Alberta Health Services

Restraint as a Last Resort in Acute Care

Seniors Health Strategic Clinical Network in collaboration with Health Professions Strategy and Practice

Alberta Health Services

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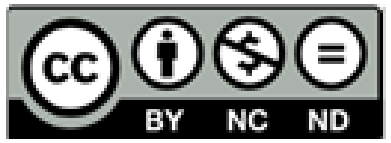
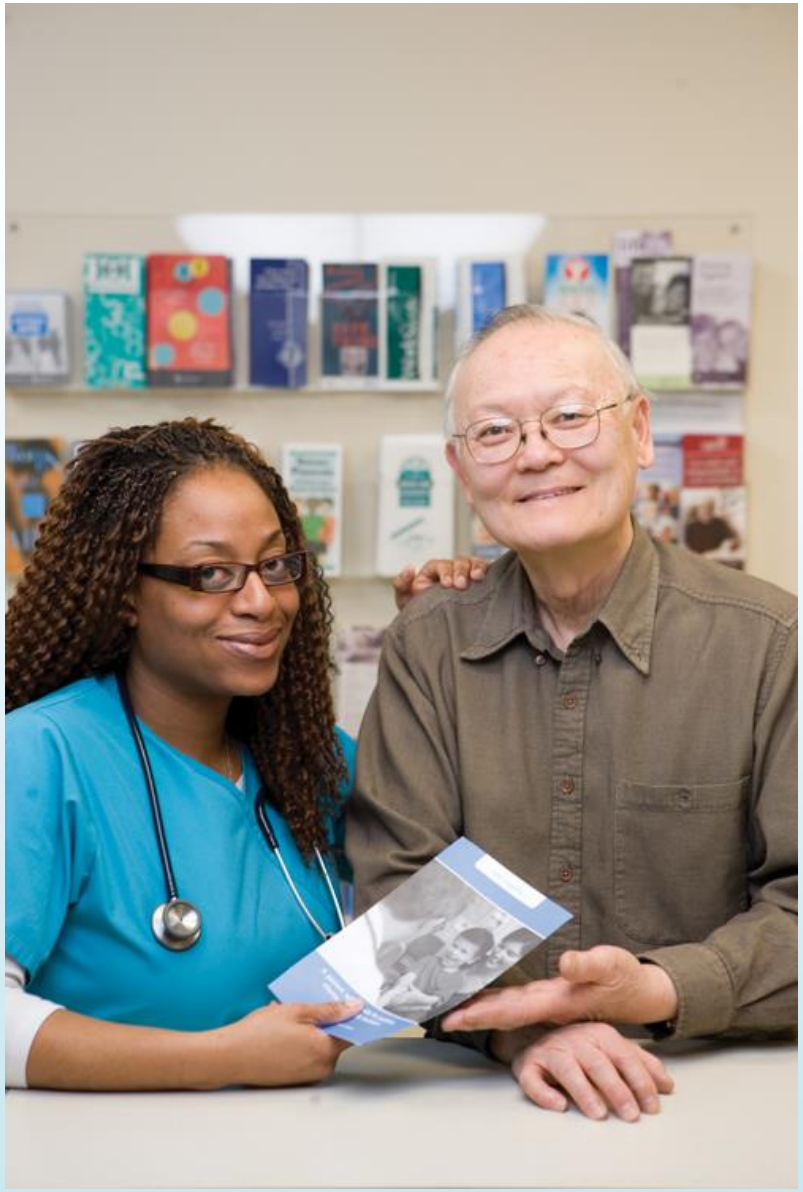


Objectives of this Presentation

- Key elements
- Alternatives
- Resources
- Plan

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



Key Differences

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

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*

Four types of Restraint

Physical

- **Restraining limbs e.g 4 persons to provide care**
- **Moving a person to another location against their will**

Environmental

- **Seclusion room**
- **Half doors, barricades**
- **WanderGuard**
- **Secure units**

Mechanical

- Limb, waist and trunk
- Back-fastening seat belt
- Full bed-side rails
- Chair with locking table
- Broda/Geri

Pharmacologic

- Antipsychotics
- Antidepressants
- Sedatives
- Benzodiazepines
- May be scheduled or prn

Are These Restraints?

