The Restraint as a Last Resort provincial policy in acute care replaces all zone restraint policies The new provincial policy builds on the best elements of existing policies. There are also some changes. In this presentation, you'll learn about expectations of the new policy and potential implications for various practice areas.

Policies no longer in effect as of Feb 1 2018
SOUTH ZONE
Clinical, Chinook Restraints: Physical Continuing Care Facilities Restraint Use
CALGARY ZONE
Addiction & Mental Health Restraints & Use of the Lockable Quiet Secure Room
Department of Critical Care Medicine (DCCM) Standing Order for the Use of Physical Restraints
Practice Support Documents – ACH Restraints - Physical R-4.0 Regional nursing manual: Policy: Restraints - Physical R-1 Emergency Departments Monitoring Patients Requiring Mechanical/Chemical Restraint
CENTRAL ZONE
Mental Health Procedure: Interventions For Control, Restraint MH-VII-80
Procedure: Mechanical Restraints for Safety MH-VIII-09 – BIRP Procedure: Restraint MH-IX-03
Acute Care Restraint - Least Restraint Procedure CC-VI-21
EDMONTON ZONE
Corporate Administrative Directives Restraints 2.4.2 Patient Care, UAH, MAHI, KEC Restraints, Use of NeonatologyRestraints policy Care Management, Seniors Health Physical/Mechanical Least Restraint Policy Administrative Manual, Royal Alexandra Hospital Policy: Use of Restraints 2.3.1 Procedure: Use of Restraints 2.3.1.1 Directive: Restraints 2.4.2 Patient Care Manual, Royal Alexandra Hospital Policy: Positioning of Patients and Safety Restraints for Surgical Procedures 67.15.13 Sturgeon Community Hospital, Edmonton ZoneProcedure: Restraints 1.8.4
NORTH ZONE
Continuing Care, Seniors Health Least Restraint CC-2-e-120
Clinical Practice, Northern Lights Restraints/Safety Devices policy CP-x-219 ; Restraints/Safety Devices policy procedure CP-x-220 ; Standing Order for the Use of Physical Restraints for Critical Care procedure CP-x-209

Alberta Health Services

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Objectives of this Presentation

- Key elements
- Alternatives
- Resources
- Plan

- Awareness of key elements of the Restraint as a Last Resort provincial policy
- Awareness of alternatives to restraint; examples from various care settings
- Know where to find resources to support practice change
- Identify areas for improvement in your practice setting and develop a plan to shift practice in your setting

Do you have the handout: “Restraint as a Last Resort worksheet”?
The front of this worksheet can help you think through any changes that may be required in your practice area.
The back of the worksheet can guide development of a plan for the quality improvements you identify.

Restraint as a Last Resort

- Least Restrictive
- Shortest time
- Informed Consent
- Safety and liberty
- Applies to anyone working for or on behalf of AHS, including protective services

What does Restraint as a Last Resort mean?
Last resort: Restraint is not considered until other strategies have been determined to be ineffective or inappropriate.

When a decision is made to use a restraint, the **least restrictive** restraint shall be used for the **shortest time.**

Except in an emergency**, informed consent** discussions occur with the patient, family and/or alternate decision-maker (risks, benefits, alternate strategies).

Safety of patients, staff and others is considered, along with patient liberty and freedom.

Applies to anyone working for or behalf of AHS, including protective services

Key Differences

- Informed consent
- Restraint harms greater than benefits
- Alternatives
- Types and definitions
- Ordering restraints

1. **Informed consent:** Explore alternatives and ideas with patient and family. Document these conversations to prevent use of restraint, any conversations about the need for restraint – and things to try first.

2. **Increased acknowledgement of restraint harms, which often cancel out or over-ride perceived benefits.** In some of the old policies, the term "restraint" is used synonymously with safety devices. One zone nursing policy allows nurses to discontinue restraints if there seems to be harm to the patient, but the physician has to be informed right away. The implication is that discontinuing restraints is risky! We now recognize that restraints come with many risks of harm.

3. **Greater emphasis on alternatives:** E.g. Out of 16 pages of another zone nursing policy, 12 pages describe how to obtain and properly fasten restraints, ½ page on alternatives, ½ page on assessing possible causes of agitated behaviour – *after* instructions on restraint sizes and phone numbers for Distribution. Impression of old policy: check for causes of agitation after patient is restrained. New emphasis: "try everything possible" to avoid restraints.

4. **Types and definitions:** Some of the old policies lumped all types of restraints, including chemical restraints, under "safety devices", others focused on "physical restraints" which are now called mechanical restraints.

5. **Ordering of restraint:** some of the old policies included standing orders for restraint, with the assumption it would be necessary. Restraint is no longer standard procedure – it is an unusual response to an unusual situation. A physician or NP order is required prior to use of any non-emergency restraint, as well as prior to use of pharmacologic restraint in an emergency.

Informed Consent and Restraint

Patients and Families say:

- *Patient and family engagement needs to be the first resort – and restraint the last resort*
- *They want to be asked to help find solutions, and to be involved in decisions*
- *Ask them how the restraint situation makes them feel*
- *When things escalate, staff need to talk with patients/families about strategies they have as professionals to keep people safe*

When we use the word “consent”, there’s the impression people need to sign a form, agreeing to restraint. This is not the expectation.

Consent for restraints similar to AHS consent policy for any other procedure, like putting in a catheter, or changing a dressing.

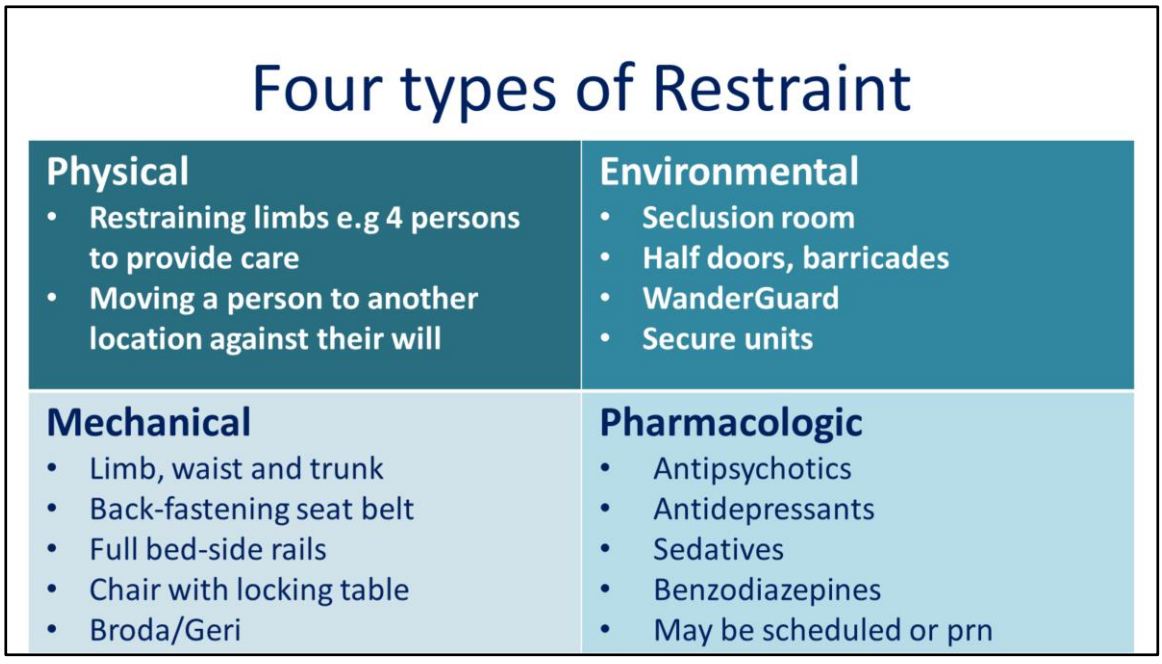
Because there are many risks associated with use of restraint, we need to have a collaborative discussion about the issues and options, and possible risks and benefits. This discussion should be documented.

This means staff don’t make decisions about restraint without patient and family involvement – unless it’s an emergency.

If an emergency arises, requiring a restraint, (i.e. the safety of the patient, staff or others is at risk), we still need to debrief afterwards with patients/families and with each other – to look for ways to avoid restraint in future, or to use the least restrictive restraint for the shortest time.

These patient and family comments are from the AHS provincial Patient Engagement Reference Group.

On your worksheet: What changes might be required in your care setting?



The 4 types of restraint are new for many practice areas e.g. mechanical restraints are differentiated from physical restraints.

In a non-emergency, all of these require a physician or NP order. In an emergency, you must have an order for pharmacologic restraint – and as soon as possible for physical, mechanical or environmental restraints if use will be ongoing.

