Posting Date: 2021-02-18 edit
Posting History Dates: 2000-09-13, 2008-02-19, 2016-05-25, 2018-11-13 Draft Review, 2019-11-20
Next Review Date: 2020-11-20

Title: IPC - Restraint Protocol

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Title: IPC – Restraint Protocol

Applies to: All Staff and Physicians at Hamilton Health Sciences (HHS).

Safety Alert: At HHS, only physicians are authorized to order restraints including chemical restraints.

1.0 Purpose & Goals

HHS aspires to provide safe, therapeutic and clinically appropriate care and services in a restraint free environment.

1.1 The purpose of this protocol is to outline the standards of practice for the use of restraining interventions/devices including the care of the patient when restraints must be used as a last resort.

1.2 This protocol applies to all inpatient and ambulatory settings (emergent and non-emergent patient care situations) at HHS where the use of physical (i.e. hands-on and mechanical techniques), environmental, or chemical interventions/devices restrict movement or behaviour. Such interventions/devices support the plan of care and can be used for restraining (also see Appendix: Managing Strategies for Incapable Adult Patients requiring Restraint Interventions during COVID-19 Situations for additional guidance.

1.3 This protocol excludes patient care situations where the use of an intervention or device that restricts movement is deemed necessary to transport a patient, carry out a procedure, investigation, or therapy safely for a set time and with constant supervision (e.g. holding a patient for a very brief period of time to do an x-ray).

2.0 Guiding Principles

2.1 HHS is committed to providing appropriate medical treatment to patients and ensuring a safe environment for patients, visitors, volunteers and staff. Patient autonomy, dignity and mobility must be respected at all times and facilitated as much as is reasonably possible while maintaining a safe, therapeutic environment.

This policy is written in compliance with:
(1) the Ontario *Health Care Consent Act,1996*, which sets out the elements of valid consent and the test for determining capacity with respect to decisions concerning treatment, admission to care facilities and personal assistance services;

(2) the Ontario *Patient Restraints Minimization Act, 2001*, which governs the use of patient restraints in public and private hospitals; and

(3) the Ontario *Mental Health Act*, which sets out documentation requirements with respect to the use of restraints in psychiatric facilities. Please note that Hamilton Health Sciences is a designated psychiatric facility under the *Mental Health Act*.

(4) Common Law, a right and a duty to restrain [the patient] when necessary to protect them, other patients, or others lawfully on the premises (staff or other patients) from harm and to prevent endangerment to the safe environment of the hospital or facility.

2.2 Appropriate care in a safe and respectful environment for patients, visitors, volunteers and staff at HHS is the priority. The use of restraints within HHS must be respectful, considered and responsible using the following principles:

- Assessment, prevention and alternative approaches to restraint use are first explored.
- De-escalation, intervention and crisis management strategies are employed in a timely way.
- Restraints are used as a last resort, and only for the shortest duration of time reasonably possible, where there is a serious risk of bodily harm to the patient or others, and when prevention, alternative approaches such as de-escalation and crisis management strategies have failed to keep the individual or others safe.

Restraints are never used for the purposes of discipline, coercion, staff convenience, or as a replacement for adequate levels of staff.

2.3 Any program-specific guidelines related to restraint use must be consistent with this protocol.

3.0 Equipment

3.1 Only HHS approved equipment is to be used (see HHS Approved Equipment List).

3.2 Staff must have easy access to current manufacturer's guidelines for HHS approved equipment, being used as a restraining device. An up to date inventory of manufacturers' guidelines will be made available.

4.0 Policy

4.1 Interdisciplinary Decision-Making

4.1.1 The health care team is responsible for using knowledge, skill, and judgment to determine the appropriate restraining intervention/device or combination thereof that meets the needs of the patient and is aligned with the principles above.

4.1.2 Restraining interventions/devices are considered temporary and must be discontinued as soon as is reasonably possible. The potential for discontinuing the restraining intervention/device and the use of alternatives must be continuously reviewed by an assigned health care practitioner throughout each shift using the SBAR assessment framework outlined in Interdisciplinary Decision-Making Using "SBAR", and the restraining intervention/device discontinued as soon as is reasonably possible.

4.2 Consent from the Patient/Substitute Decision-Maker (SDM)

4.2.1 NON EMERGENT SITUATIONS

In reviewing options (restraining interventions/devices and their alternatives), the health care team must discuss the benefits and risks of each option with the capable patient or SDM (where the patient is incapable) prior to collaborative decision-making regarding the inclusion of restraining interventions/devices in a plan of care. This care plan will be reviewed by the team with the patient and SDM (where the patient is incapable) for ongoing use or non-use of restraining interventions/devices (see MAC - Consent, Withdrawal or Refusal of Consent for Treatment Policy).

Documented informed consent is required before a restraining intervention/device can be applied unless the circumstances constitute an 'emergent situation' as set out in Emergent Situation below.

4.2.2 EMERGENT SITUATIONS

In an emergent situation a restraint may be used in the absence of consent when immediate action is necessary to prevent serious bodily harm to the person or to others (Common law). (see Restraining Interventions/Device Application in an Emergent Situation and Appendix: Managing Strategies for Incapable Adult Patients requiring Restraint Interventions during COVID-19 Situations).

4.3 Physician Order Requirements

All restraining interventions and devices require the order of a physician. For emergent situations see Restraining Interventions/Device Application in an Emergent Situation.

At HHS, only physicians are authorized to order restraints including chemical restraints.

4.4 Approved Devices

4.4.1 Only restraining interventions/devices listed in the HHS Approved Equipment List (see HHS Approved Equipment List) may be used.

4.4.2 Proposed revisions or additions to the HHS Approved Equipment List must be presented to the HHS Restraints Best Practice Committee for approval prior to use (see Request for New Restraining Interventions/Devices).

4.4.3 On approval, the HHS Restraints Best Practice Committee will provide direction to update the HHS Approved Restraining Interventions/Devices List.

4.5 Use of Restraining Interventions/Devices
General Principles

4.5.1 All restraint prevention strategies and reasonable alternatives (see Appendix: Preventative Interventions/Possible Alternatives to Restraint Use) should be considered prior to the use of restraint and all reasonable alternatives should be attempted. The use of restraint must never be for punitive reasons.

