GUIDELINES FOR USE OF CHEMICAL RESTRAINTS

PURPOSE
BC Children’s Hospital and Sunny Hill Health Centre seek to create an environment that minimizes the use of restraint and maximizes the patient’s health and safety when restraint is used.

POLICY STATEMENTS
Restraint is used when there is an imminent risk of an individual physically harming self or others (including staff), or for medical/surgical necessity to avoid the risk of injury or re-injury.

The use of chemical restraint requires clear indications for use, safe administration, consideration of alternative methods, monitoring and reassessment guidelines.

Informed consent must be obtained prior to use of chemical restraint unless in emergency situations when there is no parent/family/substitute decision maker (SDM) in attendance, in which case the patient will require certification under the Mental Health Act.

All Mental Health Act Consent to Treatment Forms (Form 2 and Form 5) must include a statement that restraint may only be used when the safety of self or others is at immediate risk.

A patient safety check must be conducted on patients assessed to be a danger to self or others and who require restraint to ensure safety of patient, staff members and/or others who may come in contact with potentially unsafe items.

Restraints should never be used as a form of punishment or consequence for behaviour or as a substitute for observation or direct care.

DEFINITIONS

Chemical restraint: Refers to the use of a medication to control behaviours or restrict the patient’s freedom of movement that is not a standard treatment for the patient’s medical or psychiatric condition. This definition does not apply to patients receiving sedation or muscle relaxants for procedures or medical treatments.

De-escalation techniques: are used to reduce the level and intensity of a difficult situation. De-escalation means making a risk assessment of the situation and using both verbal and non-verbal communication skills in combination to reduce problems.

Alternatives Methods to restraint use: refers to a method that imposes less control on the patient than restraining or confining them. Restraints may be avoided by adequate preparation of the patient and collaborative problem solving, disengaging, limit setting, continuous supervision of the patient, use of acceptable physical outlets, etc. Assess developmental stage, cognitive functioning and/or patient safety to determine most appropriate alternative intervention(s), such as:

- Increase supervision of child (eg. by family, volunteer or child & youth counselor)
- Refer to child’s careplan and note his/her triggers-respond proactively to de-escalate behaviour
- Create plan with child
- Prepare child for what is expected, consult with child life
- Provide therapeutic touch
- Provide active listening
- Provide adequate protection to site
- “make a deal” with child
- Provide physical contact
- Reduce environmental stimulation (decrease sounds, lights, people)
- Provide place to easily observe child
- Utilize distraction techniques
- Exercise/ambulate/physical outlets
- Provide less restrictive device
- Utilize clothing to camouflage site
- Toilet the child frequently (e.g. toileting schedule)
- Evaluate pain management
- Evaluate drug regimes for relationship between medications and restraints
- Use creative positioning
- Provide outlet for anxious behaviour
- Offer choices
- Decrease noise/visual stimuli
- Require transitional items from home
- Frequent reorientation
- Require parent at bedside
- Place mattress on floor

**GUIDELINES**

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<th>GUIDELINES</th>
<th>Rationale</th>
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<td>1. <strong>DETERMINE</strong> need for restraint. See Least Restraint, Last Resort Decision Tree. Chemical restraint is indicated when a patient remains agitated when physically restrained or when patient behaviour needs to be controlled rapidly.</td>
<td>The use of psychoactive medication used, not to treat illness, but to intentionally inhibit a particular behaviour or movement is considered a medical decision based on a team assessment of the need to provide safety for all patients, staff and visitors in the area.</td>
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<td>2. <strong>ATTEMPT</strong> to use de-escalation techniques and Alternative Methods to chemical restraint.</td>
<td>De-escalation strategies, including anger management and stress reduction techniques, are part of crisis management and prevention strategies that may obviate the need for seclusion or restraints.</td>
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<td>3. <strong>CONSIDER</strong> cause of behaviour and treat underlying cause.</td>
<td>When a patient is exhibiting irritable behaviours, staff must consider possible causes. Such behaviours may be related to:</td>
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<td>- Cognitive or sensory deficit</td>
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<td>- Neurological condition</td>
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<td>- Depression</td>
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<td>- Need for control or independence</td>
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<td>- Age</td>
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<td>- Medical condition</td>
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<td>- Environmental issues: lighting, furniture placement, access to/ability to use nurse call bell, room temperature, noise, equipment.</td>
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<td>4. <strong>REVIEW</strong> with family/caregivers, if possible, history of prior aggressive behavior including warning signs, triggers, repetitive behavior, prior response to therapy, previous seclusion, and/or restraint. Initial assessment should also identify any</td>
<td>Family members must be included in the discussion to ensure a complete assessment is done, that all alternatives are explored and to ensure their engagement in the planning process.</td>
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cognitive deficits, learning disabilities, and neurological limitations/deficits as well as any factors that may necessitate changes in restraint procedures.

5. **OBTAIN** certification under the Mental Health Act if patient has been brought in involuntarily and no substitute decision maker (SDM) is present.
   - Form 4: Medical Certificate (Involuntary Admission) (generally completed in the Emergency Department).

6. **EXPLAIN** to patient/family that the use of chemical restraint may be necessary to ensure safety. **ENGAGE** patient/family in the informed consent process. **REFER** to PHSA Consent to Treatment/Procedures Policy.

