Frequently asked questions: Restraint as a Last Resort

The provincial Restraint as a Last Resort policy, along with eight associated procedures, went into effect February 1, 2018. The policy provides direction in decision-making processes around use of restraint. 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. The four types of restraints include:

**Physical:** direct application of holding techniques to restrict movement

**Environmental:** barriers or devices limiting the patient’s ability to move or confining them to a specific location

**Mechanical:** any device, material, or equipment attached to or near a patient which cannot be controlled or easily removed by the patient and which prevents a patient’s free body movement and/or a patient’s normal access to their body.

**Pharmacologic:** medications given to control behaviors and actions and/or restrict the freedom of movement – and not to treat a specific medical condition

Below are common questions asked about Restraint as a Last Resort. More information and resources are available in the [Restraint as a Last Resort Toolkit](#).

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**General Questions**

1. **There are many restraint documents on the policy page. Which one do I follow?**
2. **We do not have access to Security on an urgent basis. How do we maintain a safe environment for all patients and staff while adhering to the policy?**
3. **If we do not restrain a patient, and something happens, are we not accountable?**
4. **We were trained for years to “protect” patients from harm, even if it meant using restraints. How can we keep patients safe if we don’t use restraints?**
5. **Do we need to follow this process if families request restraints such as side rails or lap belts?**
6. **What are the considerations for transport of patients who are mechanically or pharmacologically restrained?**
7. **How often do we re-evaluate if there is an alternative that would be ‘less restrictive,’ especially if restraint use is ongoing?**
8. **Is Constant Care considered a restraint? If so, does it need to be monitored and assessed as per policy to see when it can be discontinued?**
9. **What does the policy mean for patients who are inmates?**
Fall Prevention

10. Don’t side rails and lap belts keep patients from falling?
11. We use chair and bed alarms to prevent falls. Are they restraints?

Consent Processes

12. Is consent required for restraint use? How is it obtained?
13. What if I cannot get consent in a timely manner and the need for restraint is critical?
14. Do I have to notify the family member or guardian that restraint has been used?
15. Is a specific decision maker required for patients with cognitive impairment?
16. What if the patient has impaired capacity, no specific decision maker and restraint is required as a last resort?

Emergency Situations

17. Do I need an authorized prescriber’s order for restraints in an emergency?
18. Is emergency restraint use appropriate for post-operative delirium?

Pharmacologic restraints

19. Are regularly scheduled antipsychotics considered restraints?
20. How long do we monitor pharmacological restraints? What do we monitor for?
21. Where can I find more information about Appropriate use of Antipsychotics (AUA)?

Environmental Restraints

22. Is there a difference between the term “seclusion” and “environmental restraint?”
23. What if the patient wants the curtain closed during their environmental restraint?
24. How does the policy affect locked or secure units?

Mechanical Restraints

25. I thought side rails and seatbelts are safety devices, not restraints?
26. Is there a specific length of bed rail that determines whether it is a restraint or not?
27. My patient has positioning devices because he is unable to move or stay upright. Are these restraints?

Documentation

28. Is there a specific form to document restraint use?
29. The adult inpatient and older adult procedures frequently call for behavior mapping. Is there a form or tool that is recommended?
30. How often do we document when using the same restraints daily on a wheelchair?

Specific Populations and Settings

- Emergency Department / Urgent Care Centres (ED/UCC)
31. Do we need to use the Emergency/Urgent Care Patient Restraint Monitoring Record #101593 to document about all patients restrained?
32. Where do I document if physical restraint was applied?
33. Under the Emergency/Urgent Care procedure, there are parameters for continuous cardiac and oxygen monitoring according to the dose/type of parenteral medication administered. What are the
expectations for monitoring on the inpatient unit when these patients are admitted, as they do not have the ability to do continuous cardiac monitoring?

34. With the different procedures, there are different recommendations for the frequency of monitoring. What do I follow?

35. The ED/UCC procedure identifies specific monitoring parameters for haloperidol in the adult and pediatric populations. What about the frail elderly population?

