Alberta Health Services

Restraint as a Last Resort in Pediatrics

A father told staff that during an ambulatory clinic appointment, a staff member there told him that if "you don't hold down your daughter, I'll find someone who will". He cancelled the appointment and left with his 11 year old daughter. He later explained to staff that he was dumbfounded by this approach.

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In collaboration with

Alberta Children's Hospital

Stollery Children's Hospital

Alberta Health Services

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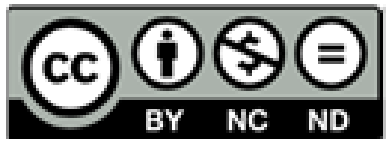


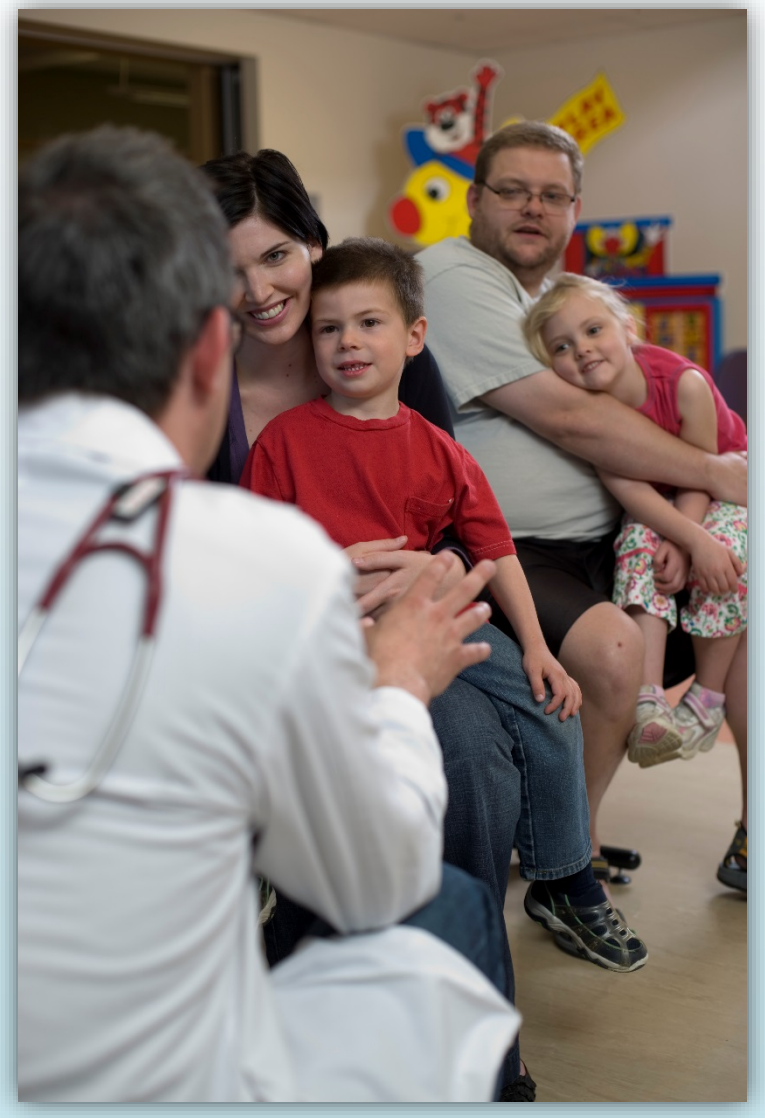
Objectives of this Presentation

- Key elements
- Alternatives
- Resources
- Plan

If you are viewing this in a PDF version ensure you read the speakers notes by hovering over the speech bubble

Restraint as a Last Resort

- Least Restrictive
  - Utilize other strategies
- Shortest time
- Informed Consent
- Safety and liberty
- Applies to anyone working for or on behalf of AHS, including protective services