- Medical tubing
- Bed alarms
- Constant care
- Chairs with locking table tops
- Broda/Geri chairs

Are These Medications Restraints?

- Antipsychotics for “behaviours”
- Antipsychotics to “calm” or “settle”
- Antipsychotics for delirium
- Midazolam for intubated patient
- HS sedation after midnight
- Anticholinergics for sedation

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?

Reasons for Restraint

82%	Protect from **falls**
59-72%	Maintain therapeutic **devices** e.g. IV
67%	**Protect others** from combativeness
65%	**Confusion**
22%	Prevent **wandering**
13%	Prevent from **bothering** other patients
12%	**Encourage rest**

Does restraint prevent falls?

Restraint use is positively associated with falls.

Res Theory Nurs Pract 2011

"Restraint use is associated with increased severity of injury in hospital patients who fall"

J Med Sci 2005

Restraint use is associated with decline in cognition, ADL performance and walking

Gerontologist, 2008

Does restraint protect medical devices?

ICU study found increases in:

- Delirium, agitation, overall adverse events
- Doses of opioids, sedatives, antipsychotics
- Extended use of antipsychotics
- Length of stay in ICU
- Post-Traumatic Stress Disorder Critical Care 2014

Mechanical restraint increased self extubation by 3.11 times

Am J Crit Care Sept 2008 vol. 17 no. 5 408-415

Some risks of restraint

- Damage therapeutic relationship
- Functional decline
- Serious injury
- Death from falls or strangulation
- Poor circulation
- Heart stress
- Incontinence
- Muscle weakness
- Psychological Trauma
- Infections
- Skin breakdown
- Reduced appetite
- Behavioural changes
- Social isolation
- Depression

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."*

Restraint and Aggression

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

Restraint and Aggression

What else is going on?

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

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?

Antipsychotics are *not* effective for:

- Calling out, repetitive questions
- Wandering, exit-seeking
- Inappropriate elimination
- Eating inedibles (soap, dirt, feces)
- Perseveration (clapping, tapping)
- Inappropriate dressing/undressing

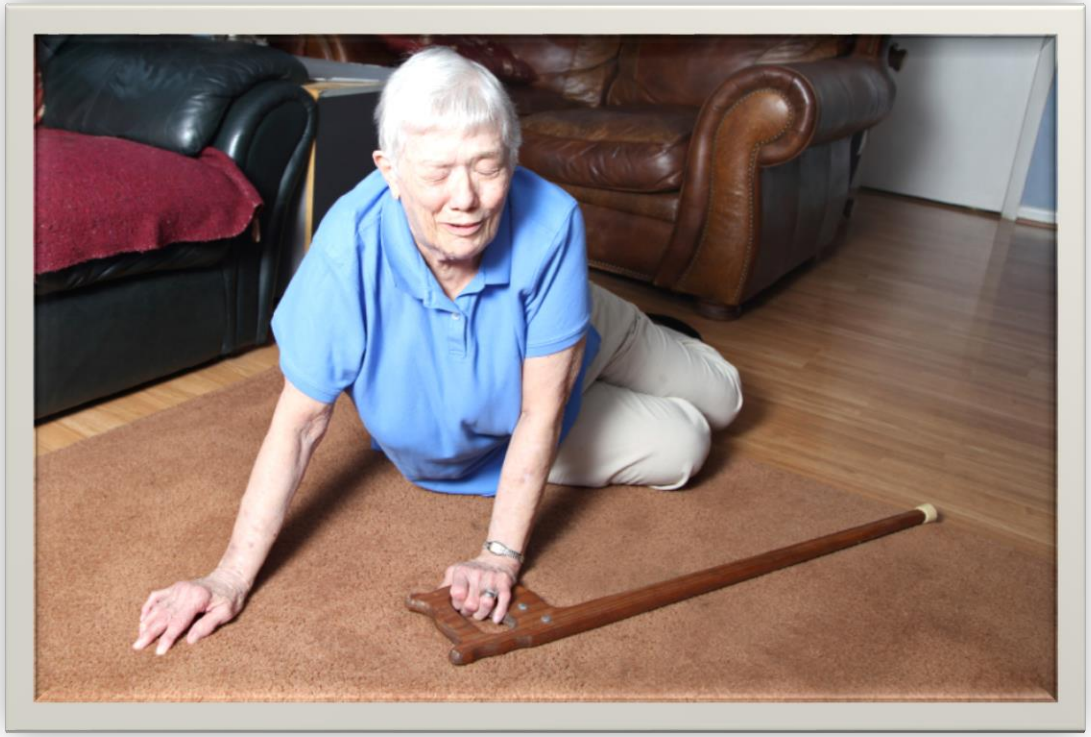
- Socially inappropriate
- Hiding/hoarding items
- Insomnia
- Spitting
- Crying
- Nervous or restless

