PPG-00324

Least Restraints in Long Term Care

Area	Personal Care Home and Transitional Care			
Section	Resident Care Management			
Subsection	N/A			
Document Type	Policy			
Scope	Applies to Transitional Care and all Personal Care Homes in Prairie Mountain Health (exception: proprietary personal care homes with their own corporate policy.)			
Approved By		**Original Effective Date**	**Revised Effective Date**	**Reviewed Date**
Debbie Poole, VP Acute, Long Term Care and EMS		2015-Jan-07	2019-Aug-21	2019-Aug-21

DEFINITIONS

Alternate Decision Maker (ADM): is a person who has decision-making capacity and is willing to make decisions on behalf of a client who does not have the capacity to make a decision. An ADM may be legally authorized (e.g. health care proxy, committee, substitute decision maker or public trustee) or may be a person designated (e.g. family member) in the absence of a legally authorized individual.

Chairs that prevent rising: A chair that has the ability to be reclined or tilted, and/or prevents independent rising by the resident. Examples include Geri-Chairs, recliners, and wheelchairs with the ability to tilt or recline.

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 is not required to treat the resident's medical or psychiatric symptoms. This includes sedatives, hypnotics, antipsychotics, antidepressants, or anti-anxiety medications. When a psychotropic medication is used in the absence of a supporting diagnosis of a mental illness, it is considered a chemical restraint.

Diagnostic and Statistical Manual (DSM): Diagnostic and Statistical Manual of Mental disorders (current version).

Emergency Restraint: When a restraint is required due to the occurrence of behavior that is of imminent danger to the resident or others, and which necessitates and leads to the use of a restraint.

Emergency Episode: Refers to a time that an emergency restraint is required for the management of a specific behavior that is of imminent danger to the resident or others. Once the resident is removed from the restraint the emergency episode is over. If the behavior reoccurs this is a new emergency episode.

Environmental Restraint: Barriers to free personal movement that serve to confine residents to specific areas (e.g. removal of a cane or walker, isolating the resident or confining to a room with the door closed).

Informed Consent: A process which involves dialogue, understanding and trust between the client or alternate decision-maker and the treating practitioner. Clients have a right to accept or refuse a proposed intervention. The individual providing informed consent has been made fully aware of all the potential benefits, burdens and other ethical considerations related to the use of the restraint.

Capacity: The ability of a person to make healthcare decisions and to consent to treatments and interventions as they are able to understand the information that is relevant to making a decision and are

able to appreciate the reasonably foreseeable consequences of their decision. Capacity should be determined as close to the time of the procedure/intervention as possible.

Interdisciplinary Team: Includes the resident/Alternate Decision Maker (if appropriate), and at minimum two staff, at least one being a RN, LPN, or RPN. The interdisciplinary team may include two nurses of different professional designations.

Restraint: Any restriction or reduction of voluntary movement or freedom implemented to ensure the safety of self, others or the physical environment. The elements of this policy apply to each category of restraint.

Restraint Assessment: A restraint assessment form is to be completed by the interdisciplinary team on initiation of a restraint, and recompletion should occur only if there is a change in restraint need or use.

Physical (or Mechanical) Restraint: Devices that the individual cannot remove at will and which restrict freedom of movement.

Potential Restraint: Any device that has the potential to become a restraint if the resident does not have the cognitive or physical capability to remove it independently.

Verification of Non-restraint: The process by which a nurse, occupational therapist or physiotherapist assesses and documents a resident's cognitive and physical ability to remove a potential restraint on request.

Witness: For the purpose of this policy a witness is an individual who observed or heard a person granting or refusing consent, to the use of a restraint. The witness does not have responsibility for the information provided or the understanding of that information. Any PMH employee may serve as a witness to the consent for restraint use.

Bedside Communication Tool: refers to the ADL guide (PMH483) and/or communication board (Bedside Communication Tool, PPG-01159).

Nurse Leader: For the purposes of this policy, the nurse leader may be any one of the following: Care Team Manager, Client Care Coordinator, Clinical Resource Nurse, Charge Nurse, or Mental Health Resource Nurse (MHRN).

Weighted Blanket: a blanket that is heavier in weight than a regular blanket and includes store purchased weighted blankets and home-made versions. Use of the weighted blanket can include specialized comfort or emotional care supported by the care plan.

POLICY STATEMENT

Prairie Mountain Health (PMH) supports a "least restraint" philosophy, and is in compliance with the *Health Services Insurance Act, the Personal Care Home Standards Regulation* and *the Province of Manitoba Health Ministerial Guidelines for the Safe Use of Restraints in Personal Care Homes (November 2014).* Restraints should only be implemented when necessary to prevent harm to residents, staff, or others. Restraints are used as a last resort after all other methods have been explored by the interdisciplinary team.