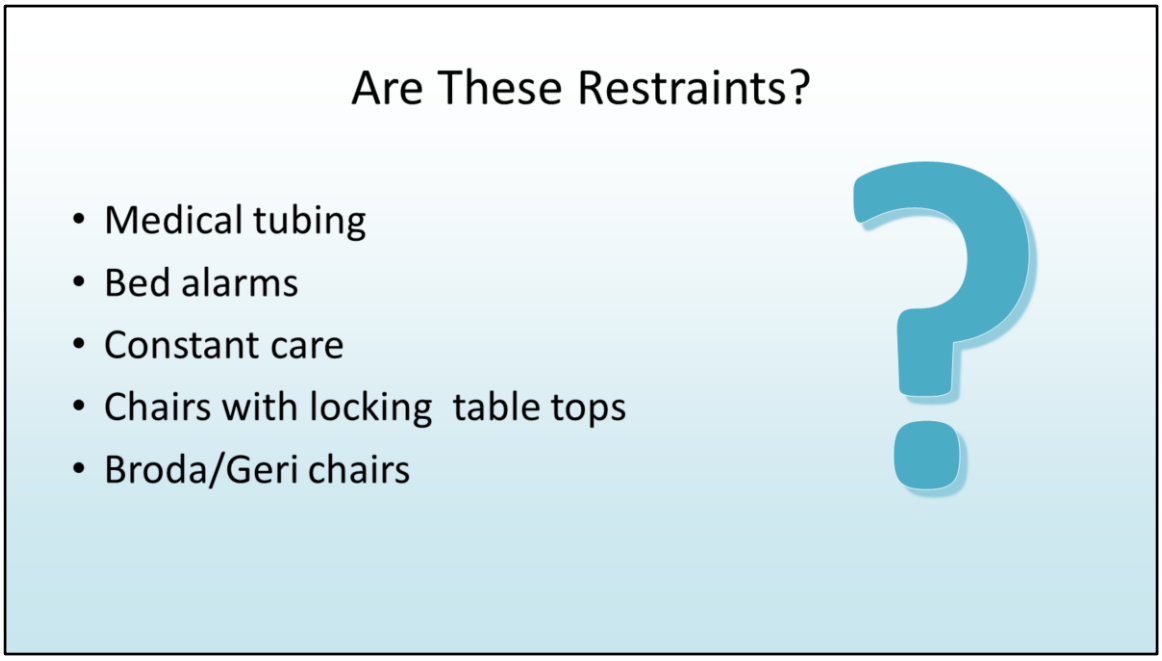
A Physical restraint: direct application of holding techniques to restrict movement.
Least physical restraint: e.g. holding a person's hands or cuddling a child during an uncomfortable procedure while providing guidance and reassurance or distraction

Environmental restraint: barriers or devices that limit patient ability to move about and confine to a specific location. Also: secure areas or outdoor spaces, barriers in doorways
Least environmental restraint: e.g. provide the access code to leave the unit, opportunity to go on passes, provide support to minimize time in a seclusion room.

Mechanical restraint: any device, material or piece of equipment attached to or near a patient that the patient cannot control or easily remove. The intent is to restrict the patient's free body movement and/or normal access to their own body. Other examples/terms: four point, Segufix, Posy vests/jackets, bed linens/sheets, neuromitt
Least mechanical restraint: e.g. family removes restraint while visiting, staff and family support patient to rehabilitate with frequent walking until no longer a fall risk (while addressing other factors e.g. medication side effects, visual impairments, clutter, footwear)

Pharmacologic restraint: medications given to control behaviors and actions and/or restrict the freedom of movement – and not to treat a specific medical condition; can be regularly scheduled or prn. Examples of specific drugs include quetiapine, olanzapine, risperidone, aripiprazole, haloperidol; trazodone, zopiclone, lorazepam
Least pharmacologic restraint: the lowest dose that allows safety, person is alert and able to safely mobilize.

Notes: On your Restraint as a Last Resort worksheet, indicate types of restraint used in your practice area



Whether or not these meet the definition of restraint, they can act as a restraint – or lead to increased use of restraint.

Medical tubing: AHS staff have identified medical tube entanglement as a safety concern to the adult population. Majority of incidents of medical tube entanglement (83%) involve seniors and result in a fall (63%). (RLS April 2010-Nov 2016). Avoid or discontinue medical tubes whenever safely possible.

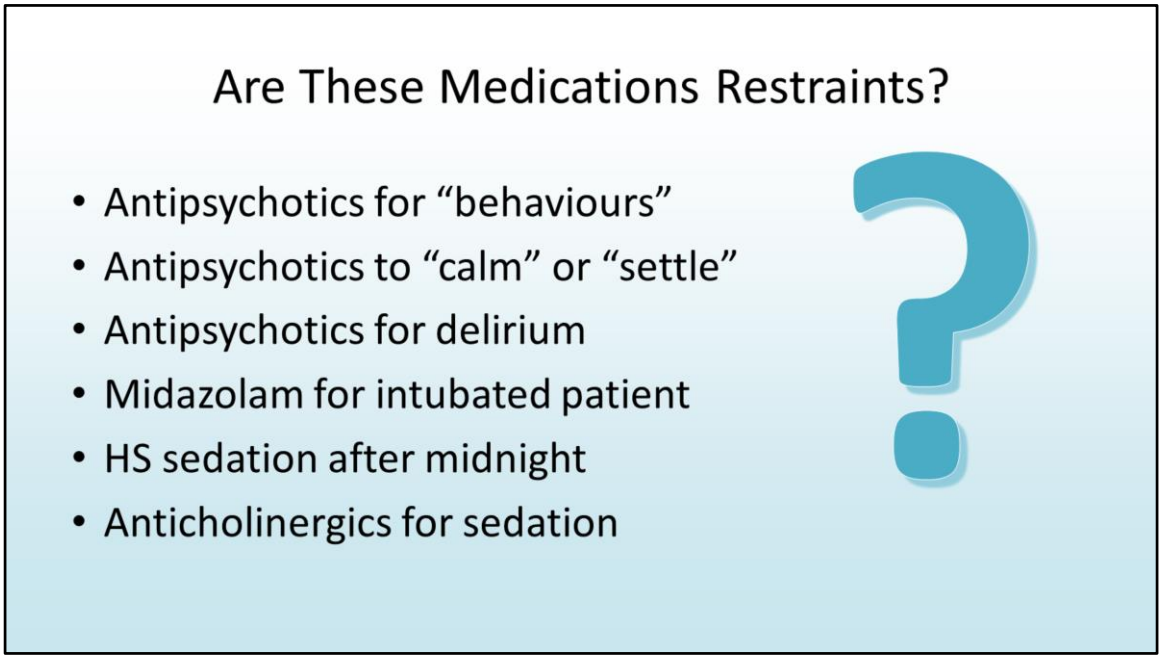
Bed alarms: Greatly over-used as an alternative to mechanical restraint. The noise and overstimulation, and sleep disruption of the person, their roommate and the entire unit creates new safety risks of falls, agitation and delirium. This can contribute to increased use of antipsychotics and lap belts. Sleep is crucial for healing, and for cognitive and physical health.

Constant care: Constant care can be a temporary alternative to restraint if the person attending the patient 1:1 is skilled in their approach, and if efforts are made to discover alternate strategies to reduce the need for constant care. UAH found that before an intervention to reduce use of constant care, patients often had constant care plus mechanical and pharmacologic restraints. Behaviour mapping allowed them to identify reasons for behaviours, implement alternate strategies into the care plan, and assess whether constant care or restraint was still needed.

Chairs with locking table tops: if the patient can't remove it, it's a restraint. If it's still there after lunch, it's a restraint. A bedside table is a great alternative.

Broda/Geri chair, reclining chair: is restraint, if the patient is not able to release themselves. A Broda chair is an obstacle to discharge to some facilities.

If the disease is what keeps the person in the chair (no longer mobile, paraplegia), it's a positioning device, and not a restraint e.g. tilt in space chairs.



Sometimes we don't recognize medications as restraint – these *could* all be chemical or pharmacologic restraint and require a physician's order.