Limited Effectiveness for Aggression:

NNT 5-14 for 3 months

Potential Side Effects of Antipsychotics

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



Health Canada Warnings

In 2002, 2004, 2005, 2015, 2016 Health Canada issued warnings of increased risk to elderly patients who take atypical antipsychotics

Risks include:

- ❑ **Heart failure**
- ❑ **Sudden cardiac death**
- ❑ **Stroke**
- ❑ **Kidney injury and urinary retention**
- ❑ **Infection (mostly pneumonia: 60% increased risk)**

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**

Emergency Department

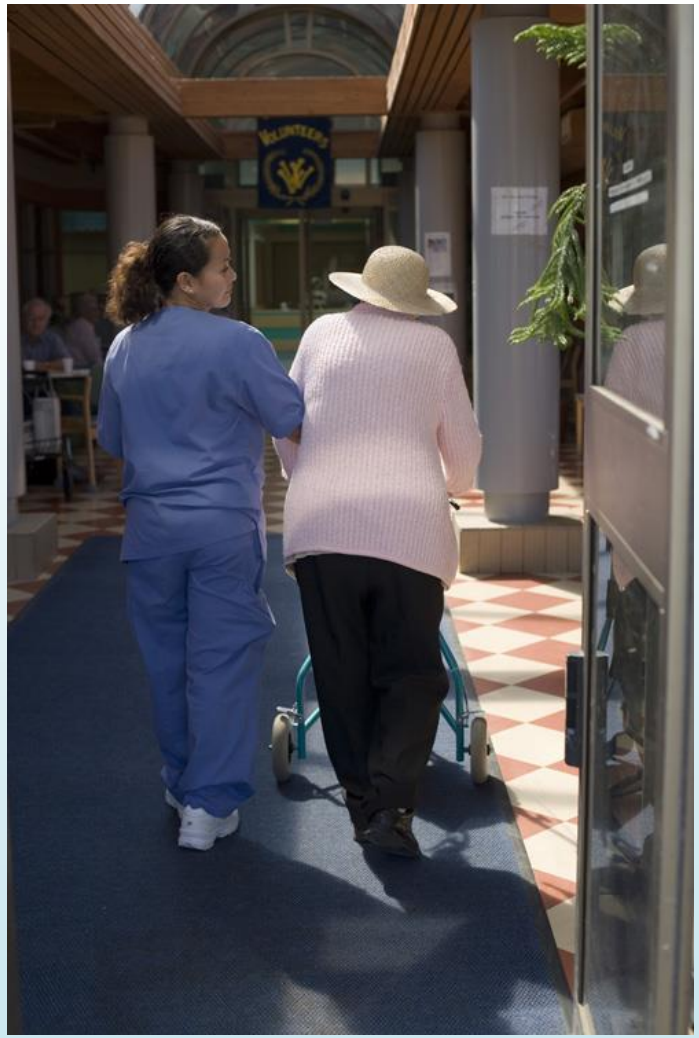
Alternatives to Restraint: Misericordia ED

- 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

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



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

Inpatient Pediatrics

Inpatient Psychiatry

Alternatives to Environmental Restraint: Alberta Hospital Edmonton

On admission:

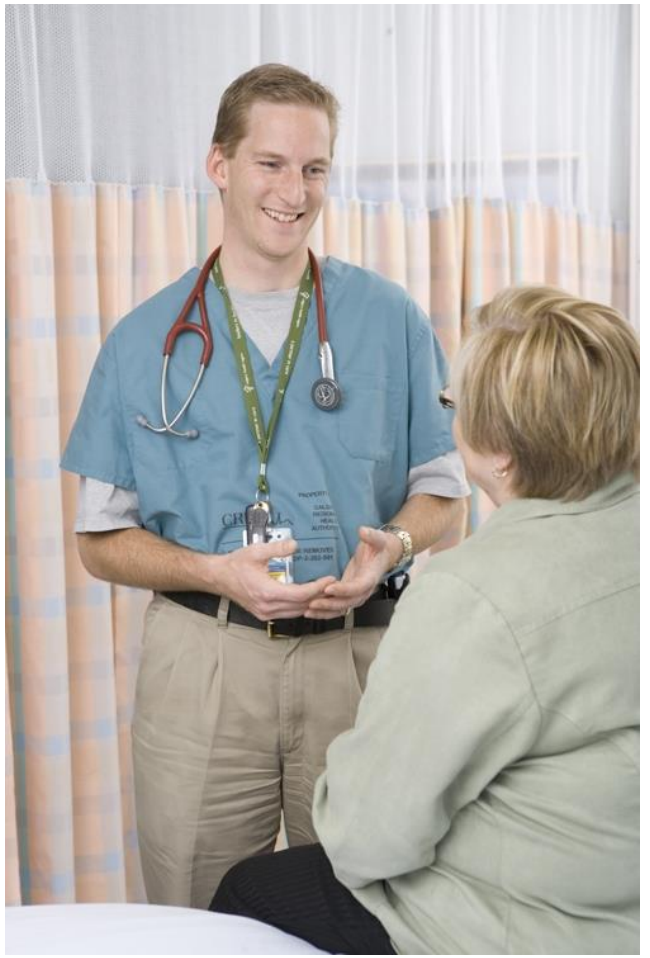
- Discuss potential stressors, strategies to prevent and manage behavioural emergencies
- Develop therapeutic care plan with the patient

In a behavioural emergency:

- Follow the care plan; use de-escalation strategies

After the emergency:

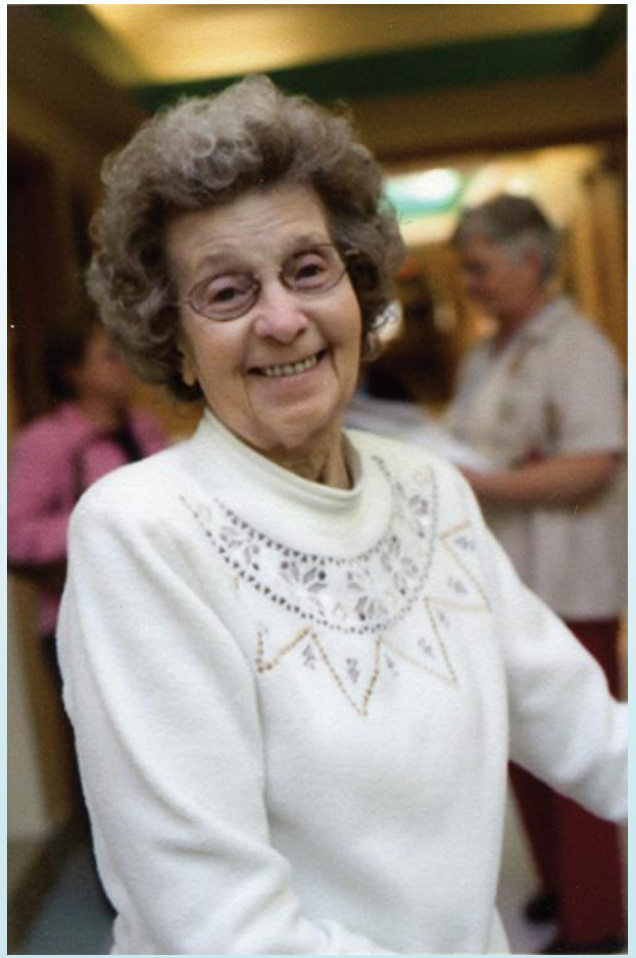
- Patients debrief with staff, discuss what could have been done differently; update the care plan.
- Staff debrief with each other: contributing factors, what worked well and areas for improvement.