Restraint(s) can be employed when required in the clinical management of a resident. This applies whether the restraint is:

- For safety or reassurance of safety;
- For fall or injury prevention;
- For positioning or comfort, or;
- Initiated at the resident's or family's request.

Restraints are not, under any circumstances, used or prescribed**:**
- For the convenience of the staff
- As a standing order
- While the resident is on a commode or toilet
- For punishment or discipline

A restraint applied in an emergency situation must meet the following criteria:
- The restraint must be the minimum necessary
- The restraint must be a measure of last resort to protect the safety of the resident

Staff providing care for the resident in a restraint have received education in the promotion of a least restraints environment and the use, monitoring and documentation related to restraint use. Staff are familiar with the policy before providing resident care.

A continuous quality improvement and risk management program is in place that includes a mechanism for auditing the use of restraints.

Approved/Not-Approved Restraints:
Staff must be able to quickly and easily remove any mechanical device used as a physical restraint.

Table 1: The following restraints are approved and not approved for use:

Approved for Use:	**Notes:**
Hand Mitts	
Chairs that prevent rising	*Use of a chair that prevents rising is considered a restraint, even if the resident is immobile (e.g. Broda chair, recliner, Geri Chair, tilt wheelchair).* *If the resident can safely and independently move the power self-tilt wheelchair, or the control on a recliner to position themselves from an upright to a reclined position and back again, the recliner or power self-tilt wheelchair is not a restraint. This requires nurse verification.*
Lap table (do not tie in the back or lock)	*Lap tables that fasten at the back or lock are not approved for use.* *If the resident is able to push off the lap table if asked to, it is not considered a restraint. This requires nurse verification.*
Front fastening seat belts	*The use of seat belts on tub chairs (as per the manufacturer's recommendations) to provide safe care in the bath tub are not considered a restraint.* *Seatbelts used for transportation in a vehicle are not considered a restraint. Seatbelts attached to the resident's wheelchair to be used for transportation only, are indicated with red tape.*
Thigh belt **	***The thigh belt requires an Occupational Therapy (OT) consult before use.* *Thigh belts can be used in an emergency situation with a Broda for the episode only (without an OT consult).*
Foot/arm positioning device that restrict movement	

Bed Rails	*Bed rails that prevent 'normal' or 'usual' exit/entrance from the bed (e.g. full rails, ¾ length rails, 26 ½" rails in the horizontal position) are considered restraints.*
Four point positioning belt **	***The four point positioning belt requires an OT consult before use. A Four point positioning belt cannot be used for an emergency episode.*
Chemical restraints	*A psychotropic medication is considered a chemical restraint when:* • *Used in the absence of a supporting diagnosis of a mental disorder.* • *Where a diagnosis of dementia is present, and a psychotropic medication is being used on a PRN basis for managing one specific behavior (i.e. a PRN to increase cooperation with a bath or decrease episodic agitation).* *For the purposes of this policy, Dementia and Behavioral Psychological Symptoms of Dementia (BPSD) are not considered appropriate diagnosis; for the psychotropic medication to not be considered a chemical restraint.* *'Dementia with' a specific behavior (e.g. agitation, aggression) does not meet supporting diagnosis of a mental disorder.* *A medication is not considered a chemical restraint when:* • *Resident's diagnosis has met the criteria as defined in the DSM (current version).* • *In situations where a psychotropic medication is being used off-label to treat a documented medical diagnosis (e.g. restless leg syndrome, neuropathic or neurological pain) and there is documented evidence that the medication has been prescribed for this purpose.*
Not Approved for Use:	
Jackets or vests	
Strapping mechanisms	
Locking lap table tops	
Arm restraints	
Soft ties	
Pin/pen style release seat belts (buckle security cover)	
Non-manufactured varieties, including sheets	
Rear fastening seat belts	
Chest positioning belts	
Wheelchair safety bars	
Cloth/mesh/triangular pelvic restraints	
Weighted blanket as a restraint ***Note:*** *Careful consideration of the resident's health status should be made prior to applying a weighted blankets. The nurse will be required to verify movement, consider resident's general health condition, comorbidities, and cognitive capability to have insight and judgement into weighted blanket complication. The nurse documents in the IPN that the weighted blanket is in use, and documents in the care plan restraint section that the weighted blanket is a 'potential restraint'. The use of the weighted blanket as a potential restraint is reassessed every three months or more frequently with change in resident's condition. If the weighted blanked becomes a restraint, it is to be discontinued.*	

Note: Use of restraints outside the facility by family, where staff is unable to observe, are not considered a restraint.

