CHILD HEALTH BC PROVINCIAL LEAST RESTRAINT GUIDELINE FREQUENTLY ASKED QUESTIONS

FAQ'S

In 2018, a Provincial Least Restraint guideline for urgent and emergent care settings was developed with support from BC Health Authorities. In 2021, this guideline was updated to include all inpatient settings.

The purpose of the guideline is to:

- Provide guidance on a least restraint approach to address safety concerns in emergency situations for children and youth with mental health concerns
- Protect the safety of the child/youth, staff and others and to protect the developing autonomy of the child/youth, by providing direction for child/youth-centered care that avoids or minimizes restraints where possible
- Ensure the least restrictive restraint suitable to achieve the intended outcome shall be used for the least amount of time
- Promote engagement and collaboration at every stage, when possible, along the hierarchy of safety
- Use a developmentally appropriate, child/youth and family-centered, trauma-informed, culturally sensitive, gender-affirming, recovery-orientated and stigma free approach to least restraint
- Ensure the use of restraints complies with current legislation, professional standards and evidence informed practices
- Ensure that the principles of consent are applied appropriately and consistently in practice

BACKGROUND

Who is Child Health BC?

Child Health BC (CHBC), a Health Information Network under the Provincial Health Services Authority (PHSA), which includes all health authorities, key child-serving ministries, health professionals, and provincial partners dedicated to improving the health status and health outcomes of BC's children and youth.

RESTRAINT

What are the definitions of restraint?

Restraint is any method of restricting a child/youth's freedom of movement, physical activity, or normal access to their body.[1] The scope of this guideline excludes restraint for medically necessary procedures (for example inserting a feeding tube) and refers to restraint use in emergency situations where there is immediate or imminent risk of harm to self or others and when all other interventions have been tried or deemed clinically inappropriate.

Seclusion/Environmental: a method of restraint involving involuntary confinement in a locked room, or any space "from which free exit is denied".[2] In emergency/urgent care settings, this definition applies to all rooms or spaces used for the purpose of seclusion; including secure rooms, and isolation rooms. Being admitted to a locked unit does not qualify as seclusion.

Physical: The use of a technique to manually prevent, restrict or subdue the free physical movement of a person, or of a portion of the body.[3]

Mechanical: involves the implementation of devices or appliances to physically restrain the patient. [4]

Chemical: medication used to restrain (restrict movement, control behavior) a child/youth in emergencies and not in treatment for the condition.[5] Chemical restraint results from use of medications with the specific intent of reducing a patient's mobility or to promote sedation beyond that required for a normal sleep cycle.

1. Joint Commission on Accreditation of Healthcare Organizations. Comprehensive Accreditation Manual for Hospitals. Refresher Course. January 2005.
2. Mayers, Pat, et al. (2010). Mental health service users' perceptions and experiences of sedation, seclusion and restraint. International Journal of Social Psychiatry, 56(1), 60-73.
3. Dorfman DH (2000). CME REVIEW ARTICLE: The use of physical and chemical restraints in the pediatric emergency department. Pediatric Emergency Care. 16 (5): 355-360.
4. Nielson, Simon et al. (2020). Physical restraint in children and adolescents in mental health inpatient services: A systematic review and narrative synthesis. Journal of Child Health Care, 0(0) 1-26.
5. Dorfman DH & Kastner B (2004). The use of restraint for pediatric psychiatric patients in Emergency Departments. Pediatric Emergency Care. 20 (3): 151-156.

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SCOPE

Who does this guideline apply to?

This guideline applies to all staff working in emergency/urgent care and inpatient settings (as determined by your Health Authority (HA)). The focus of this guideline is children and youth.

RISKS

What are the risks associated with the use of restraints?

The use of restraint has been identified as a risk factor that may precipitate the following outcomes, including but not limited to:

- Increased risk of trauma and re-traumatization
- Impacts the ability to complete a comprehensive assessment
- May deter patients from seeking care in the future and engaging in care during present encounter
- Increased risk of asphyxiation and sudden cardiac death when agitated patients are restrained in the prone position with pressure applied to the back
- Increased risk of pulmonary embolism if inability to ambulate
- Increased risk of agitation, delirium, and aspiration pneumonia
- Increased risk of falls, fall injuries, deconditioning, and skin breakdown

When restraint is indicated, the least restrictive restraint suitable to achieve the intended outcome shall be used for the least amount of time.

CONSENT

Is informed consent required for restraint use? How is it obtained?

Yes. Obtain consent and authorization from child/youth or substitute decision-maker where possible. In keeping with the **Infants Act** in British Columbia, capable children and youth under 19 years of age do not need parental consent to receive treatment, provided the treatment is in their best interest. Capacity to consent is determined based on the capacity to fully understand the treatment and possible consequences of treatment. Where it is clear that the child or youth is competent to consent to treatment and that the treatment is in their best interest, as outlined in the Infant's Act, the health care provider will obtain informed consent from the patient. For further information please refer to your Health Authority guidelines on informed consent.

