PURPOSE

1. To define the term restraint.
2. To define the types of restraints approved for use at Salem Home.
3. To identify the circumstances under which a restraint may be used.
4. To promote the resident's personal independence through a culture of "least restraint".
5. To ensure restraint application protects resident well-being by promoting meaning and purpose in the resident's daily life.
6. To outline alternate and/or options used in restraint application.
7. To outline options used when safety is critical, but restraint application interferes with the resident's state of wellness.
8. To outline a critical path to be followed when assessing the need for application of a restraint.

DEFINITIONS

Restraint

Any restriction/reduction of voluntary movement or freedom implemented to ensure the safety of self, others, or the physical environment.

Well-being

The state of being healthy, happy, successful, or prosperous.

Personal Independence

The ability to determine a course of action for one self, and the self-empowerment to have that course of action implemented.

Least Restraint

The minimum restrictive approach is used while promoting autonomy preserving dignity and maximizing safety.

Consent

The exercising of one's right to accept or reject a proposed treatment, or procedure. Implies that the individual, and/or their Health Care Proxy understands the actual situation, knows what the choices are and can appreciate the consequences of the choice.

Assent

The continued agreement for a treatment and/or procedure of which the resident is the recipient. This may be exhibited verbally or non-verbally.

Restraint Classification and Restrictions

The following are approved for use at Salem Home according to the protocols specified.

~~A.~~ Mechanical Restraint is a manual or physical device that the individual cannot remove and which restricts freedom of movement.

Mechanical Restraints	Ordered By	Minimum Supervision Required
Side rails (3/4 and full length)	RCM	q2h
Lap boards	RCM	q1h
Seat belts	RCM	q1h
Mitts: for time-limited intervention	RCM/BTU consult	constant
Chairs that prevent rising	RCM	q2h
Masks during care for resident	RCM	constant

The following mechanical restraints are not allowed at Salem Home:

- Wrist or leg restraints
- Posey jackets/chest harness
- Lap boards on commodes
- Hand/Arm restraints, including splints that are attached to chair/table top
- Wheelchair foot boxes with closures that do not permit voluntary movement
- Wheelchair safety bars

B. Physical Restraint

The following Violence Prevention Program holds, blocks, and releases" may be used to defend against and neutralize uncontrolled attacks of aggression by a resident:

- One and two hand grab release
- Hair pull release – one or two hand
- Block of punch or kick
- Front and back choke release
- Bite release
- Transport technique (BTU only)

Not allowed: Any other physical intervention.

C. Chemical Restraint

Medication given for the specific and sole purpose of inhibiting a behaviour or movement (e.g. pacing, wandering, restlessness, agitation, aggression or uncooperative behaviour) and not required to treat the resident's medical or psychiatric symptoms. This includes sedatives, hypnotics, antipsychotics, antidepressants or antianxiety medications. When a psychotropic medication is being used in the absence of a diagnosis of a mental illness it is to be considered a chemical restraint. If the medication inhibits movement and impairs functioning, it is a restraint.

When a medication is used specifically to restrain a resident, the minimal dose should be used and the resident reviewed and closely monitored to ensure her/his safety. **The Physician must include a review and a discontinuation date in the actual chemical restraint order.**

See attached Province of Manitoba Guidelines for the Safe Use of Restraints in PCH's for examples.

D. Environmental Restraints – any barrier that restricts free personal movement which serves to confine residents to specific area (examples: removal of a mobility aid – walker or isolated in a room with door closed and/or applying wheelchair brakes to prevent the resident from wheeling away).

Use of the above to occur in consultation with the RCM, Social Worker and family.

Allowed approaches include:

- secured units
- masked exits
- wandering paths
- controlled elevators
- locked service entry doors
- locked sections of resident's closet/drawers
- controlled exit devices

Locked resident room doors and/or locked resident bathroom doors is permitted on BTU only.

For the purpose of this policy and the Province of Manitoba Guidelines for the Safe Use of Restraints in Personal Care Homes the following will not be considered a restraint:

- Electronic location bracelets) e.g. Wanderguards/Roam Alerts.
- The use of brakes on a wheelchair for safety. Examples include: when providing assistance, to keep the resident close enough to the table to so they can feed themselves, to keep the chair from rolling away during transfers, or to enhance the resident's ability to participate in an activity.
- Isolation for protection purposes during an infectious outbreak is not considered a restraint.