- **Antipsychotics prescribed for responsive behaviours in dementia, or to "calm" or "settle" the patient** and not for a chronic mental health condition: e.g. wandering, calling out, screaming, crying, aggression, sexual disinhibition, agitation. Instead, look for the reason for the behaviour, which could be medication side effects, pain, social isolation, sleep deprivation etc. On the other hand, if an addiction & mental health patient feels an anxiety attack coming, they might ask for a prn antipsychotic to manage symptoms. This would *not* be a restraint.
- **Antipsychotics prescribed for delirium:** Note, antipsychotics are not a treatment for delirium, may worsen delirium and increase risk of mortality. Use as a last resort only for severe and dangerous agitation and psychosis; use alternate strategies (reassurance, hydration, decrease anticholinergic burden), consider one time dose; stop as soon as possible.
- **Midazolam for a ventilated patient** in ICU; Use the lowest dose for as short a time as possible; allow sleep/wake cycles and treat pain.
- **HS sedation given after midnight**. No evidence of long term benefit for sleeping pills of any kind, especially in older adults. More likely to fall, be confused, sleep all day and be awake all night – especially if given after midnight.
- **Anticholinergics** such as dimenhydrinate (Gravol) and diphenhydramine (Benadryl) Avoid in patients over 65, as these medicatons block a crucial brain neurotransmitter (acetylcholine) which is already low in persons with dementia. These are common ingredients in over-the-counter sleep medications. Even young healthy people experience brain fog with these highly anticholinergic medications.

Caution!

Haloperidol and Older Adults

- Initial dose: 0.25 – 0.5 mg mg. od-bid

Canadian Coalition for Seniors Mental Health

What's the standard dose of pharmacologic restraint given on your unit?

Has the patient been admitted on pharmacologic restraint – and if so, are there alternative strategies?

Pharmacologic restraint may be necessary in an emergency, or for safety, *and* it has many risks and side-effects. Caution is advised with dosage.

- Initial dose of haloperidol for an older adult is 0.25 mg BID-TID; usual dose is 0.25mg-1 mg BID
- NOTE: the acute care emergency/urgent care procedure advises monitoring of adult patients who received more than 10 mg of haloperidol intramuscularly / in combination with benzodiazepines:10 mg is up to 40 times too high for an older adult. Even 1-2 mg can be too much.

Consider not just new requests for pharmacologic restraints, but those already in place. Patients are often admitted on multiple medications and antipsychotics .

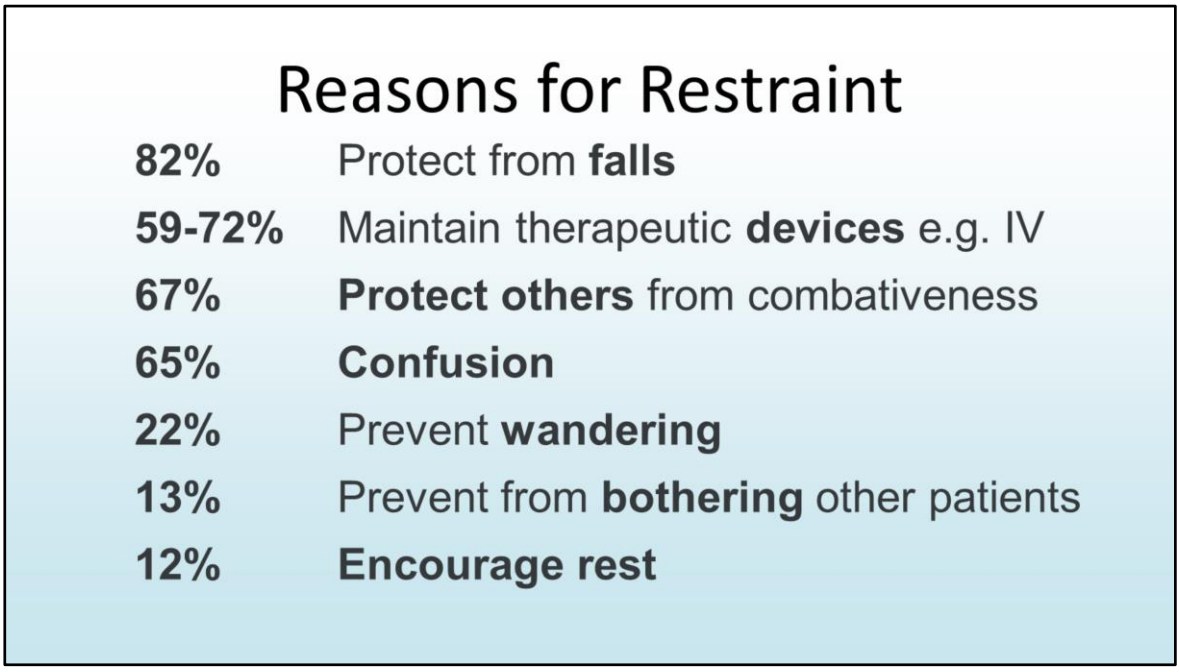
- Is there an underlying psychiatric diagnosis for which the medication may be appropriate? (in this case, don't adjust without psychiatrist consultation!)
- Is the dose too high (because it isn't working?)
- Have other medications been added (without de-prescribing medications that weren't helping)? Is there more than one type of antipsychotic prescribed?
- To try first: decrease medications vs add antipsychotics

Risperidone 0.25-2.0mg/day* Initial: 0.125mg – 0.25mg daily
Usual: 0.5mg – 2.0mg daily
Quetiapine 12.5-200mg/day* Initial: 12.5mg daily
Usual: 25-100mg daily
Olanzapine 1.25-10mg/day* Initial: 1.25mg daily Usual 2.5-7.5m

References:

http://ccsmh.ca/wp-content/uploads/2016/03/Delirium-tool-layout-FINAL.pdf
http://www.rxfiles.ca/rxfiles/uploads/documents/Dementia-Newsletter-Overview-Booklet-WEB.pdf

Note: on your worksheet, indicate anything new you've realized about types of restraints or dosages.



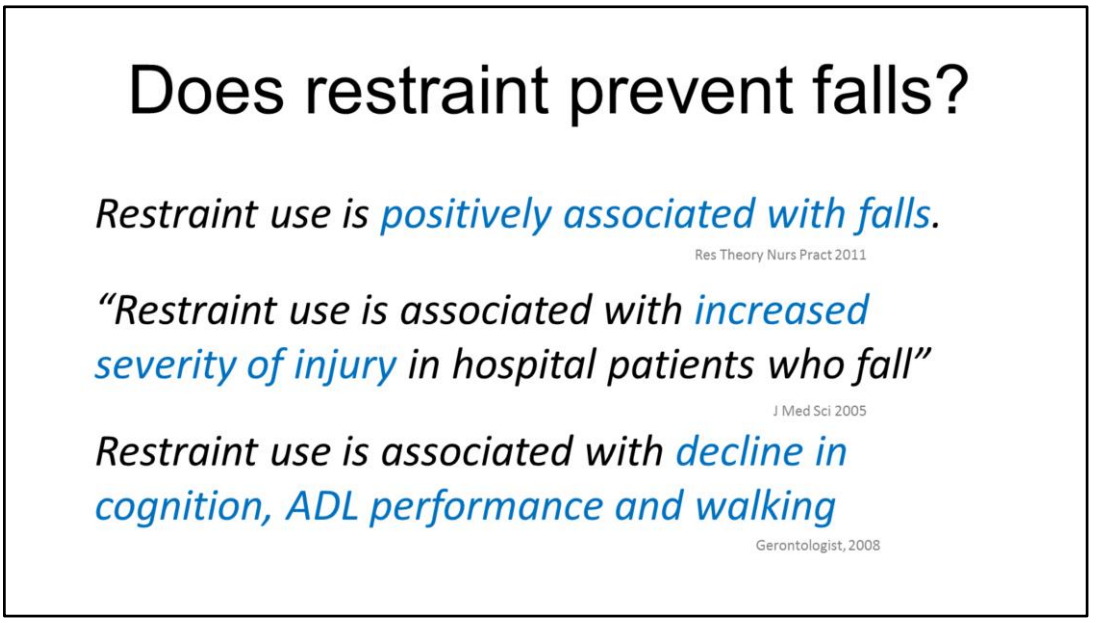
Why do we tend to use restraint? SAFETY is usually the intent.

But restraint comes with many risks and harms, and may not be as safe as we believe.

Note: What are some of the reasons restraint is used in your care setting?

References:

Tolson,D. & Morley, JE. (2012). Physical restraint: Abusive and harmful. *Journal of the American Medical Directors Association*, 13(4), 311-313.



