FNIHB-OR Nursing Policy and Procedure

Section:	**Professional Nursing Practice**	Policy Number:	**II - 23**
Subject:	**Restraints**	Issued:	**March 31, 2015**
		Revised:	
Distribution:	**All Nursing Facilities**		

1. POLICY:

1.1 Alternatives to restraints must be explored prior to the use of restraints. In the event that alternatives have not been successful in eliminating / reducing the risk of harm to self or others, the least restrictive type of restraint will be used for the shortest period of time.

1.2 In non-emergent conditions, the physician shall be consulted prior to the use of restraints.

1.3 The original physician's order for the use of restraints is limited to 4 hours for adults; 2 hours for children ages 9-17; and 1 hour for children under the age of 9. After which the physician must be consulted again for reassessment and on-going plan of care. The original orders may be renewed up to a maximum of 24 hours.

1.4 When a restraint is being used, the client will be monitored at least every hour; and more frequently (at least every 15 minutes) if the client is agitated to monitor for any signs of injury or distress.

2. PRINCIPLES:

2.1 According to *Prevention of Falls and Fall Injuries in the Older Adult* (2002, Nursing Best Practice Guideline, Registered Nurses Association of Ontario), several studies have found that restraints increase the severity of falls and can increase confusion, muscle atrophy, chronic constipation, incontinence, loss of bone mass, decubitus ulcers, emotional distress, and increased agitation. In severe cases, clients have been seriously injured or have died after becoming trapped in a restraint (CNO, 2009).

2.2 Restraints require frequent assessments to prevent injury to the client and to promote removal of restraints at the earliest possible time.

2.3 Ontario government passed Bill 85, the *Patient Restraints Minimization Act*. This Act regulates when and how restraints may be used and addresses the principle of minimal restraint on clients.

2.4 A least restraint policy does not mean that it is acceptable for clients to abuse staff. A No Abuse Policy is still enforced.

2.5 FNIHB-OR offers the Nurses Safety Awareness Training Program (NSAT).

3. DEFINITION:

3.1 **Restraint** refers to physical, chemical, or environmental measures used to control the physical or behavioural activity of a person or a portion of his/her body (CNO, 2009).

3.2 **Physical Restraints** are the use of a device that limits the freedom of movement. (e.g. lap belts, pelvic restraints, mittens, and chairs with locked trays.)

3.3 **Environmental Restraint** involves the use of the environment, including seclusion to or in a time out room, to involuntarily confine a person and to restrict freedom of movement.

3.4 **Chemical Restraint** includes:

i. The use of a psychopharmologic drug not required to treat medical symptoms, for any purpose of discipline or convenience.
ii. A pharmacological intervention intended to control, inhibit or restrict a person's behaviour.
iii. The therapeutic use of any pharmacological agent with the purpose of providing treatment for mental health or associated behaviour is not considered a restraint

3.5 **Nurse:** For the purpose of this policy, Nurse **r**efers to Registered Nurse, Nurse Practitioner and Registered Practical Nurses.

4. PROCEDURE:

4.1 The nurse and/or other staff shall assess the client's behaviour, evaluate the client's risk of injury to self and/or others, and potential adverse effects of using a restraint.

4.2 The nurse shall discuss alternative methods (restraint-free strategies) to address the underlying cause of behaviour with the client, family, or substitute decision maker. If the situation is urgent, de-escalation strategies should be implemented immediately. Document the client's response to the restraint-free interventions.

4.2.1 Non restraint strategies for adults and children are included in **Appendix A** of this policy.
4.2.2 De-escalation strategies from the Nurse's Safety Awareness Training Program are included in **Appendix B**.

4.3 If the restraint-free strategies are ineffective and restraints are deemed necessary, the Nurse will discuss this with the patient and/or family. The Nurse will need to consult with the physician for an order to apply physical restraints.

4.4 Details of the consultation are to be documented in the client's health record. The documentation must include, at minimum:

a. Alternative methods already attempted and the results
b. Description of the client's current behaviour and the evaluated risk of injury to self or others.
c. Type of restraint that is being suggested.
d. Time period that the restraint may be necessary

4.5 The nurse shall obtain consent from the client or family (as clinically indicated) for the use of restraints. Prior consent may not be required in an emergency situation when there is a serious imminent threat of harm to self or others. Once the situation is no longer critical, client consent is required. Details of the consent must be clearly documented in the client's health record.