4.5.2 Restraining interventions/devices should only be used as a last resort when there exists an imminent risk of serious bodily harm to the individual or others, and where no other less restrictive intervention would be effective.
Wherever possible, staff should provide patients and/or SDM with a choice of available restraint options, and patient's selected restraint should be implemented.
Staff should provide the patient and/or SDM with an explanation of the preparation and application of the restraint.

4.5.3 Debriefing with the patient and/or SDM after initial use of a restraining intervention/device is a necessary component of the process and can assist with preventing future scenarios requiring the use of a restraining intervention/device. Debriefing should include a summary of the application of the SBAR process (see Interdisciplinary Decision-Making Using "SBAR").

4.5.4 All physical (hands-on and mechanical), environmental and chemical restraining interventions/devices must be applied or used according to this protocol and program-specific guidelines. In addition, all mechanical (physical) restraining devices must be applied according to the manufacturer's instructions.

4.6 Restraining Interventions/Device Application in an Emergent Situation
(see Appendix: Managing Strategies for Incapable Adult Patients requiring Restraint Interventions during COVID-19 Situations).

4.6.1 When immediate action is necessary to protect a patient or others from serious bodily harm a health care provider can initiate a physical (i.e. hands-on and mechanical techniques), or environmental restraint without consent and without a physician's order. The physician's order must be obtained as soon as is reasonably possible following the initiation of the patient's restraint if the restraint use is to continue (Please note re **chemical restraints**: A physician's order is required **prior to administration**).
The consent of the patient's SDM should be obtained where possible and as appropriate.

4.6.2 Emergencies are time-limited. The restraining intervention/device must be removed when the situation no longer meets the 'emergent situation' criteria set out in section 4.2.2 above (i.e., there is no longer imminent danger to the patient or to others).

4.6.3 The SDM (where patient is incapable) and physician must be contacted at the first reasonable opportunity to advise of the use of the restraining intervention/device.

4.6.4 The team uses the SBAR process outlined in Interdisciplinary Decision-Making Using "SBAR" to determine whether the intervention is required on an ongoing basis and appropriate consent and orders are obtained.

4.6.5 In all cases where restraining interventions/devices have been used, debriefing with staff should be conducted to provide opportunity for learning, reflection, quality improvement and team support. Debriefing with the patient is also necessary in order to establish strategies to prevent the need for restraint in the future.

4.7 Program and Staff Responsibilities

4.7.1 Clinical Programs have an ongoing responsibility to:

- Ensure all levels of staff have education, training and regular updates regarding the restraint policy and procedures, and the application and use of equipment.
- Provide access to manufacturers' instructions for the use of restraining devices.
- Develop program-specific guidelines (as required) to direct the application of this protocol to the specific program's patient population.

4.7.2 Staff are responsible to remain current and competent regarding this protocol.

5.0 Procedure - Use of Restraining Interventions/Devices

5.1 Interdisciplinary Decision-Making Using "SBAR" (Situation, Background, Assessment, Recommendations) [see Appendix: Interdisciplinary Decision-Making Using SBAR Flowchart].

Using the SBAR framework the health care team:

S -	Reviews the patient safety/risk **situation** • What is the patient doing?
B –	Reviews the **background** to the situation • Why is the patient doing this? • What is the underlying cause? • When or under what circumstances is the situation occurring? • Where does the situation occur? Considers the patient's: • Cognitive status (psychosis, delirium, confusion) • Mental status • Medical status • Physical status (hunger, fatigue, pain, substance use/withdrawal) • Functional status • Psychosocial factors (loneliness, sadness) • Culture • Environmental factors/triggers • Capacity for decision-making (see MAC - Consent, Withdrawal or Refusal of Consent for Treatment Policy) • History of use of restraining interventions/devices • Trauma history
A -	**Assesses:** • Alternatives tried and results, which could include - ° Removing triggering stimulus when possible. ° Moving patient to a more or less stimulating environment. ° Moving other patients out of the area if the patient cannot be safely moved to an alternative location. ° Diversion strategies (i.e. music, food, conversation) ° Communicating clearly with the patient – be direct – set behavioural limits – explain the progression of intervention should the behaviour continue. ° Asking the patient what measures help meet his/her behavioural expectations. ° Observational care (see NUR - Patient Observational Care Protocol). ° Risks and benefits of all possible alternatives for responding to the safety/risk situation (see Appendix: Preventative Interventions/Possible Alternatives to Restraint Use for alternatives). • Risk and benefit of using restraining interventions/devices or choosing not to use one. Risk for potential harm could include: ° Bruising, skin abrasions ° Loss of balance

	° Emotional responses including depression, anger and humiliation ° Serious life threatening medical complications including cardiac event, fractures, asphyxiation and strangulation.
R -	**Recommends**: Document a plan of care related to alternatives and/or use of restraining interventions/devices.

5.2 Obtaining Consent

- Outline goals of care, care plan and intervention options within plan including restraint use.
- Describe risks and benefits of the restraint proposed.
- Provide patient/SDM with information on how they can be involved in patient care (see Restraint – Patient and Family Information pamphlet).
- Through discussion with patient and SDM, obtain informed consent for the use of the restraint(s).
- When conflict emerges the team works collaboratively with the patient and SDM to resolve issues. If needed the team or patient and family can access support through the Patient Experience office or through the clinical ethics office.
- Document treatment goals, plan and consent as per HHS standards.

5.3 Obtaining a Physician's Order for a Physical, Environmental and Chemical Restraining Intervention/Device

5.3.1 An order for a physical or environmental restraining intervention/device must include:

- Specific behaviours requiring the use of restraint.
- Specific type of restraint.
- Any additional clinical monitoring required such as vital signs and their frequency (refer to Application and Care when using Physical, Environmental and Chemical Restraining Interventions/Devices for standard care of patient while a restraining intervention/device is in use).
- Behavioural criteria for termination of intervention/device.

Note: The reassessment date for discontinuing or reordering a restraining intervention/device by the physician needs to be determined by each program and outlined in the program-specific guidelines of the particular program. The need for the use of the restraining intervention/device must be continually reassessed (a minimum of every shift) and as described in Assessing the Continuing Need for a Restraining/Intervention Device.

5.3.2 Chemical restraints can be ordered ***by physicians only*** (i.e. when psychoactive medications are ordered for the purpose of chemically restraining patient). An order for a chemical restraint must include:

- Clinical indication for use and be specified on the order that it is "For Restraint"
- Name of medication, dose, route and frequency
- Frequency of vital signs and level of monitoring required

Note: Whenever possible, chemical restraint medication should always be administered via the least intrusive route, e.g. oral route should be considered and offered to the patient before an injection route.