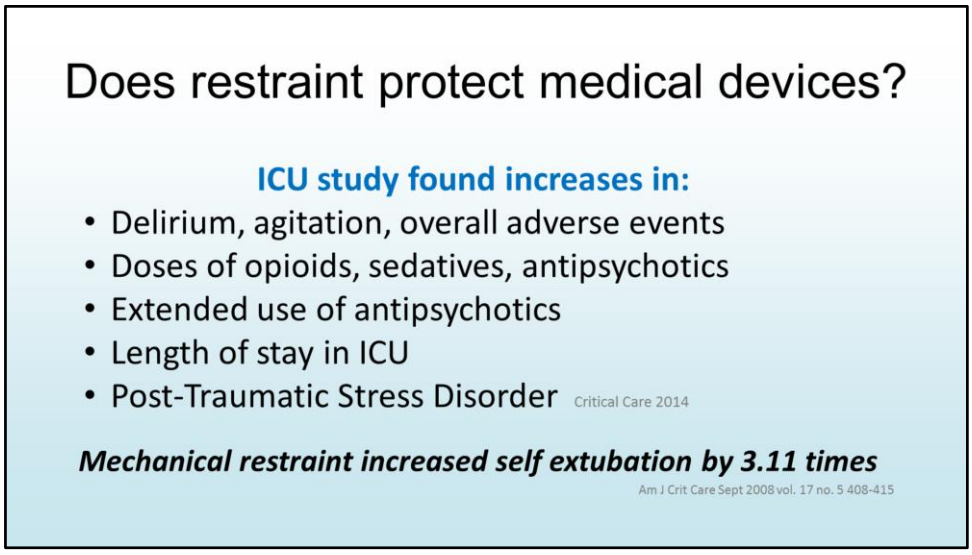
Restraints lead to deconditioning, which increases risk of falls. Some better options:

- De-prescribe. Many commonly prescribed medications increase risk of falls. https://www2.gov.bc.ca/assets/gov/people/seniors/health-safety/pdf/medications-and-the-risk-of-falling.pdf)
- Rehabilitate: Walk with patient to bathroom regularly e.g. every 2 hours. Walk in hallway at least 3 times per day. Involve family with walking.
- De-clutter: remove extra supplies and equipment each shift, clear a safe path to the bathroom
- Wearing their glasses? Prescription current? Are the glasses clean?
- Non-slip footwear
- Avoid lines and tubes when possible, discontinue as early as possible.

Supplementary Information:
A large study followed over 7800 adults aged 60 or older through more than 10,000 hospitalizations. They concluded that restraint use is positively associated with falls (2011). Another study found increased severity of injury in patients who fall (2005).

Restraint use is associated with decline in multiple domains. *"We examined eight mental and physical outcomes 3 months post physical restraint initiation. Even after controlling for prior health status and resident, facility, and market factors, we found that restrained residents are significantly more likely to exhibit low cognitive performance, low ADL performance, and more walking dependence than similar residents who are not restrained. The magnitude of the findings would suggest that the benefits to residents of not using restraints are substantial.* (Gerontologist, 2008)

References:
Titler MG; Shever LL; Kanak MF; et al. (2011). Factors associated with falls during hospitalization in an older adult population. Research & Theory for Nursing Practice, 25(2),127-152.
Tan KM; Austin B; Shaughnassy M; et al. (2005). Falls in an acute hospital and their relationship to restraint use. Irish Journal of Medical Science, 174(3), 28-31.
Engberg J; Castle NG; McCaffrey D. (2008). Physical restraint initiation in nursing homes and subsequent resident health. The Gerontologist,(48)4, 442-452.



Often, mechanical restraints such as wrist ties are used to protect medical devices such as an intravenous or central line, chest tubes, oxygen tubing, dressings and drains.

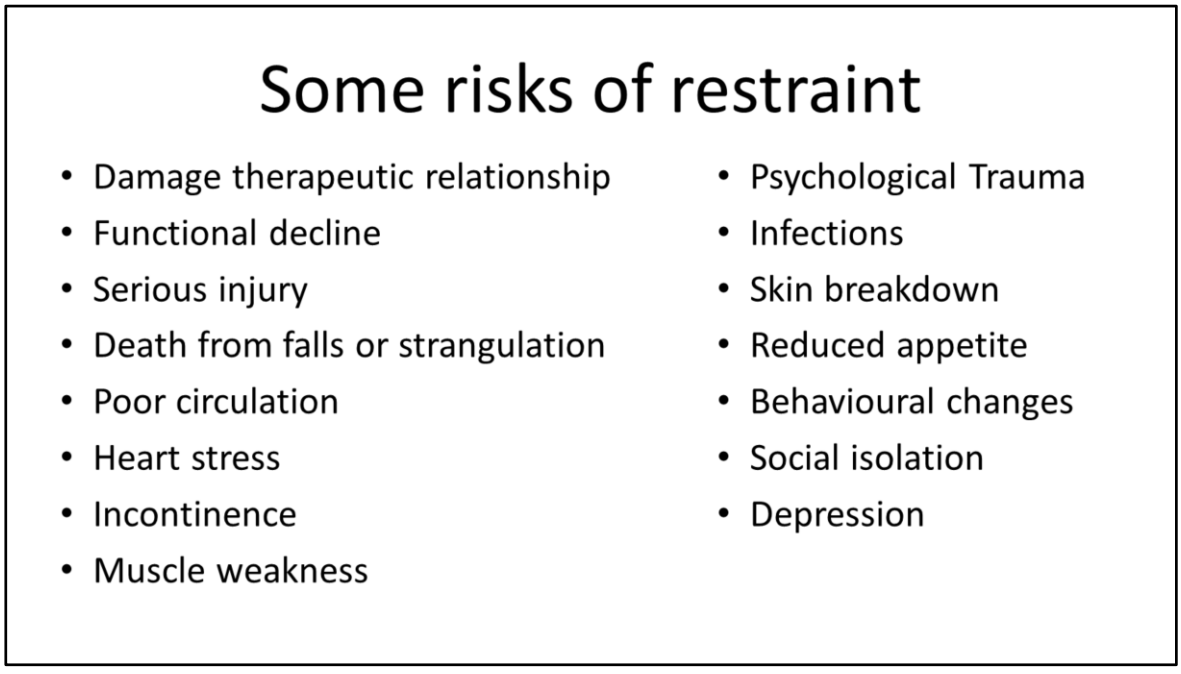
But mechanical restraints not only failed to protect medical devices – they more than tripled the risk of self-extubation in this study of 51 Canadian ICUs, and 711 patients. Restraints also increased delirium and adverse events, medication use, ICU length of stay and PTSD.

Restraints create distress. Distress increases the risk of more restraints, delirium and other complications.

References

Chang, LY; Wang, KW; Chao, YF. (2008). Influence of physical restraint on unplanned extubation of adult intensive care patients: a case-control study. *American Journal of Critical Care*, 17(5), 408-41.

Luk E; Sneyers B; Rose L; Perreault MM; et al. (2014). Predictors of physical restraint use in Canadian intensive care units. *Critical Care*, 18(2), R46



Far from keeping patients “safe”, restrained patients are at risk for functional decline, serious injury or death from falls or strangulation – which includes restraint inhibiting chest inhalation/exhalation, poor circulation, heart stress, incontinence, muscle weakness, infections, skin breakdown (pressure ulcers), reduced appetite, behavioral changes, social isolation and depression among other adverse events (Evans & Cotter, 2008).

Restraint also damages the therapeutic relationship. Once trust is broken, it becomes more difficult for others to provide care.

These are some of the reasons why we no longer refer to restraint devices as “safety devices”.

References

Evans, L.E., & Cotter, C.T. (2008). Avoiding restraints in patients with dementia. American Journal of Nursing, 108(3), 40-50. [as quoted in American Academy of Nursing, ChoosingWisely, Physical Restraints].

Do patients & families mind?

- ***"I have done nothing to deserve this. To think you fought a war – now I am a POW!"***
- ***"I tried to untie my hands to resist. I think any human being would"***
- *"My mom was put in a private home at 95 where they gave her 2-3 Ativan per day. She fell and broke her hip and we weren't told until the next day. When my mom was in the hospital, they took her walker away, locked it in the bathroom and told her she couldn't get up. Considerations for "safety" took over any quality of life. My mother would have rather died a few years early and be allowed to walk."*

Weeks and even decades after discharge, patients remember the experience of being tied down, and may be left with permanent traumatic memories.

Families are saddened and frustrated when health care providers use restraint without consultation, especially when this results in patient harm and impacts quality of life.

References:

patient quotes from Strumpf, N.E., & Evans, L.K. (1988). Physical restraint of hospitalized elderly: Perceptions of patients and nurses. Nursing Research, 37(3).132-137.
Family quote: AHS patient and family advisor

Restraint and Aggression

Over 50% of behaviours reported to AHS involve physical assault or physical aggression

Over 50% of behaviours reported to the AHS Reporting and Learning System (RLS) involve physical assault or physical aggression. Restraint continues to be acceptable for Emergency Treatment if there is an immediate threat to the safety of patients, caregivers or others (e.g. physical assault, self-harm) and immediate action is required.

But a review of 510 RLS reports involving physical assault or physical aggression, between (October 2016 to June 2017) showed that 64.5% of the reported physical violence occurred during provision of personal care (needing to undress the patient – bath, peri-care) and tasks being done with the patient (e.g. v/s, med administration, feeding). Many of these incidences can be prevented by modifying staff approach; examples will be provided later in this presentation.