Note: For the purpose of this policy, the following are not considered an environmental restraint:

- Low beds
- Electronic monitoring bracelets (e.g. Wanderguard/Roam Alert) and/or locked/secure units
- The use of brakes on a wheelchair to facilitate a resident engaging in an activity or meal
- Isolation for protection purposes during a time of infectious outbreak

PROCEDURE

1. Resident/ ADM / Staff Education

a. The resident/ADM is oriented to the *Least Restraints in Long Term Care policy* through the *PCH Resident and Family Handbook* (PMH148).

b. Where a restraint is required, the resident or ADM is provided a copy of the *Use of Restraints in Prairie Mountain Health* handout (PMH380).

c. During orientation, all staff who may care for a resident in a restraint, receive education on the promotion of the least restraints philosophy, and the use, monitoring and documentation of restraints.

d. Restraint education is offered annually to personal care home staff through SPOT modules, recorded webinar and/or in-services.

2. Acknowledgement of Restraint(s): *Admitted with a Restraint form* (PMH183) is used when a resident is admitted with a restraint(s) and is completed within 24 hours of admission (all admitted with restraints can be included onto one form). Document the known reason(s) the restraint(s) are being used for the resident in Section 1 of the form.

3. Assessment: Comprehensive Restraint form (PMH185)

a. Prior to considering restraint(s) for a resident, the interdisciplinary team explores other alternatives or interventions to the restraint use (refer to the *Reference Guide for use of Restraints* (PMH2154) and PMH Responsive Behavior Pathways Part 1 and 3 (Appendix A and C)).

b. After the interdisciplinary team has explored all possible alternatives or interventions to a restraint, the team completes an assessment, and documents on the form. The interdisciplinary team takes into account results of other assessments as appropriate.

c. The *Comprehensive Restraint form* (PMH185) is used when the application of a chemical, physical or environmental restraint is being considered. This form is completed within 6-8 weeks of admission, when the team is considering ongoing use of a restraint. A new Comprehensive Restraint form is completed with a change in resident condition or restraint requirements (not annually).

- Section 1: a description of the behavior, including the time of day and environment in which the behavior occurs, and any precipitating factors.
- Section 2: identifies all possible underlying causes: environmental, emotional/psychological, a description of the resident's physical state, including pain management; emotional state; and nutritional, and physical
- Section 3: identifies any actual and/or potential alternatives or interventions which have been tried and exhausted
- Section 4: identifies the benefits, burdens and ethical considerations of restraint use for the resident. The benefits must clearly outweigh the burdens for a restraint to be applied
- Section 5: All members of the team sign the *Interdisciplinary Team Recommendation* with their name and designation

Note: Each restraint requires a separate restraint form to be completed unless the restraints meet the following conditions:

- are used at the same time for the same purpose
- have similar alternatives and interventions to be trialed and exhausted
- have the same benefits and burdens, and for chemical restraints, have similar administration times and side effects

Note: If the need for an alternate or additional restraint is identified, a new Comprehensive Restraint form is required. A new restraint cannot be added to an existing restraint form.

4. Restraint Order (Includes PMH183 and PMH185, excludes: emergency restraints (PMH186))

a. Physical and Environmental Restraints: the order for use of a restraint is given by the nurse, nurse practitioner or physician. The order is documented on the appropriate form and includes the:

- Type of restraint to be used
- Frequency for observation
- Signature, and designation of the person giving the order

b. Chemical restraint order is documented on the Physician Order form and the Order section on the appropriate form:

- Is time limited with a discontinuation date
- Is ordered in person by the physician (not by phone)
- Includes the frequency for observation (refer to Procedure #6b: Observation and Monitoring, Chemical Restraints).

Note: If this process is not possible (requirements are unable to be met), the nurse is to complete an incident report.

Note: When medications are used specifically to restrain a resident, the minimal dose should be used and the resident reassessed and closely monitored to ensure his/her safety.

5. Consent (Includes PMH183 and PMH185, excludes: emergency restraints (PMH186))

Prior to application of the restraint, the nurse communicates the risks, benefits and other ethical considerations related to the restraint use or non-use. The informed consent from the resident/ADM is documented on the consent section on the appropriate form (See Informed Consent for Health Care Intervention, PPG-00172).

a. If the resident has capacity, informed consent is obtained from the resident. The ADM is included in the discussion, if the resident with capacity consents. If the resident lacks capacity, informed consent is obtained from the ADM.

b. When consent is given over the telephone, there must be a witness who has heard: the nurse's explanation of the benefits, burdens and other ethical considerations for use of the restraint; and the ADM's response. The nurse receiving consent, and the witness both sign the consent section on the appropriate form. The signature of the ADM should be obtained on the consent form at the first opportunity (within 2 weeks is preferred).

c. If the consent form is faxed to the ADM, the fax cover page is kept on the health record and not destroyed. The original faxed copy of the consent form (with the telephone consent documented) is kept on the health record until the signed copy is faxed back and received by the nurse. This signed copy should have the telephone consent and the consent area filled out. At this point, the unsigned copy (original, with the telephone consent only) can be destroyed.

d. If the consent form will be mailed for ADM consent signature, a copy of the signed telephone consent is mailed and the original signed telephone consent is kept on file until the copy is returned. When the copy is returned, the original telephone consent (without signed ADM signature) may be destroyed.

