Alberta Health Services
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September 2020

Frequently Asked Questions: Restraint as a Last Resort

In 2019, the provincial Restraint as a Last Resort policy, procedure and supporting educational resources were reviewed one year post implementation. The Policy Suite 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 restraint means the direct application of physical holding techniques to a patient that involuntarily restricts their movement.

Environmental restraint means any barrier or device that limits the locomotion of a patient, and thereby confines an individual to a specific geographic area or location.

Mechanical restraint means 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 restraint means the use of pharmaceutical products to control behaviors and actions and/or restrict the freedom of movement, but which the purpose in the situation is not to treat an identified medical or psychiatric condition.

Below are common questions asked about *Restraint as a Last Resort Policy Suite*. More information and resources are available in the *Restraint as a Last Resort* Toolkit.

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Seniors Health/Continuing Care

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

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46. There is a Mental Health team in our ED. Will they be required to use the same documentation as the Emergency/Urgent Care staff?
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48. Within the Emergency/Urgent Care practice area, there are parameters required 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?
49. The ED/UCC practice area identifies specific monitoring parameters for haloperidol in the adult and pediatric populations. What about the frail elderly population?
50. Are Protective Hoods (Spit Hoods) restraints? What is required of AHS staff when patients arrive in the ED in Spit Hoods and wrist restraints?

Diagnostic Imaging (DI)

51. I am a technologist in Diagnostic Imaging (DI), does the Restraint as Last Resort Policy and Procedure apply to me; we frequently use devices for short periods of time to immobilize patient anatomy to avoid motion on our images?

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 a policy, procedure and supporting educational resources located in the *Restraint as a Last Resort* Toolkit. Prior to the review, eight care setting specific procedures existed, which have been amalgamated into one procedure; now applicable to all care settings. The policy describes the "what" and the procedure describe the "how" for specific populations or settings. 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 situation or behavioural 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?
   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.

These situations may vary depending on the environment, the patient's clinical condition and response. Engage in ongoing communication with the health care team to ensure the safety of all.

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, family, or alternate decision maker and their health care team are always the primary point of reference in any consideration to initiate, decrease or discontinue restraints. Consider members of the interdisciplinary 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 procedure for further information on re-evaluation timelines specific to care settings and types of restraints.

8. **Who sets of frequency of monitoring restraints?**

   The level of observation and monitoring of restraints is set by the Most Responsible Health Practitioner (MRHP) and clearly communicated with the health care provider caring for the restrained patient. Engage in ongoing communication with the health care team to ensure the safety of all.

9. **What are the minimum restraint monitoring requirements based on a patients response and condition?**

   If patient safety is a factor; the health care provider shall increase the frequency of observation and/or monitoring based on clinical assessment and judgment; and

   If the Physician or Nurse Practitioner (NP) orders the frequency of observation or monitoring requirements for the restraint, defer to the order, the patient's clinical condition and response.

10. **What are the observation and monitoring requirements for each type of restraint?**

    Patient and staff safety is paramount. The procedure identifies minimum monitoring requirements depending on the type of restraints used. Recommendations in the procedure vary according to patient population, clinical condition, health care professional's assessment and/or care setting. If the health care provider is concerned about the patient, family, alternate decision maker or provider and others' safety, they may increase the frequency of observation/monitoring to decrease risk in clinical situations and should document decisions in the plan of care and/or communicate decisions to the health care team.

Refer to Section 6, Type of Restraint, Observation, and Monitoring Requirements in the Restraint as a Last Resort Procedure for further information.

11. **Is Constant Observation (by security guard/officer or health care provider) considered a restraint? If so, does it need to be monitored and assessed as per policy to see when it can be discontinued?**

Constant observation doesn't fall neatly under any of the four restraint definitions. Constant observation means an assigned AHS people member is with the patient at all times with unrestricted field of vision. If we consider the person providing constant observation as a "barrier" to the patient leaving the room or the unit. This is sometimes used as an environmental restraint. Constant observation is sometimes provided for patients with responsive behaviours in dementia (e.g. agitation, aggression, and calling out, wandering) or those patients who are asses to be a danger to themselves or others (e.g. suicidal ideation).

If the person providing constant observation isn't skilled or proactive in their approach, constant observation can lead to patient frustration and the addition of mechanical and pharmacologic restraint. Behaviour mapping maybe a tool used to identify alternate strategies and to develop a care plan, in order to use constant observation for the right reason, and the least amount of time. See question #12 for patients whose clinical condition is assessed that they are a danger to themselves or others.

Constant observation can also be considered an alternative to restraint e.g.:

- Alcohol withdrawal patients: a constant observation 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

  When constant observation is applied at the same time as a restraint and the restraint is removed, constant observation levels remain in place. A decision to change observation levels must be made separate from the decision to remove/reduce the restraint. It is important the health care provider communicate with the interdisciplinary team for reassessment of observation levels.

