements set out in the policy and procedure, assess and document the following information:

1. History of physical or sexual abuse, post-traumatic stress disorder or history of trauma.
2. Patient's cognitive functioning, physical limitations and special needs.
3. Patient's ability to communicate (receptive and expressive).
4. Patient's physical and mental health status including pre-existing medical conditions/physical disabilities and limitations that would place the patient at greater physical risk (including neurological, pulmonary and cardiac conditions).
5. Current medications being used and illicit drug use.
6. Information about aggressive behaviours including triggers, frequency, patterns and types of aggressive behaviours usually exhibited by this patient. Also obtain from patient, parent, or alternate decision-maker, known best responses to aggressive behaviours.
7. Past history of aggressive behavior (i.e. assaults, damage to property, etc.), self-injuring behavior, or any other information relevant to the provision of care and patient's response to previous restrictive interventions.
8. Alternatives which could be effective in decreasing the need for the use of restraint (i.e. predictable routine, single room, room closer to nursing station, TV in room, increased supervision, one-to-one care, family presence, and exercise).
9. Consultations with other health care team members such as social workers, psychologists, child life worker, etc.
10. Any additional information that could minimize the use of and/or guide the use of restraint/seclusion.

Communicate regularly with patient, family, and/or alternate decision-maker.
APPENDIX C

Restraints - Emergency Department

1. Patients who receive the following:
   - Adult patients who receive more than 10 mg of haloperidol intramuscularly or haloperidol in combination with benzodiazepines (orally, intramuscularly, or intravenously);
     OR
   - Pediatric patients who receive a second dose of haloperidol or a single dose of haloperidol combined with benzodiazepines (orally, intramuscularly, or intravenously).

   1.1 Require:
   - Observation as determined by the health care team.
   - Documentation of vital signs (blood pressure, heart rate, respiratory rate, oxygen saturation) as per unit protocol.

     Supplemental oxygen should be administered to patients demonstrating any respiratory depression (dyspnea or limited breathing) and/or oxygen saturations less than 92 percent.

     NOTE: If patient has chronic hypercapnia (a carbon dioxide retainer), an oxygen saturation of 88 percent may be reasonable, and oxygen therapy may not be required. An order from an authorized prescriber for oxygen is required in this population.

     - Level of consciousness using Glasgow Coma Scale documented every hour, or more frequently as patient condition warrants.

   1.2 Once pharmacologic restraint is effective, the mechanical restraints should be removed. Continue monitoring patient as per the pharmacologic restraint monitoring process.

2. For patients requiring environmental restraint (such as a locked secure/seclusion room), the following applies:

   2.1 If the patient is in a locked seclusion room, the patient must be within direct sight of a health care professional at all times.

   2.2 If mechanical or pharmacologic restraint is in effect, monitor patient as per section 1.1 above.

   2.3 Patients in seclusion must also be assessed for:

     2.3.1 signs of injury associated with seclusion;

     2.3.2 psychological status; and
2.3.3 readiness for discontinuation of restraint or seclusion.

2.4 When mechanical devices are in use, the door of the room shall never be locked.

2.5 Protective Services may be accessed for assistance and risk management.

3. Emergency Department staff may maintain the use of restraints that have been applied by Emergency Medical Services or law enforcement personnel until the patient is assessed by an Emergency Department physician/nurse practitioner.
## Restraints – Continuing Care

### When a resident is at risk of restraint

1. Engage the interdisciplinary team, patient/alternate decision maker, and family to look for alternatives to restraint and underlying causes of behaviours that may lead to the use of any type of restraint,
   
   1.1 Consider that behaviours may occur as a response to the person’s unmet needs or the environment. Identify potential triggers for the resident and minimize them.
   
   1.2 If removal of triggers does not reduce targeted behaviour, rule out delirium;

2. Track targeted behavior(s) for a minimum of three days prior to implementing a restraint in a non-emergency situation.
   
   2.1 Review the documentation to identify behaviour patterns and possible alternatives to restraint.

3. Modify/develop a plan of care based on assessment and behaviour tracking information. Determine if an alternative to restraint is appropriate.