4.6 If the client, family or substitute decision maker do not give consent for the use of restraints and it is not an emergency, then other methods must be considered. For example a psychiatric consultation for assessment under the Mental Health Act; medical consultation; and/or discharge the client from the health care facility.

4.7 For the procedure on applying restraints, the nurse shall refer to *Clinical Nursing Skills and Techniques 8th ed*. (Perry, Potter, and Ostendorf, W, 2013).

4.8 The nurse must ensure the following safety strategies are employed when using physical restraints to reduce the risk of injury:

4.7.1 Only equipment which has been specifically manufactured as a restraint may be used. These equipment pieces are not to be modified or adapted and must be used in accordance to the manufacturer's instructions.

4.7.2 Attach restraint straps only to the bed frame that supports the mattress not to the bed frame that supports the bed wheels.

4.7.3 If the client is being restrained in bed, he/she must be kept either in fowlers or side lying position with both arms and/or legs secured to the same side of the bed. The client is never to be restrained while in prone position.

4.7.4 The client shall be reassessed at least every hour, while restrained. Increase frequency of monitoring if the client is agitated – every 15 minutes until the client's behaviour has stabilized.

4.7.5 If the client is in 4 or 5 point restraints, the nurse must arrange continuous observation (refer to FNIHB-OR Policy: *Continuous Observation*)

4.9 At minimum, the assessment includes:

a. Respiratory status
b. Level of consciousness
c. Any signs of any injury associated with the restraint
d. Circulation and range of motion in the extremities
e. General physical / psychological status (include nutrition and elimination needs)
f. Skin integrity
g. The need to continue use of the restraint

4.10 Any injuries noted or adverse events should result in stopping the restraint. The injury is to be reported immediately to the supervisor and consulting physician as clinically indicated. First aid is to be administered as needed.

4.11 Discontinue the use of restraints at the earliest possible time – when the client no longer poses a threat of harm to self or others. A physician order is not required to discontinue.

4.12 If pharmacologic agents are used for the purpose of chemical restraints, all orders must be clearly documented in the client's health record, including specific dosage, intervals and the specific condition for which the treatment is required.

4.13 All adverse drug events must be reported promptly to the consulting physician, the supervisor. The adverse event and follow up actions are to be documented in the client's health record.

5. RELATED POLICIES:

FNIHB-OR Policy: Management of Abuse in the Workplace
Nurses Safety Awareness Training Program
Perry, A. G., Potter, P.A., and Ostendorf, W. (2013). Clinical Nursing Skills and Techniques 8th ed. Mosby.
College of Nurses of Ontario (1996). *Ethics*. Toronto, ON.
Registered Nurses Association of Ontario (2012). Promoting Safety: Alternative Approaches to the Use of Restraints. Toronto, ON.

6. REFERENCES:

Alberta Association of Registered Nurses (2003). *Position Statement: The use of restraints in client care settings.*

College of Nurses of Ontario (2009). Practice Standards: Restraints. Toronto, ON.

Government of Ontario (2001 S.O. 2001, CHAPTER 16). Patient Restraints Minimization Act.

Nurses Safety Awareness Training Program (2006). NSAT Participant Guide: Unit 4.

Occupational Health and Safety Agency for Healthcare in BC and Y. Cvitkovich (2005). Preventing Violent and Aggressive Behaviour in Healthcare: A literature review. Vancouver, BC.

Perry, A. G., Potter, P.A., and Ostendorf, W. (2013). Clinical Nursing Skills and Techniques 8th ed. Mosby.

Registered Nurses Association of Ontario (2002). Nursing Best Practice Guidelines: Prevention of falls and fall injuries in the older adult. . Toronto, ON.

Registered Nurses Association of Ontario (2012). Promoting Safety: Alternative Approaches to the Use of Restraints. Toronto, ON.