Geriatric Mental Health

Alternatives to Pharmacologic Restraint: Villa Caritas Edmonton

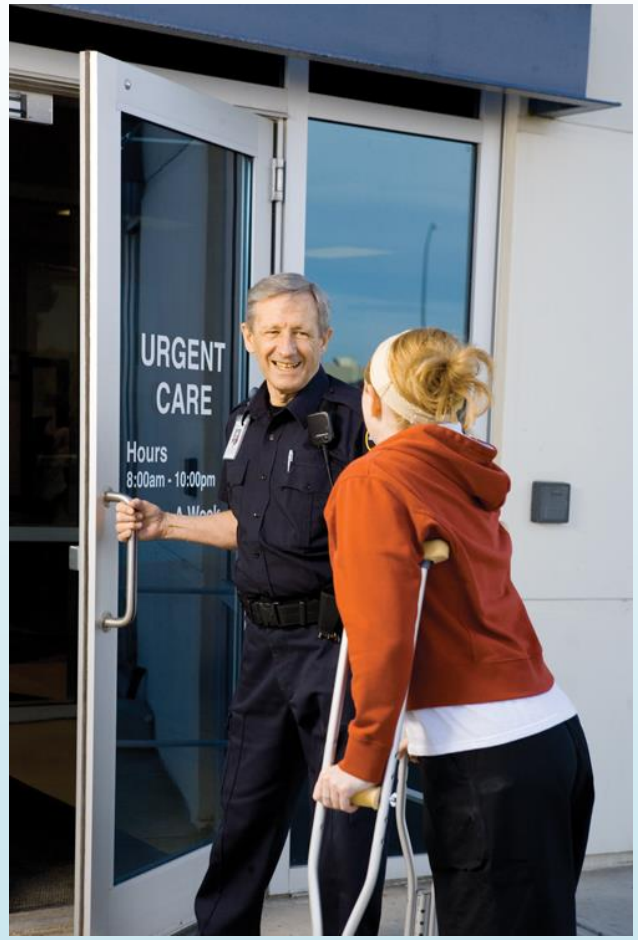
- Develop a person-centred care plan: involve patient, family and previous health care providers
- Behaviour mapping to identify triggers and patterns (informs care plan)
- Review medications, reduce potentially inappropriate medications



