



Alberta Health  
Services

# Restraint as a Last Resort in Acute Care



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

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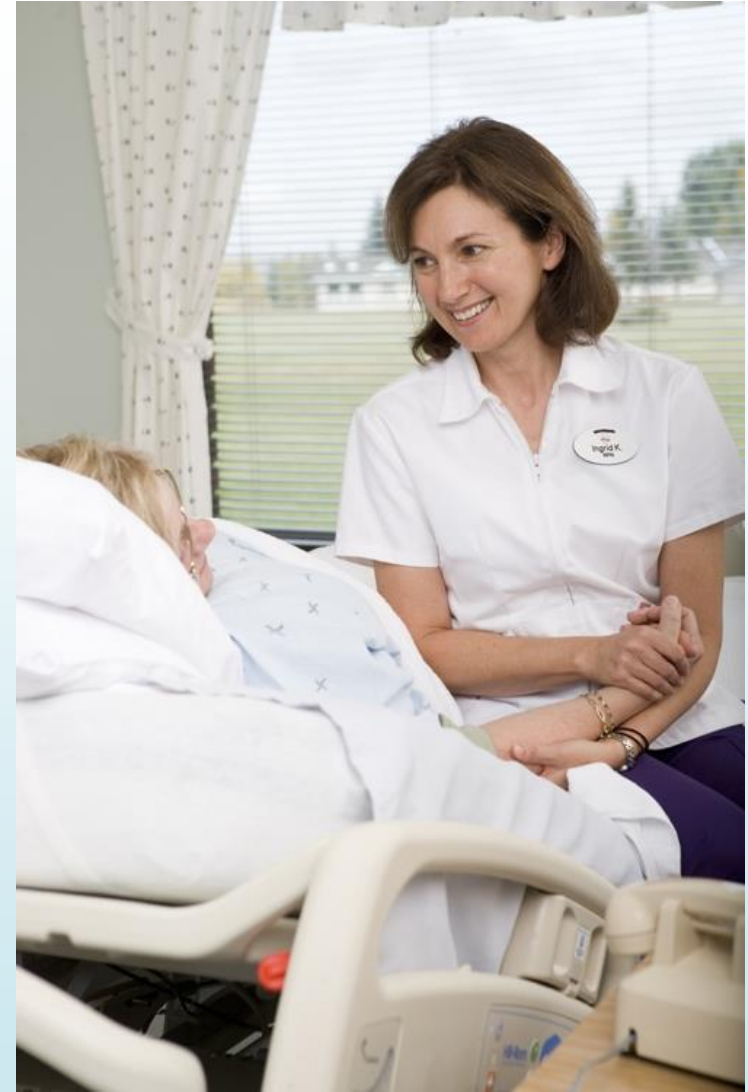
# Objectives of this Presentation

- 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***

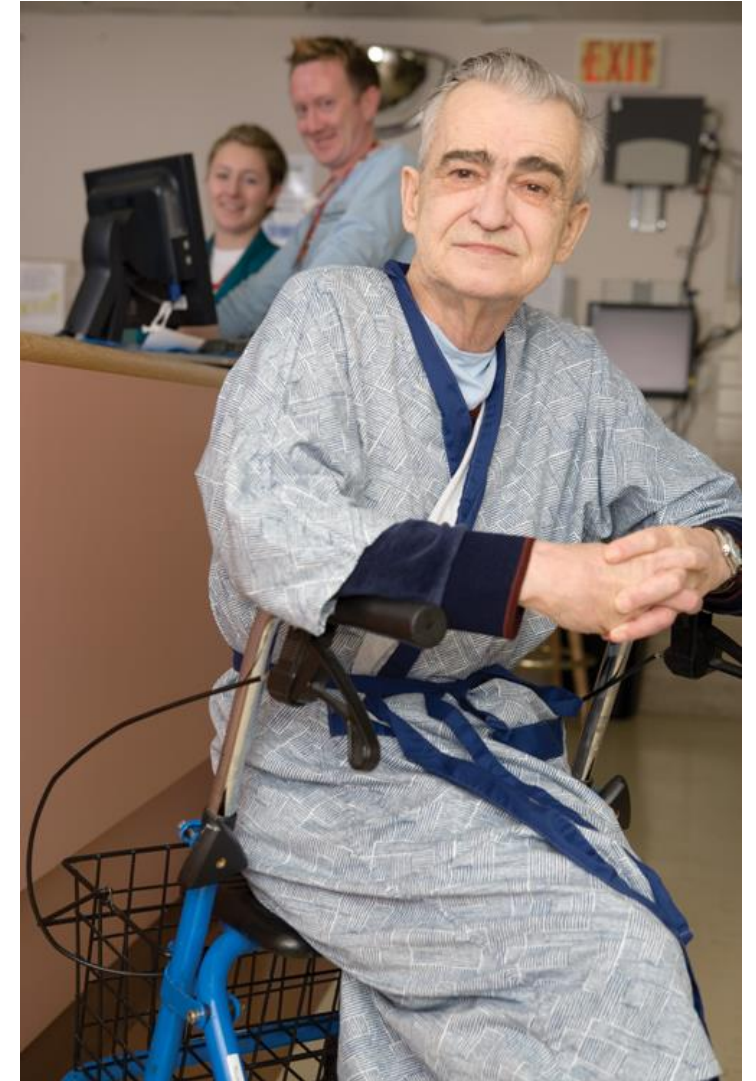
Am J Crit Care Sept 2008 vol. 17 no. 5 408-415