Note: A restraint is not to be applied without either verbal or signed consent. For example, if waiting for faxed consent from public trustee/alternate, the restraint cannot be applied unless verbal/telephone consent is received in the interim.

6. Care Plan (excludes: emergency restraints)

Restraint use is/are documented on the *Resident's Integrated Care Plan* (PMH484). The care plan is to include**:**

- Restraint type and method of application
- Specific length of time the restraint is to be used (e.g. when in bed, when in wheelchair, for meals only, when agitated, as needed, or regular schedule, etc.)
- Frequency of observing the resident, as identified in the order section of the applicable restraint form.
- When/how often the physical/ environmental restraint is to be removed (minimally every 2 hours, this is already reflected on the *Resident Integrated Care Plan* (PMH484))

a. The *Resident's Integrated Care Plan* (PMH484) and Bedside Communication Tool(s) are updated to reflect any changes (refer to Bedside Communication Tool policy PPG-01159).
b. For any potential restraints that the nurse, occupational therapist or physiotherapist, has verified that the resident can remove/move/release upon request, is to be documented on the *Resident Integrated Care Plan* (PMH484) in the *Restraint section:* V*erification of Non-Restraint*. Documentation in the *Interdisciplinary Progress Note* (PMH877) is to be completed by the nurse (e.g. resident able to undo seatbelt when asked to, therefore the seatbelt is not considered a restraint).

7. Observation and Monitoring (Includes PMH183, PMH185, and PMH186)

(Refer to PMH Responsive Behavior Pathways Part 1 and 3 (Appendix A and C)).

a. Physical or environmental restraint:

i. The frequency of monitoring of a resident is determined prior to the application of the restraint by the interdisciplinary team. The frequency of monitoring is documented in the *Restraint Order* section on the appropriate form.
ii. Following initial or emergency application of the restraint, a member of the interdisciplinary team monitors the resident every 15 minutes until the resident is settled, for safety, comfort and care needs. This is documented on page 2 of the *LTC Observation Record – Closer Observation* (PMH184).
iii. Once the resident is settled, staff monitor the resident at minimum hourly while the restraint is in use. This is documented on page 1 of the *LTC Observation Record - Hourly* (PMH184). The nurse documents clinical indication of the resident's response to the restraint in the *Interdisciplinary Progress Notes (PMH877)*.
iv. Staff remove physical restraints ten minutes every two hours, at minimum, in order to provide opportunity for ambulating, toileting, exercises and other care. The only exception to removing a resident's restraint is when the resident is using side rails, which can remain in place as long as the resident is in bed.

b. Chemical restraint:

i. The frequency of monitoring of a resident, prior to application of a chemical restraint, is determined by the nurse, in consultation with the physician, pharmacist or MHRN as necessary. The frequency of monitoring is documented in the restraint order section on the appropriate form.
ii. When a resident is considered stable (regular scheduled medication only), based on clinical judgement (the medication effects for the resident are known), the frequency of monitoring can be decreased. The updated frequency of monitoring is to be documented in the order section of the appropriate form (excludes emergency restraints). Document the clinical indications and discussion with ADM/resident related to the decreased frequency of monitoring in the *Interdisciplinary Progress Notes* (PMH877). Frequency of monitoring cannot be decreased at the time of the initial order.
iii. It is the responsibility of the nurse to reassess the client after the administration of a chemical restraint observing for side effects and efficacy of the medication. Resident outcomes following administration of the medication, including effectiveness, side effects, signs of adverse

reactions and/or drug interactions, are documented in the health record. Any concerns are communicated to the nurse leader or physician/nurse practitioner as needed.

iv. Monitoring/observation of the client's safety post administration of the chemical restraint and the associated documentation is the responsibility of the health care team. A member of the interdisciplinary team documents each time an observation is provided, using the *LTC Observation Record* (PMH184).

v. For ongoing, regular use of chemical restraints (excludes PRN chemical restraints), staff monitor the resident, as per the frequency of monitoring ordered (at minimum hourly). This does not require documentation on the *LTC Observation Record* (PMH184).

c. Staff monitor for circulatory impairment, skin pressure/breakdown, confinement anxiety, any changes to level of consciousness, and other physical or emotional needs. Any identified concerns are reported to the nurse. The nurse assesses and documents the outcome related to the use of restraint(s) in the *Interdisciplinary Progress Notes* (PMH877). The nurse communicates any concerns with the nurse leader or physician/nurse practitioner as needed.