5.4 Application and Care when using Physical, Environmental and Chemical Restraining Interventions/Devices

The restraining intervention/device is noted in the plan of care which includes specific type, purpose, and plan for care and evaluation.

5.4.1 **Physical (Hands-on) Restraining Intervention**

Application of Physical (Hands-on) Restraining Intervention

The only hands-on restraining interventions that may be used are those approved and included in program-specific guidelines (e.g. Safe Management, Nonviolent Crisis Intervention (NCI) techniques, and Gentle Persuasive Approaches (GPA) techniques).

5.4.2 **Physical (Mechanical) Restraining Device**

Application of a Physical (includes Mechanical) Restraining Device

1. Any clinical member of the health care team, competent in application of a restraining device, can apply a device once it has become part of the plan of care.
2. Where possible and appropriate, patients should be provided with a choice in available restraint options and that choice should be followed.
3. Staff will consider the type of assistance they need for the safe application of mechanical restraint, i.e. additional staff, security team. If necessary, a situation lead is assigned among staff to communicate with the patient, fellow staff and security (if present).
4. Patient privacy should be maintained whenever possible when applying mechanical restraints while ensuring staff have adequate room to safely perform the procedure.
5. Manufacturer's instructions must be followed when applying mechanical restraints.
6. When using mechanical restraints on a stretcher or bed, place the stretcher/bed (on which the restraints are applied) in its lowest position, closest to the ground.
7. A mechanical restraint key must be accessible to all staff in the area, out of reach of the patient, and in a consistent location as per unit guidelines.

Care of Patient in Mechanical Restraints

1. On initiation of any new device:
   - Patient observation must occur at a minimum of every 15 minutes.
   - Patient's response to the device must be assessed.
2. If after two hours restraints remain clinically indicated and there are no serious observable untoward effects:
   - The patient must be observed, care provided, and the device released a minimum of every two hours – see below under "Exceptions" for limb restraints, Pinel restraints, and other exceptions.
   - If any serious observable untoward effects are noted, the clinical team members will reassess the situation and return to observing at a minimum of every 15 minutes.
3. Clinical staff are responsible to assess, monitor and document (in the health record) the following:
   - The patient's response to being restrained.
   - The effects of the restraint including assessing for pain and/or discomfort.
   - Assessing the placement and condition of the restraints.
   - Monitoring and assessing the need for continued use of restraint.
   - Assisting the patient to toilet every two hours or as required.
   - Provide frequent oral fluids and regular meals.
   - All additional documentation requirements indicated in Documentation section of this protocol.
4. Clinical staff are responsible for communicating the following to the patient/SDM:
   - Explanation of the purpose of the mechanical restraint.
   - Identification of the behaviour which necessitated the use of mechanical restraint.
   - Behavioural indications for the removal of the mechanical restraint.
   - Exploration of the process of reintegration into the therapeutic milieu.

Exceptions:

1. Limb and Pinel Restraints:
    - Circulation and skin integrity of restrained limbs and pressure areas must be assessed at a minimum of every 30 minutes or more often if clinical findings suggest that more frequent assessment is indicated.
    - Patient must be repositioned hourly, or more frequently if clinically indicated, while awake, with a minimum of two staff present, one limb unsecured at a time. Passive range of motion and skin care of each limb in sequence (as each limb is released) must be performed.
    - Vital signs must be monitored and recorded every four hours, or more frequently as ordered, or if clinically indicated.
2. If the patient's responsive behaviour prohibits safe release/removal of the restraining intervention/device every two hours, team decisions and rationale are documented. Release of the patient from the device at the earliest opportunity must be facilitated.
3. In the event that a patient is sleeping in a restraining intervention/device, the staff must assess and use clinical judgment to determine whether the device should be released and this assessment must be documented.

5.4.3 Environmental Restraining Intervention/Device

Definition

"Any barrier or device that limits the locomotion of a patient and thereby confines that person to a specific geographic area or location" (University of Iowa, 1997). Examples of environmental restraints include a secured unit, locked seclusion/time out room, bed rails, wheelchair wheel-locks, wheelchair tray, and tilt chair.

Application of Environmental Restraining Intervention/Device

1. Any clinical member of the health care team competent in the application of a restraining device can apply an environmental device once it has become part of the plan of care
2. Where possible and appropriate, patients should be provided with a choice in available restraint options and that choice should be followed.
3. Manufacturer's instructions must be followed when applying environmental restraints. See link to manufacturer's instructions.
4. See below for specific considerations related to the use of environmental restraining devices:

- **Bedrails**
    - The potential for serious injury is more likely to be related to a fall from a bed over the bedrails than from a bed with a lowered bedrail.
    - Full rail beds: Two full rails up is considered a restraint.
    - Split rail beds: Four split rails up is considered a restraint.
    - Bedrails are **not** considered a restraint if applied for the purposes of: facilitating turning and repositioning within the bed, transferring in or out of bed, providing (as requested by the patient) a feeling of comfort, security or a reminder to the patient of the bed perimeters or that this is a hospital bed, or facilitating access to bed controls; and will be removed if the patient requests that the rails be lowered.
    - Bedrails are **not** considered a restraint if required in conjunction with medically indicated devices that are intended to stabilize a body part such as traction.
    - Care is to be taken when positioning and adjusting bedrails to ensure that any spaces between the rails and mattress or parts of the bed minimize the risk of entrapment of the patient's head or body.
    - Consideration is given to the size and physiological condition of the patient and an assessment of the bedrails made to ensure the spacing between the bars of the rails is not wide enough to present a hazard.

- **Bedrails on Stretchers**
  - The potential for serious injury is more likely to be related to a fall from a stretcher without raised bedrails, than from a stretcher with rails in use. Staff is expected to assess the relative risk of using bedrails compared with not using them for each patient.
- **Wheelchair Wheel Locks(brakes)**
  - The application of wheel lock(s**) is considered a restraint if**:
    1. they restrict freedom of movement by preventing the patient from mobilizing his/her wheelchair as they prefer
       AND
    2. They cannot be removed independently by the patient.
  - Wheel locks are **not** considered a restraint if the patient requests them and they would be removed by staff upon request.
  - Wheel locks are **not** considered a restraint when they are applied for the purpose of stabilizing a wheelchair during transfers.