PRINCIPLES

1. Care approaches for residents will optimize their sense of wellness and their opportunity to find meaning and purpose in day to day life.
2. Restraint use may be appropriate if the benefits outweigh the burdens and the resident's state of wellness is maintained and/or enhanced.
3. The resident's desire for personal independence, and her/his willingness to take risks will be respected.

POLICY

1. A restraint device may only be used to help a resident compensate for an identified loss of ability. There must be reason to believe that the restraint will benefit the resident's total well being.
2. All possible alternatives to restraint must be considered and documented in the progress notes prior to the application of a restraint.
3. Documented consent must be obtained for restraint use that involves all restraints. If you cannot obtain immediate written consent, two staff members must obtain consent verbally. One of these staff members must be a Professional Nurse. Written consent must be obtained from the resident using Form 10-A-10-02.

4. Where the resident is not competent, verbal or telephone consent is received, documented, dated and signed by a nurse and a second staff member using Form 10-A-10-02. The second staff member must hear the verbal consent either via speakerphone or by speaking with the representative/designate. The second staff member does not need to be a Registered Professional. The person giving the verbal (telephone) consent is asked to sign the consent form at the first possible opportunity, preferably within 14 days. They will be adequately informed of the risk of restraint up to and including the potential death where applicable.
5. The decision to apply a restraint will be assessed and evaluated according to an established critical path. (See Restraint Application: Critical Path)
6. There will be a reduction plan that includes regular re-evaluation for all restraints at least quarterly or more often as needed.
7. Once applied, restraints will be removed for a minimum of 10 minutes every two hours to allow for opportunity to ambulate, toilet, exercise, and/or any other care.
8. Reactions to restraint application will be monitored to determine client assent. Any non-consensual sign requires review of the decision to restrain the resident.
9. All nurses have the ability to initiate a Restraint Assessment Questionnaire provided the critical path has been applied. This involves a thorough analysis of the resident's situation and completion of the appropriate Restraint Assessment Questionnaire on the electronic health record. The questionnaire will only be OK'd by the nurse, not approved. The nurse will enter a progress note outlining her/his action and alerting it for the Resident Care Manager.
10. Only the Resident Care Manager can approve the order and implementation of a restraint by reviewing the completed questionnaire for critical analysis of the resident situation and then electronically approving the questionnaire.
    Exception: Chemical restraints require a physician's order. The order will be documented under the physician's orders in the electronic health record and must have a discontinuation date in the initial order.
11. The Resident Care Manager will ensure thorough documentation is completed. If the resident does not appear to warrant the restraint proposed, the Resident Care Manager will not approve the proposed restraint and will document reasons and alternatives to the use of a restraint.
12. Names of Residents who have a restraint and travel to other program areas will be forwarded to the applicable area. Staff in such areas are designated with responsibility to monitor.
13. Emergency Restraint Application: There may be occasion when the emergency use of a restraint is warranted. "If a residents' unanticipated violent or aggressive behaviour places her/him and/or others in imminent danger, the resident or substitute decision-maker does not have the right to refuse the use of restraints. In this situation the use of a restraint is a measure of last resort to protect the safety of the resident and/or others and must not extend beyond the immediate episode." This may include other behaviours that place the resident and/or others in imminent danger e.g. Falls etc. An emergency restraint must be ordered by the Resident Care Manager or Facility Charge Nurse with a RN/RPN designation, or physician. A chemical restraint requires a physician order. A telephone order can be accepted by a nurse from the physician for a chemical restraint in an emergency.

POLICY (Cont'd)

The physician must assess the resident within 24 hours for the chemical restraint to be continued. The physician's order for chemical restraint will be documented under the physician's orders in the electronic health record and must have a discontinuation date in the order.

The resident's substitute decision-maker or next of kin will be notified as soon as possible and no more than 24 hours following the implementation of the emergency restraint. Proper consent will be obtained as quickly as possible following such an event using form 10-A-10-02.

Documentation in the electronic health record will reflect:

- details surrounding need for application of the emergency restraint
- how frequently safety checks were conducted
- other care provided to the resident while in restraint
- notification of resident's substitute decision-maker or next of kin
- resident's response to the restraint
- timeline for reassessment to occur
- a plan for managing episodes such as this in the future

A full assessment, involving the interdisciplinary team, for continued use of a restraint will be made as soon as possible. Staff will be given the opportunity to debrief following the implementation of an emergency restraint. (See policy 10-F-10 Post Aggression Debriefing in the Resident Care Services Manual).