Principles to guide restraint use

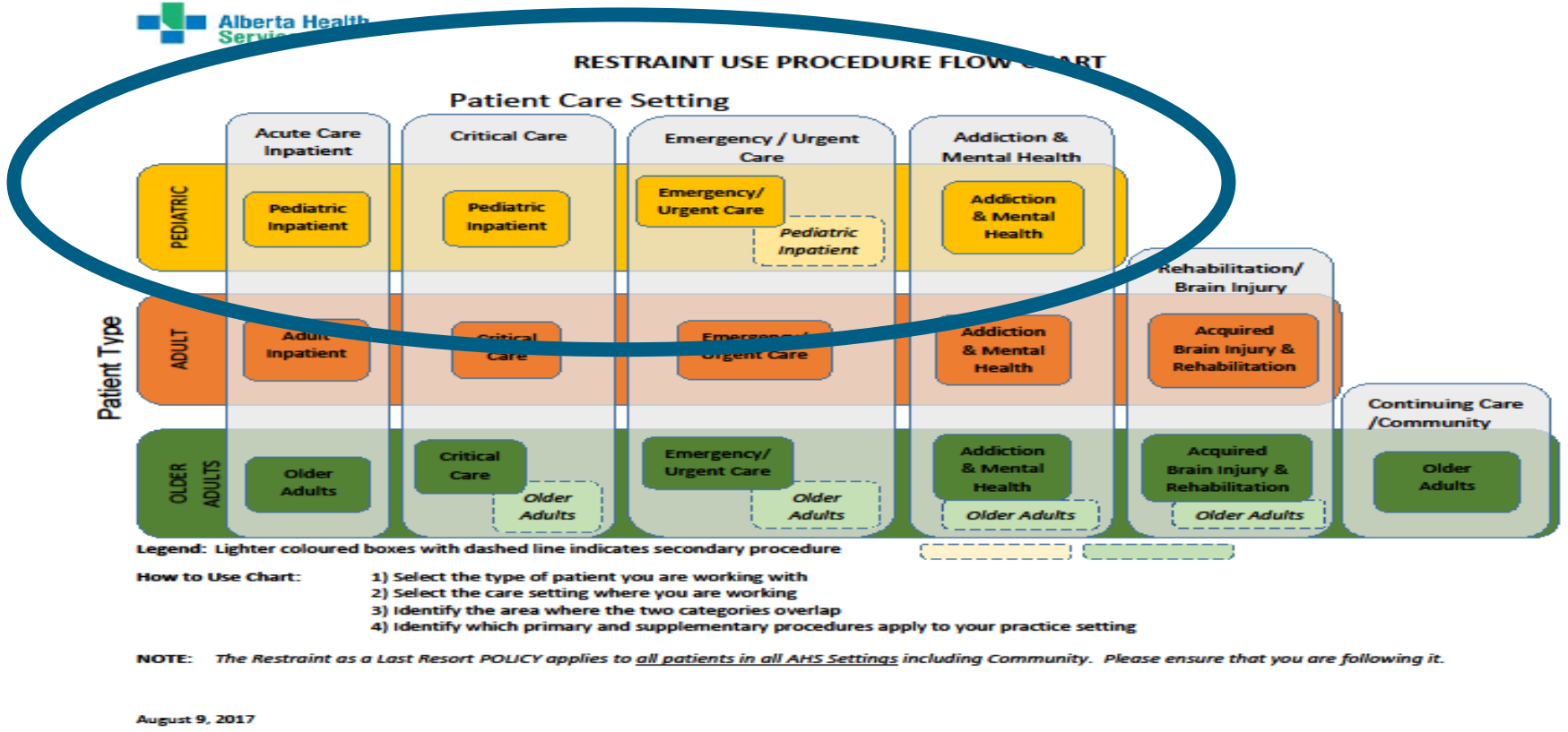
Respect for persons

Maximum benefit and minimum harm

Minimal restriction

Fairness and consistency

Pediatric Procedure Flow Chart



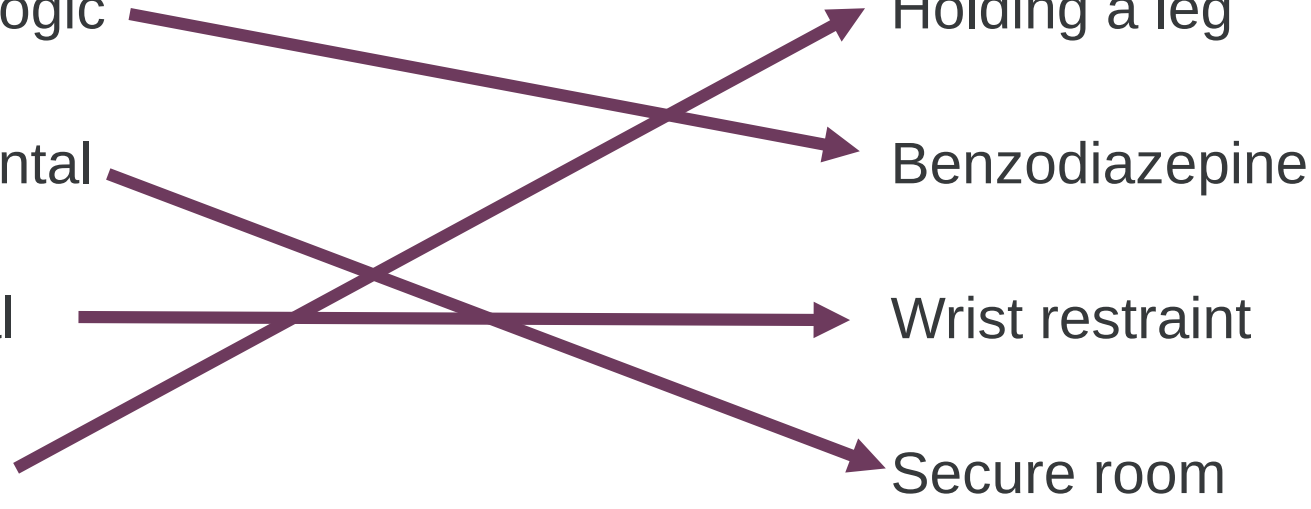
“The moment we restrain a child for a medical procedure is the moment we as health professionals have failed the child. Failed to be respectful, failed to adequately prepare the child and family, and failed to implement developmentally-appropriate evidence-based fear and pain management strategies. And we've already failed when it comes to this child's next procedure, because we've set up a situation that now will only get worse, not better.”

–Dr. Christine Chambers

Types of Restraints

Matching Game

Type	Example
Pharmacologic	Holding a leg
Environmental	Benzodiazepine
Mechanical	Wrist restraint
Physical	Secure room



6 year old: *“All those people held me tight. I couldn’t move. I didn’t like it, it scared me. I screamed and screamed and nobody helped me.”*