Chair Trays

- The application of a chair tray **is considered a restraint if**:
  1. It restricts the patients ability to rise from the chair or move as preferred
     AND
  2. It cannot be removed independently by the patient
- A chair tray is not considered a restraint if the patient requests it and it would be removed by staff upon patient's request.
- A chair tray must not be used with any patient to manage aggressive or violent behaviours.
- If a chair tray is being used for any reason, consideration should be given to the added use of a lap belt for positioning to prevent the patient from sliding below the table.

- **Tilt Wheelchair**
  - Use of a wheelchair in tilt position **is considered a restraint if**:
    1. The use of tilt restricts movement i.e. wheelchair mobility or rising from the chair.
       AND
    2. The patient cannot independently remove the tilt position.
  - Use of a wheelchair in tilt position is **not** considered a restraint if tilt is used for the purpose of facilitating and/or maintaining an upright trunk posture and it will be removed at the request of the patient or the patient is capable of removing it independently.
- **Seclusion and Secured Units**
  - Seclusion rooms and secured units are considered environmental restraints.
  - HHS recognizes that some patient care areas are locked units. In such cases, locked units will be considered a form of environmental restraint under this protocol. However, such situations will not require an order on the patient's chart for environmental restraint.
  - Each program that utilizes a secured unit or seclusion rooms is required to develop their own practice guidelines related to environmental restraints.
  - Patient or SDM needs to give informed consent prior to being admitted into a locked unit or the unit that uses seclusion rooms for the purpose of environmentally restraining patients.
  - As part of the admission process to the unit, patient or SDM (where patient is incapable) needs to be informed about the use of an environmental restraint in a form of secured unit or seclusion room (e.g. Unit Orientation - Information for Patients and Families).

Care of Patient Who is Environmentally Restrained (excluding seclusion and secured units – for seclusion and secured units see program-specific guidelines)

1. On initiation of any new device:
   - Patient observation must occur at a minimum of every 15 minutes.
   - Patient's response to the device must be documented.
2. If after two hours the restraining device remains clinically indicated and there are no serious observable untoward effects:
   - The patient must be observed and care provided a minimum of every two hours.
   - If any serious observable untoward effects are noted, the clinical team members will reassess the situation and return to observing a minimum of every 15 minutes.
3. Clinical staff are responsible to assess, monitor and document (in the health record) the following:
   - The patient's response to being restrained.
   - The effects of the restraint including assessing for pain and/or discomfort.
   - Assessing any risks related to the use of the restraint including risk of falls over a raised bedrail, risk of entrapment when bedrails and wheelchair trays are in use, risk of tipping the wheelchair when wheel locks and tilt are being used.
   - Monitoring and assessing the need for continued use of restraint.
   - Assisting the patient to toilet a minimum of every two hours or as required.
   - Providing frequent oral fluids and regular meals.
   - All additional documentation requirements indicated in Documentation section of this protocol.
4. Clinical staff are responsible for communicating the following to the patient/SDM:
   - Explanation of the purpose of the environmental restraint.
   - Identification of the behaviour that necessitated the use of environmental restraint.
   - Behavioural indications for the removal of the environmental restraint.
   - Exploration of the process of reintegration into the therapeutic milieu.

5.4.4 Chemical Restraining Intervention

Administration of a Chemical Restraining Intervention

1. A situation lead is assigned to communicate with the patient receiving the chemical restraint.
2. Where possible and appropriate, patients should be provided with a choice in available restraint options and that choice should be followed.
3. When a patient undergoes a physical hold to assist with the administration of a chemical restraint (i.e. injection), staff acknowledge this hold as a physical hands-on restraint (See Application of Physical (Hands-on) Restraining Intervention above).
4. This event is communicated to the patient's SDM (if applicable) and documented accordingly.
5. Patient privacy should be maintained whenever possible when administering a chemical restraint while ensuring staff have adequate room to safely perform the procedure.

Care of Patient Who Has Received a Chemical Restraint

1. Clinical staff are responsible to monitor and document (in the health record) the following:
   - Identification of medication used, method of administration and time of administration and dosage.
   - Patient's response to the chemical restraint:
     - effects of the restraint including desired and adverse effects
     - mental status including any changes
     - vital signs
   - Intake and output status of the patient as indicated.
   - All additional documentation requirements indicated in Documentation section of this protocol.

- Observations and considerations for any underlying physical/medical issue or complications.

2. Clinical staff are responsible to communicate with the patient/SDM as soon as clinically indicated following the initiation of chemical restraint and inform him or her of the following:
   - Rationale for use of restraint, behavioural indications for the need of the restraint.
   - Name of medication delivered for the chemical restraint.
   - How and where the medication was administered.
   - Patient's response to the chemical restraint.
   - If any physical hold was employed during the administration of the chemical restraint.
   - How staff will monitor the effects of the chemical restraint.
   - Behaviour required to discontinue chemical restraint.

5.5 Debriefing with patient/SDM and staff following the use of a physical, environmental or chemical restraining intervention/device.

5.5.1 Continue to use the SBAR framework to guide decision-making for the patient.
A post restraint discussion must be conducted following the initiation of a restraining intervention or device.

5.5.2 The purpose of debriefing with the patient/SDM is to:
- Explore the patient's perceptions of the event.
- Re-establish therapeutic rapport.
- Identify any necessary changes to the treatment plan.

5.5.3 The purpose of debriefing with all involved staff members affected by the experience is to:
- Determine the physical/emotional well-being of staff.
- Identify strengths and weaknesses in the clinical response.
- Identify the need for any process improvements.
- Learn from the experience.

6.0 Assessing the Continuing Need for a Restraining/Intervention Device

6.1 A minimum of every shift, the assigned health care provider must:
- Assess the continued need for the restraining intervention/device.
- Assess whether that level of restraint is still required.
- Explore alternatives to the restraining intervention/device.

6.2 If this assessment points to a change in level of restraint, the restraining intervention/device must be discontinued. Consultation should occur with other health team members working that shift and a trial of the alternative conducted and assessed.

6.3 Notify physician and obtain new orders if required.

6.4 Update patient/SDM and obtain consent if required.

7.0 Documentation

The clinical members of the health care team must clearly document that a restraint has been used. The following must be clearly documented in the patient's health record:
- The physician order for restraint.
- A description of the behaviour of the patient that required that the patient be restrained.
- Alternatives contemplated and/or attempted and subsequent outcomes (where applicable).
- Rational for choice of restraint device including team discussions if applicable.
- Consent conversation with patient/SDM (in non-emergent situations) see Obtaining Consent.
- A statement that the patient was restrained.
- Specific device used, time of application/administration, frequency and duration of use.
- When a chemical restraint is used see MAR for details of dosage, frequency, and route.