# 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



*He didn't know his own strength.*

ACCEPTING WORKPLACE VIOLENCE IS **NEVER** PART OF YOUR JOB.

- 1 Take Action: First Aid / Emergency Response
- 2 Tell Your Supervisor: IMMEDIATELY
- 3 Report Using MySafetyNet

 Alberta Health Services

 AHS cares

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



# Restraint and Aggression



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## What else is going on?

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

# Restraint and Aggression



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**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



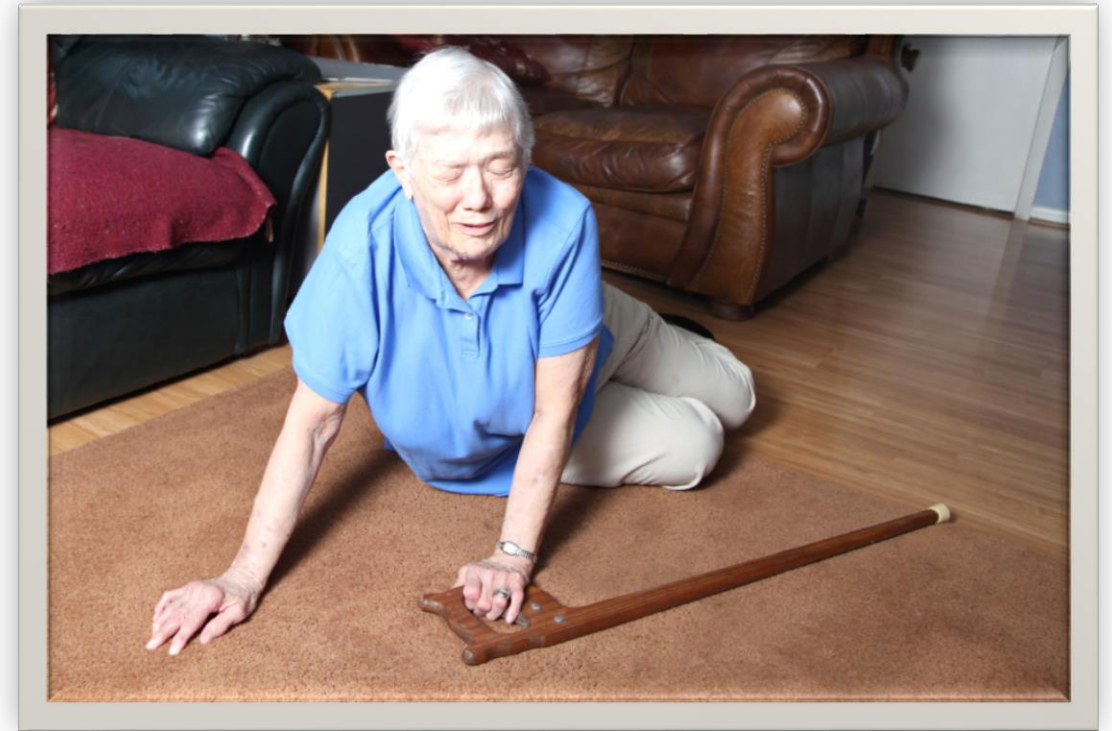
- Socially inappropriate
- Hiding/hoarding items
- Insomnia
- Spitting
- Crying
- Nervous or restless