36. Are Spit Hoods restraints? What is required of AHS staff when patients arrive in the ED in Spit Hoods and wrist restraints?

- Addiction & Mental Health (AMH)
  (See AMH Policy Resources on Insite)

- Pediatrics
  Pediatric Frequently Asked Questions

- Seniors Health/Continuing Care
  (See Continuing Care Desktop or Seniors Health Provincial on Insite: Clinical Practice Development)
General Questions

1. **There are many restraint documents on the policy page. Which one do I follow?**

   The Restraint as a Last Resort suite consists of one single policy with eight care setting specific procedures. The policy describes the “what” and the procedures describe the “how” for specific populations or settings. More than one procedure may apply in a care setting (e.g. older adults in emergency/urgent care or mental health patients on inpatient units). Not all care settings have their own procedure. When in doubt, follow the principles of the policy.

2. **We do not have access to Security on an urgent basis. How do we maintain a safe environment for all patients and staff while adhering to the policy?**

   The primary approach is to identify risks and prevent escalations. This may require additional staff training in Nonviolent Crisis Intervention Training, de-escalation strategies, dementia care, Trauma Informed Care, Behaviour Mapping and/or medication review. Restraint, including physical restraint by security personnel or others, may still be required in an emergency, however this is a last resort. Protective services is also obligated to attempt verbal de-escalation as a first resort, and must be able to justify physical restraint in a court of law. Any behavioural crisis should be followed by debriefing with the patient, family and staff in order to identify what went well, areas for improvement and updates to the care plan. See also AHS policy Workplace Violence: Prevention and Response.

3. **If we do not restrain a patient, and something happens, are we not accountable?**

   We are always accountable for the care we provide, which means we are also accountable for risks associated with restraint, including psychological distress, damage to the therapeutic relationship, delirium, adverse drug reactions, skin breakdown, impaired circulation, physical injury, falls and functional decline. It’s a team responsibility to assess risks, and work with the patient and family to protect safety – while supporting dignity and liberty.

4. **We were trained for years to “protect” patients from harm, even if it meant using restraints. How can we keep patients safe if we don’t use restraints?**

   We protect patients from harm by exploring all options before resorting to restraints – and when necessary, using the least restraint for the shortest time. Restraints are not a fail-safe solution and can cause significant mental and physical harm. We keep patients safe when we anticipate risks, include the patient and their family in discussions to avoid or minimize restraint use, document those strategies in the care plan, and follow the care plan.

5. **Do we need to follow this process if families request restraints such as side rails or lap belts?**

   The risks of the restraint must still be considered and discussed with the patient and family. Document discussions with the patient/family as you work together to develop a patient-centred plan that considers safety, dignity and liberty. Discuss and document strategies to use the least restrictive restraint for the shortest time.

6. **What are the considerations for transport of patients who are mechanically or pharmacologically restrained?**

   **Communication:** Is the restraint still needed? What type of restraint is being used and what is the plan for discontinuation? (continued on next page)
Monitoring: How often is monitoring required? Are there any specific concerns e.g. cardiac, respiratory, risk of asphyxiation?

Safety: Is the restraint properly and safely applied? Is the person transporting the patient educated on appropriate restraint use, application and monitoring? Porters are not educated on restraint use or competent to monitor them. It may be necessary to have a trained health care provider accompany the patient for transport. This could be a Health Care Aide if the patient is medically stable, or a Registered Nurse or Paramedic if the patient is medically unstable.

7. How often do we re-evaluate if there is an alternative that would be ‘less restrictive,’ especially if restraint use is ongoing?

There is not one answer to this question, as there are four types of restraints and many variations in care settings and patient populations. Patients and their care partners are always the primary point of reference in any consideration to initiate, decrease or discontinue restraints. Consider members of the inter-professional team who could contribute to the discussion e.g. clinical experts, pharmacy, occupational therapy, physiotherapy, recreation therapy. “What else can we try?” is always a good question to ask. Review the policy and appropriate procedure(s) for further information on re-evaluation timelines specific to care settings and types of restraints.

8. Is Constant Care considered a restraint? If so, does it need to be monitored and assessed as per policy to see when it can be discontinued?