4. Continue tracking behaviour on a behaviour map after the initiation of the restraint to assess the impact of the restraint.

5. Consider external consultation in the development of the plan of care, such as allied health, specialized geriatric services, mental health/psychiatry.
   
   Note: Agitation is known to increase when restraint is used.

### Pharmacological Restraint

1. Reduced dosing is recommended for antipsychotic medication.

2. In the order describe the intended goal of the medication on the targeted behavior.

3. Ensure the pharmacological restraint is being prescribed for a behaviour where there is known efficacy. Behaviours that are NOT responsive to antipsychotic use include:
   
   ✓ wandering/exit seeking
   ✓ hoarding
   ✓ inappropriate dressing
   ✓ repetitive behaviours or vocalizations
   ✓ eating in-edibles
   ✓ interfering with others
   ✓ tugging/removing mechanical restraints
   ✓ inappropriate elimination

4. Monitor for side effects of antipsychotic medications.
4.1 Extrapyramidal side-effects including akinesia (inability to initiate movement) and akathisia (inability to remain motionless) and tardive dyskinesia (e.g., repetitive tongue protrusion/lip smacking).

5. Implement falls prevention strategies.

6. Track behaviour each shift for the first three days and with any subsequent change in dose or frequency.

7. If the pharmacological restraint is deemed appropriate for long term management, reassessment of behaviour and the order shall occur:
   - weekly for a minimum of one month
   - a minimum of monthly by the most responsible health practitioner prescriber and multidisciplinary team

8. Discontinuation

8.1 When the pharmacological restraint is no longer required, the authorized prescriber shall document instructions regarding the process for gradual dose reduction and discontinuation.

**Resources**


[Alberta Government Continuing Health Service Standards (CCHSS) FAQ 16.3](http://www.health.alberta.ca/services/continuing-care-standards.html)
## Type of Restraint

<table>
<thead>
<tr>
<th>Physical: The direct application of physical holding techniques to a patient that involuntarily restricts their movement.</th>
<th>Monitoring/Reassessment of Orders</th>
<th>Why This Restraint Should be Avoided</th>
<th>What does 'least restraint' look like?</th>
<th>Assess Patient For:</th>
</tr>
</thead>
</table>
| Ensure holding technique allows for unobstructed airway and effective respiration. Each patient should be assessed on an individual basis to determine appropriate monitoring level. | Can cause fear, mistrust of caregivers, depression, bruising and injury. Can increase agitation and aggression. In the elderly skin tears and bruising are common results | Least amount of physical force to keep patient or others safe while preparing alternative action; e.g., mechanical restraint, Code White, etc. Health care providers using skills taught at courses such as Supportive Pathways and Non-Violent Crisis Intervention | ✓ pain  
✓ discomfort, pressure or trauma associated with the use of restraints  
✓ the possibility of injury from entrapment or fall  
✓ skin breakdown  
✓ deconditioning  
✓ delirium  
✓ unprotected airway  
✓ circulation and range of motion in the extremities | For all restraint use, document the following as applicable:  
• assessment of the patient;  
• alternatives used/considered  
• reason for restraint  
• consent obtained  
• description of the incident  
• consideration of underlying causes  
• patient's response to the restraint  
• identified triggers  
• adherence to the care plan;  
• alternative interventions attempted;  
• duration of restraint application;  
• observations during monitoring;  
• evaluation of the outcomes  
• discussion with family / support  
• reassessments and ongoing alternative strategies  
• family / support present  
• type of restraint  
• date and time of restraint application and health care practitioners involved  
• discontinuation of restraint, by whom, date and time, and a description of the patients response and/or outcome. |

### Mechanical: Items include, but may not be limited to:
- bed-side rails, seatbelts that cannot be un-fastened by the patient, chairs with locking table tops, Broda/Geri chairs, any limb restraint, mitt, and/or any positioning device that is not intended to enable occupation or promote function (see Definition section).