Other acceptable uses of restraint indicated in the policy:

- Part of an approved treatment or care plan, developed in collaboration with the patient and/or alternate decision-makers. E.g. a very strong, head-injured patient pulls out essential tubes and monitoring devices unless wrists are mechanically restrained; lines and tubes are discontinued as soon as possible, and in the meantime, family and staff work together to remind, reassure, and occupy the person.
- The patient's behavior is severely disruptive and negatively impacts or interferes with the care of others, their rest or recovery. E.g. While minimal restraint is applied, look for possible reasons for agitation: Is the person in pain? Overstimulated? Exhausted? Taking too many medications?

Always attempt to address the underlying reasons for aggression, and discontinue restraints as soon as possible. When needed, use the least restrictive restraint for the shortest period of time

This Workplace Health and Safety poster and the next two that follow are meant to invite discussion. If you were the patient, would 4 point restraint calm you down? What *would* help?

Restraint and Aggression

What else is going on?

- History of trauma
- Delirium
- Substance withdrawal
- Acute pain
- Grief reaction
- Stressors: noise, bright lights and uniforms

There are things we can do to de-escalate anxiety and reduce agitation before it progresses to aggression

- Validate feelings, find things to agree on
- Don't react, argue or be defensive
- Respond in a calm voice
- Offer reassurance and assistance
- Check for underlying needs.
- Provide more personal space, allow time before trying another approach
- Offer positive choices
- Recognize the difference between venting and abusive language

Talk to the patient to find out what upsets them, and what helps them the most when they're upset. Include these insights in the care plan.

The policy principles stipulate that "staff caring for patients at risk for the use of restraint (or all patients with potential or real behavioural challenges) shall receive education on appropriate restraint use and application. Program areas shall identify training requirements for staff."

On your worksheet:
What training is provided to staff in your practice area, to prevent escalation of behaviours, or to de-escalate situations that may occur?

Restraint and Aggression

Is she aggressive or terrified?

Can she see & hear?

Does she understand what you're doing?

Is she in pain?

Is it your approach?

What else can you try?

This woman has a reputation for aggression. Staff have been kicked in the head, scratched and bitten during personal care. 3-4 people are required to give care. She's on antipsychotics to protect staff from injury, though it doesn't seem to be working. There have been 5 staff injuries in the past 2 weeks.

But what's her side of the story?

- Visually Impaired – sees blurry movement, light and darkness
- Mostly deaf and hears no high tones – hearing aids were lost in the laundry or left on the meal tray last week
- Cognitive impairment (dementia) – difficulty making sense of limited information
- Arthritis and degenerative disc disease – stiff from sitting in chair for past 3 hours, it feels like staff are ripping her arms off when she's assisted in and out of clothing
- Over-medicated (a mistake was made with her med orders, and she has received 5 times her usual dose of Elavil)
- Staff came in talking to each other, hoisted her by arms out of chair and into bed, restrained arms and legs, removed clothing, began cleaning private areas

What might she think is going on? How might she respond?

We need to consider how we're handling patients, and adjust to their barriers to communication and comprehension.

The family and care partners need to be included, they're the ones who know best the personality of that person. They can help us develop a care plan that will help the patient feel safe.

Note: What are you already doing well, to help patients feel safe?

Some information on use of antipsychotics for responsive behaviours:

There is no clinical evidence to support use of antipsychotics for these behaviours. Some of these behaviours can be caused by antipsychotics, such as nervousness, restlessness, calling out and insomnia.

Antipsychotics can worsen responsive behaviours by adding confusion and akathisia or restlessness. Do you have a person who rarely sleeps and calls out all the time? Try tapering antipsychotics and other medications.

Evidence of benefit: Aggression and antipsychotics: 5-14 people need to be treated for 3 months, for one person to improve. Marginal benefit over placebo.

A low dose of antipsychotic may help a small percentage of people with aggression, but we need to monitor if it's helping, not helping, or making things worse (adding falls, confusion, more impulsivity, increased aggression)

Antipsychotics increase the risk of falls, which often leads to mechanical restraints, the combination of which increases the risk of delirium, prolongs hospitalization, and may result in hospital acquired disability and even death.

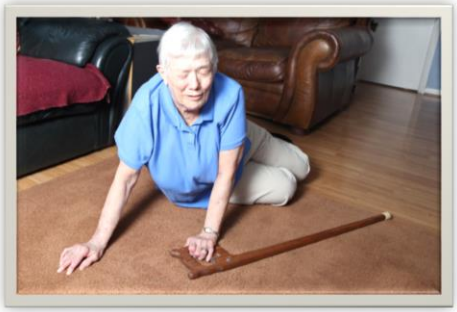
References:

Clinical Indications for Prescribing Antipsychotics

https://www.albertahealthservices.ca/assets/about/scn/ahs-scn-srs-aua-prescribing-antipsychotic.pdf

Potential Side Effects of Antipsychotics

- Confusion
- Agitation, restlessness
- Sleep disturbances
- Muscle stiffness, weakness, pain
- Difficulty urinating
- Nausea
- Hyper-salivation
- Falls



Not only are antipsychotics ineffective for most responsive behaviours, they have many side effects that can increase distress. A 2011 study showed atypical antipsychotics used in persons with dementia advance cognitive decline by one year compared to placebo (Vigen)

They increase risk of falls by causing muscle stiffness and weakness, tremors, shuffling gait, jerky movements, restlessness (extrapyramidal side-effects) blurred vision and orthostatic hypotension
They disrupt rest and sleep by akathisia - the need to be in constant motion.
They may contribute to diabetes and increased lipids.
The lip-smacking and tongue thrusting of tardive dyskinesia may be irreversible.

Many stories have emerged from the 170 LTC sites involved in the AUA project in Alberta:

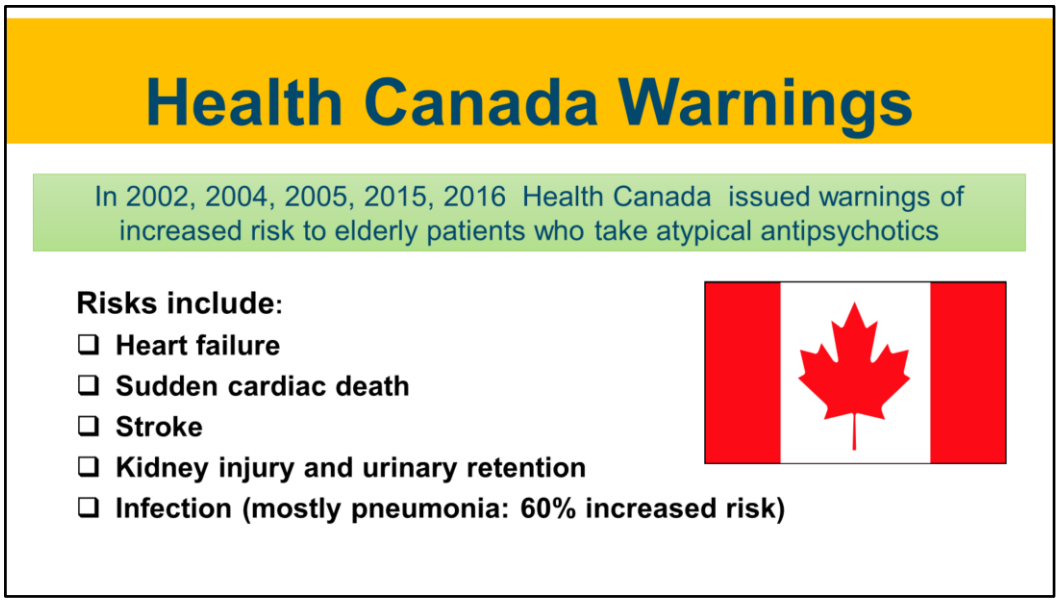
- One man had 45 aggressive incidents per month – his antipsychotic hadn't been discontinued after a delirium. Once his antipsychotic was tapered and discontinued, he had no further aggressive incidents.

- Many residents who screamed and called out constantly became quieter after their antipsychotics were discontinued. They were able to have conversations again, and express their needs without frustration.

- In many cases, staff found it easier to care for residents, and they sleep better when they are not on antipsychotics.

Note: Reduce dose cautiously e.g. ¼ to ½ dose every 1-2 weeks.
Note: The antipsychotic may be an appropriate treatment for a chronic mental health diagnosis. Adjustments without expert consultation may lead to a de-stabilization of symptoms such as psychosis.

References:
http://www.open-pharmacy-research.ca/wordpress/wp-content/uploads/antipsychotic-deprescribing-algorithm.pdf



Antipsychotics come with many risks.