Physical Restraint

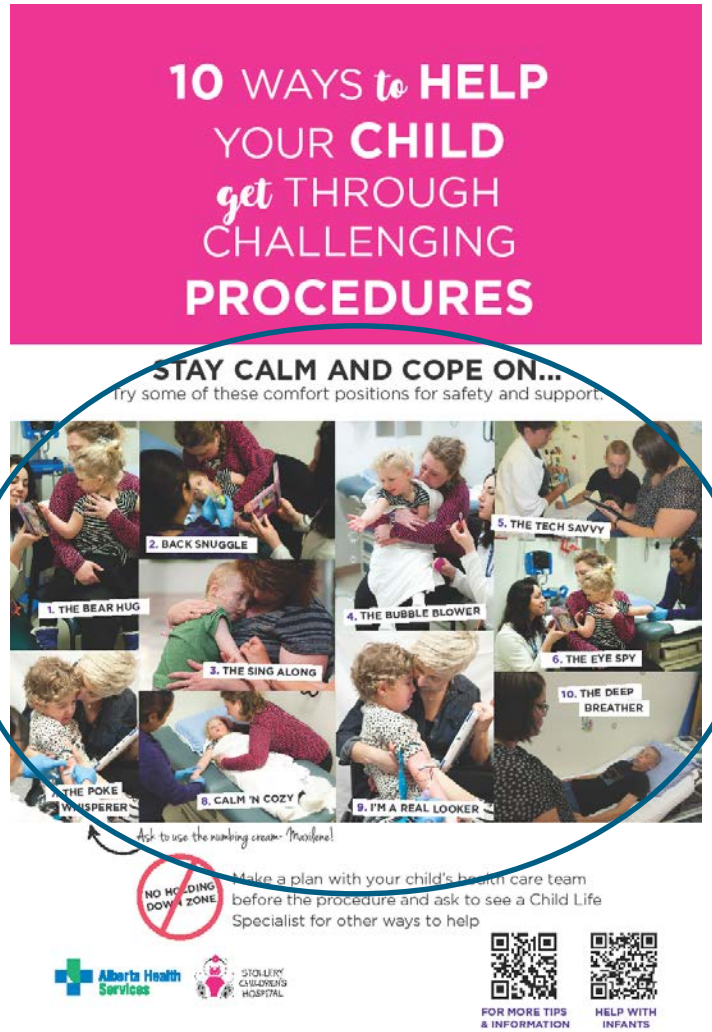
Direct application of physical holding techniques to a patient that involuntarily restricts movement

Examples	Alternatives:
• Holding arm while drawing blood work • Holding patient down while inserting an NG • Holding limbs while completed a dressing change	• Create a plan • Offer caregivers/patient available options/choices (e.g. distraction) • Ask for help from a child life specialist or mental health team • Use positions of comfort (see next slide) • Consider topical anesthetic (if applicable)

If restraint is required:

- Document the situation leading up to restraint event, description and outcome
- Document any use of physical restraint into the patient care record per episode
- Least amount of physical force is used to keep patient &/or others safe while preparing alternative action (i.e. mechanical restraint)
- Reassess as quickly as possible- if not stabilized consider use of mechanical restraint or seclusion
- Watch for signs of distress, requests for release, discomfort, and safety issues.

Ways to help a caregiver help a child



COMFORT POSITIONING:

In hospital, children often need medical procedures that may cause worry and stress. Helping patients and their families through these stressful situations is likely very important to you. Comfort positioning can lead to a more positive health care experience, and can help to build confidence, and resiliency for possible future stressful events. These positions can be used as soon as children have good head and truck control (as early as 5 months) and are very adaptable.




GOALS OF COMFORT POSITIONING

- Successfully immobilizes extremity for procedure
- Offers secure, comforting hugging hold for child
- Comfort through close contact with the parent or caregiver
- Parent or caregiver participates in positive assistance, not negative restraining
- Sitting position promotes sense of control
- Fewer people are needed to complete procedure

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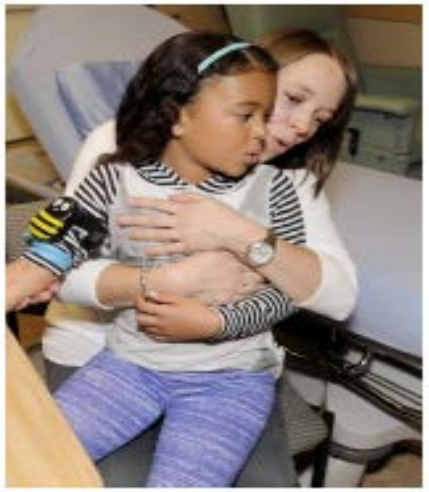


Alberta Children's Hospital Comfort Positioning Poster

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Environmental Restraint

Are barriers or devices that limit the patient's ability to move about and confine them to a specific location