12. Is constant observation ordered by a Physician or Nurse Practitioner (NP)?

A Physician or NP may order constant observation or observation levels if clinically indicated by the patient's response and condition (e.g., patients whose clinical condition is assessed that they are a danger to themselves or others). Where observation levels have been ordered by a Physician or NP, these shall remain in place until the order is reviewed by the authorized prescriber.

13. 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

14. 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 interdisciplinary team is successful in reducing incidence of falls.

15. 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 #11 above. For more information, see Preventing Falls – Adults & Older Adults.

Informed Consent Processes

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

Informed consent is required prior to the use of restraints in non-emergency situations. The process for consents is consistent with AHS *Consent to Treatment/Procedure(s)* Policy Suite for other high-risk treatments. Document the informed consent discussion with the patient, family or alternate decision-maker and health care team. 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.

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

As outlined in the Restraint as a Last Resort Policy Suite, informed consent is not required for restraint use in an emergency situation or behavioural emergency, (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.

18. Do I have to notify the family member or alternate decision maker that restraint has been used?

The patient, their family, and alternate decision maker, 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 through the following 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).

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

The Restraint as a Last Resort policy suite 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 (i.e., 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.

20. 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 a family member or an alternate decision-maker.

Emergency Situations or Behavioural Emergency

21. Do I need an authorized prescriber's order for restraints in an emergency situation or behavioural emergency?

In an emergency situation or behavioural emergency, an order is not required, unless it is a pharmacological restraint: see Sections 23-25. A physician or nurse practitioner (NP) order must be received as soon as possible if restraint use will be ongoing.

22. 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

23. Do pharmacological restraints require an order?

All pharmacological restraints require an order.

24. Can Pro Re Nata (PRN) pharmacological restraint orders be used?

PRN pharmacological restraint orders may be used when it is part of the individualized plan of care and informed consent has been obtained.

25. Can Pro Re Nata (PRN) pharmacological restraint be used in the absence of patient consent?

When PRN orders are required in anticipation of emergency situations, in the absence of patient consent refer to Appendix C in the *Restraint as a Last Resort* Procedure for further instructions.

26. 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 Appropriate Use of Antipsychotic Medication Guideline and Clinical Indications for Prescribing Antipsychotic Medication).

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

- For all pharmacologic restraint monitor adverse effects (e.g., falls, dizziness, drowsiness, confusion, delirium, movement and non-movement side-effects) as identified by the medication monograph, patient condition and response.

- For long-term pharmacologic restraint as part of a treatment plan, monitoring should also include behaviour mapping to monitor for effectiveness of pharmacologic and non-pharmacologic strategies.

- Following administration of PRN pharmacological restraint monitor vital signs as follows:

    - commencing 15 minutes post administration, if safe to do so;

    - whenever the medication is expected to reach peak onset and then every four (4) hours for 24 hours;

    - more frequent or additional monitoring as determined by the NP or Physician or Parenteral Manual; (e.g., respiratory rate, oxygen saturation, continuous cardiac monitoring, sedation level (e.g., Glasgow Coma Scale, Richmond Agitation Sedation Scale); and

    - any concerns shall be communicated to the Physician or NP.

In addition to the above, refer to the *Restraint as a Last Resort* Procedure, Section 12, and Considerations for Program Settings, Populations, and Protective Services for further information on monitoring in specific practice areas.

28. 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

29. Is there a difference between the term "seclusion" and "environmental restraint"?

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

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

If the Health Care Professional 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.

31. 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.

32. What is a secure space?

A secure space means a secure unit within a facility, a secure facility or a technological measure that limits a Client's ability to exit a facility or unit that is used with the intention of protecting a patient from harm. For clarity, a technological measure includes, but is not limited to, a wander alert system as per

the Continuing Care Health Services Standards.

33. Are secure spaces in Continuing Care settings considered a restraint?

No, secure spaces according to the *Continuing Care Health Services Standards* (2018) are not considered a restraint.

34. What requirements and monitoring is to be in place for patients assessed as requiring a secure space?

Please see the requirements and monitoring in Appendix B of the *Restraint as a Last Resort* Procedure.

Mechanical Restraints

35. 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).

36. 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.

37. 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.

For more information refer to the AHS Restraint as a Last Resort in the Context of Occupational Therapy and Physiotherapy Practice Professional Practice Notice

Documentation

38. 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 (see the "Forms & Documentation" section). Provincial forms are being built into Connect Care.

39. The procedure refers to 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 Restraint as a Last Resort Education Resources website.

