Alberta Health Services

Restraint as a Last Resort in Acute Care: What's Changed?

1. **Informed consent:** Most legacy policies required the family to be informed after health care teams determined restraint was necessary. The new policy requires collaborative discussions between staff, patients and/or care partners prior to non-emergency restraint use.
2. **Increased acknowledgement of harm related to restraint use:** It is now recognized that restraint has many risks of harm, including damage to the therapeutic relationship, psychological trauma, functional decline, delirium, serious injury and death, poor circulation, heart stress, incontinence, muscle weakness, skin breakdown, infections, reduced appetite, behavioral changes, social isolation and depression.
3. **Greater emphasis on use of alternative strategies:** Some legacy policies instructed the health care team to assess causes of agitation after the patient had been restrained, or to reassess restraint use weekly or monthly. The new emphasis is to try alternatives prior to using any restraint, and to discontinue the restraint at the earliest and safest opportunity. Staff training is required regarding restraint alternatives and appropriate/safe restraint use.
4. **Ordering of restraint:** Some legacy policies included standing orders for restraint. Restraint is no longer standard procedure – it is an unusual response to an unusual situation, and/or the least restraint/lowest dose for the shortest time. A Physician or Nurse Practitioner order is required prior to use of any non-emergency restraint, and prior to pharmacologic restraint in an emergency.
5. **Types and definitions:** Some legacy policies didn't include chemical restraint, while others categorized most forms of restraint as "physical restraint". The provincial policy describes four types of restraint:
    - **Physical:** e.g. restraining limbs to provide emergency or routine care, moving a person to another location against their will
    - **Mechanical:** e.g. limb, waist and trunk restraints, back-fastening seat belt, full bed-side rails, chairs with locking tables, Broda or Geri chairs the person cannot get out of
    - **Environmental:** e.g. seclusion room, half doors, barricades
    - **Pharmacologic:** e.g. antipsychotics or benzodiazepines given to control behaviours and actions versus treat an appropriate mental health diagnosis

Not considered restraint: positioning devices (e.g. when the disease itself prevents mobility) and routine safety measures (e.g. arm stabilization during blood draws and immunizations, side-rails on stretchers during transport).

6. **Documentation:** Document in the Progress Record, discussions with patients and care partners regarding risks and alternate strategies. Include strategies to avoid or minimize restraint in the Care/Safety plan. Document patient responses to alternate strategies. If restraint is required in an emergency and/or as a last resort, document safety as well as physical, psychosocial and functional well-being, and plans to use the least restraint for shortest time. See the Restraint as a Last Resort procedures for more detailed instruction regarding specific care settings.

For more resources and information, see the Restraint as a Last Resort Toolkit webpage.