Examples:	Alternatives:
• Secured/Locked Room	• Offer available options/choices • Create a safe environment where patient can be given space • Use time-out (in an unlocked space) or move patient where risk is minimized • Move patient rooms • Encourage family presence

If restraint is required:

Assess patient every 15 minutes until behavior is stable; once stable assess every 30 to 60 minutes (may increase to more frequent if you feel this is required)

Ensure environment is safe for patient

Communicate regularly with patient and/or caregivers

Create care plan to remove environmental restraint as soon as possible

Mechanical Restraint

Any device, material or piece of equipment attached to or near a patient that the patient cannot control or easily move.

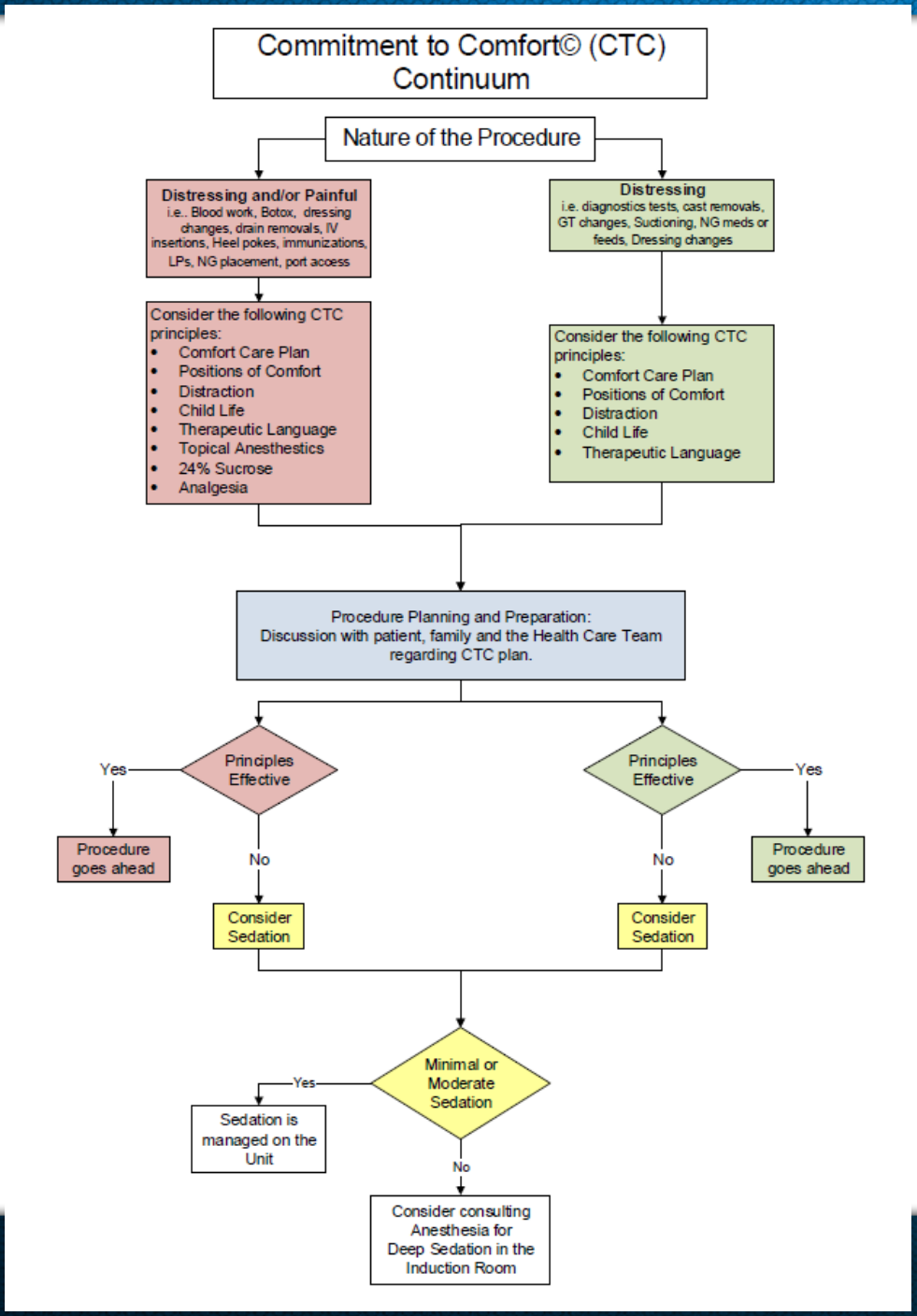
Examples:	Alternatives
• Bed linens/sheets • Wrist restraint • Pigg-o-stat; Octostop (used in diagnostic imaging) • Pinel Restraint	• Use position of comfort (if required temporarily) • Enlist help of other staff • Encourage patient to remain in control • Involve patient/family in decision making • Create a plan prior to (if possible) application of restraint

