Providence HEALTH CARE

Provincial Health Services Authority
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☐ Holy Family Hospital
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RESTRAINT INITIATION: NURSING RECORD

Ensuring Informed Consent

1. Discuss the application of restraint with the capable patient. Provide information and attempt to get consent. Document discussion in the progress notes. A patient who is capable has the right to personal risk and so to refuse a restraint when his/her unsettled/challenging behaviour does *not* pose an imminent danger, defined as violent or life-threatening towards self or others.
2. Discuss the application of restraint with the patient's Substitute Decision Maker (SDM) or Temporary Substitute Decision Maker (TSDM), if the patient is unable to make his/her own decision [see form PHC-MR081]. Provide information and attempt to get consent, as soon as possible within 72 hours
3. Work with the interdisciplinary team in discussing restraint with the TSDM and refer to Social Work if necessary.
4. If the patient is certified under the Mental Health Act of British Columbia, consent for restraint use is not required; however, discussion should still occur with patient and be documented.

Section A - Nursing Protocol

For *all restraints,* the RN/RPN writes a Nursing Protocol on this record. A Nursing Protocol for restraint initiation is always required, whether or not a physician has already written an order on the Physician Order Sheet.

Date:	**Behaviour Code(s):**
Time:	**Alternative Intervention Code(s):**
RN/RPN Name:	
Signature:	**Restraint Type Code:**

Section B - Physician Notification/Orders

The physician must be informed of the use of restraints and the behaviour that necessitated it as follows:

1. For *4 - Limb Restraints*: Inform physician **within 1 (one) hour**.
2. *For Seclusion:* Inform physician **and** obtain a physician order **within 1 (one) hour.** Avoid PRN orders. Request an order that reads "*Seclusion x 12 hours".*
3. For *all* other restraints: Inform **within 72 hours**.

Name of MD notified/order obtained from:	Signature of RN/RPN:	Date/Time:

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ASSESSMENT PARAMETERS

Please enter all that apply on the Restraint Initiation and/or Restraint Use Nursing Records

BEHAVIOURS OBSERVED (Codes)

1. Agitation
2. Aggression
3. Combative
4. Pulling out tubes
5. Level of consciousness
   - 5.1 Alert
   - 5.2 Responsive to voice
   - 5.3 Responsive to pain
   - 5.4 Non-responsive to pain stimulus
6. Mental status
   - 6.1 Disoriented
   - 6.2 Hallucinating
7. Memory deficit
8. Impaired mobility
9. Falling
10. Movement disorder
11. Participating in other activities
12. Calm and settled
13. Sleeping
14. Other ________________

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INTERVENTIONS / ALTERNATIVES ATTEMPTED (Codes)

Establishing Rapport

- 1.1 Eye contact
- 1.2 Friendly tone
- 1.3 Calm manner
- 1.4 Approach slowly
- 1.5 Explain procedures
- 1.6 Listen to non-verbal/verbal communication
- 1.7 Maintain consistent care plan
- 1.8 Provide communication aids
- 1.9 Involve family members, as appropriate

Nursing Interventions

- 2.1 Regular toileting
- 2.2 Pain control
- 2.3 Food and intake
- 2.4 Eliminate unnecessary tube/lines
- 2.5 Administration of psychoactive medications
- 2.6 Review of prescribed medications
- 2.7 Consider constant/close care
- 2.8 Diversionary activities
- 2.9 Involve OT/PT

3. Environmental Interventions

- 3.1 Adjust stimuli (lighting, noise, proximity to nursing station, number of contacts, roommate selection)
- 3.2 Consider using a private room

NON-RESTRAINT ALTERNATIVES (Codes)

4. Non-restraint product alternatives

- 4.1 Pinel self-release waist belt
- 4.2 Self-release wheelchair belts
- 4.3 Bed and chair alarms
- 4.4 Exit alarms
- 4.5 Floor mats
- 4.6 Non-skid socks
- 4.7 Hip protectors (O.T. consult required)
- 4.8 Helmet (O.T. consult required)
- 4.9 One, two or three split side rails

RESTRAINT TYPE (Codes)

1. Wheelchair belts
2. Waist restraint
3. Limb restraint
4. Mitts
5. Arm splint
6. Secure room
7. Four side rails, (must be used with bed alarm, waist or limb restraint)

PHYSICAL ASSESSMENT

Positioning	Respiratory Status
✓ Side-lying is preferred for limb restraints, but supine or prone may be used, dependent on clinical judgement & patient condition	✓ Ensure breathing is not compromised
Limb Circulation	**Skin Condition Under Restraint**
✓ Ensure that the hand/foot is not discoloured, edematous, cold, or painful	✓ Ensure that the skin under the restraint is intact and that there is no chafing or skin breakdown