Restraint as a Last Resort Policy
Allied Health Clinical Scenarios: Adult

An 85 year old male with severe dementia is on an inpatient medicine unit. He is confused, often wanders and is at risk for falls. The unit staff have asked PT/OT to put the patient in a Broda chair after rehab, in the reclined position so the patient cannot get up to wander. The patient does not consent to stay in the chair and insists on returning home. The rehab staff covers many units and will not be back on this unit today.

The policy requires an informed consent discussion regarding risks, benefits and alternatives to restraint. The care team no longer makes paternalistic decisions to use restraint. The patient, family and/or alternate decision-maker are to be involved in the development of a person-centred plan that considers patient safety, dignity and liberty. Alternate strategies could include patient engagement in meaningful activities, involving family or visitors to walk with the patient, redirection, distraction and environmental restraint with close observation (e.g. half door).

Rehab staff complete bed exercises with a patient who has 4 point restraints. The restraints were removed for the exercises and rehab staff don't agree with continued use. Is it their obligation to refasten the limb restraints or do they have the discretion to leave off and notify the nurse? Can rehab staff refuse to comply with this restraint if they don't agree it's the best option?

The policy states restraint shall only be used in circumstances such as an immediate threat to safety, emergency treatments must be provided, or as part of an approved care or treatment plan. Long term use of four point restraint does not support rehabilitation or recovery, is dehumanizing, interferes with the development of a therapeutic relationship, and increases risk of delirium and other medical complications. If the patient is calm, a discussion with the care team is recommended regarding the reason for restraint, and the plan to decrease or remove/discontinue the restraint. Note that with the new policy, there is no order required for restraint discontinuation; the policy stipulates restraints must be removed at the earliest and safest opportunity.

A neuro patient is referred to physio for a falls risk assessment. The patient demonstrates impulsive behaviour and has left-sided neglect. PT recommends supervised ambulation using a transfer belt and mobility aid frequently throughout the day. Nursing staff report limited resources and inability to walk the patient regularly. To mitigate risk of injury, they place the patient in a Broda Chair.

Though falling is a risk, there are also many risks associated with restraint, including skin breakdown, agitation, delirium, insomnia, loss of functional capacity and skin breakdown. Broda chairs provide very poor support, and long term use is associated with spinal deformities. If the Broda chair prevents free body movement or limits locomotion, it is a restraint, and requires a clinical evaluation, an order, an informed consent discussion with the patient/family or alternate decision-maker, and a plan to use the least restrictive restraint for the shortest time.

The policy stipulates that restraint is not to be used for convenience. Mobility can be incorporated into unit routines e.g. Walk with the person to the bathroom every 2 hours with comfort rounds, once they're up, walk in the hallway a minimum of 3 times during the day. Or, work within the care hub to take turns walking with the patient to enhance strength, balance and independence. Consider involving the family. The benefits of mobility include improved sleep, more discharge options and decreased length of stay.

A 25 year old male sustains a traumatic brain injury (TBI) following a quad accident. He becomes agitated during physiotherapy sessions in the brightly lit, noisy therapy environment. As part of her treatment plan, the therapist dims the lights, draws curtains and closes the door to reduce noise, which results in a more productive treatment session. The physiotherapist documents these measures of environmental modification and communicates with the team regarding the positive impact on therapy. The therapist later notices the environmental strategies are being applied throughout the

day, not only during therapy sessions, to decrease the patient's agitation. Is this considered seclusion or therapeutic management of agitation?

The policy defines environmental restraint as any barrier or device that limits the locomotion *of an individual, and thereby confines an individual to a specific geographic area or location. These measures are not considered seclusion, unless the patient is unable to leave the room.*

Additional considerations:

- *Environmental modifications can be effective strategies for therapeutic management of agitation*
- *Decreasing the amount of light in the patient's room must be evaluated from a holistic perspective – how will this impact his sleep/wake cycle, awareness of time and place, level of activity, engagement in self-care activities, etc.? There may be negative consequences on brain recovery.*
- *Collaborative goal setting and treatment planning will assist the client, family and treatment team to determine the appropriate 'dose' of environmental modifications, balanced with activity.*

General Questions:

What information is needed for staff to provide care and use restraint as a last resort?

A physician order and patient-centred care plan are required, which should include alternate strategies to restraint and the least restrictive restraint for the shortest time. The care plan should be developed in collaboration with the patient, interprofessional team and family/alternate decision-makers. Behaviour mapping is an important tool for identifying underlying needs. E.g. the patient may be looking for a bathroom, and regular toileting can support them. The patient may be looking for food or a drink at a certain time every morning, or require reassurance that today is a day off and they don't need to go to work. Walking with the patient 3 laps around the unit, and settling them with a snack and beverage provides exercise, nutrition and hydration. By protecting mobility and independence, the patient can be more quickly discharged to a more suitable care environment.

Who is responsible for documentation and review of the behavior map?

Anyone involved in the patient's care can chart on the behaviour map. E.g. if the patient was agitated during rehab, and settled with a drink of water, this is helpful for the care team to know. Or if rehab is always at 1100, and the patient is always agitated, are they hungry? Would a snack be helpful at 1030? If use of the least restrictive restraint is part of the patient's care plan, communication between allied health and the care team is essential to ensure monitoring and documentation is initiated upon the patient's return to the unit.

Who is responsible to monitor the patient every 30 mins, ambulate the patient every 2 hours and complete ROM exercises?

Monitoring, comfort rounds and ambulation/ROM exercises are a team responsibility. The Elder Friendly Care Project supports care teams to use alternatives to restraint and to reduce time spent delivering high numbers of medications. This reduces resources required to respond to falls/confusion/delirium and medical instability, and frees up time for value-added patient care such as mobility and toileting.