## 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

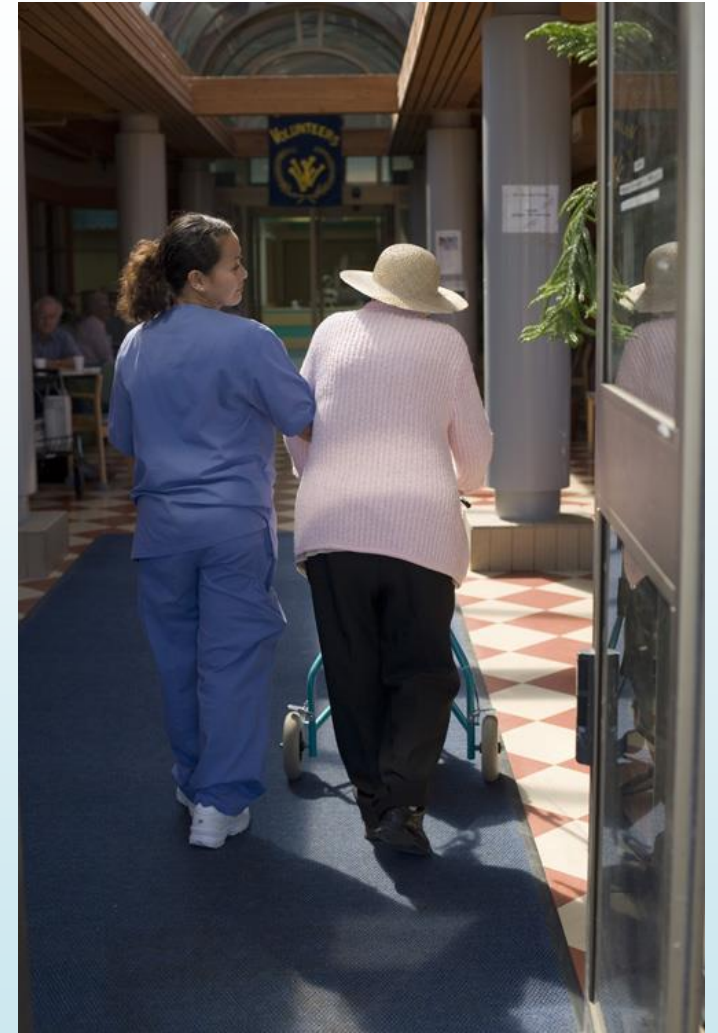
- Early recognition of delirium and dementia
- Early involvement of geriatric experts
- Non-slip socks
- Avoid indwelling catheters
- HCAs assist to walk/to the bathroom regularly
- Support sleep