Health Canada has issued multiple warnings of increased risks from antipsychotic medications in elderly patients.
This includes risk of death from

- Heart failure, sudden cardiac death, stroke and infection (mostly pneumonia).
- Risk of acute kidney injury and urinary retention

Antipsychotic medications can increase saliva – which may present as drooling or spitting - along with decreased ability to swallow. This increases the risk for aspiration pneumonia. Antipsychotics were shown to cause a 60% increase risk of aspiration pneumonia in the elderly (Knol 2008)

References

Knol W; van Marum RJ; Jansen PA; et al. (2008). Antipsychotic drug use and risk of pneumonia in elderly people. *Journal of the American Geriatrics Society*, 56(4), 661-6.

Alternatives to Restraint

Success Stories from:

- **Emergency Department**
- **Adult Inpatient: Orthopedic Surgery**
- **Adult Inpatient: Medical and Transition Units**
- **Pediatrics**
- **Addiction and Mental Health: Inpatient psychiatry**
- **Geriatric mental health**
- **Protective Services**
- **Older Adult: Medical and Transition Units**

The next series of slides describe leading practices from throughout Alberta

Resources specific to a variety of practice settings are being developed.

Emergency Department

Alternatives to Restraint: Misericordia ED

- Early recognition of delirium and dementia
- Early involvement of geriatric experts
- Non-slip socks
- Avoid indwelling catheters
- HCAs assist to walk/to the bathroom regularly
- Support sleep

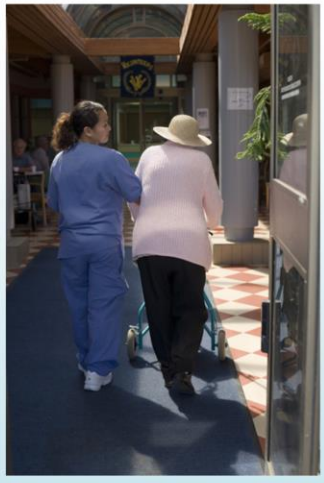
Emergency department: Misericordia ED provides non-slip socks to prevent falls. Indwelling catheters are avoided in older adults, and questioned when they're ordered. HCAs assist older patients to the bathroom & keep them mobile. Early recognition of delirium and dementia prompts involvement of a geriatric team: A geriatric physician and Geriatric RN (mon to Fri) and NP (7 days/week 10-6) assesses what supports are in place, what to set up in community. Ear plugs and eye masks are available on their carts to support sleep at night.

Alternatives to restraint: non-slip socks, avoid indwelling catheters (a tripping risk); assist to walk and to the bathroom regularly, support sleep, early recognition of delirium and dementia – and early involvement of geriatric experts.

Orthopedic Surgery

Alternatives to lap belts: Misericordia Orthopedic Team

- Mobilize and strengthen
- Assist to BR regularly
- Involve families
- Reduce social isolation
- Support sleep
- Hydrate
- Review and reduce medications



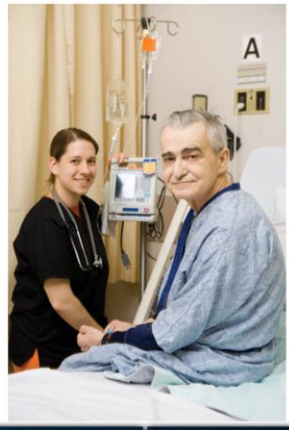
Orthopedic Surgery: Misericordia orthopedic surgery unit has many frail older adults admitted for hip surgery. Falls are always a concern – and are often a reason for injury and surgery. They noticed that 75% of patients over 65 had some type of restraint in place, including lap belts, trays, full bed rails and soft limb restraints. For example, many patients were automatically restrained in their chairs with a lap belt that fastened from behind. Staff viewed it as a safety measure – like the seat belt in a car. But the restraints were not safe – Restraints *increased* the risk of injury of patients with cognitive impairments and contributed to agitation and mental distress. They decreased restraint use by 84% across the surgery program: one strategy was to lock up the lap belts. These were only provided if there was a clear reason, agreed to by patients, families and staff – and used in the least restrictive way for the shortest period of time. The patients are easier to work with, and less distressed. Patients eat breakfast and lunch together, and sit together in the hallways instead of alone in their rooms. Families are more involved in care and patients without a restraint can stay safe under the supervision of their loved ones.
To date, there has not been an increase in the number of falls!

Alternatives to restraint: Mobilize and strengthen, walk with patients to the bathroom regularly, involve families in supervision of patients, reduce social isolation by providing opportunities to be with other patients e.g. group rehabilitation, meals, sit beside each other in the hallway or lounge area

Adult Inpatient: Medical and Transition Unit

Alternatives to physical restraint: Unit 71/72 Foothills Medical Centre

- Staff Education for all: managers, unit clerks, HCAs, nursing, allied health and housekeeping
- Let the patient take the lead: do *with* not *to*
- The courage of one: 1 person provides care
- Approach and re-approach
- Everyone works together



Alberta Health Services

The majority of patients on Unit 71/72 have dementia and a history of aggression, but they are not restrained by multiple people for personal care:

- First of all, Unit 71/72 staff consider this “attacking the patient”.
- Second, it can take hours for patients to calm down after physical restraint. While upset, patients may lash out, leading to environmental, mechanical and pharmacologic restraints.
- Third, it takes too long to physically restrain for care. It can take 15 to 30 minutes to round up four staff and provide hygiene. It takes one person 5 to 10 minutes.

It’s not easy to rebuild trust, but they persist. One person approaches and offers care. If the patient refuses, they return later with another approach or staff member. They offer warm blankets, they’re calm and gentle. One patient loved knitting, so the unit clerk talked to her about yarn while another staff quietly provided hygiene care.

All 200 staff participate in an annual education day, from managers to housekeeping. Staff education includes dementia training, an emphasis on restraint as a last resort and team-building. Everyone works together so patients can walk around and be assisted to the toilet. Even housekeeping participates – e.g. if they notice a patient has forgotten his walker, they bring the walker to the patient. Falls and fall injuries have declined dramatically.

In addition to education, the heart-warming outcomes sustain a patient-centred culture:

- A patient came with the instruction “4 person hygiene, call security.” Within 8 days, she became semi-independent. One staff member supported her to pull on her own briefs. She sat quietly at the desk with a fidget mat. She could still react to too much stimulation in the environment, but was headed to a more home-like facility, probably within a month, instead of “changing her postal code to FMC.”
- Another patient came heavily medicated, incontinent, total care, total lift. She sat in a Geri chair, yelled and didn’t sleep. The doctor removed the drugs and she woke up. Staff walked with her, at first with assist of two and a transfer belt. She went to assisted living, not LTC, and she was continent. The day she left, she was walking with a 2ww, dancing to a catchy tune, wearing red lipstick. She had her life back!

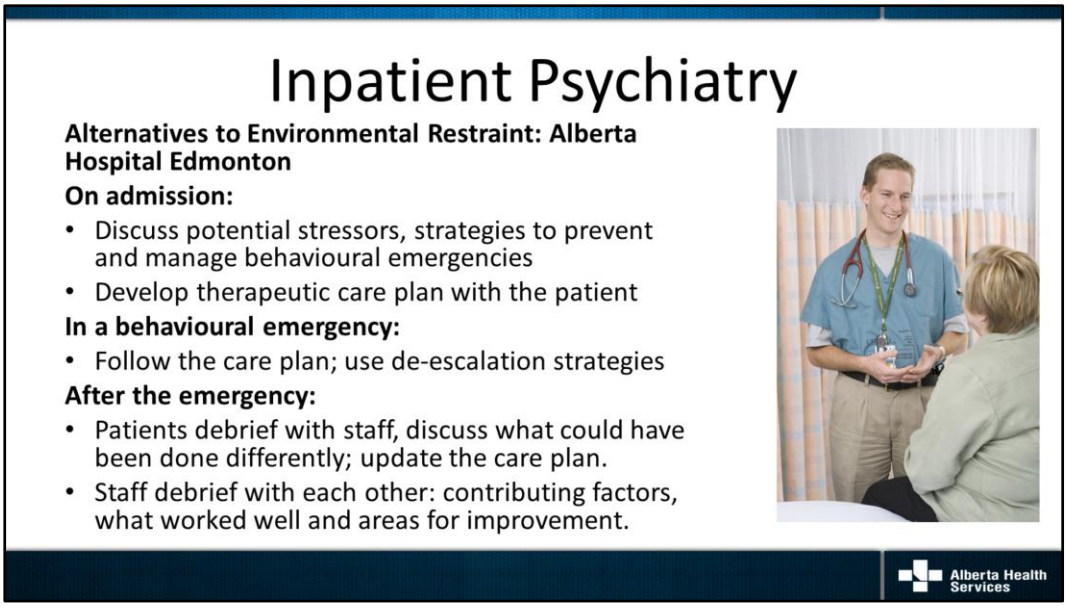
Sharp needles and uncomfortable procedures are terrifying for children. This poster illustrates 10 ways to support children with the least restraint – and the most comfort.