Constant care doesn’t fall neatly under any of the four restraint definitions. Constant care is sometimes used as an environmental restraint (e.g. security presence), if we consider the person providing constant care as a “barrier” to e.g. leaving the room or the unit. Constant care is sometimes provided for patients with responsive behaviours in dementia (e.g. agitation, aggression, calling out, wandering). If the person providing constant care isn’t skilled or proactive in their approach, constant care can lead to patient frustration and the addition of mechanical and pharmacologic restraint. Behaviour mapping is important to identify alternate strategies and to develop a care plan, in order to use constant care for the right reason, and the least amount of time.

Constant care can also be considered an alternative to restraint e.g.:
   - Alcohol withdrawal patients: a constant care provider can support an unsteady client to walk with support, walk to the toilet regularly, and avoid deconditioning
   - Older adults in delirium or at risk of falls: assist to toilet regularly, offer fluids to maintain hydration, support with nutrition, cognitive/orientation support and reassurance

9. What does the policy mean for patients who are inmates?

There is a difference between restraint for health care reasons, and restraint for the safety and security related to incarceration level. AHS staff may be asked to monitor the health of an inmate, but it is not a medical decision whether restraints such as shackles should be used or not.

Fall Prevention

10. Don’t side rails and lap belts keep patients from falling?

Restraints carry inherent risk of harm/injury; they are not a fail-safe solution. The risk of patients falling is increased when attempting to climb over side rails. Patients restrained from mobilizing freely lose motor function and mobility, which increases risk of falls and fall injuries. Loss of independence reduces discharge options, which prolongs length of stay, and increases risk of delirium, adverse drug reactions and other iatrogenic harms.
Prevention of falls and fall injuries is a multi-disciplinary effort that explores all potential contributing factors. It involves an evaluation of medications, falls patterns, risk factors such as footwear, clutter, medical tubing, patterns of behaviour, toileting routine, vision, pain, environmental barriers, balance, equipment/gait aids, etc. It also involves intentional measures to strengthen and rehabilitate (e.g. regular assistance to the toilet and frequent walking). Clinical evidence shows a consistent falls review procedure that includes the multi-disciplinary team is successful in reducing incidence of falls.

11. We use chair and bed alarms to prevent falls. Are they restraints?

Chair alarms and bed alarms aren’t technically restraints. They should be used judiciously however, as alarms interfere with sleep and rest, and contribute to agitation and deconditioning. The first resort includes a fall risk assessment, as described in #10 above. For more information, see Preventing Falls – Adults & Older Adults.

Consent Processes

12. Is consent required for restraint use? How is it obtained?

Consent is required prior to the use of restraints in non-emergency situations. The process for consents is consistent with AHS consent policy for other high-risk treatments. Document the informed consent discussion with the patient or alternate decision-maker and care partners. Include the reasons restraints are/may be considered, risks of restraints, risks of not using restraints, and alternative strategies discussed. Document in the care plan the alternate strategies to avoid or minimize restraint use. Refer to Consent Policy Resources for further information. The form Consent to Treatment Plan or Procedure is not a requirement, but may be used.

13. What if I cannot get consent in a timely manner and the need for restraint is critical?

As outlined in the policy, consent is not required for restraint use in an emergency situation, e.g. risk of serious bodily harm to the patient or others, immediate threat to safety, or to provide emergency treatment. If restraint is needed in an emergency, document steps taken to de-escalate or prevent the situation, or to use the least restrictive restraint for the shortest time. Debrief afterward with staff, patient and alternate decision-makers to prevent future emergencies. Document these discussions.

14. Do I have to notify the family member or guardian that restraint has been used?

The patient and their family/care partners should be considered part of the health care team, even if the patient has capacity to make their own decisions. Include patients, families and/or alternate decision-makers in discussions and decisions relating to restraint use and restraint alternatives.

Information sharing can be supported by resources for Personal Decision Making such as Form 1: Supported Decision-Making Authorization (the patient identifies person(s) who can be included in discussions about their care).