8. Quarterly Reassessment (Exception Emergency Restraints)

a. All restraints shall be re-assessed, at minimum, every 3 months by the interdisciplinary team, to determine if the restraint(s) continue to be required; and are the least restraint needed for the resident at that time. The re-assessment must include discussion related to the potential efforts to resolve the issue for which the restraint was initiated, and is documented on the *Interdisciplinary Quarterly Care Plan and Restraints Review form* (PMH187). Chemical restraints are also reviewed at quarterly medication reviews.

b. If the Interdisciplinary team identifies a potential to discontinue a restraint, the nurse documents on the *Interdisciplinary Quarterly Care Plan and Restraints Review form* (PMH187) (refer to Procedure #9: Discontinuation of a Restraint).

c. The nurse updates the *Resident Integrated Care Plan* (PMH484) and Bedside Communication Tool to ensure they are current and consistent.

d. Potential restraints are reassessed every 3 months by the nurse, occupational therapist, or physiotherapist, to verify if it continues to not be a restraint. This is documented on the *Interdisciplinary Quarterly Care Plan and Restraints Review* and noted on form (PMH187).

9. Emergency Use of Restraints

(Refer to PMH Responsive Behavior Pathways Part 2 (Appendix B)).
a. When a situation occurs where the use of emergency restraints are assessed as necessary by the nurse, nurse practitioner or physician. The nurse documents on the *Emergency Restraint form* (PMH186). A Code White should be called, if additional support is required.

- Section 1: The nurse documents the events leading up to the need for the emergency restraint use
- Section 2: The restraint order, the nurse documents:
  - Type of restraint to be used
  - Frequency of observation
  - Signature, and designation of the person giving the order
  - Date of the order
  - Chemical restraint frequency of observation, is determined by the nurse based on knowledge of the medication, the resident's health status in consultation with the physician, pharmacist, and MHRN (refer to Procedure # 6.b: Observation and Monitoring, Chemical Restraints).
- Section 3: The nurse documents the date and time the restraint was initiated, and when the family was notified (within 24 hours). Consent is not required.
- Section 4: The initial re-assessment date is chosen at the time the restraint is implemented and is to occur within 24 hours. Following the initial re-assessment, if the restraint is determined to continue to be required for the episode, a new re-assessment date is determined (to occur within the next 24

hours). If the episode is over, or a *Comprehensive Restraint form* (PMH185) is completed, the re-assessment is completed.
Emergency chemical restraints are to be reassessed in person, within 24 hours by the physician, prior to reordering (Ministerial Guideline requirements). If this process is not possible (requirements and/or timelines are unable to be met), the nurse is to complete an incident report.

- Section 5: The nurse documents the reassessment, including the care provided to the resident and the resident's response to the restraint while in the restraint.
  Any discontinuation of a restraint, utilized during the emergency episode (where multiple restraints are used and some remain in use), are documented in this section.
  Each reassessment requires a date, signature and designation. If additional space is required for documentation, the nurse is to use an asterisk (*) on the *Emergency Restraint form* (PMH186) and continue the documentation of the care provided in the *Interdisciplinary Progress Notes* (PMH877).
  The nurse determines through assessment/reassessment when the episode is over, or if necessary, a *Comprehensive Restraint form* (PMH185) is initiated. All emergency restraints are discontinued if a Comprehensive Restraint form is not initiated.

Note: Effort will be made to ensure an opportunity for staff to debrief following a stressful event.
Note: For each emergency episode, one emergency restraint documentation form (PMH186) is used.
Note: All restraints used for the emergency episode are documented on one form (PMH186).

10. Discontinuation of a restraint: (Exception Emergency Restraints)

A physical or environmental restraint may be discontinued at the interdisciplinary team's discretion, and in communication with the resident/ADM. Chemical restraints require a physician order to withhold or discontinue. The discontinuation of a restraint is to follow a process to promote safe reduction of restraints which is completed by the interdisciplinary team:
a. The nurse discusses the trial of removing the restraint with the resident/ADM and documents this in the *Interdisciplinary Progress Notes* (PMH877).
b. When the restraint removal has been initiated, the nursing staff increases the frequency of observation during the trial period, for a minimum of 24-48 hours. This is variable, depending on clinical indications and resident risk level, as determined by the interdisciplinary team. Observations are documented on the *LTC Observation Record* (PMH184).
c. If no adverse outcomes are observed during the trial restraint removal period, the nurse leader discusses the restraint discontinuation with the resident/ADM. The restraint can be formally discontinued. This is documented in the *Interdisciplinary Progress Notes* (PMH877).

11. Restraint Audits

a. Annually, at minimum, the nurse leader or LTC Standards & Project Facilitator:

- Completes a *Least Restraint Documentation Audit* (PMH384) on 10% of residents with restraints, or a minimum of 5 residents.
- Summarizes the results of the audit on the *Least Restraint Documentation Audit* (PMH384). This includes areas identified as needing improvement, action plan for improvement, communication of results and follow-up required.
- If the results of any component of the *Least Restraint Documentation Audit* (PMH384) are less than 100%, further follow-up is required to ensure improvement. The action plan on the audit form (PMH384) outlines the improvement plan. The Nurse Leader completes the recommendations and actions identified on the Audit (PMH384). After an appropriate time frame, but no more than 6 months, the Nurse Leader completes another audit on 10% of residents with restraints (or a minimum of 5 residents), for those components only.
- Completes a *LTC Restraint Usage Audit* (PMH386).
- Forwards the *Least Restraint Documentation Audit* (PMH384) and *LTC Restraint Usage Audit* (PMH386) to the Care Team Manager of the home, who forwards the data to the Standards & Projects Facilitators.

