Policy Name: **RESTRAINTS**	Policy Number: **0226**
	Effective Date: **MAY 9, 1996**
Approved By: Executive Team	Date Revised: November 26, 2018
Reason for Revision: Click on item below and select item from list. **CONTENT- Enter BELOW Reason for change Ex: Combined Policy ## and ##.** New policy – Definitions have changed re: "types of restraints". Complete procedure has changed especially documentation re: "any type of restraint". Policy requiring high attention to staff.	Next Date for Review: November 26, 2021
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Policy

Agapé Hospice follows the philosophy of "least restraint". Physical, chemical and environmental restraints may be used on neurologically compromised residents to protect the safety of the resident and/or others at risk of harm*.* Supportive interventions must be considered, and deemed inappropriate or ineffective, prior to the utilization of a restraint. Prior to considering a restraint, a collaborative approach will be used. The resident and/or the legal representative, and care team will review the risks, benefits, and treatment goals. Documentation, in the resident's health record, of symptoms, restraint and follow through by the Registered Nurse is required.

DEFINITIONS

Mechanical Restraints:

Any manual method, or and physical or mechanical device, material or equipment attached or adjacent to the person's body that the person cannot remove easily and that restricts the person's freedom of movement or normal access to his or her body. It is the effect the device has on the person that classifies it as a restraint, not the name, label given to the device, nor the purpose or intent of the device.

Examples at Agapé include seat belts on wheelchairs, lap tables, lounger chairs and full side rails. Used only when the team has explored all supportive and least restrictive approaches. This may be appropriate when a resident's responsive behaviours, such as uncontrolled symptoms of an agitated delirium or dementia, put themselves or others at risk of serious harm.

Chemical Restraints:	Any psychotropic drug not required for treatment of end of life symptom management, but whose use is intended to inhibit a particular behaviour or movement. **Examples include** using psychotropic and/or sedative medications for responsive behaviours (i.e. wandering or behaviours related to dementia).
Environment Restraints:	The use of environment, including seclusion or a time out room, to involuntarily confine a person and to restrict freedom of movement. **Examples at Agape** include bed alarms. These are used at Nurse's discretion if the Resident is neurologically compromised.

REFERENCES

Alberta Health Services. (2016). HCS-176-01 Restraint (Interim) Procedure. May 20, 2016
College & Association of Registered Nurses of Alberta. (2009). Position Statement on the Use of Restraints in Client Care Settings. June 2009.
Canadian Institute for Health. (2013). Documenting Devices and Restraints (P4). https://www.cihi.ca/sites/default/files/document/p4_jobaid_en.pdf [October 30, 2016]

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Procedure

1. The philosophy of "**least restraint**" must be practiced in our care of residents. Due to the prevalence of delirium at the end of life, all efforts must be made to reverse the cause of the delirium therefore minimizing the use of restraints.

2. Before any physical restraints are used, all efforts are made to have family/volunteer support to stay with the resident to help prevent injury/falls until symptoms are under control. In the event the resident is a risk for elopement or has attempted to elope, a family meeting will be held to discuss options regarding safety.

3. Health advocate/family members need to be made aware of the restraint(s) being used and the reasoning behind it. The Memorandum of Understanding for Admission to Agapé Hospice is signed on admission. Health teaching should be done with family regarding delirium and/or dementia.

4. When a physician prescribes a medication commonly classified as a chemical restraint for end of life symptom management, the indication for use will be provided. This will make it clear to staff when, in the very rare occurrence, the medication is intended as a chemical restraint.

5. In cases where a restraint is being explored, the RN may consider behaviour mapping as an assessment tool

6. A mechanical restraint may be used in the case of an emergency without a physician's order. Use of a restraint requires a physician's order within 72 hours of application. Resident and/or legal substitute decision maker consent must also be obtained.

7. The least restrictive or least impacting form of the restraint must be selected and tried first (e.g. partial rails instead of full side rails).

8. The use of mechanical restraints, when not at the request of the resident, will be monitored:

- **a.** Every 15 minutes for the first hour;
- **b.** Every hour within the first 24 hours;
- **c.** Ongoing at a minimum of every 2 hours.

9. Mechanical restraints will be removed every 2 hours while the resident is awake to provide for skin care and range of motion exercises. If the resident is asleep, assess for tissue perfusion every two hours if the mechanical restraint is in direct contact with the skin.

10. Ongoing monitoring of the need for any type of restraint will be made by the interdisciplinary team.

11. Documentation in the resident's health record and care plan will include:

- **a.** Resident assessment (prior to, during and after the use of restraint);

b. Alternatives tried and considered and the resident's response;
c. Reason for the restraint;
d. Consent obtained;
e. Consideration of the underlying causes;
f. Frequency of monitoring the resident;
g. Strategies to minimize the need for the restraint;
h. Resident's response to the use of the restraint;
i. Monitoring of resident during restraint use;

12. Staff will receive education during orientation and on an annual basis*.*