Informed consent and discussion of rationale for treatment should be documented.

What if I cannot get informed consent in a timely manner and the need for restraint is critical?

Health care may be provided to a patient on an urgent or emergency basis without the patient's consent if:

- It is necessary to provide health care without delay in order to preserve the patient's life, to prevent serious physical or mental harm, or to alleviate severe pain; AND
- The patient is apparently impaired by drugs or alcohol or is unconscious or semiconscious or is, in the MRP's opinion, otherwise incapable of giving or refusing consent (pending proper assessment); AND
- The patient does not have a personal guardian or representative who is authorized to consent to the health care, is capable of doing so and available; AND
- Where practicable, a second health care provider confirms the first health care provider's opinion about the need for health care and the patient's incapability

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ORDERS

Do I need an authorized prescriber's (Physician or Nurse Practitioner (NP)) order for restraints?

A physician/NP's order must be obtained for use of restraint. The order should include the reason(s) for use, be time-limited and must specify the rationale for restraint in relation to the child/youth's condition and/or plan of care.

- If the situation remains unresolved after the specified length of time, a physician or NP must assess the child/youth and support treatment decisions
- Restraint may not be ordered on a Pro Re Nata(PRN) basis
- A physician's/NP's order is not required to discontinue restraint

USING A RESTRAINT IN AN EMERGENCY SITUATION

How do I know which is the best restraint to use in an emergency situation?

Restraint use can result in adverse physical, emotional, and psychological outcomes for the child/youth and staff. Therefore, it is only to be used in emergency situations where there is immediate or imminent risk of harm to self or others and when all other interventions have been tried or deemed clinically inappropriate. An assessment of risk should be undertaken prior to the use of emergency restraint. When restraint use is necessary, the restraint that applies the least amount of restriction will be implemented for the shortest duration possible with child/youth &/or family/substitute decision maker preference taken into consideration whenever possible.

When use of restraints cannot be prevented, the hierarchy of safety should be supported at the "minimally sufficient level", and opportunities to "decrease the level" should ALWAYS and FREQUENTLY be explored. Engagement with the child/youth should be maintained throughout the situation and include debriefing. The hierarchy of safety includes:

1. Engagement/de-escalation
2. Environmental modification strategies
3. Oral medications
4. Seclusion/Injectable medications/Physical/Mechanical restraints

For further information, see the Hierarchy of Safety Resources (Appendix A and B)

OBSERVATION AND MONITORING

What are the observation and monitoring requirements for each type of restraint?

Best practice recommends that a health care provider (RN or RPN) be available within sight and sound at all times. Regular re-assessment can only be performed by an RN/RPN, NP or physician and should include assessment of vital signs, signs of physical and psychological distress, and mental status changes as per your health authority guidelines. Any concerning issues should be addressed. The team should regularly assess the need for continued use of restraints and discontinue as early as possible.

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DOCUMENTATION

Do I need to document the use of restraint? Is there a specific form to document restraint use?

Always document the use of restraint in the child/youth's health record. Documentation should include the assessment, the interventions, the monitoring done and the discontinuation of restraint. Patient response to restraint shall be tracked, documented, and reviewed to assist further decision-making. Any code white events and any security assistance should also be documented. The form(s) you use will depend on your care setting and your Health Authority. Follow your Health Authority guidelines regarding documentation of the use of restraint.

REPORTING

Do I need to report when a restraint has been used?

As the use of a restraint is considered a patient safety event, it is recommended that all events be reported through agency Patient Safety and Learning System (PSLS) and where appropriate, follow health authority incident reporting procedure. Timely, complete, accurate and factual account of a patient safety event is the responsibility of any individual who discovers or has knowledge of the event.

Collecting, monitoring, reporting, reviewing, and acting on relevant data is critical to assessing the quality and outcomes of restraint interventions and ensuring that staff are delivering best-practice care.

DEBRIEFING

What is Debriefing?

Debriefing following the use of restraint is distinct from the debriefing process associated with the Employee and Family Assistance Program (EFAP).

Offer debriefing with the child/youth, family/caregivers and all staff involved in a restraint event. The purpose is to rebuild trust and relationship, promote emotional and physical safety, enable learning and reduce future use of restraint.

- Debrief/discussion with child/youth/family/caregiver (either together or separately) should be completed as soon as the child/youth is able to engage and be documented in the health record
- Staff debrief/discussion will include a thorough assessment of factors leading up to the use of restraint, a reflection on possible alternative interventions (pre/during/post) and a review of adherence to guidelines/policies
- Key learnings from the debrief sessions should be shared with the care team and the child/youth/family/caregivers as appropriate to inform ongoing care and quality improvement