If restraint is required:

- An order is required for ongoing restraint use; or if required in excess of what is safely reasonable
- Ensure proper application and positioning of device
- Assess skin condition and circulation
- Monitor patient's behavior
- Monitor patient safety
- If applicable, reposition as often as possible (ideally hourly)

Pharmacologic Restraint

Are medications given to control behaviors, actions and/or restrict the freedom of movement	
Examples • Lorazepam • Procedural sedation	Alternatives • Encourage patient to remain in control of themselves • Collaborate with other members of the health care team (e.g. mental health team) • Use medication “as needed” • Discuss options with patient and/or caregiver
If restraint is required: • An order must be obtained prior to administration • Document in the appropriate medication record • Vital signs need to be monitored starting 15 minutes post administration • Communicate any concerns to the most responsible health care provider • Continually assess response to restraint	



Commitment to Comfort Continuum

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When is it appropriate to use restraints?

- Immediate threat e.g. physical assault, self-harm
- Emergency treatment

Assessment – consider:

- Reasons for actions & behaviours
- Patient and family involvement
- Alternate strategies

Are These Restraints?

- Medical tubing
- Constant care/observation
- Arm board
- High Chair/Car Seat
- Crib Rails
- Bed Rails

What does “*reasonably* required to *safely* perform a medically necessary procedure” mean?

- Safety restraints used in every day care

Informed Consent and Restraint

Patients and Families say:

- *Patient and family engagement needs to be the first resort – and restraint the last resort*
- *They want to be asked to help find solutions, and to be involved in decisions*
- *Ask them how the restraint situation makes them feel*
- *When things escalate, staff need to talk with patients/families about strategies they have as professionals to keep people safe*

Questions to ask yourself

1) What are (if any) are the potential harms and benefits associated with the care?
2) What effect does the care have on the individual and/or family?
3) What are (if any) the way to minimize any potential harm?
4) Have the caregivers been consulted? What are their thoughts?
5) Is this action/care similar or dissimilar to more clear-cut, harmful [physical] restraints?

Do patients & families mind?

“Restraint can be associated with physical and psychological trauma to the individual undergoing the procedure and to others including parents and family members in the room.”- Dr. Bruce Dick

“Ethically, “the best interests of the child” principal is often ignored in the interest of the provider to “get the procedure done” the child’s voice is then lost. Children have the right to have their voice heard, and when they have a voice about what needs to be done in their care, their voice needs to be heard. This doesn’t mean they can refuse necessary care, but we need to step back and listen to their voice – their fears, and work together to mitigate these fears.” - Kathy Reid

“In our experience restraining did not work for our child. We felt rushed and the lab was busy so we agreed, but in reality it ended up taking a lot longer to find people to hold her down, and distract her, (while she panicked) than it would have if we hadn't. Since she was panicking it was also lot harder for them to take her blood so they had to make several tries. I think if she would have been given the time she asked for she might of felt more secure in the scary situation and could have built on her coping skills and confidence, making it easier in the future. Being held down set her back on her treatment plan and gave her severe anxiety which has taken us a long time to work through.”