Protective Services

Alternatives to Restraint: FMC U32 & 71/72

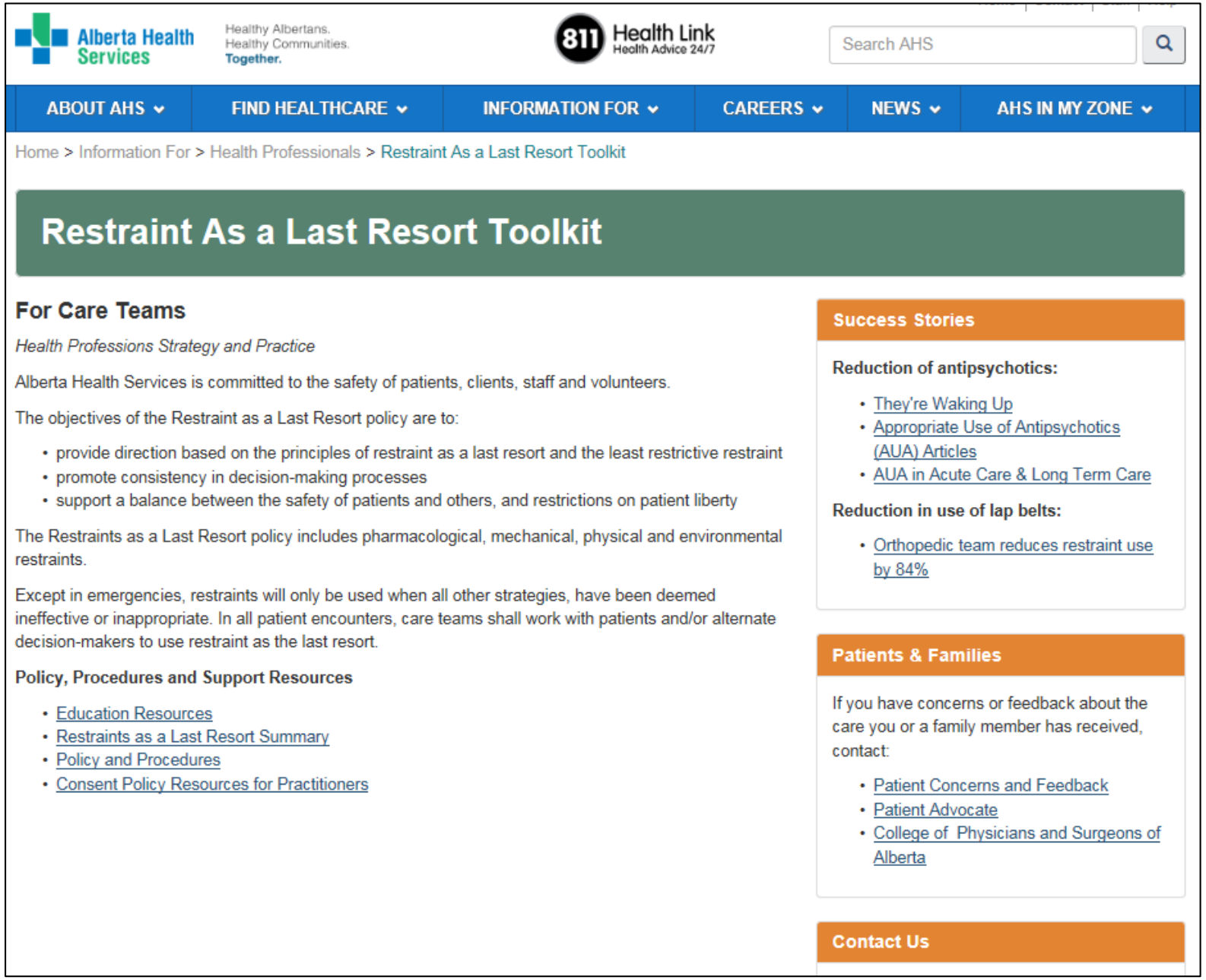
- Identify potential for aggression
- Collaborate with unit staff and the patient's care partners to develop a person-centred care plan
- Care planning is a process: Approaches are attempted along with behaviour mapping
- Clinical staff follow the care plan
- Clinical staff try to de-escalate the situation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



Medical and Transition Units

Alternatives to Restraint: Oilfields Black Diamond, Calgary SHC, FMC Transition Unit

- Person-centred approaches
- Listening to music
- Playing music (kalimba)
- Individualized care plans
- Walking and talking
- Activities: cards, reading materials, buttons, activity mats