- Care including any assessments, interventions and patient responses as outlined in Application and Care when using Physical, Environmental and Chemical Restraining Interventions/Devices.
- Ongoing reassessment of the continued need for restraint.
- Communication with the patient/SDM (as appropriate).

Documentation of the above information occurs in the established location in the electronic/paper health care record as outlined by the program and/or site specific guidelines.

8.0 Definitions

Chemical Restraint: "Any form of psychoactive medication used not to treat illness, but to intentionally inhibit a particular behaviour or movement" (RNAO, 2012, p. 19).

Emergent Situations: Circumstances where immediate action is necessary to prevent serious bodily harm to the person or to others.

Environmental Restraint: "Any barrier or device that limits the locomotion of a patient and thereby confines that person to a specific geographic area or location" (University of Iowa, 1997). Examples of environmental restraints include a secured unit, locked seclusion/time out room, bed rails, wheelchair wheel-locks, tilt chair.

Physical Restraint (Mechanical and Hands-on Techniques)

Mechanical Restraint**:** A device applied to the patient that restricts freedom of movement (e.g. seatbelt that patient cannot release).

Hands-on Techniques: Any nonviolent "hands-on" technique used to restrain the movement of the whole or a portion of patient's body as a means of controlling his/her physical activities [i.e. Safe Management, Nonviolent Crisis Intervention (NCI), Gentle Persuasive Approaches (GPA)].

Patient Care Situations: Refers to the population from neonates to seniors and to all inpatient and ambulatory settings within Hamilton Health Sciences.

Physical Aggression (in an health care context)**:** A heterogeneous phenomenon that can include:

- "Responsive behaviour" – i.e.: hitting, kicking, grabbing, pushing in response to internal or external stimuli not appropriately interpreted by the patient.
- Physical attacks on co-patients, visitors or staff.
- Self-harm.
- Destructive behavior.

Restrain: To "place the person under control by the minimal use of such force, mechanical means or chemicals as is reasonable having regard to the person's physical and mental condition". (*Patient Restraints Minimization Act, 2001*).

Restraining Intervention/Device: Any physical (hands-on or mechanical), environmental, or chemical restraint.

Trauma History: One in ten people in Canada suffer from Post-Traumatic Stress Disorder (PTSD) which can occur when one has experienced an event or events that cause terror, horror, helplessness and physical stress reactions. Events of violence such as sexual assault, child abuse, domestic violence, prisoners of war, terrorism, residential school experiences, etc. can be especially traumatic for the individual. It is essential that possible issues of PTSD be considered for any patient as restraints could contribute to re-traumatization or re-living of the original traumatic event.

9.0 Cross References

EDM - Code White Protocol Flowchart Forms Worksheets
MAC - Consent, Withdrawal or Refusal of Consent for Treatment Policy
NUR - Patient Observational Care Protocol

10.0 Other HHS References

E-learning module on Education Intranet - Restraining Interventions and Devices: The Protocol at HHS

Health Professionals Orientation Presentation - Toward a Restraint Free Environment
HHS Ethics Framework
Patient and Family Centred Care Philosophy
HHS Approved Equipment List
Request for New Restraining Interventions/Devices
Manufacturer's instructions (for mechanical restraints)
Restraint - Patient and Family Information pamphlet PD #4908 09/2018

11.0 External References

Health Care Consent Act, 1996, SO 1996, c 2, Sch A. Available from http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_96h02_e.htm

Ontario Hospital Association. October 2012. A Practical Guide to Mental Health and the Law in Ontario. Toronto, Ontario. Available from http://www.oha.com/KnowledgeCentre/Library/Toolkits/Documents/Final%20-20Mental%20Health%20and%20the%20Law%20Toolkit.pdf

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2019 Consultation/Approval

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Joint Health and Safety Committee (yearly requirement - as of December 2018)
Patient and Family Advisory Committee
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15.0 Appendices:

Appendix: Preventative Interventions/Possible Alternatives to Restraint Use
Appendix: Interdisciplinary Decision-Making Using the SBAR Process
Appendix: Managing Strategies for Incapable Adult Patients requiring Restraint Interventions during COVID-19 Situations

Keyword Assignment	restraining, restrain, restraints, Safework, COVID, COVID- 19, COVID-19

Preventative Interventions/Possible Alternatives to Restraint Use

Many situations that require the emergency use of restraint are preventable. HHS expects all staff to employ restraint prevention strategies and exhaust all alternatives to restrain prior to their application in both emergency and non-emergency situations.

Prevention of the use of restraining interventions/devices starts with assessment and use of alternative approaches, such as:

- Acknowledging and recognizing patient and family strengths, as well as skill deficits
- Developing and using individualized patient safety plans
- Developing and using individualized treatment plans
- Providing staff education in alternative strategies to prevent and diffuse escalating situations.
- Examples of current staff education programs include:
- Safe Management
- Nonviolent Crisis Intervention (NCI)
- Gentle Persuasive Approaches (GPA) in Dementia Care

Restraint alternatives should be chosen according to the type of patient situation encountered, i.e. a person who slides down in a chair will need a different alternative than a person who is prone to falling from a standing position.
The application of restraints or their alternatives should only be considered following a thorough patient assessment.
Note: Consider the risks and benefits of each alternative as it applies to each patient

Behaviour/Risk Factor	Suggested Alternatives
Behaviour: Agitation	• Opportunities for regular exercise and pacing in a safe area • Routine positioning (Q2H) • Medication review • Pain relief/comfort measures • Regular toileting • Normal schedule/individual routine • Assess for basic needs such as hunger, pain, heat, cold • Increase social interactions • Redirect with simple commands • Relaxation techniques • Gentle touch • Assessing past coping strategies • Involve family in planning care • Diversional activities: pets, puzzles, crafts, cards, snacks, humour, music, singing, conversation, audio visuals, photo albums, poetry or reading passages, phone calls to family etc. • Scheduling daily naps • Pacing permitted

Preventative Interventions/Possible Alternatives to Restraint Use (cont'd)