Restraint is still the last resort. A parent writes, “In our experience restraining did not work for our child. We felt rushed and the lab was busy so we agreed, but in reality it ended up taking a lot longer to find people to hold her down, and distract her, (while she panicked) than it would have if we hadn't. Since she was panicking it was also lot harder for them to take her blood so they had to make several tries. I think if she would have been given the time she asked for she might of felt more secure in the scary situation and could have built on her coping skills and confidence, making it easier in the future. Being held down set her back on her treatment plan and gave her severe anxiety which has taken us a long time to work through.”

The photograph on the right illustrates a child with positioning devices. These are not restraints, because the disability is what immobilizes – the positioning device allows her to sit upright, eat and drink safely and interact with others.

Safety restraints used in everyday care of children are also not impacted by the new policy and pediatric inpatient procedure (e.g. appropriate use of crib rails, arm boards, and restraints that are part of products such as highchairs, swings, strollers, car seats). A “time out” for the purpose of regaining emotional control is also not classified as a restraint by the policy and pediatric inpatient procedure.

Poster: 10 Ways to Help your Child get Through Challenging Procedures
https://www.albertahealthservices.ca/stollery/Page14246.aspx



Inpatient psychiatry: At Alberta Hospital Edmonton, restraints such as seclusion rooms are used as a temporary control for behavioural emergencies (situations where imminent action is required to prevent harm to the patient or others). Many factors can contribute to behavioural emergencies, including extreme anxiety, a history of trauma, dementia, delirium, substance withdrawal, acute pain, a visit from or separation from a significant other, a grief reaction, and environmental stressors such as noise, bright lights and uniforms.

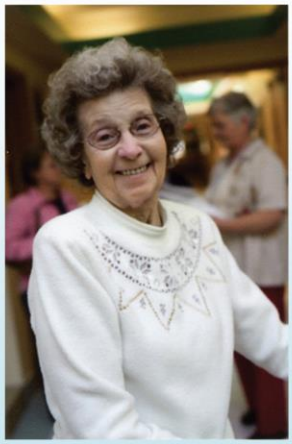
AHE has seen a significant reduction in the frequency of environmental restraint (seclusion) events, and the duration of each seclusion event has dropped from more than 18 hours to less than 3. At the same time, staff have acknowledged an increased therapeutic threshold to work things through in times of behavioral escalation on the unit, and have expressed increased confidence in their team members.

Alternatives to restraint:
•On admission, staff and patients discuss potential stressors, and preferred strategies for prevention and management of behavioural emergencies. A therapeutic care plan is developed in partnership with the patient.
•Should a behavioural emergency arise during admission, the care plan is followed and de-escalation strategies employed. Staff carry pocket cards with the 10 Domains of De-escalation, a reminder of crucial responses such as: respect the patient's personal space, be aware of your own body language, only one person verbally interacts with the patient at a time, pay attention to the patient's words and body language, use active listening and find something about the patient's position to agree with.
•Debriefing after the emergency allows everyone to learn from the experience: Patients debrief with staff, allowing opportunity to explain their side of the incident, discuss what staff could have done differently, and update the therapeutic care plan. Support and encouragement are provided, and control is given back to the patient. Staff also debrief with each other. Contributing factors are identified and interventions evaluated. Staff look for what worked well, and areas for improvement.

Geriatric Mental Health

Alternatives to Pharmacologic Restraint: Villa Caritas Edmonton

- Develop a person-centred care plan: involve patient, family and previous health care providers
- Behaviour mapping to identify triggers and patterns (informs care plan)
- Review medications, reduce potentially inappropriate medications



At Villa Caritas in Edmonton, staff work with the patient, family and previous health care providers/facilities to develop a care plan.

They use behaviour mapping to identify triggers, patterns and strategies.

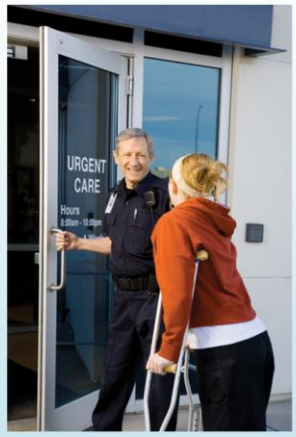
Their geriatric psychiatrists review medications on admission. Often the only treatment the person needs is fewer medications.

They have many good news stories, including a gentleman who was destined for Long Term Care. Staff noticed he was probably recovering from a delirium, as he was quite high functioning. They supported his care, and he was able to go to an assisted living facility instead!

Protective Services

Alternatives to Restraint: FMC U32 & 71/72

- Identify potential for aggression
- Collaborate with unit staff and the patient's care partners to develop a person-centred care plan
- Care planning is a process: Approaches are attempted along with behaviour mapping
- Clinical staff follow the care plan
- Clinical staff try to de-escalate the situation
- If called, Protective Services attempts dialogue first
- If needed, least restraint is used for the shortest time



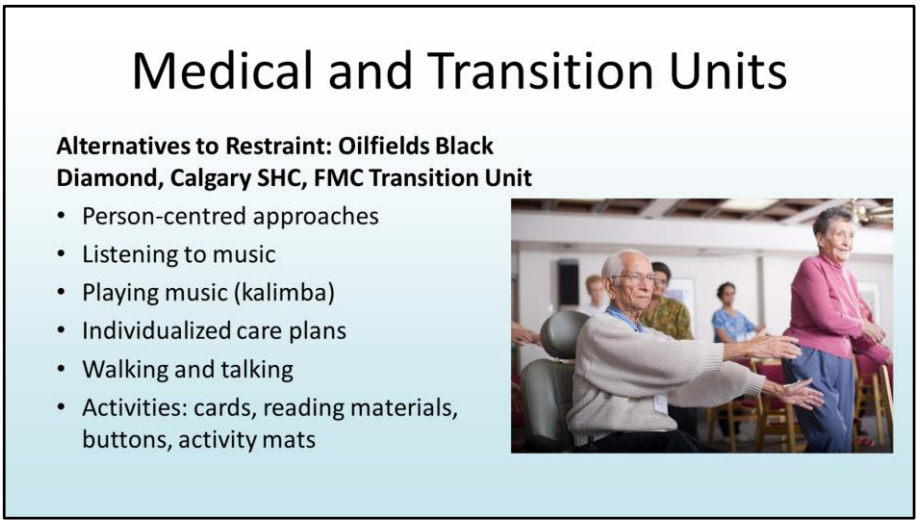
Richard Hutchinson, manager of protective services at Foothills Medical Centre, noticed security was called frequently to support hygiene of a particular patient on Unit 32. He wondered if there was a better strategy for the patient and staff. Together, Protective services and the care team explored ideas, and developed a person-centred care plan. Now they collaborate regularly. They ask questions such as:

- Is there another way, other than a shower, to support this patient's hygiene?
- Does the patient need to shower this frequently?
- Is this procedure, treatment or medication necessary?
- Does anyone have a strategy that works better?

This partnership between Protective Services and the care team enhances safety for patients and staff. Staff follow the care plan, which prevents aggravating the situation. If a behavioural crisis occurs, staff try first to de-escalate the situation. If Protective Services is needed, they talk with the patient first, as they must justify use of force in a court of law. If restraint is needed, they work with staff to use the least restrictive restraint.

Here are two stories from another FMC unit, Unit 71/72, about restraint as a last resort, and effective collaboration with protective services.