**NOTE:** for Mental Health admissions, the following consent documents are used:
- Form 2: Consent for Treatment (Voluntary Patient)
- Form 5: Consent for Treatment (Involuntary Patient)

**NOTE:** In non-emergency situations, verbal consent from the patient/family/SDM is required.

In emergency situations, if patient/family/SDM is not able/available to give consent, an explanation with rationale should be provided as soon as possible after the event.

7. **ASSESS** patient and obtain history to ensure that chemical restraint is not medically contraindicated. Contraindications include:
   - Prior history of dystonic reactions
   - Allergy to drugs used
   - Potential unknown poly-substance use

   Prevents possible adverse events.

8. **CHECK** chart for physicians order for chemical restraint/sedation. The order must specify:
   - Date/time
   - Drug name
   - Dose
   - Dose formula
   - Route
   - Rationale in relation to patient’s condition and/or plan of care.

   Required elements of safe prescribing practices to reduce medication related adverse events.

9. **MEASURE** baseline vital signs (VS) including respiratory rate and depth, blood pressure, pulse and temperature, oxygen saturation (SpO₂) and arousal score, if possible, and **DOCUMENT** on nursing record.

   Baseline measurements allows for comparison of readings following sedation.

10. **CONDUCT** safety check and **ENSURE** patient remains in his/her street clothes unless a

    Ensures safety of patient, staff and others who may come in contact with unsafe items.
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<th>Physical Exam is Required. If Not Safe to Conduct Safety Check at This Point, Conduct It Once the Patient is Chemically Restrained.</th>
<th>Maintains Patient Dignity and Promotes Self-Care.</th>
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<tr>
<td><strong>11. IDENTIFY</strong> Patient, <strong>EXPLAIN</strong> Procedure and <strong>ADMINISTER</strong> Sedation as Ordered.</td>
<td>If Required, the Patient May Be Held Briefly in a Recovery Position in Order for Staff Members to Provide IM Medication and to Safely Leave the Room.</td>
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**Prone Restraints Must Never Be Used.** Literature shows that sudden death during prone restraint, particularly for those in a state of agitation, is not an uncommon phenomenon. The mechanism of death is thought to be a sudden fatal cardiac arrhythmia or respiratory arrest due to a combination of factors causing decreased oxygen delivery at a time of increased oxygen demand. |

| **12. MONITOR** SpO² Continuously While Arousal Score is Above 2. Patient Must Have Constant 1:1 Supervision by Qualified Staff Member If Arousal Score is Above 2 and/or If Physically Restrained. | Complications of Chemical Restraint May Include Oversedation Leading to Respiratory Depression and Loss of Gag Reflex, Thereby Compromising the Patient's Ability to Protect the Airway, and Increased Risk of Choking and Aspiration for the Patient Who Vomits While in a Restraint. |

Allows for Early Recognition of Effectiveness or Complications and Prompt Initiation of Interventions. |

| **13. MEASURE** and **RECORD** VS, SpO², and Arousal Score Every 5 Minutes While Arousal Score is Above 2; Every 15 Minutes for 1 Hour When Arousal Score is 1 or 2; Then Hourly for 4 Hours If Stable. | Allows for Early Recognition of Effectiveness or Complications and Prompt Initiation of Interventions. |

| **14. POSITION** Patient on Side or in Recovery Position While Arousal Score is Above 2. |
| **15. MONITOR** Patient for Desired Effect and Need for Further Medication. |

| **16. If More Medication Is Needed or If Medication Was Not Effective, the Physician Must Follow Up in Person and Evaluate Patient. If the Medication Was Effective, the Physician Must See and Evaluate the Patient Within One Hour. | All Staff Where Possible Who Were Involved in the Incident with at Least One of the Following: Medical Director, Program Manager, CNC, Charge Nurse or Nurse Educator Should Discuss How the Situation Went, What Was Done Well and What Could Be Improved on the Next Time. |

| **17. CONDUCT** A Staff Debriefing Session If Possible. |

**DOCUMENTATION**

**DOCUMENT** on Appropriate Records:

- Date and Time
- Antecedent Behaviours
- Alternative Interventions Attempted
- Rationale for Decision to Use Chemical Restraint (Specific Reasons: Actual Violent Behaviour, Threat, etc. Such as “Threatened to Hit Nurse, Tried to Hit Physician” Rather Than General Indication Such as “Was Violent”)
- Medication Administered (Drug, Dose, Route, Patient Response)
- Staff Involved
- Record of Monitoring Patient While Sedated and Post Event with Times Noted
- Debriefing with Patient
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- Post event sequence such as return to room, changes to care plan, response of patient, etc.
- Any other pertinent actions or observations

REFERENCES


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Hospital Review:

BENCHmarking Effort for Networking Children’s Hospitals. Conference Call: Behaviour Management as an Alternative to Restraints. May 12, 2009. Participants: Children’s Hospital of Alabama, Birmingham; Connecticut Children’s Medical Center, Hartford, CT; Cardinal Glennon Children’s Medical Center, St. Louis; Children’s Memorial Hospital, Chicago, IL; Children’s Hospital Medical Center, Cincinnati, OH; DuPont Hospital for Children, Wilmington DE; East Tennessee Children’s Hospital, Knoxville, TN; Kosair Children’s Hospital, Louisville KY; Methodist Children’s Hospital of South Texas; Children's Hospital and Regional Medical Center, Seattle, WA.


Toronto Sick Children’s Hospital. Policy, Procedure & Guideline: Least Restraint. Last modified 03/05/08. Toronto, Ontario.