Behaviour/Risk Factor	Suggested Alternatives
Behaviour: Wandering Assess if wandering is: Purposeful - Patient actively seeks an exit -- there is "intent" or Benign - Patient is aimlessly wandering and will get himself into an unsafe situation if the opportunity presents itself -- there is no direct "intent".	• Assess for basic needs such as hunger, pain, heat, cold • Accompany person on walks • Label environment e.g. bathroom door • Increase social interactions • Redirect with simple commands • Involve family in planning care • Use stop sign to prevent entry • Clutter free rooms • Night light • Room close to nursing station • Use glasses, hearing aids, walking aids • Memory boxes/drawer for client to rummage through • Diversional activities: pets, puzzles, crafts, cards, snacks, humour, music, singing, conversation, audio visuals, photo albums, poetry or reading passages, phone calls to family etc. • Opportunities for exercise and pacing in a safe area • Promote activity during day to ensure sleep at night • If unable to sit for meals offer finger foods/fluids regularly and allow person to walk • Regular toileting • Normal schedule/individual routine • Gentle touch • Schedule daily naps

Behaviour: Responsive Behaviours
(i.e.: punches, kicks, hits, grabs)
	• Use GPA approach –
	  ○ Stop and Go - Do not insist on providing care, leave and re-approach later
	  ○ Recognize and diffuse escalating situations
	  ○ Protect oneself, patient & co-patients from harm
	• Medication review
	• Pain relief/comfort measures
	• Normal schedule/individual routine
	• Assess for basic needs; hunger, pain, heat, cold
	• Increase/decrease social interactions
	• Relaxation techniques
	• Assessing past coping strategies
	• Involve family in planning care and enlist their help when possible

Preventative Interventions/Possible Alternatives to Restraint Use (cont'd)

Behaviour/Risk Factor	Suggested Alternatives
Behaviour: Responsive Behaviours (cont'd)	• Opportunities for exercise and pacing in a safe area • Diversional activities: pets, puzzles, crafts, cards, snacks, humour, music, singing, conversation, audio visuals, photo albums, poetry or reading passages, phone calls to family etc. • Smile, keep voice calm and friendly • Obtain a psychiatric/geriatric consultation • Provide care in pairs, and during times when the patient is receptive. • Place soft objects such as sponges/wash cloths in the patient's hands prior to care delivery for those with grasp reflex • Reduce noise/stimulus in the environment • Consider bathing alternatives i.e. a warm towel bed bath if a shower or tub bath is not tolerated • Assign consistent staff members that have a good rapport with the patient • Prior to initiating care, explain to the patient in simple terms the care you would like to provide
Behaviour: Interfering with treatments, pulling out tubes, resisting insertion of tubes Assess whether the patient's interference with treatment is purposeful or benign, i.e. whether the patient is attempting to send a specific message or whether he is just fidgeting.	• Evaluate whether treatment goals can be achieved by alternate methods • Eliminate tubes that are causing distress as soon as feasible • Consider use of IV sleeves, long sleeve shirts, alternative sites, time of day of treatment • Provide distractions from tampering with tubes by using diversional activities , visits from volunteers, family and friends • Assess and treat for delirium • Keep pain-free and comfortable • Assess for basic needs; hunger, pain, heat, cold • Consider use of Observational Care

Preventative Interventions/Possible Alternatives to Restraint Use (cont'd)

Behaviour/Risk Factor	Suggested Alternatives
Risk Factor: Falls **Note:** It is important to rule out reversible acute problems and identify chronic medical conditions and treat each appropriately. • For every patient, there is an individual level of risk for falls that is acceptable to the patient or his substitute decision maker (SDM). • The patient or SDM needs to be provided with clear information regarding the risk for falls versus the risk of restraint use so that an informed decision can be made. • The level of risk that one person may consider acceptable, may be very different and totally unacceptable for another person or for staff. Ultimately, it is the patient/SDM's decision.	• Medication review • Regular toileting • Opportunities for regular exercise and pacing in a safe area • Routine positioning (Q2H) • Increased participation in ADL • Pain relief/comfort measures • Normal schedule/individual routine • Assess for basic needs; hunger, pain, heat, cold • Use glasses, hearing aids, walking aids • Increase social interactions • Redirect with simple commands • Call bell education and demonstration • Involve family in planning care • Diversional activities: pets, puzzles, crafts, cards, snacks, humour, music, singing, conversation, audio visuals, photo albums, poetry or reading passages, phone calls to family etc. • Schedule daily naps • Clutter free rooms • Consider low height bed • Use of non-slip socks • Falls mat beside bed if person non-ambulatory • Night light/leave bathroom light on • Acceptance of risk • Bed and/or chair alarms/sensors • Supervised walking program • Hip protectors • Motion sensor in room • Consult with physiotherapy and occupational therapy

Preventative Interventions/Possible Alternatives to Restraint Use (cont'd)

Behaviour/Risk Factor	Suggested Alternatives
Risk Factor: Bed-Exiting Assess exiting method, determine the reason, detect patterns, resolve obvious issues	• If non ambulatory set bed in lowest position • If ambulatory assess for appropriate height of the bed to facilitate safe transfer • Use of low height beds • Side of bed against the wall • Keep one or both top rails up to facilitate rolling/transfers • Bed alarm • Routine positioning (Q2H) • Pain relief/comfort measures • Q. 30 minute checks • Assess for basic needs; hunger, pain, heat, cold • Night light/bathroom light left on • Choose room near nursing station • Companion/family/volunteer to sit with patient • Ensure call bell within reach • Hip protectors while in bed • Falls mat bedside bed if person non ambulatory • Minimize excessive noise/activity • Wheelchair/ heavy stationary chair/lazy boy chair beside bed • When using pressure relieve mattresses select one that will keep the overall height of the bed low and does not promote sliding (i.e. V4 mattress with Roho or RIK mattress) • Motion sensor in room
Risk Factor: Sliding from wheelchair	• Routine positioning (Q2H) • Pain relief/comfort measures • Monitor and adjust sitting tolerance (time up in chair) • Call bell education and demonstration • Wheelchair seating assessment by OT • Use of anti-slip wheelchair cushion cover

Posting Date: 2021-02-18 edit
Posting History Dates: 2000-09-13, 2008-02-19, 2016-05-25, 2018-11-13 Draft Review, 2019-11-20
Next Review Date: 2020-11-20

Title: IPC - Restraint Protocol

Appendix: **SBAR Flowchart**

Situation, Background, Assessment & Recommendations (SBAR) Flowchart

Use an SBAR Assessment when considering the use of restraints or alternative.