RESTRAINT APPLICATION: CRITICAL PATH

1. Identify resident behaviour that has led to consideration of a restraint.
   - Complete "*Restraint Consideration"* and *"Behaviour Analysis" sections* of the *Restraint Assessment questionnaire and "OK" the questionnaire*

2. Identify and address any underlying etiologies for the behaviour.
   - Complete "*Underlying Etiology" section* of the *Restraint Assessment questionnaire and "OK" the questionnaire*

3. Investigate alternative to restrain application prior to applying a restraint
   - Conduct interdisciplinary, family and resident consultations i.e. Physician, Resident Care Attendant, Therapeutic Recreation Staff, Social Worker, Occupational Therapist, Dietician etc. where possible and/or applicable. Document discussion in progress notes.

4. Trial alternatives, evaluate and document in progress notes
   - Complete "Alternatives to Restraint Use" section of the Restraint Assessment Questionnaire and "OK" your entry

5. If restraint use is still being considered, assess benefits and burdens to restraint
   - Complete "*If still seriously considering a restraint"… section* of the *Restraint Assessment questionnaire* and "OK" your entry

6. If decision is made to apply a restraint; develop care plan approach; determine competency and how to obtain consent. Document Consent using Form # 10-A10-02 and file completed Consent form in miscellaneous section of the paper health record.
    - Complete "*Nursing Orders* and *Care Plan Development"* sections of the *Restraint Assessment questionnaire* and "OK" your entry
    - *Document in progress notes the date and time that the restraint was applied, and the date the restraint is to be reviewed.*

DOCUMENTATION

1. The *Restraint Assessment questionnaire* will be scheduled onto the resident's carepath. Restraint options include:
    - ♦ Siderails (3/4 and full length)
    - ♦ Chemical-Restraint Asst Questionnaire-Chemical
    - ♦ Lapboard-Restraint Asst Questionnaire-Lapboard
    - ♦ Mitts-Restraint Asst Questionnaire-Mitts
    - ♦ Seatbelt-Restraint Asst Questionnaire-Seatbelt
    - ♦ Chairs that prevent rising-Restraint Asst Questionnaire-Chair
2. A thorough and comprehensive completion of the *Restraint Assessment* questionnaire will result in direction to resident care staff that specifies the type of restraint, criteria for use, frequency of supervision and regular release from restraint and the reassessment date. The questionnaire will only be OK'd by the initiating nurse, not approved.
3. Resident care staff will document that timely checks, regular removal/release from restraint (restraint must be removed for a minimum of 10 minutes every two hours) and reassessment were completed as scheduled. If they were not done, a variance report providing a reason will be completed.
4. The problem will be defined in terms of the resident's functional loss and added to their FOCUS list under SAFETY.
5. An alerted progress note will be made by the initiating nurse, outlining the circumstances and actions taken. The Resident Care Manager will review and approve the OK'd Restraint Assessment questionnaire as appropriate.
6. Staff from other areas will be notified of the resident's restraint and any required monitoring and safety checks by the Resident Care Manager or designate.
7. When a reassessment is required, the nurse must complete the *Restraint Reassessment* questionnaire after a comprehensive re-evaluation of the resident's status and the benefits and burdens of continued restraint use. It is an expectation that the nurse will lead the interdisciplinary team in the active pursuit of a reduction in the resident's restraint use and/or the elimination of the restraint entirely.
8. Consider if there are any ethical implications to applying the restraint; if the answer is yes- Complete the Ethical Framework (Policy GM 1-A-15 and GM 1-A-15-01). Complete a progress note linking it to the Focus of Restraints.

QUALITY ASSURANCE

1. A Restraint audit is conducted annually using Form RCS 10-A-10-01 by the Director of Resident Care Services, or designate.
2. 10% of applicable health records will be audited using a random sample.
3. Where practice fails to reflect the policy, Resident Care Managers will ensure that corrective action is taken.
4. A report of the audit results and follow up recommendations will be submitted to the Safety, Standards and Ethics Committee and the Resident Care Management Committee for their review and input.

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COMMUNICATION

- Safety, Standards and Ethics Review Team
- Resident Care Management Committee
- All RCS staff

REFERENCES

1. CNA Code of Ethics re: “Individual Rights and Choices”.
2. Resident Care Management ~~Clinical~~ Committee, Salem Home Inc.
3. Province of Manitoba Ministerial Guidelines for the Safe Use if Restraints in Personal Care Homes-November 21, 2014
4. Southern Health-Santé Sud-Restraints in Personal Care Homes-December 19, 2016