Restraints are NOT used for:

- A form of punishment
- The convenience of the unit/staff
- A replacement for personal attention to the patient
- Accommodating staff shortages/timing
- The staff to reduce the need for supervision/medical treatment for the patient

Documentation

- Assessment of the patient and contributing factors
- Discussions about other strategies with the care team
- Discussions with the person or their decision-maker (informed consent)
- What else you tried – how did the person respond?

Monitoring

- Comfort, emotional distress
- Safety
- Physical needs e.g. discomfort, hydration, toileting, hunger, temperature regulation

Restraint use:
Removing and discontinuing

- Debrief restraint use with patients, staff and families.
- Identify plan for avoiding, reducing or discontinuing restraints

Scenario 1

An 8 year old requires an NG tube for temporary use. She has never had one before. The nurse explains the procedure to the caregiver and offers support of a Child Life Specialist to help prior to insertion of the tube. The caregiver refuses and “just wants to get it over with.” The nurse briefly explains to the patient what is going to happen and asks another nurse to assist with the insertion. An attempt is made and the patient is not cooperative and the caregiver insists on having it inserted “right now.” The nurses both know that in order to complete the task the patient will have to be restrained.

Scenario 1 Questions

- What would you do?
- What are some strategies/solutions?

Scenario 2

6 year old patient is due for routine blood work this morning. The lab staff go into the patients room at 0620 to draw the blood. The patient's Mom is at the bedside. The Mom mentions that previously she was asked to hold the child's arm still while the staff drew blood. It is apparent that the child has memories of this and starts crying while the phlebotomist gets her supplies ready. The Mom is adamant that she does not want to hold her child's arm again.

Scenario 2 Questions

- What are some strategies to help the child and Mother cope with the blood work draw?
- What do you think should be included in the plan on care?

Scenario 3

12 year old boy with PSD/ADHD and abdominal wound with dressing changes every 2 days. The nurse went in to complete the first dressing change. The old dressing was removed and the patient displayed behavior issues. He became upset and combative, the nurse was worried about her safety as well as keeping the wound sterile. She pulled the emergency bell to get help. Two additional nurses came into the room to help with a physical two prong approach.

Scenario 3 Questions

- Do you feel it was appropriate to use a physical restraint in this situation? Was it emergent?
- What steps should be taken next? And by who?

Scenario 4

A 7 year old girl with Rhett syndrome presented to ambulatory care with a caregiver request for something to prevent her from biting her fingers. She has thickened skin and scarring on her fingers, as well as apparent joint deformity. Her caregiver indicates she often has open sores from constantly sucking or biting her hand. The caregiver has seen other children at her child's school with hard plastic splints that stop kids from bending their elbows and would like to use these to get her to "break the habit and let her fingers heal".