- The nurse leader discusses the results of the audit with the nursing team and identifies areas for quality improvement.
- Copies of the completed audits (PMH384 and PMH386) are kept for 2 years and used as evidence for PCH Standards reviews.
- The Standards & Projects Facilitators develop an annual report on the use of restraints. This information is reviewed at appropriate forum/meetings.

RELATED MATERIAL

Appendix A, The Responsive Behavior Pathway for LTC: Interdisciplinary Decision and Practice Support
Appendix B: The Responsive Behavior Pathway for LTC: Crisis Management
Appendix C: The Responsive Behavior Pathway for LTC: Medication Pathway
PMH148, Resident and Family Handbook
PMH183, Admitted with a Restraint Assessment/Order/Consent
PMH184, LTC Observation Record
PMH185, Comprehensive Restraint Form
PMH186, Emergency Restraint Form
PMH187, Interdisciplinary Quarterly Care Plan and Restraints Review
PMH380, Information Guide on the Use of Restraints
PMH384, Least Restraints Documentation Audit
PMH386, LTC Restraint Usage Audit
PMH484, Resident Integrated Care Plan
PMH502, Violence Screening Tool
PMH877, Interdisciplinary Progress Notes
PMH2154, Restraint Reference Guide
PPG-00074, Workplace Violence Prevention Program Client Risk Screening and Alerts
PPG-00100, Abuse (Client)
PPG-00172, Informed Consent for Health Care Intervention
PPG-00557, Falls Prevention and Management
PPG-01159, Bedside Communication Tool
PPG-01260, Care Transitions and Handovers
Sample of Admitted with a Restraint Assessment/Order/Consent (PMH183) – completed
Sample of Comprehensive Restraint Form (PMH185) – completed (Chemical Restraint)
Sample of Comprehensive Restraint Form (PMH185) – completed (Physical Restraint)
Sample of Emergency Restraint Form (PMH186) – completed
Least Restraints in LTC FAQ

REFERENCES

College of Nurses of Ontario. (2014) *Practice Standard – Medication.* Retrieved from http://www.cno.org/Global/docs/prac/41007_Medication.pdf

Province of Manitoba Ministerial Guidelines For the Safe Use of Restraints in Personal Care Homes, Effective November 21, 2014

Province of Manitoba Personal Care Home Standards, January 1, 2015.

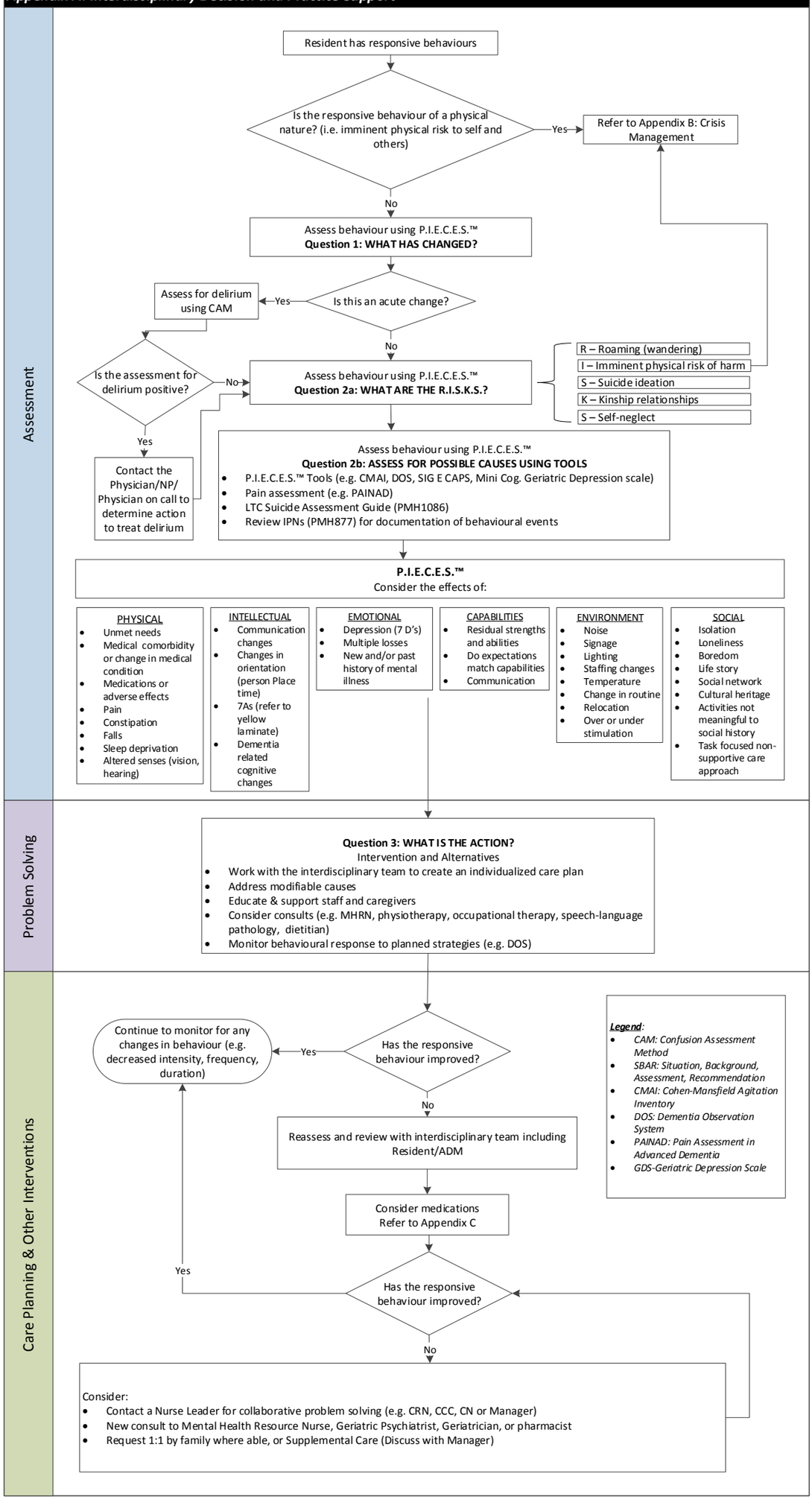
Winnipeg Regional Health Authority. (2018) Responsive Behavior Pathways for Long Term Care.