# 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

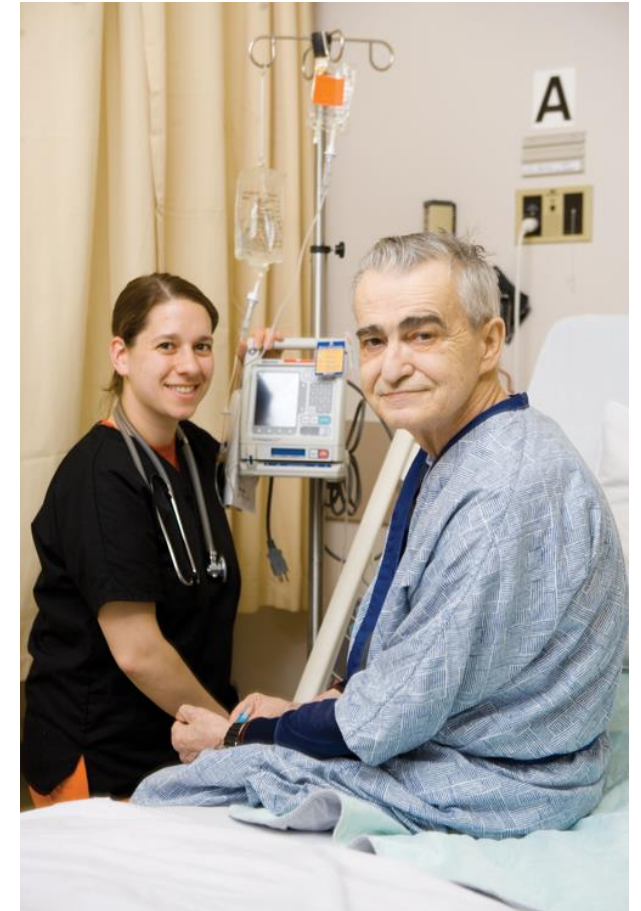




# Adult Inpatient: Medical and Transition Unit

## 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

**STAY CALM AND COPE ON...**  
Try some of these comfort positions for safety and support.



# Inpatient Psychiatry

## Alternatives to Environmental Restraint: Alberta Hospital Edmonton

### On admission:

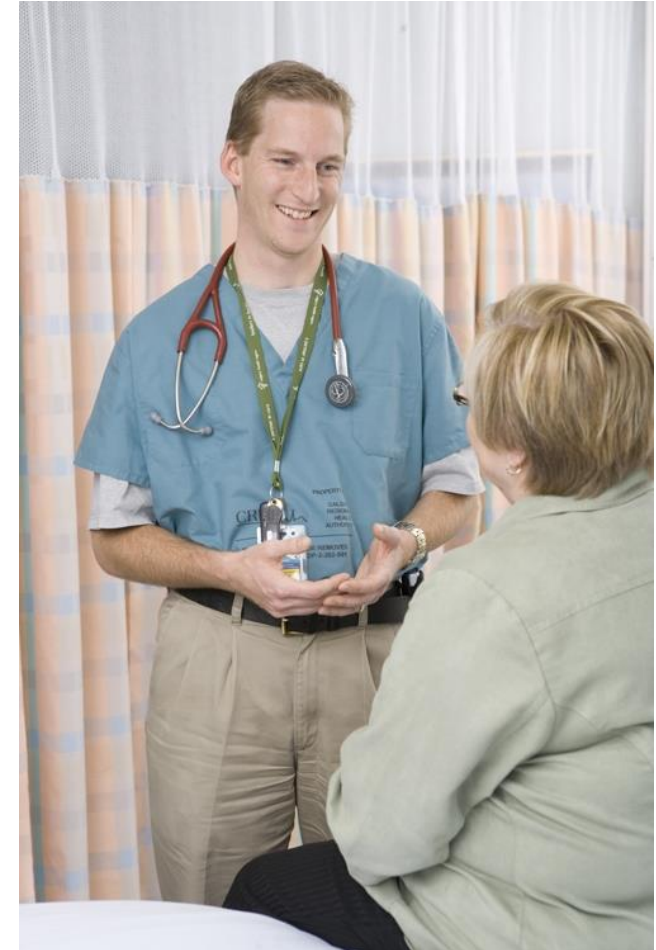
- Discuss potential stressors, strategies to prevent and manage behavioural emergencies
- Develop therapeutic care plan with the patient

### In a behavioural emergency:

- Follow the care plan; use de-escalation strategies

### After the emergency:

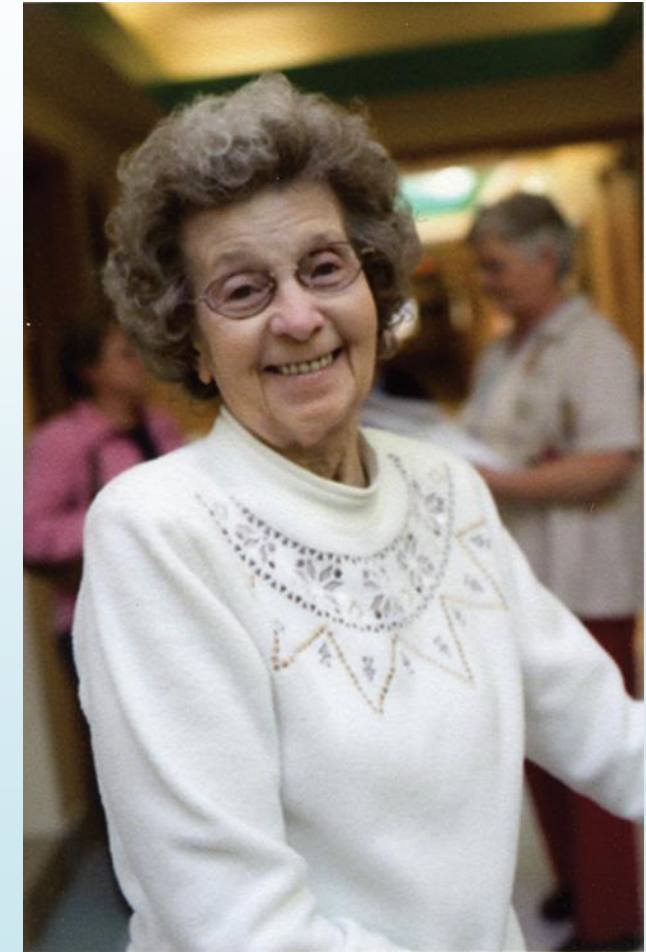
- Patients debrief with staff, discuss what could have been done differently; update the care plan.
- Staff debrief with each other: contributing factors, what worked well and areas for improvement.