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

Mechanical devices, such as positioning devices may be used to promote function and healing, support the patient in functional postural support, enable occupation, prevent contracture or reduce the risk of other complications. Refer to the AHS Restraint as a Last Resort in the Context of Occupational Therapy and Physiotherapy Practice Professional Practice Notice. Regardless of whether the devices is used a positioning device or a restraint, close monitoring, care and documentation is required to prevent risk to the patient.

FAQs for Specific Populations and Settings

Addiction & Mental Health (AMH)

See AMH resources on Insite at: https://insite.albertahealthservices.ca/amh/Page5307.aspx

41. Is there a difference between the term "PRN" and "Pharmacological Restraint"?

PRN orders for Pharmacological Restraint are written in anticipation of a future behavioural emergency. If a patient requests or accepts a PRN medication to help them regain self-control, this is not considered a pharmacological restraint. The Restraint as a Last Resort policy does not restrict physicians and NPs from making orders for PRN medications that may be used in a pharmacological restraint. However, these orders shall be part of a safety plan created in collaboration with the patient and family whenever possible. This supports a trauma-informed and patient-centered approach to restraint as a last resort. Refer to Appendix C of the *Restraint as a Last Resort* Procedure for more information.

42. If a patient requests a PRN (Pro Re Nata) Ativan is this considered pharmacological restraint?

No. If a patient is aware that they are anxious or restless and asks for a PRN, this is considered self-regulation. If the nurse offers a patient a PRN when they have assessed the patient for pre-cursors to a behavioural issue and the patient accepts the offer, this is also considered self-regulation. Pharmacological restraint means the use of pharmaceutical products to control behaviors and actions and/or restrict the freedom of movement, but which are not required – to treat an identified medical or psychiatric condition. In Addiction and Mental Health (AMH) settings, this type of restraint is usually used in behavioural emergencies where the patient is unable to self-regulate (e.g. they refuse to take a prn medication) and there is a risk of harming themselves or others.

43. In a behavioural emergency when a pharmacological restraint is needed, can a health care professional administer the medication without a physician order?

Behavioural emergencies means a situation when the patient is presenting with behaviour where immediate action is required to prevent serious bodily harm to themselves or others. It is always best to find ways to prevent behavioural emergencies from occurring and to intervene with the least intrusive measures as early as possible. In some situations, a pharmacological restraint may be needed to keep patients and staff safe.

Medications cannot be administered without a physician or nurse practitioner order. Preferred alternatives to restraint and, when necessary, the preferred type of restraint for use in behavioural emergencies shall be described in a safety plan. This plan will ideally be developed at admission, in collaboration with the patient and their family.

44. How does the health care team determine which is the least restrictive restraint?

Use of restraint(s) with patients shall be considered on a case-by-case basis. Debriefing is a good way to understand and determine which the least restrictive restraint is for that patient. Get to know your patient and their responses to a particular alternative strategy or restraint and proceed accordingly. It is important to understand the patient's history of behavioural emergency and the recommendations of their safety plan.

Pediatrics

Pediatric Frequently Asked Questions

Seniors Health/Continuing Care

Refer to Continuing Care Connection | Insite or Seniors Health Provincial | Insite Clinical Practice Development.

Emergency Department / Urgent Care Centres (ED/UCC)

45. 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 Emergency/Urgent Care Patient Restraint Monitoring Record or electronic health record to ensure compliance with monitoring standards identified in *Restraint as a Last Resort* Procedure.

46. There is a Mental Health team in our ED. Will they be required to use the same documentation as the Emergency/Urgent Care staff?

No. Addiction and Mental Health have developed their own processes and documentation to address the needs of their patient population. Even though the patients are in the ED, they will follow the guidelines developed for their sector (which has more frequent monitoring every 15 minutes). For more information, see Section 14 in *the Restraint as a Last Resort* Procedure.

47. 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).

48. Within the Emergency/Urgent Care practice area, there are parameters required 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 practice area 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 interdisciplinary team during the transfer of patient care. (See # 6, Considerations for Transport)

49. The ED/UCC practice area 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 adults in the ED/UCC practice area. 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.

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

Protective 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. Protective 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, prior to the removal of the protective hood. 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.

Diagnostic Imaging (DI)

51. I am a technologist in Diagnostic Imaging (DI), does the *Restraint as Last Resort* Policy and Procedure apply to me; we frequently use devices for short periods of time to immobilize patient anatomy to avoid motion on our images?

Yes, the *Restraint as Last Resort* policy suite does apply to DI. However, a physician order is not required for immobilization within DI. The DI policy support team is in the process of providing a practical support document for technologists and sonographers who may need to briefly immobilize a patient body part during an imaging exam.

For more information contact: policy@ahs.ca