DOCUMENT HISTORY

Version	Changes
2015-Jan-07	New.
2019-Jan-23	Revised. Added definitions, information on weighted blankets, potential/verification of restraints process, emergency restraint re-assessment process, discontinuation of restraint process. Changes to approved/not approved list of physical restraints and frequency of audits. Removed algorithms: chemical restraints, falls/physical restraints, and agitation/aggression. Addition of Responsive Behavior pathways.
2019-Feb-20	Revised. Added Occupational therapist and Physiotherapist to pages 2, 7 and 8.
2019-Aug-21	Revised. Changed wording for procedure #11 – any component of the audit that scores less than 100% requires follow-up. Revised the summary section of the Restraint Documentation Audit (PMH384) to reflect the procedure change.

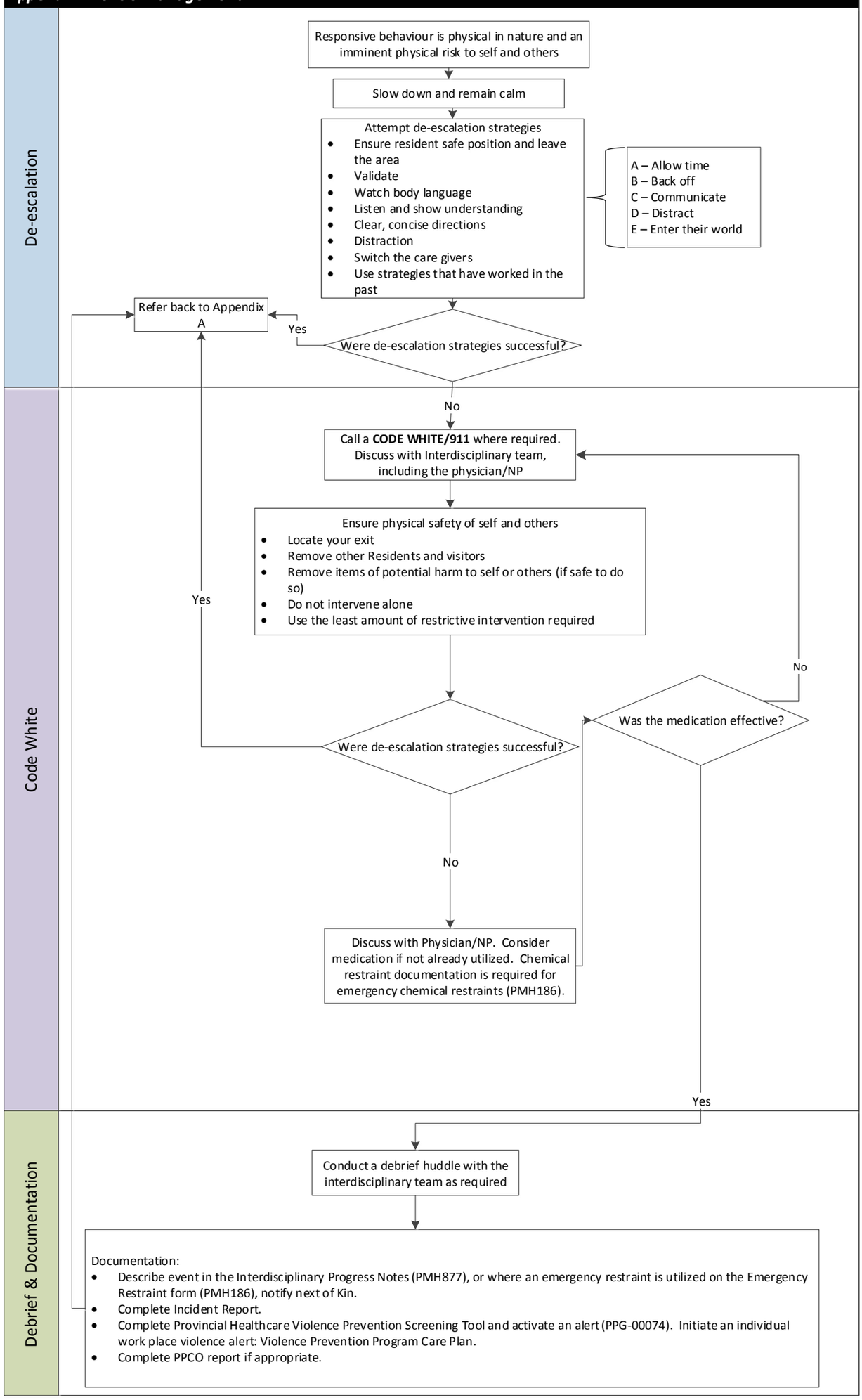
Responsive Behaviour Pathway for Long Term Care