15. Is a specific decision maker required for patients with cognitive impairment?

The Restraint as a Last Resort policy requires informed consent for non-emergency restraint use, in compliance with AHS Consent policy. If there is no Personal Directive in effect, and no appointed Guardian, there should be an informed consent discussion (re risks, benefits and alternatives) with the Specific Decision-Maker as per Consent to Treatment/Procedure(s) Adults with Impaired Capacity and Adults who Lack Capacity - PPR-01 -02.
16. What if the patient has impaired capacity, no specific decision maker and restraint is required?

In an emergency, consent is not required. In a non-emergency, document alternatives tried, and strategies to use the least restrictive restraint for the shortest time. Document conversations about restraint with the most responsible health provider. Document difficulties / attempts to locate an alternate decision-maker or family member.

Emergency Situations

17. Do I need an authorized prescriber’s order for restraints in an emergency?

An order is always required for pharmacologic restraints. In an emergency, other types of restraint (e.g. limb, lap belt, seclusion room) can be applied, however physician or nurse practitioner orders must be received as soon as possible if restraint use will be ongoing.

18. Is emergency restraint use appropriate for post-operative delirium?

Restraint is a last resort in post-operative delirium. Antipsychotics are not a treatment for delirium. A one-time very low dose may be appropriate for distressing psychosis unresponsive to non-pharmacologic strategies (e.g. meet underlying needs such as regular toileting, pain relief, hunger and thirst; reassure, family presence). Document steps to mitigate and address delirium risk factors pre- and post-operatively. For more information see Elder Friendly Care Toolkit, Delirium and Dementia.

Pharmacologic restraints

19. Are regularly scheduled antipsychotics considered restraints?

Not if the clinical indication is treatment of a mental health condition. If the antipsychotic is prescribed for responsive behaviours in dementia, then it is being used as a pharmacologic restraint (see the AUA Guideline and Clinical Indications for Prescribing Antipsychotic Medication).

20. How long do we monitor pharmacological restraints? What do we monitor for?

The policy doesn’t specify frequency of monitoring for pharmacologic restraint. The procedures have different monitoring expectations, based on age, care setting, and reason for restraint.

Emergency/PRN pharmacologic restraint:
- **Pediatric Inpatient Procedure**: assess every 15 minutes until behaviour stabilizes and once stable, every 30-60 minutes as indicated by the patient’s response/condition, along with assessment at peak onset, and then every 4 hours for 24 hours.
- **Acute Care Emergency/Urgent Care Procedure**: assess every 30 minutes, or more frequently as needed, a minimum of one hour and until the patient is able to speak coherently and walk unassisted with a steady gait. Patients who receive high doses of pharmacologic restraint with or without benzodiazepines require constant observation and cardiac/oxygen saturation monitoring with alarms, along with Glasgow Coma Scale documented every hour.
- **Acquired Brain Injury and Rehabilitation Procedure**: provides an hourly agitated behaviour mapping tool; pharmacologic restraint is a last resort for severe agitation, for the shortest possible time, as it interferes with cognitive function.
- **Adult Inpatient procedure**: advises assessment every 30 minutes, and behaviour mapping every shift until successful discontinuation. Considerations for older adults: the half-life of antipsychotics is quite long. The rate of drug elimination (e.g. of risperidone metabolites) from the plasma in older adults is around 25 hours, but the drug is bound to fat, and so may linger longer in the brain (For more information, see Clinical Indications for Prescribing Antipsychotic Medication).
Regularly scheduled pharmacologic restraint:

- **Adult Inpatient**: Monitor changes in behaviour or level of agitation and responses to alternative interventions.
- **Older Adult**: Monitor for:
  - Increased risk of falls. Other side effects include confusion, agitation, sleep disturbances, difficulty urinating, nausea, difficulty swallowing and hyper-salivation.
  - Extrapyramidal side-effects including akinesia (inability to initiate movement), akathisia (inability to remain motionless) and tardive dyskinesia (e.g., repetitive tongue protrusions/lip smacking).
  - Effect on the targeted behaviour e.g. aggression (improvement, worsening, no change)

The process and frequency of monitoring is behaviour tracking (e.g. hourly) for 3 days or with each change in dose/frequency. Regularly scheduled pharmacologic restraint: weekly for 1 month, monthly thereafter. Behaviour tracking also supports identification of supportive strategies, which often enable discontinuation or reduction of the pharmacologic restraint.

