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

A 7 year old girl with Autism Spectrum Disorder presents to ambulatory care with a physician's order for splints to prevent her from biting her fingers. She has thickened skin and scarring on her fingers, and finger joint deformity. Her caregiver indicates she often has open sores from constantly sucking or biting her hand. The physician has requested hard plastic splints that restrict bending at the elbows to "break the habit and let her fingers heal".

Comprehensive assessment will provide the basis for considering restraints. Understanding the etiology of the behaviour is important, and least restraint alternatives should first be trialed. If alternatives are unsuccessful, the clinician may decide to move forward with restraints. The benefits, risks, and alternative strategies to restraint should be discussed with the patient, family and care team. Despite the physician's order, the clinician has an obligation to ensure appropriate restraint use, and may decide to pursue other approaches. If the clinician decides to use a restraint option that is different from the hard plastic splints requested by the physician, and the option differs from the order's intention, the physician would need to be contacted for a different order.

If the clinician decides to move forward with restraint use:

- *Criteria should be outlined for splint wearing (duration, frequency, etc.)*
- *Functional implications of the splinted position should be considered (if elbow extension splints limit her finger biting, will she still be able to self-feed, play, draw, etc.?)*
- *Interventions should be monitored, and re-evaluated at agreed upon intervals*
- *Consider short-term solutions to allow for healing, while implementing alternative long term solutions*
- *Document the assessment, rationale, informed consent and treatment plan*

A 17 year old female client with a diagnosis of Rett's Syndrome is on OT/PT/SLP community caseload. She is cognitively impaired, communicates through eye gaze and is dependent in all aspects of ADL's and transfers. She uses a manual chair with a seating system, hip belt, 4 point chest strap and wheelchair tray, and is dependent on others for mobility. Although the intent of the wheelchair adaptations are to support posture and function, is the effect restraint?

These wheelchair adaptations provide proper positioning of the client to support respiration, aid digestion and maximize function. By providing stability to the pelvis and trunk, head control can be maximized allowing for improved eye gaze, communication, social interaction, and participation in daily activities. Despite the client's inability to undo or remove the devices, they are not considered a restraint because they don't limit her functional movement.

Important considerations:

- *Informed consent of the guardian*
- *Explore alternative seating or positioning throughout the day*
- *Closely monitor client behaviour and response to devices*
- *Provide education to the family and team in order to appropriately apply and monitor the positioning device*

A 6 year old boy with Cerebral Palsy presents to seating clinic for an adjustment to his wheelchair. He has a pelvic belt that supports posture. He has recently learned to unfasten this belt himself. His parents request a way to prevent him from removing it, in order to keep him properly positioned.

Currently, the belt is supporting the child's positioning and not restricting his freedom of movement as he can unfasten the belt himself. It is intended to improve function and doesn't limit his abilities. Assess and explore:

- *Why is the boy removing the belt?*
- *What is the context of the behaviour (i.e. environmental, daily routine, etc.)*
- *Are the boy's emotional needs being met?*
- *Have seating options other than the wheelchair been explored?*
- *Can the child be taught to leave his pelvic belt on? (i.e., consider cognitive functioning)*
- *Is there a safety risk if the belt is removed?*
- *Consider whether the pelvic belt is being used as a form of punishment, for convenience, or to due to supervision shortages.*
- *What education, support and treatment are most appropriate for the child in the context of his family?*
- *What education and support would be helpful for his family/caregivers?*

If the therapist were to move towards a belt that couldn't be self-removed by the child, then it would become a restraint and would require a physician's order, along with supportive documentation and planning as per the Restraint as a Last Resort Policy.

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