Restraint as a Last Resort: Information for Prescribing Practitioners working with older adults

All Restraints *(environmental, physical, mechanical and pharmacological)* ***increase morbidity and mortality*** *& are a* ***last resort for aggressive behaviours with serious risks to safety,*** *unsuccessfully mitigated by other interventions. Restraint as a Last Resort is a team responsibility involving ongoing communication, collaborative problem-solving and evaluation.*

When asked to order restraints think: **"REFRAME** & **REFRAIN** before I **RESTRAIN"**

REFRAME the problem in the moment (reaction to restraint request):

1. Why is the team asking for the restraint? **Restraints are *not* indicated for** convenience, insufficient staff, fall prevention, poor sleep / day-night reversal, wandering, inappropriate voiding, calling out
2. What has the team already tried (and documented)? Consider:
   - **Unmet needs** – see Appendix A and B in the acute inpatient adult procedure. Interventions to reduce behaviours/ unmet needs include: comfort rounds, non-slip footwear, accessible sensory and mobility aids, watch for postural hypotension, volunteer visits, positive distractions and meaningful activities
   - **Staff approach** – **NICE and EASY**, p13 **Dementia Clinical Knowledge Topic,** Insite
   - De-escalation strategies
3. Has **behaviour mapping** been initiated? Encourage:
   - Hourly documentation of behaviours using a behaviour map. Look for trends and triggers, including periods of calm, in order to develop a person-centred care plan.
   - Team conversations and documentation about possible reasons for behaviours e.g. **A**ntecedent/trigger, **B**ehaviour description, **C**onsequences of interventions tried – see Responsive Behavour Tracking and Assessment Tool and page 9-11 **Dementia Clinical Knowledge Topic**
4. Can you avoid restraint by staff **re-approach/ reschedule/ remove current trigger**?
   - Consider the risk/benefit of investigations, vital signs or personal care that may trigger/ exacerbate behavior – is it necessary? If so, can staff try again later?
   - Can you discontinue catheters, intravenous lines, etc.?
   - Can you use people instead of restraint? E.g. 1:1 staff, family, or sitter
5. **Rule out new delirium, discomfort or medical issue**, especially in new behaviour.
   - see **Delirium Clinical Knowledge Topic** Table 4, 5 and Delirium Order set (see Insite)
   - Review medications with aim to reduce anticholinergic burden, sedating and cognitive side-effects and drug-drug interactions which exacerbate behaviours and contribute to falls
   - **Consider further medical assessment**

REFRAIN from Restraints (Prevention) by Rethinking the team approach using creative and person-centred strategies and care planning:

1. Involve the family to explore alternatives and develop an individualized care plan. Use **'Getting to Know You'** form #20079 to learn about patient likes / dislikes / needs
2. **Protect Day / Night routine** by avoiding vitals/ unnecessary care at night; don't wake to give HS meds – move them earlier instead. Avoid or wean sedatives. Respect home sleep schedule.
3. Use **AHS Resources** for optimal elder friendly care including: AUA toolkit, behavior mapping, Restraint As a Last Resort Toolkit, Elder Friendly Care Toolkit; Fall prevention; Knowledge topics for dementia & delirium (found on Insite &/or AHS external – see links next page)
4. **Interventions to reduce behaviours/ unmet needs (see above)**
5. Review **Goals of Care** to ensure they are appropriate for patient prognosis or whether it is time to discuss greater emphasis on comfort vs treatment with patient/ decision-maker.

Before you RESTRAIN thoughtfully as a **Last Resort,** when all of the above fail:

1. Discuss risks, benefits and alternative strategies with the family or alternate decision maker, and **document** this conversation (**Informed Consent Discussion**) **when restraints are ordered.**
2. **After an emergency,** obtain consent and order if restraint use will be ongoing.
3. **Time limited order of shortest possible duration; *No* standing "just in case" orders**.
4. Remember: ***All*** restraints, especially Mechanical and Physical, **may *increase* agitation** as patient resists/ suffers adverse effects
5. Least restraint means **least impact on patient voluntary movement**
   - Examples include Mitts or wrapping a dressing/line to reduce risk of picking/removal rather than wrist restraint; environmental restraint (e.g. locked door or unit) rather than mechanical restraints (eg. Posey); dose of pharmacological restraint rather than mechanical; pharmacological restraint given orally rather than parenterally with physical restraint
   - Monitor patient frequently if unable to avoid mechanical restraint use (e.g. every 15 min)
   - Have a **clear Removal plan in the order** (e.g. when family present, when patient sleeping, when calm for x minutes for mechanical)
6. **Appropriate use of pharmacological restraints (Antipsychotics)** is for distressing psychosis or aggression when non-pharmacologic alternatives are unsuccessful. See Clinical Indications for Prescribing Antipsychotic Medication or Pharmacologic Restraint Management Worksheet
   - **Review existing medications *first*** before adding new – watch anti-cholinergic burden, renal dosing, drug interactions, withdrawal from home medications/ substances
   - **Benzodiazepines and sedatives are *not* recommended** outside of alcohol/ benzdiazepine withdrawal as they worsen delirium/ cognition/ behaviour
   - Anti-psychotics **do *not* reverse delirium**; they can cause or worsen delirium.
   - **Do *not* use intravenous anti-psychotics**; subcutaneous or intramuscular forms are more potent and higher risk, and should be saved for situations where oral formulas (e.g. rapid disintegrating, liquid, mixed with food) are not able to be administered safely.
   - Consider a one-time dose of a single oral agent and re-evaluate, while addressing underlying causes. **Do *not* mix anti-psychotics.**

7. **Suggested starting dose for severe distressing psychosis or aggression with significant risk of harm** to self or other *not* responsive to non-pharmacologic interventions; **single dose preferred, avoid ordering dose range, reserve standing PRN dose as a last resort with plans to reassess within 48 hours**
   - risperidone 0.125-0.25 mg PO BID PRN. *(caution in patients with renal failure)*
     or
   - olanzapine 2.5 mg PO daily PRN
     or
   - quetiapine 6.25-12.5 mg PO QHS PRN *(recommended for patients with pre-existing Parkinson Disease, Lewy Body Dementia or parkinsonism)*
     or
   - haloperidol 0.25-0.5 mg PO every 8 hours PRN (*avoid in patients with Parkinson Disease or Lewy Body Dementia)*

REDUCE and REMOVE existing Restraints ASAP; **REFER** cases to a (single) Geriatric service when needed

For more information, see:

- Restraint as Last Resort Policy; Older adult (seniors and continuing care) procedure
- Seniors Health Strategic Clinical Network Resources: AUA toolkit; Elder Friendly Care Toolkit
- Restraint As a Last Resort Toolkit – Education Resources
- Clinical Knowledge topics for Inpatient Dementia & Delirium (on Insite)
- Printable pages on MyHealth.Alberta to support informed consent discussions