21. Where can I find more information about Appropriate use of Antipsychotics (AUA)?

The AUA Guideline and AUA toolkit provide health care professionals with direction regarding assessment and management of responsive behaviours associated with dementia. AUA resources are developed for continuing care settings, though the principles are applicable in all care settings.

For care of frail older adults in acute care, see the Elder Friendly Care (EFC) Toolkit.

Environmental Restraints

22. Is there a difference between the term “seclusion” and “environmental restraint?”

No, these terms mean the same thing. The new policy and procedure uses the new terminology of “environmental restraint” in place of the old terminology of “seclusion.”

23. What if the patient wants the curtain closed during their environmental restraint?

If the nurse or physician has assessed the patient and agrees the patient is stable enough to have intermittent visual contact, we can close the curtain as long as the patient is visually seen a minimum of every 15 minutes. If possible/available, utilize other forms of monitoring.

24. How does the policy affect locked or secure units?

If a secure unit is part of the person’s care, a Physician or Nurse Practitioner order is required. Least restraint means opportunities are arranged to allow the person to leave the unit on passes, accompanied as needed for safety. Patients or residents on secure units who do not require environmental restraints may be given the code to the door or be assisted to come and go freely. The policy requires monitoring with sufficient frequency to minimize risk of potential harm which varies depending on the patient and care area but at a minimum is every 8 hours of continuous restraint particularly while sleeping.

Mechanical Restraints

25. I thought side rails and seatbelts are safety devices, not restraints?

Previous policies used the terms safety devices and restraints interchangeably. Now that we understand the many harms of restraints, restraints are no longer considered to be safety devices. Restraints may be used – as a rare response to a rare situation – to protect safety. They are not to be used routinely or indefinitely. This includes items such as: bed-side rails, seatbelts that cannot be
unfastened by the patient, chairs with locking table tops, Broda/Geri chairs the person can’t get out of, and limb restraints or mitts. An exception is bedside rails or seat belts used during patient transport. Other exceptions include safety restraints used in everyday care of children e.g. appropriate use of crib rails, arm boards, and restraints that are part of products (e.g. highchairs, swings, strollers or car seats) or a ‘time-out’ for the purpose of regaining emotional control. (For more information, see Acute Care Inpatient Pediatric Procedure)

26. Is there a specific length of bed rail that determines whether it is a restraint or not?

A bedrail of any size is considered a restraint when it is used to limit the activity or control the behaviour of a patient or a portion of their body. If a bedrail does not limit activity and is used to help the patient with independence in transfers or bed mobility then it is not a restraint.

27. My patient has positioning devices – is unable to move or stay upright. Are these restraints?

It depends. If disease or injury limits free movement, devices used to position the patient are positioning devices, not restraints (e.g., devices to keep patient upright in order to support breathing and eating; to support the head, to keep them from falling over). Close monitoring, care and documentation is required to prevent risks associated with use of the device regardless of whether it is used as a positioning device or restraint.

Documentation

28. Is there a specific form to document restraint use?

The form(s) you use will depend on your care setting. There are a number of forms available on the Restraint as a Last Resort Education Resources website. Provincial forms will be developed in conjunction with Connect Care.

29. The adult inpatient and older adult procedures frequently call for behavior mapping. Is there a form or tool that is recommended?

Yes, AHS has an approved form, called the Behaviour Mapping Chart, as well as supporting education resources. Look for these on the Education Resources page of the Restraint as a Last Resort Toolkit.

30. How often do we document when using the same restraints daily on a wheelchair?

This depends on the patient population, care setting and purpose of restraint. For more information, see the Restraint as a Last Resort procedure(s) and resources applicable to your care setting.