Approved by:		**Effective Date:**
		March 31, 2015
Director of Nursing, Ontario Region	**Date:**	
Regional Executive, Ontario Region	**Date:**	

Non Restraint Strategies to Prevent Treatment Interference in Adults

Explanation and Reminders

- Frequent verbal explanation
- Guided visualization of device
- Written reminder

Distraction and Diversion

- Activity apron
- Occupational therapy consult
- Writing tools
- Reading material
- Gadgets
- Photo albums
- Washcloths
- Empty tubing/packaging
- Music
- Television

Camouflage

- Long sleeved gowns
- Generous tape, ace wrap or dressings at site
- Commercial device-protective, cushioned sleeve, or IV site guard
- Abdominal binder
- Tubing out of visual field

Comfort and Positioning

- Repositioning/specialty mattress
- Tube stabilizer
- Augmentative communication
- Analgesia/sedation
- Aromatherapy
- Massage/touch therapies

Technologic Reduction

- Discontinue nonessential devices
- Intravenous adaptor
- Replace with less restrictive/less intrusive device

Environment

- Maximize Visualization
- Video camera
- Noise reduction
- Family presence
- Sitter/companion

(RNAO, 2012)

Non Restraint Strategies to Prevent Treatment Interference in Children

- Establish rapport with child and family
- Provide child and family with pertinent information
- Provide child with creative and stimulating activities
- Attach devices in a way that maintains comfort
- Insert devices in locations that do not interfere with natural body movements
- Use camouflage that is lightweight and comfortable
- Use tape judiciously
- Prepare child adequately for stressful procedures
- Engage child while carrying out procedures
- Offer the child choices
- Use guided exploration
- Embrace family-centered care
- Choose interventions that may prevent treatment interference carefully
- Use distraction during stressful procedures

(RNAO, 2012)

APPENDIX B: **De-Escalation Technique**

VERBAL DE-ESCALATION TECHNIQUES

The worker in control of himself or herself

- Appear calm, centered and self-assured, even if you don't feel it.
- Use a modulated, low, monotonous tone of voice.
- If you have time, remove necktie, scarf, hanging jewelry, and religious or political symbols that could be used as weapons against you. However, do not do this if the individual is watching.
- Do not be defensive, even if the insults are directed against you. Do not try to defend the position or roles of your employer or others.
- Be aware of resources available to you for back-up.
- Be very respectful, even when setting limits or calling for help. Agitated individuals can be very sensitive to feeling shamed and disrespected.

The physical stance

- Never turn your back on the individual
- Always be at the same eye level. Encouraged the individual to be seated, but if he/she needs to stand, you should stand as well.
- Allow four times your usual distance between yourself and the individual.
- Do not maintain constant eye contact. Allow the person to look away.
- Do not point or shake your finger.
- Do not touch the person; touching may be misinterpreted.
- Keep your hands out of your pockets, this keeps them available to protect yourself, and sends a non-verbal message that you do not have a concealed weapon.

The de-escalation discussion

- Remember that the main objective is to calmly reduce the degree of arousal to a safer level.
- Do not speak loudly, even if the individual is screaming at you.
- Respond selectively. Answer only informational questions, no matter how rudely asked.
- Explain limits and rules in an authoritative, firm but always respectful tone. Give choices, where possible, as long as every choice is safe.
- Empathize with the person's feelings but not with the behaviour.
- Do not solicit how a person is feeling or interpret feelings in an analytic way.
- Do not argue or try to convince.
- Whenever possible, tap into the person's cognitive mode. Do not say "Tell me how you feel". Instead say "help me to understand what you are saying to me". A person cannot attack you while teaching you what they want you to know.
- Suggest alternative behaviours where appropriate
- State the consequences of inappropriate behaviour without threats or anger.
- Represent external controls as institutional rather than personal.
- Trust your instincts! If you assess or feel that de-escalation is not working, leave immediately and get help.

DO NOT ATTEMPT DE-ESCALATION WHEN A PERSON HAS A GUN OR OTHER WEAPON. WHEN A WEAPON IS INVOLVED, SIMPLY CO-OPERATE AND LEAVE AS SOON AS POSSIBLE

Adapted from NSAT Program (2006)