# 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

### For Care Teams

*Health Professions Strategy and Practice*

Alberta Health Services is committed to the safety of patients, clients, staff and volunteers.

The objectives of the Restraint as a Last Resort policy are to:

- provide direction based on the principles of restraint as a last resort and the least restrictive restraint
- promote consistency in decision-making processes
- support a balance between the safety of patients and others, and restrictions on patient liberty

The Restraints as a Last Resort policy includes pharmacological, mechanical, physical and environmental restraints.

Except in emergencies, restraints will only be used when all other strategies, have been deemed ineffective or inappropriate. In all patient encounters, care teams shall work with patients and/or alternate decision-makers to use restraint as the last resort.

### Policy, Procedures and Support Resources

- [Education Resources](#)
- [Restraints as a Last Resort Summary](#)
- [Policy and Procedures](#)
- [Consent Policy Resources for Practitioners](#)

### Success Stories

#### Reduction of antipsychotics:

- [They're Waking Up](#)
- [Appropriate Use of Antipsychotics \(AUA\) Articles](#)
- [AUA in Acute Care & Long Term Care](#)

#### Reduction in use of lap belts:

- [Orthopedic team reduces restraint use by 84%](#)

### Patients & Families

If you have concerns or feedback about the care you or a family member has received, contact:

- [Patient Concerns and Feedback](#)
- [Patient Advocate](#)
- [College of Physicians and Surgeons of Alberta](#)

### Contact Us

**Restraint as a Last  
Resort Toolkit**  
Education resources  
Success stories  
Posters  
PowerPoints

More resources 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>

### Appropriate Use of Antipsychotics (AUA) Toolkit

For Care Teams

Seniors SCN



The Alberta Guideline on the Appropriate Use of Antipsychotic (AUA) Medications (2016) and accompanying resources provide health care professionals with direction regarding assessment and management of responsive behaviours associated with dementia.

The AUA Toolkit Working Group reviews all resources, and will continue to identify promising and leading practices for the Toolkit.

The AUA project is sponsored by the Seniors Health SCN in collaboration with the [Addiction and Mental Health SCN](#).

#### Are You New to AUA?

- [AUA in Dementia Summary](#)
- [AUA Quick Facts](#)
- [Choosing Wisely Canada](#)
  - Physicians: [When Psychosis isn't the Diagnosis](#)
  - Nursing: [Nine Things Nurses and Patients Should Question](#)

#### AUA News & Ideas

- [Responsive Behaviour Tracking and Assessment Tool](#)
- [Curbside Consultations](#)
- [AUA Moves Upstream to Acute Care, Summer 2017 Project Bulletin](#)
  - View more, [bulletin archives](#)
- [Published Stories & Articles](#)

#### Continuing Education

AUA EFC Telehealth Videoconferences:

- [AUA/EFC Restraints as a Last Resort](#) Sept 19/17
- [AUA 101](#) Oct 17/17
- [AUA/EFC Supporting Sleep in Dementia](#) Nov 23/17
- [AUA/EFC Prevention of Delirium in Dementia](#) Dec 12/17

Reference Documentation

- [session descriptions & how to register](#)

#### Resident Success Stories



[We are Detectives](#): care teams come together to improve lives of vulnerable seniors (YouTube)

#### Archived Success Stories

- [They're waking up](#)
- Dementia patients are "[Coming Alive](#)"
- [Her eyes sparkle again](#)
- [New perspective for dementia patients](#) (YouTube)

- ▶ [Appropriate Use of Antipsychotics \(AUA\)](#)
- ▶ [Responsive Behaviours: Assessment & Care Planning](#)
- ▶ [Responsive Behaviour Prevention: Dementia Friendly Environments](#)
- ▶ [Involving Families in AUA](#)
- ▶ [Meaningful Activities](#)
- ▶ [Quality Improvement \(QI\) Project: Reduce Antipsychotics](#)
- ▶ [QI Project: Prevent Delirium on Dementia](#)
- ▶ [QI Project: Support Sleep in Dementia](#)
- ▶ [Dementia Education Resources](#)



## 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](mailto:efc@ahs.ca).



### Quick Links

- [AUA Toolkit](#)
- [Dementia](#)
- [Dementia Advice](#)
- [Seniors Health SCN](#)
- [Strategic Clinical Networks](#)

▶ [Quality Improvement](#)

▶ [Geriatric Education](#)

***Questions?***  
***Success stories?***  
***Resources to recommend?***

Contact [policy@ahs.ca](mailto:policy@ahs.ca)