Scenario 4 Questions

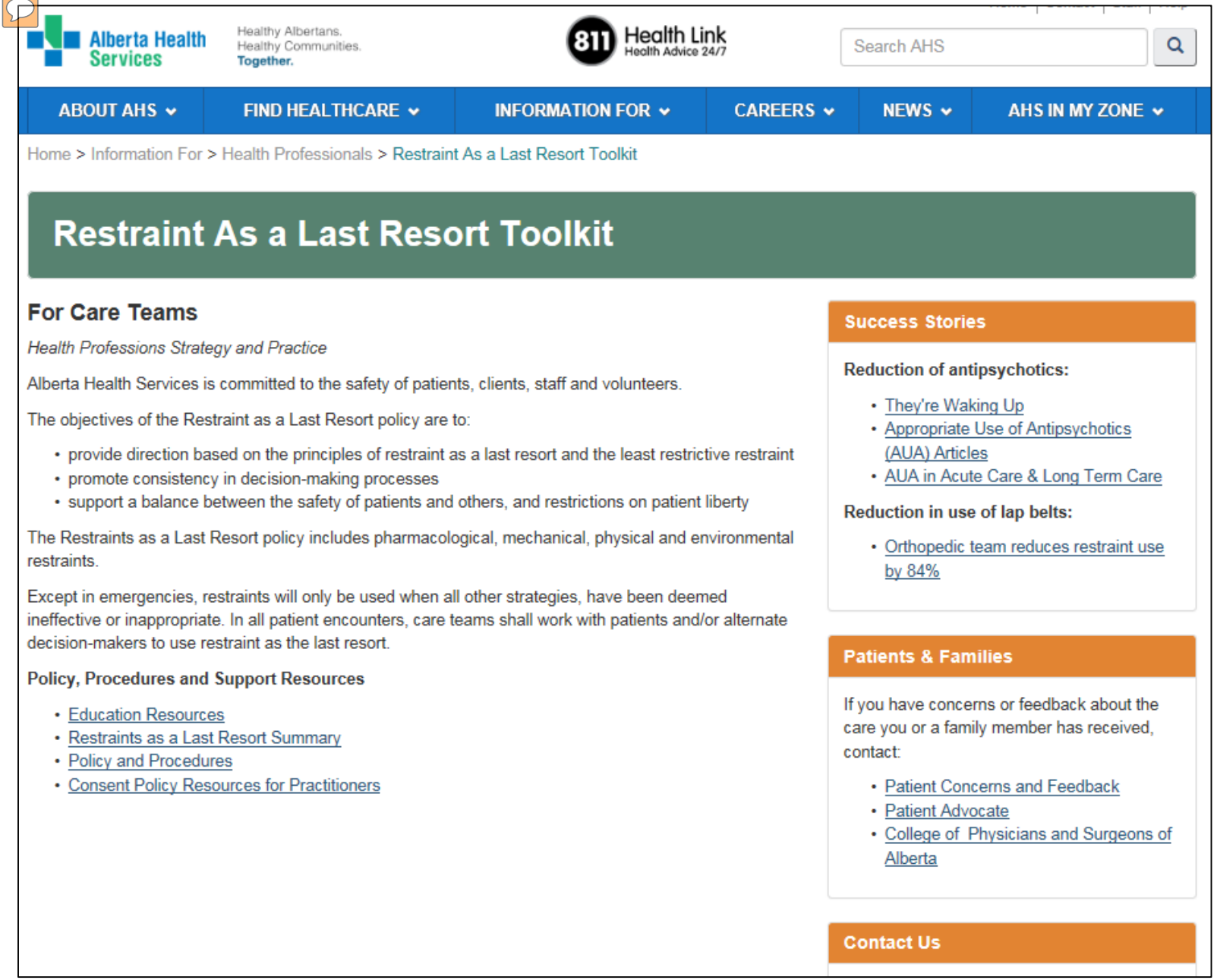
- Should the healthcare provider supply these splints?
- What additional information would be needed to come up with a solution for this problem?
- If a restraint were to be provided, what are the factors that must be considered, discussed, and documented? What would the follow up plan be?

Scenario 5

A 6 year old boy with Cerebral Palsy presents to seating clinic for an adjustment to his wheelchair. He has a positioning belt that is necessary to keep him from falling out of the chair – but he has recently learned to unfasten this belt himself. His parents are requesting a way to prevent him from removing it as they want to keep him safe.

Scenario 5 Questions

- Is a positioning belt considered a restraint? Would it become a restraint if he was unable to remove it on his own?
- What are the risks/benefits to adding a component that prevents him from taking it off?
- Should the health care provider alter the belt?



Restraint as a Last Resort Toolkit

Education resources

Success stories

Posters

PowerPoints

More resources will be added as they become available

https://www.albertahealthservices.ca/info/Page15702.aspx

Questions?
Success stories?
Resources to recommend?

Contact policy@ahs.ca