Restraint as a Last Resort
Pediatric Frequently Asked Questions

The provincial Restraint as a Last Resort policy, along with eight associated procedures, rolled out February 1, 2018. The policy provides direction in decision-making processes around the use of restraints. The principles of restraint as a last resort and least restrictive restraint support a balance between the safety of the patient and others, and restrictions on patient liberty.

Below are common questions asked about Restraint as a Last Resort in Pediatrics. Click here for the general FAQ. As the policy and procedure are implemented, additional questions and answers will be added.

1) What is the difference between comfort holds and restraints?

Restraint is any measure utilized for a patient to restrict the child's movement or behavior where a comfort hold is used to successfully secure and provide comfort to a child for a procedure, therapy or investigation (where appropriate.) Comfort holds are, most often, utilized in collaboration with the patient and family and are incorporated into the plan of care. Comfort positions are about engaging the child and caregiver in the best most comforting approach. This can include a gentle helping hand to keep a limb still or a "hug" from a parent.

2) How do I decide if the way I (as a staff members) hold the child is a restraint? (eg. PIV start, vaccine etc.) What is reasonable?

It is important to consider how you are holding the child. Often care can be justified with the known benefits of the action (e.g. stabilizing a limb to safely administer a vaccine). The known benefits are often necessary in order to deliver the care and meet the outcome (e.g. successfully administering the entire vaccine into the muscle.)
Always consider what is reasonably required to safely perform any medical procedure or task. For example if you require to comfortably position a child while utilizing a safety restraint (e.g. your arm) while completing a diaper change this is reasonable and is necessary, an order is not required for this. Use your own clinical judgement to do assess the situation. If you are unsure ask a colleague or reach out to the below contacts.

** *Slide 23 of the pediatric PowerPoint has great questions to ask yourself prior to creating the plan of care.*

3) The policy states an order is required for all non-emergency restraints but the procedure states only for a pharmacologic, ongoing restraint or in excess if what would be reasonable- when do we need an order?

The procedure is to be followed for pediatric patients. An ordered is required for any pharmacologic restraint, any restraint that is ongoing or any restraint that is required in excess of what is reasonably safe to perform a procedure, therapy or investigation. Clinical judgement should be utilized for the appropriateness of getting an order. Consider collaborating with the health care team including the physician/nurse practitioner to discuss and create the plan but an order may not be required.

4) What about the arm restraints for children post cleft lip/palate surgery?

These are considered mechanical restraints. These are necessary and utilized for the safety of the child. Prior to the known surgery a discussion should occur with the patient and family about expectations post-operative. The wrist restraints should be mentioned including a plan with the team members (e.g. length of time, if patient is being watched can have them removed etc.) Consider collaborating with other health care professionals to help prepare the child about what to expect post-operatively.

5) What constitutes an emergency and when is it okay to use a restraint to perform a medically necessary procedure, investigation or therapy?

Clinical judgement should be used to determine if the situation is an emergency. Emergency treatment/situation cannot be defined. The members of the health care team should decide if what is happening is an emergency and the **least restrict restraint** is to be utilized. Always attempt to address the underlying reasons for the restraint, and discontinue the restraint as soon as possible. Examples of an emergent situation where a restraint may be applied:

- An immediate threat to the safety of patients, caregivers or others (e.g. physical assault, self-harm) and immediate action is required
- As part of an approved treatment or care plan, developed in collaboration with the patient and/or family/caregivers
- The patient's behavior is severely disruptive and negatively impacts or interferes with the care of others, their rest or recovery

In preparation of any task, procedure or investigation that happen outside of an emergency a plan should be made with the patient and family. We want to minimize restraint use and we need to prepare ourselves (as health professionals) and the patient/family of what to expect to ensure the proper techniques are utilized. Every situation may look different.

6) **Does this apply to me in ambulatory?**

Yes. If you are providing patient care you should be utilizing the appropriate procedure.

7) **I need to provide care to a child and require a staff member to help with holding. Can I engage a staff member to assist the child in a comfort hold?**

When a parent or caregiver is unable to be present for the procedure, therapy or investigation another individual may help with supporting the patient. It would be important to ensure a plan of care is made with the child and the child is comfortable with the individual helping.

8) **Does the new policy and procedure apply to things such as IV arm boards, and safety straps on high chairs etc.?**

The Acute Care Inpatient Pediatric policy 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) or in a 'time-out' for the purpose of regaining emotional control. For more information, see Restraint as a Last Resort – Acute Care Inpatient – Pediatric procedure.