S - Situation
Review the patient safety/risk **situation:**
- What is the patient doing?

B – Background
Review the **background** to the situation:
- Why is the patient doing this?
- What is the underlying cause?
- When or under what circumstances is the situation occurring?
- Where does the situation occur?

Consider the patient's:
- Cognitive status (psychosis, delirium, confusion)
- Mental status
- Medical status
- Physical status (hunger, fatigue, pain, substance use/withdrawal)
- Functional status
- Psychosocial factors (loneliness, sadness)
- Culture
- Environmental factors/triggers
- Capacity for decision-making (Link to HHS Consent Policy)
- History of use of restraining interventions/devices
- Trauma history

Able to resolve without use of restraints or alternatives

Yes

No

A – Assess
Assess for possible use of alternatives or restraints with Risks and Benefits
Could include:
- Removing triggering stimulus when possible.
- Moving patient to a more or less stimulating environment.
- Moving other patients out of the area if the patient cannot be safely moved to an alternative location.
- Diversion strategies (i.e. music, food, conversation)
- Communicating clearly with the patient – be direct – set behavioural limits – explain the progression of intervention should the behaviour continue.
- Asking the patient what measures help meet his/her behavioural expectations.
- Observational care (link to "Patient Observation Care Protocol").
- Risks and benefits of all possible alternatives for responding to the safety/risk situation (see Appendix: Preventative Interventions/Possible Alternatives to Restraint Use for alternatives).

Risk and benefit of using restraining interventions/devices or choosing not to use one.
Risk for potential harm, such as:
- Bruising, skin abrasions
- Loss of balance
- Emotional responses including depression, anger and humiliation
- Serious life threatening medical complications including cardiac event, fractures, asphyxiation and strangulation.

R – Recommend - Document plan of care related to alternatives and/or use of restraining interventions/devices.

R E A S S E S S

Managing Strategies for Incapable Adult Patients requiring Restraint Interventions during COVID-19 Situations

NOTE: This Addendum is part of the HHS IPC - Restraint Protocol and as such it needs to be utilized within the context of the Restraint protocol and other relevant HHS polices including HHS MAC - Consent, Withdrawal or Refusal of Consent for Treatment Policy.

In the event of a COVID -19 outbreak on a hospital unit[1], the need may arise to restrain, including to confine patients who are incapable at the time with respect to a restraint intervention decision. Incapable patients may have difficulty following infection control directions to remain isolated in their room to avoid contracting or spreading COVID-19, which places all patients and staff at risk of serious bodily harm, especially those patients with demographic characteristics or comorbidities that put them at heightened risk of severe complications from COVID-19 infection. An example of one such behaviour that presents an increased risk of harm to self or others within the COVID-19 context is wandering (see Appendix: Considerations for Wandering Behaviour in Patients with Dementia below).

Incorporating restraints into the *incapable* patient's Plan of Treatment

In cases when all appropriate alternative approaches for the patient to prevent harm to self or others have been exhausted (see Restraints Protocol for Preventative Interventions/Possible Alternatives to Restraint Use), the use of a "restraint" with informed consent will be part of a **plan of treatment.** As soon is possible, a proactive discussion should be initiated by the physician with the incapable patient's SDM about including a restraining intervention as a last resort in the plan of treatment if there is a significant infectious disease risk. The discussion should include seeking consent at that time.

As part of obtaining informed consent, the risks and benefits of the restraining intervention should be explained, including the desired outcome of avoiding serious complications, including death, arising from a COVID-19 infection in the patient and other co-patients and staff on the unit.

Emergency Situation

If informed consent to restrain the patient is **not** obtained during the proactive discussion, then the patient or SDM should be advised that restraints may be used in an "emergency" situation to prevent the patient from either inadvertently spreading COVID-19 if positive, or contracting COVID-19, if currently negative. The recommendation for a restraining intervention, including the proposed method and reasons for the recommendation, as well as the content of discussion with the patient or SDM and their voiced reason for refusing consent, should be clearly documented in the patient's chart.

Managing Strategies for Incapable Adult Patients requiring Restraint Interventions during COVID-19 Situations

The definition of ***Emergent Situation*** under HHS' Restraint Protocol recognizes the common law duty imposed on health care providers and caregivers to restrain a person, without consent, when immediate action is necessary to prevent serious bodily harm.

In addition, during the COVID-19 pandemic, certain patient situations are considered exceptional and, where the following conditions are met, a person may be restrained without consent, when immediate action is necessary to prevent serious bodily harm, and other reasonable alternatives to restraining have been exhausted:

- the patient does not have capacity to follow Infection Prevention and Control strategies and as a result puts self and others at immediate risk for harm. For example, the patient may be wandering out of their room and into other patients' space, and/or not wearing a facial mask as required
  AND
- there is a significant risk of contracting or spreading COVID 19 (and therefore they or others are at risk for serious bodily harm) because either the unit is in COVID-19 outbreak *OR* the patient has COVID-19 *OR* there is a patient (s) with COVID 19 on the unit and a wandering patient is likely to enter that room.

The SDM should be notified in the event of the use of restraints, using this notification as an opportunity for a further discussion with the SDM about the inclusion of safety measures in the plan of care.
When those two conditions on page 2 are met, **and a restraint has been used**, a follow-up discussion takes place as soon as possible with the SDM and includes:

- Informing the SDM of the outbreak
- Informing the SDM that this is considered an emergency situation due to risk of severe complications of COVID -19 for the patient and for other patients
- Informing the SDM (if not informed already) that during these exceptional times it may become necessary to restrain in order to prevent the spread of COVID-19. Explain that it may again become necessary to restrain without prior consent, explain the circumstances under which we would do so, and provide all of the information we would normally cover as outlined in the Restraint protocol, and explain that we will alert the SDM if it has become necessary to use restraint(s), and describe how we will mitigate risk.
- Advising the SDM that in the event that restraint is necessary, the team will endeavour to use the least restraint possible; and
- Advising the SDM of how the patient will be monitored and reassessed.

*** All of the above discussions should be documented in the patient's health record.**

Managing Strategies for Incapable Adult Patients requiring Restraint Interventions during COVID-19 Situations

Ethical Considerations

The COVID-19 pandemic has precipitated a shift from care focused on individual patients to care from a public health ethics perspective centering on minimizing illness, death, and community disruption.

