Restraint as a Last Resort: Information for Prescribing Practitioners

The Restraint as a Last Resort provincial policy suite came into effect Feb. 1, 2018, replacing all legacy zone policies.

What Has Changed?

- **Informed consent is required** for all types of restraint in non-emergencies.
  - AHS Consent Policy states *the Most Responsible Health Practitioner (MRHP) providing a Treatment/ Procedure to a Patient has a duty to inform the Patient of the nature of the Treatment/Procedure, its risks, benefits and alternatives, and consequences*. MRHPs include prescribing practitioners, nurses and other regulated health professionals.
  - The MRHP will discuss with the patient and/or alternate decision-maker and, whenever possible, the family, anticipated needs for restraint and/or observed safety risks, and alternate strategies to restraint. Printable resources to support informed consent conversations can be found on MyHealth.Alberta.
  - Document the consent conversation on the health record or "Consent to Treatment Plan or Procedure".

- **Alternatives to restraint must be tried first**, unless it is an emergency. Examples include:
  - Conversations between the care team, patient and family to develop a care/safety plan
  - Behaviour mapping to identify trends and triggers, and effective strategies
  - Medication review to reduce anticholinergic burden, drug side effects and fall risk
  - Modify staff approach (e.g. for persons with dementia, trauma informed care, de-escalation techniques).
  - Address underlying causes of agitation, support sleep, comfort rounds (e.g. regular toileting, hydration, pain assessment, walking).

- **Physician or Nurse Practitioner orders are required for all non-emergency restraint**, and any pharmacologic restraint. If restraint is required, the **least restrictive restraint** is used for the **shortest time.** Consider intended outcomes, potential effects, frequency of monitoring, frequency of documentation review, conditions for use of restraint, and criteria and timelines for discontinuation.

- **Mechanical restraints are no longer considered safety devices.** Restraints such as lap belts introduce many risks including hospital-acquired disability, agitation, skin breakdown, infection and delirium. Restraints are not effective for preventing falls/fall injuries; consider non-pharmacologic strategies such as regular assistance to the bathroom along with medication review (3 or more medications increases risk of falls). Restraints are associated with increased morbidity and mortality, and triple the risk of self-extubation..

- **Pharmacologic restraint:**
  - Antipsychotics are not a treatment for delirium; they contribute to anticholinergic burden which may cause or worsen delirium. Dosages for older adults are much lower (e.g. 0.25 to 0.50 mg haloperidol bid). See Delirium Clinical Knowledge Topic on Insite: Avoid parenteral antipsychotics, mixing/combining different antipsychotics, ordering range doses
  - Antipsychotics can worsen Behavioural and Psychological Symptoms of Dementia (BPSD), and are often not effective for aggression: see also Appropriate Use of Antipsychotics Guideline and Clinical Indications for Prescribing Antipsychotic Medication.

How are AHS staff being supported?

This policy represents significant practice change for care teams. Education resources have been developed for a variety of practice settings. Strategies for provincial implementation have been developed, and local programs are currently working to apply these changes.

For more information, see the Restraint as a Last Resort Toolkit website, or contact policy@ahs.ca.

- Restraint as a Last Resort in Acute Care: What's Changed?
- Restraint as a Last Resort FAQs

June 2018 Health Professions Strategy and Practice