FAQs for Specific Populations and Settings

Emergency Department / Urgent Care Centres (ED/UCC):

31. Do we need to use the Emergency/Urgent Care Patient Restraint Monitoring Record #101593 to document about all patients restrained?

Yes. Emergency Department/UCC should all be using the new form to ensure compliance with monitoring standards identified in Restraint as a Last Resort - Acute Care Emergency/Urgent Care.
32. Where do I document if physical restraint was applied?

Physical restraint should be time limited and in many situations is a pre-cursor to another type of restraint. Documentation of physical restraint, should include who it was applied by, duration, mechanism (i.e. arms, legs and shoulders pinned down until Pinel restraints applied), patient’s response, and any untoward outcomes (i.e. bruising).

33. Under the Emergency/Urgent Care procedure, there are parameters for continuous cardiac and oxygen monitoring according to the dose/type of parenteral medication administered. What are the expectations for monitoring on the inpatient unit when these patients are admitted, as they do not have the ability to do continuous cardiac monitoring?

The monitoring parameters included in the Emergency Department/Urgent Care procedure apply to the patient while they are in the ED/UCC setting. Inpatient units have established their own parameters for monitoring and ensuring patient safety. This does not preclude the importance of communication between the ED/UCC physicians, psychiatrists and other members of the health care team during the transfer of patient care. (See # 6, Considerations for Transport)

34. With the different procedures, there are different recommendations for the frequency of monitoring. What do I follow?

Patient and staff safety is paramount. The Emergency/UCC procedure identifies minimum monitoring requirements of every 30 minutes or more frequently as patient condition or manufacturer’s instructions warrant.

Mechanical restraint monitoring recommendations in the procedures vary according to patient population and/or care setting, e.g.:
- Pediatrics - Inpatient: every 15 minutes until behavior stabilizes. See: Restraint as a Last Resort - Acute Care Inpatient - Pediatric
- Addiction and Mental Health Inpatient: Record respirations and circulation, and examine extremities every 15 minutes but the patient must be under constant observation. See: Restraint as a Last Resort - Addiction and Mental Health - Inpatient
- Adult – Inpatient: every 30 minutes (every 15 minutes for 4 point mechanical restraint). For more information see: Restraint as a Last Resort - Acute Care Inpatient - Adult HCS-176-04

35. The ED/UCC procedure identifies specific monitoring parameters for haloperidol in the adult and pediatric populations. What about the frail elderly population?

Dosages for the frail elderly are significantly lower than what is indicated on the ED/UCC procedure for adults. The frail older adult dosage for haloperidol is 0.25 to 0.5 mg two – three times/day. Avoid as needed (prn) haloperidol if any type of regularly scheduled or prn antipsychotic has already been given. Avoid benzodiazepine use in frail older adults. In older patients benzodiazepines may worsen the behaviours they are intended to manage. Benzodiazepines should be reserved for delirium caused by alcohol withdrawal.

36. Are Spit Hoods restraints? What is required of AHS staff when patients arrive in the ED in Spit Hoods and wrist restraints?

Spit hoods don’t fall neatly into a restraint category, but are a type of restraint sometimes used for Police Services and Emergency Medical Services (EMS) protection during conveyance. They are accompanied by wrist restraints. Spit hoods interfere with airway assessment and management, and introduce considerable risk e.g. if the patient is vomiting or choking. Agitation is also increased by interference with the patient’s vision. Placing these patients in a treatment space upon arrival is a priority – EMS and police services should communicate to the triage team ahead of their arrival. Constant visual supervision is required until the transfer of custody (care) to AHS staff. Staff must
wear appropriate protective gear, at which time the spit hood should be removed. The wrist restraints need to be assessed on a case by case basis. Often, these patients express anger and agitation towards the officer but may be cooperative and manageable with hospital staff. There may be a temporary need to maintain wrist restraints until the tension of the situation dissipates and a therapeutic relationship can be established.

**Addiction & Mental Health (AMH):** see AMH policy resources on Insite

**Pediatrics** – [Pediatric Frequently Asked Questions](#)

**Seniors Health/Continuing Care:** see Continuing Care Desktop or SH Provincial on Insite: Clinical Practice Development

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