Restraint as a Last Resort Toolkit

Education resources
Success stories
Posters
PowerPoints

More resources will be added as they become available

https://www.albertahealthservices.ca/info/Page15702.aspx

Dementia Resources

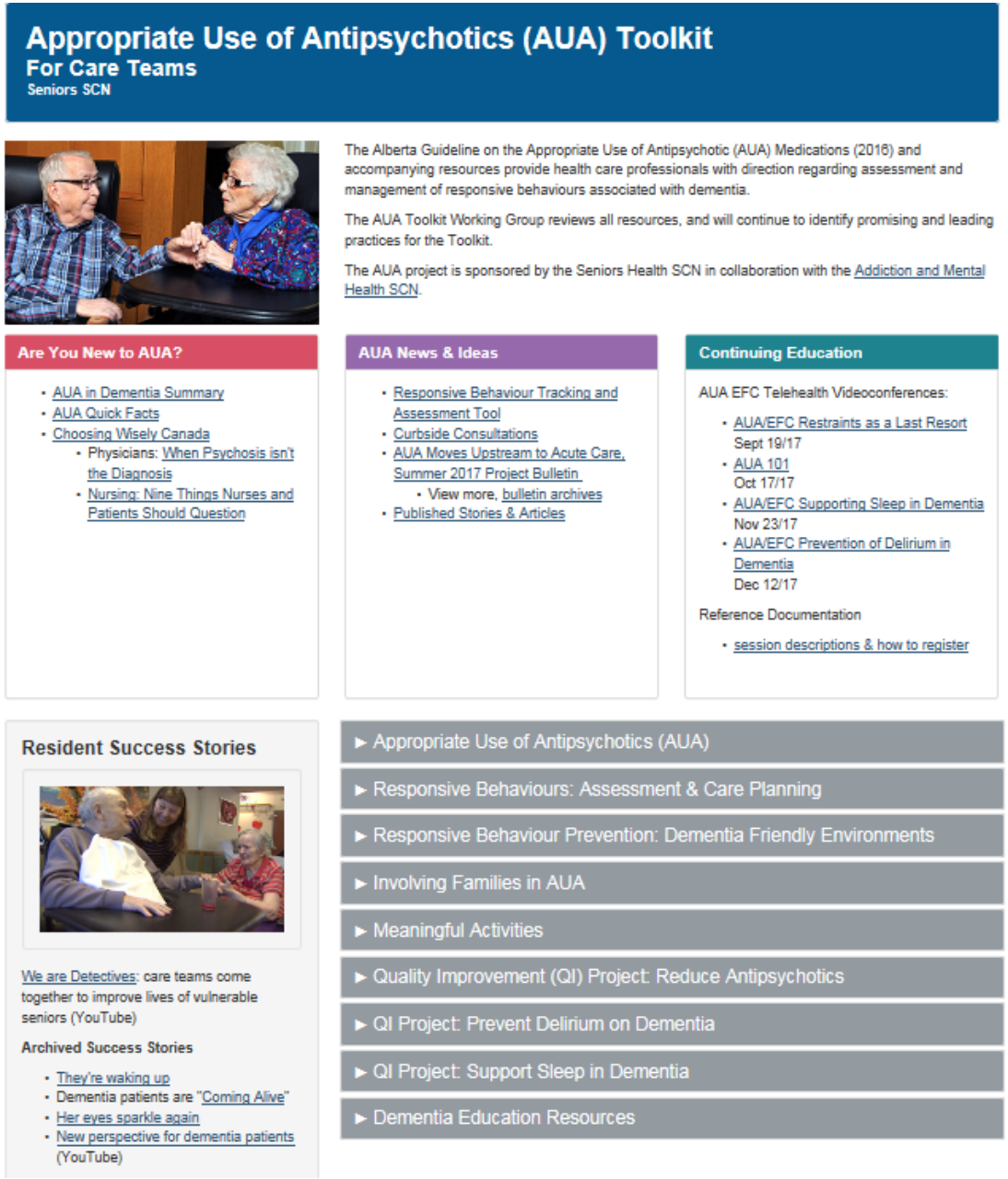
Google AUA Toolkit:

- Curbside Consultations
- Education Resources

MyLearningLink:

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

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



Elder Friendly Care Toolkit

What is the Elder Friendly Care Project?

The Elder Friendly Care (EFC) Toolkit supports care teams working with older adults in acute care facilities.

These resources are designed to protect cognition and function, decrease adverse events such as delirium, and support effective transitions to home or continuing care.

Includes Quality Improvement (QI) resources to help shift workplace culture and processes, involve patients, families and staff, and measure outcomes.

For more information contact us at efc@ahs.ca.

Quick Links

- AUA Toolkit
- Dementia
- Dementia Advice
- Seniors Health SCN
- Strategic Clinical Networks

► Quality Improvement

► Geriatric Education

http://www.albertahealthservices.ca/scns/Page13345.aspx

Questions?
Success stories?
Resources to recommend?

Contact policy@ahs.ca