Pandemic ethics frameworks seek to protect the greatest number of community members while not placing overly burdensome restrictions on individuals. This **utilitarian** perspective is justified in a public health emergency.

Given the limitations to individual liberty that come with pandemic restrictions, we need to be particularly careful to preserve a sphere of individual autonomy and dignity for our patients.

Though we are making community protection our foremost goal, treatments, interventions, and care plans should reflect least restrictive measures. Restrictions should be carefully considered, **proportionate** to the risks involved, and fair. To promote **fairness**, we need to treat patients in equal proportion to their individual need so that patients with equivalent needs will receive equivalent care.

Within the context of restrictions, we should continue to seek opportunities to enhance patient well-being. Providing quality care for COVID-19-positive patients with cognitive issues will require collaborative multidisciplinary teamwork.

To maintain trusting relationships with patients and their loved ones, clinicians, staff and administrators should be able to explain the reasons for restrictions in **transparent** communication and to provide clarification to facilitate understanding.

Health care professionals have a **duty to care**, i.e., to use their knowledge and skills for the betterment of patients. With COVID-19, the duty to care for patients must be balanced with the duty to self, family and others but must not lead to patient abandonment.

Our leaders in administration owe a reciprocal duty of care to staff to ensure that they do not experience harm to physical, emotional, or mental health while caring for COVID+ patients with cognitive issues. Given the complexity of this vulnerable population and the massive changes in health care caused by COVID-19, it is not unexpected that clinicians may experience **moral distress**. Ethics, Psychospiritual Care, and Resiliency resources are available to all staff.

Managing Strategies for Incapable Adult Patients requiring Restraint Interventions during COVID-19 Situations

Applying a fair process for decision-making that is transparent, inclusive, publicly defensible, and iteratively reviewed, should guide decision-making and help foster and enhance trust.

The risk of COVID-19 affects all people in an institutional setting. We are guided in our endeavor to care for the vulnerable population of COVID-19-positive patients with cognitive issues by upholding the following ethical values:

Ethical Value	Description	Application in COVID-19 Pandemic
Respect for Persons	All persons have an inherent worth and deserve to be treated to in a manner to maximize their dignity and autonomy	• Persons with wandering behaviours that pose a risk to self or others deserve to be treated with respect and dignity • Limits to autonomy should be the least restrictive necessary to reduce potential harm • Persons with cognitive impairments may lack the ability to understand the need for isolation and may be unable to understand or articulate how this negatively impacts them. This vulnerability should help inform an incremental approach to mitigate risk. • Absent emergency situations, consent for use of restraints should be obtained
Equity	Similar cases should be treated similarly and dissimilar cases should be treated in a manner that reflects the dissimilarities	• COVID positive or suspected patients should be treated comparably to other patients that pose the same degree of harm to self or others, e.g. similar to other patients on droplet precautions • Apply a fair and consistent process for decision-making on case management • Benefits and burdens should be fairly distributed
Proportionality (Risk/Benefit)	Restrictions on individual liberty (e.g. restraints) should be in proportion to the probability and magnitude of risk of harm posed to self or others	• Patients that are suspected or confirmed COVID positive would pose an increased risk of harm to others • Least restrictive measures should be implemented incrementally only to the point needed to mitigate risk • Safety measures need to be put in place to ensure risk of harm related to restraints is mitigated

Managing Strategies for Incapable Adult Patients requiring Restraint Interventions during COVID-19 Situations

Ethical Value	Description	Application in COVID-19 Pandemic
Reciprocity	Supporting those who face a disproportionate burden from a limitation on movement and taking steps to minimize potential negative impacts to the extent possible	• If restrictive measures are put in place for a patient, specific efforts should be made to mitigate the burden of restrictive measures to the extent possible. o For example, older adults restrained for several days are more likely to develop permanent mobility impairment. Therefore, in addition to providing routine care related to restraint use, consideration needs to be given to a restraining device that allows for a range of motion exercises (e.g., a wheelchair with locks). o Patients who are restrained may feel isolated or abandoned, particularly when they do not understand the rationale for being restrained. Staff must support patients by encouraging family visits (unless contraindicated by the HHS Visiting Policy or if the harm outweighs the benefits), provide access to virtual or other creative support approaches to prevent a feeling of isolation or abandonment. .

Note

[1]Unit is not limited to wards and also includes Emergency Department, Intensive Care Unit, etc.

Reference

[2]Cipriani, G., Lucetti, C., Nuti, A., & Danti, S. (2014). Wandering and dementia. Psychogeriatrics, 14(2), 135-142.

[3]Management Strategies for the Wandering COVID-19 Patient in Acute Care. Alberta Health Services, Covenant Health. August 2020.

[4]The need for restraints as an ongoing treatment needs to be continuously reassessed, recognizing that patient's response to alternatives to restraints may change.

Ethical considerations for managing residents who lack the cognitive ability to adhere to IPAC protocols in long-term care settings. Developed by GTA Ethicists; Lead: Sally Bean. April 2020

Health Care Consent Act s. 7 and s. 25

Patient Restraints Minimization Act s. 6

Appendix: **Considerations for Wandering Behaviour in Patients with Dementia**

Wandering behaviour refers to seemingly aimless or disoriented ambulation (or mobilization, if a patient requires assistive devices such as wheelchairs) throughout the geographic area, often with observable patterns such as lapping, pacing, or random ambulation[2]. While treatment of patients with wandering behaviours can be challenging for physicians and the healthcare team, the following information may help inform behavioural management strategies[3]:

- Wandering is not an uncommon symptom in patients with cognitive impairment.
- Agitation is defined as a state of excessive psychomotor activity accompanied by increased tension and irritability and may include aberrant hyperactive motor behavior such as wandering. It is accompanied by emotional distress and excess emotional lability.
- Majority of these patients are usually redirectable and manageable.
- There are multiple contributing factors to restlessness and wandering.
- Non-pharmacological approaches should be considered the mainstay of therapy, complemented by psychotropic medications only when unavoidable
- There will be conflicting needs between best practice in senior and dementia care whilst balancing infection control considerations to contain transmission and spread of COVID-19.
- These behaviours during COVID -19 outbreak are complex and specialist consultation, such as psychiatry, geriatric psychiatry, behavioural support specialists, geriatricians are encouraged to support the local care team, where feasible.