Appendix A: Interdisciplinary Decision and Practice Support



Responsive Behaviour Pathway for Long Term Care

Appendix B: Crisis Management



Responsive Behaviour Pathway for Long Term Care

Appendix C: Medication Pathway

Assessment

Clinical Assessment
- Untreated medical conditions (e.g. pain, constipation, delirium)
- Review current medications/side effects

Non-drug alternative/intervention options have been consistently tried and were unsuccessful

Discuss with physician/Np for consideration of pharmacological treatment for target responsive behaviour if behaviour is persistent and dangerous, distressing, or disturbing for the resident.

Is behaviour likely to respond to medication?

No →

Behaviours not likely to respond to medication:
- Wandering or exit seeking
- Repetitive actions
- Resistance to care
- Calling out
- Dressing/undressing
- Hiding or hoarding
- Disinhibition

→ Return to Appendix A

Yes

Medication Options (Physician/Np)

Behaviours may respond to medication and benefits outweigh the burdens

Discuss medication options with resident/ADM prior to initiation of pharmacological treatment

Continue to follow individualized care plan for responsive behaviours

Example medications for use with target responsive behaviour

SLEEP DISTURBANCES
- Short-term sedatives e.g. benzodiazepines, zopiclone
- Trazodone
- Quetiapine not recommended
- Melatonin
- REM Sleep Behaviour Disorder – low dose clonzepam

PSYCHOSIS
- 2nd generation (atypical) antipsychotics*
- 1st generation antipsychotics
- Cholinesterase inhibitor for Lewy Body Dementia

AGGRESSION (physical)
- 2nd generation (atypical) antipsychotics*
- Mood Stabilizer's

SEVERE AGITATION
- 2nd generation (atypical) antipsychotics*
- Trazodone
- Citalopram

DEPRESSION
- SSRI e.g. citalopram, escitalopram, sertraline
- SNRI e.g. venlafaxine
- NaSSA e.g. mirtazapine

ANXIETY
- SSRI e.g. citalopram, escitalopram, sertraline
- Trazodone
- Mirtazapine
- Benzodiazepine

Monitoring & Reassessment

Monitor:
- Effectiveness of medication on target behaviours using the Dementia Observation System (DOS - frequency and severity of behaviours); quality of life; functional status
- Adverse effects: sedation, falls, postural hypotension, QT prolongation, confusion/ delirium, extrapyramidal symptoms, tardive dyskinesia, diabetes, weight change

Assess response over 1-3 weeks:
- If lack of response and/or tolerability, Discuss adjusting therapy with prescriber

Discuss medication effectiveness with physician/NP for potential elimination/reduction if:
- Is not effective
- Has intolerable adverse effects or
- Behaviours have been manageable and stable for 3-6 months

Reassess the need for the medication, at each quarterly medication review (minimally)

In consultation with resident/ADM decide if therapeutic goals are met

Continue to follow individualized care plan for responsive behaviours

Monitor for withdrawal effects and/or recurrence/emergence of behaviours if medication is being eliminated/reduced