Does not include safety restraints used in everyday care of children; e.g., high chairs, crib rails, car seats, etc.

| Monitor per program protocol, or at minimum:  
• every 15 minutes for the first hour;  
• every hour within the first 24 hours; and then  
• ongoing at a minimum of every two hours; or more often if indicated by manufacturer instructions  
For 4-point restraints, every 15 minutes until restraint discontinued.  
Each patient should be assessed on an individual basis to determine if more frequent observation is appropriate.  
Acute Care - reassess orders every 24 hours.  
Continuing Care – reassess:  
• with significant change in the resident’s responsive behavior;  
• quarterly for mechanical. | Increased distress and anxiety  
Increased risk of delirium  
Risk of skin breakdown, aspiration, strangulation  
Depression, humiliation  
Loss of muscle strength and increased risk of falls | At a minimum every two hours, or more often if recommended by manufacturer recommendations or patient condition:  
• mobilize the patient as often as possible. E.g., walk with and assist to the bathroom every 1-2 hours while awake, until stronger and less likely to fall  
• provide range of motion exercises, and/or reposition the patient  
• release the restraint | For additional assessment requirements for pediatrics, refer to Appendix B – Restraints Pediatric Patient Population. |

For additional documentation requirements for pediatrics, refer to Appendices B – Document per unit standards using an approved AHS/Covenant Health documentation tool.
<table>
<thead>
<tr>
<th>Type of Restraint</th>
<th>Monitoring/Reassessment Requirements</th>
<th>Why This Restraint Should be Avoided</th>
<th>What does 'least restraint' look like?</th>
<th>Assess Patient For:</th>
</tr>
</thead>
</table>
| Pharmacological: | Monitor per requirements as identified by product monograph. Each patient should be assessed on an individual basis to determine if more frequent observation is appropriate. | Side effects; e.g., confusion, insomnia, increased agitation, restlessness, and paradoxical effects. Adverse events (e.g., interactions with other medicines). | The lowest possible dose shall be used for pharmacological restraint. Administering the lowest dose that allows the person to stay calm, awake and mobile. | ✓ Pain  
✓ Discomfort, pressure or trauma associated with the use of restraints  
✓ The possibility of injury from entrapment or fall  
✓ Skin breakdown  
✓ Decedenting  
✓ Delirium  
✓ Unprotected airway  
✓ Circulation and range of motion in the extremities  
✓ Changes in behavior or level of agitation  
✓ Nutritional status – thirst / hunger  
✓ The need for toileting / elimination (e.g., constipation)  
✓ Hygiene  |
| Environmental: Items include, but may not be limited to: | Each patient should be assessed on an individual basis to determine frequency of monitoring requirements. | Increased distress and anxiety  
✓ Depression, humiliation  
✓ Loss of muscle strength and increased risk of falls  | Allowing the patient as much freedom as reasonable and in alignment with the Managed Risk Agreement (CH Policy #VII-C-55, Managed Risk Agreement) | For additional assessment requirements for pediatric, refer to Appendix B – Restraints Pediatric Patient Population. |

**Locked Seclusion Rooms:**  
1. Patient must be on constant observation.  
2. Audio visual surveillance does not replace staff observation.  
3. When the patient appears to be sleeping, staff shall monitor patient for respirations.  
Reassessment of ongoing use shall occur as per program protocol.  

For all restraint use, document the following as applicable:  
- Assessment of the patient;  
- Alternatives used/ considered/trialed  
- Reason for restraint  
- Consent obtained  
- Description of the incident/behaviour  
- Consideration of underlying causes  
- Patient's response to the restraint  
- Identified triggers  
- Adherence to the care plan;  
- Alternative interventions attempted;  
- Duration of restraint application;  
- Observations during monitoring;  
- Evaluation of the outcomes  
- Discussion with family / support  
- Reassessments and ongoing alternative strategies  
- Family / support present  
- Type of restraint  
- Date and time of restraint application and health care practitioners involved  
- Reassessments and ongoing alternative strategies  
- Discontinuation of restraint, by whom, date and time, and a description of the patient's response and/or outcome.  

For pharmacological restraint, in addition to the above:  
- Document the behavior of the patient;  
- Use behavior mapping per program protocol  
- Implement and chart alternative interventions and consequences; and  
- Evaluate the outcome if medication is considered.  

Document per unit standards using an approved AHS/Covenant Health documentation tool.  
For additional documentation requirements refer to Appendices.