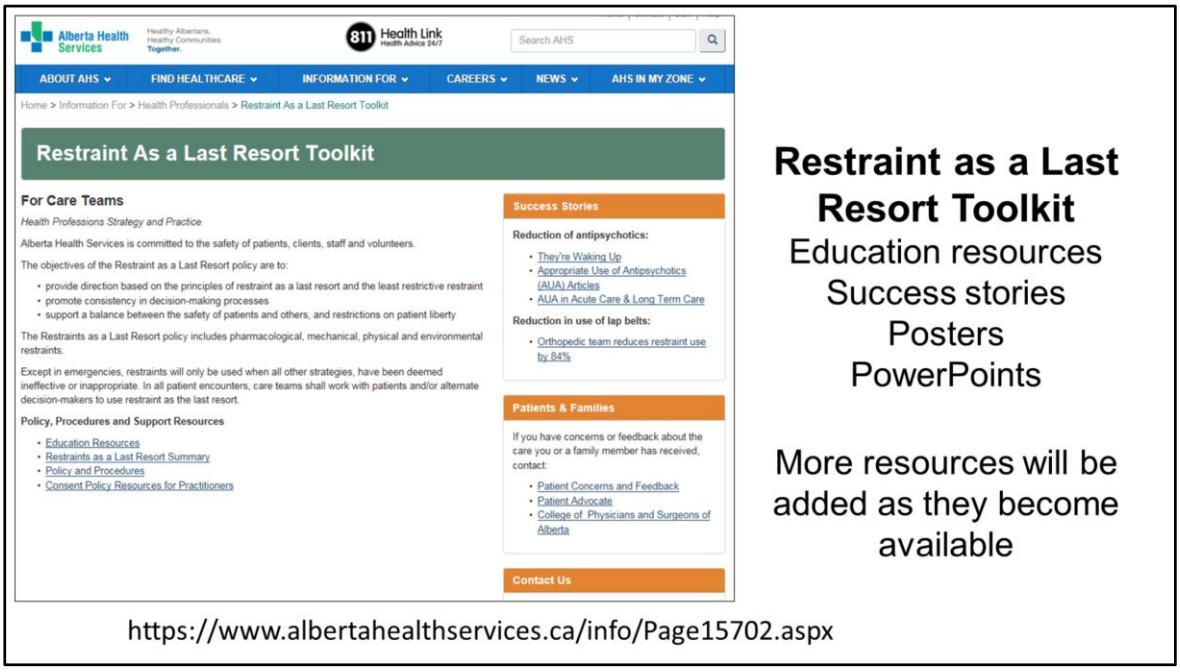
- A dementia patient's father was a naval officer, and he responded well to men in uniform. The patient found shift change overwhelming, so around 1430, protective services would invite him to the quiet of his room, which had a half door. He was always willing to follow! After shift change, the door was opened.
- A woman's arm had been broken by use of physical restraint, during an altercation with another patient. On the way back from the cast clinic, she became alarmed by an argument in the hallway and attempted to run from the building. The nurse with her used gentle physical restraint to stop her at the Emergency Doors. The nurse held up her hands, to signal the officer to approach slowly. "There's a nice man here, who will help you get home safely," she said. The officer approached in a calm and friendly manner. "Hi, I'm Stu," he said as he held out a hand. "I'll help you get back to your unit."



Sometimes patients are bored, and wander into other people's rooms, or sleep too much in the day and too little at night.
An elderly patient came to **Oilfields General Hospital in Black Diamond** after a hip replacement, and his dementia had advanced significantly. At a weekly multidisciplinary meeting, his nurse shared that he was a former bus driver. The occupational therapist and her aide worked with engineering to fashion a table top with a steering wheel for his wheelchair. The patient could remove the apparatus whenever he chose, but never did. "This patient was happiest in his wheelchair, driving his school bus," recalls Norma Schock, acute and ER care manager.

Calgary South Health Campus: Kaitlin Segboer, a Recreation Therapist, has found music to be a great way to create bonds with dementia patients. "Music and memories are deeply connected," Segboer emphasizes." Often times, people who are unable to have a conversation are still able to sing along to their favourite songs."

Calgary Foothills Medical Centre Transition Unit: Shyann Rogan, a Clinical Nurse Educator, agrees. "We embrace getting to know our patients and developing individualized care plans. We do activities based on individual needs, and likes/dislikes, such as music." The Transition units have a pair of kalimbas, which are wooden instruments with metal tines. Patients can play them by plucking the tines with their thumbs. Other activities include adult colouring books and washable markers, online colouring pages that can be printed for free, durable and washable playing cards from education stores, plastic cribbage boards, dementia mats, a bag of buttons for sorting, and reading materials. Ambulatory patients walk in a loop around the units with staff. "While we walk, we talk. It's a culture change that's bigger than just activities. If we get to know our elderly beyond their disease, we can provide the best care for all patients."



Looking for resources to support staff education and practice change?

The Restraint as a Last Resort Toolkit is available on the AHS External Website

Additional general resources, and resources for Specific Care settings are being developed, and will be added as they become available.

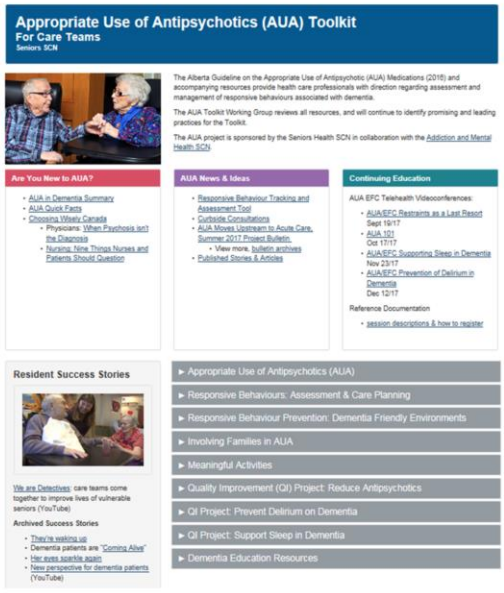
Dementia Resources

Google AUA Toolkit:

- Curbside Consultations
- Education Resources

MyLearningLink:

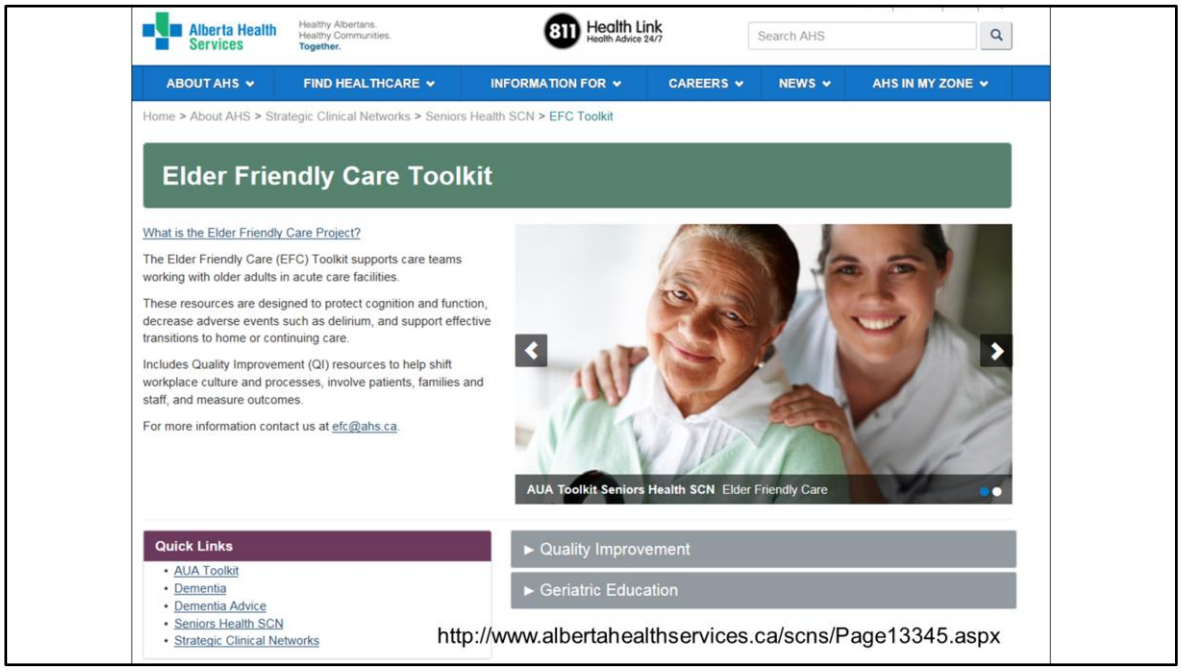
- See the Person
- Normal Aging Changes
- Dementia
- Supportive Pathways



https://www.albertahealthservices.ca/scns/auatoolkit.aspx

Some acute care facilities are already familiar with the AUA Toolkit developed for continuing care; many of the resources are applicable for persons with dementia in any setting.

There are also many excellent courses to support dementia care on MyLearningLink.



The Elder Friendly Care Toolkit includes quality improvement packages to support care of older adults in acute care.

The EFC project supports teams from ED, medicine, surgery, continuing care and the community to work together to:

- Decrease hospital acquired disabilities
- Improve outcomes for older adults
- Stop doing things that are not value-added (e.g. too many medications) to free up resources for excellent care and more timely discharge/transition

Quality Improvement resources include:

- Restraint as a Last Resort
- Delirium prevention
- Support of Sleep
- More to come!

For more information, contact efc@ahs.ca

Questions?
Success stories?
Resources to recommend?

Contact policy@ahs.ca