PART ONE

Child Health BC

Provincial Least Restraint Guideline

Initial Management of Least Restraint in Emergent/Urgent Care Settings

Background and Evidence

APRIL 2018

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How to cite the CHBC Provincial Least Restraint Guideline:

We encourage you to share these guidelines with others and we welcome their use as a reference. Please cite each document (part 1 and part 2) in the guideline in keeping with the citation on the table of contents of each of the two documents. If referencing the full guideline, please cite as:

Child Health BC. *Provincial Least Restraint Guideline; Initial Management of Least Restraint in Emergent/Urgent Care Settings*. Vancouver, BC: Child Health BC, April 2018.

Child Health BC acknowledges the contribution of the Provincial Least Restraint Working Group. See Part 1, Appendix A for a list of representatives.

This document outlines the methodology used to develop recommendations to support the safe and appropriate use of restraint; including seclusion, chemical and physical/mechanical restraint, on children and youth who present to emergent/urgent care settings across British Columbia. 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. This provincial work was led by Child Heath BC (CHBC) in partnership with clinical and content experts, representing rural and urban centers within the various provincial health authorities. The Appraisal of Guidelines for Research and Evaluation II (AGREE II) instrument provided the methodological strategy for the development of this guideline (Brouwers et al, 2010). The following document reviews each component of the AGREE II instrument. The resulting work consists of a package of clinical support documents and educational tools that used together assist the emergency clinician in supporting the safety and autonomy of patients, staff and others by providing direction for the provision of child and youth centered care that minimizes the need for restraints in the emergent/urgent care setting. They are not intended for inpatient use.

The provincial resource package includes:

Guideline Bundle

- Guideline Part One: Evidence and Background (this document)
- Guideline Part Two: Practical Summary and Tools

Tools

- Procedure for the use of Seclusion, Chemical and Physical/Mechanical Restraints with Children and Youth in Emergent/Urgent Care Settings
- Hierarchy of Safety
- Chemical Restraint Algorithm

Background

Scope and Purpose

Child Health BC Provincial Least Restraint Guideline for Children and Youth in Emergent/Urgent Care Settings

According to the available international literature, the use of restraints is a controversial but widely used practice in Emergency Departments (ED) (Dorfman & Katsner, 2004). In British Columbia (BC), a self-assessment of 109 emergency departments based on the Tiers of Service for Children's Emergency Department Services, identified that only 35 % of Tier 1a sites, 28 % of Tier 1b sites and 47 % of Tier 2 sites have a policy or documented protocol for physical and chemical restraint use for Children/Youth (Child Health BC, 2016).

BC is committed to a trauma informed model of care and the philosophy of least restraint with an aim towards preventing, reducing and ultimately eliminating the use of seclusion and restraint (BC Ministry of Health, 2014).

The purpose of physical and chemical restraint and/or seclusion is to protect the individual and/or other persons in the environment from imminent harm. The purpose of the least restrictive method is to enable individuals to safely function within their environment by providing a full continuum of methods to support safety.

The goal of this document is to communicate best practice standards on the alternatives to, and the appropriate use of, emergency restraint and seclusion within emergency/urgent care settings and to specifically outline the procedures for emergency seclusion and restraint. These procedures help ensure that the actual use of restraint and seclusion are safety interventions of last resort, to be used only when a child or youth poses an imminent danger to themselves or someone else's safety. They also help ensure that children and youth are treated with dignity and respect and that their rights are protected when the safety interventions are utilized.

Scope

This guideline is for use with Children and Youth up to 19 years of age less 1 day who require emergency restraint when there is imminent risk to self or others.

Target User of this Guideline

This document applies to all staff working in Emergency/Urgent Care settings who use emergency restraint with children & youth **up to 19** years of age less 1 day.

Purpose

This provincial guideline and related tools outline the recommendations for the provision a least restraint approach to maximizing safety in emergency situations.

- To protect the safety and autonomy of child/youth, staff and others by providing direction for the provision of child/youth centered care that minimizes the need for restraints.
- To ensure the least restrictive form of restraint is used for the shortest possible duration when restraint is necessary for the safety of child/youth and/or others.
- To ensure the use of restraints complies with legislation, professional standards and, evidence informed practices.
- To ensure that the principles of consent are applied appropriately and consistently in practice.

In situations when all other interventions have been tried, and restraint cannot be prevented, to deliver in a manner that is trauma-informed, recovery-oriented, culturally sensitive and person/family centered (BC Ministry of Health, 2012).

Methodology

The Appraisal of Guidelines for Research and Evaluation II (AGREE II) instrument provided the methodological strategy for the development of this guideline.

Literature Search Strategy

A scoping review was completed as part of the guideline development. PubMEd and CINAHL were searched using search terms restraint AND pediatric AND emergency. Titles and abstracts were read for approximately 150 articles and in total, 21 articles were reviewed and included in this summary, as they were relevant to the guideline.

In addition to the literature review, an environmental scan was conducted which included a jurisdictional review of current health authority guidelines and a provincial survey of health authority practice. 88 out of 109 emergency centres responded to the survey and the results helped inform the development of the guideline.

Methods for Formulating Recommendations

Based on the results from the scoping literature review and the environmental scan, pediatric recommendations were determined by the provincial working group by seeking advice and consensus from clinical experts across the Health Authorities. A series of provincial meetings were held to review the guideline (Part Two) and care algorithms, line by line and seek consensus. Draft documents were distributed to the working group members following each set of revisions and feedback was reviewed at the next meeting. Once a final draft was agreed upon by the provincial working group the guideline and supporting tools were circulated for wider feedback within the Provincial Health Authorities and to content experts. Feedback was collected and final revisions were circulated to the group for consensus. Acceptance of the guideline was sought from the CHBC steering committee and the Provincial Emergency Services Advisory Council.

Patient/Family Feedback Process

Child Health BC would like to thank Lina Thompson from Family Smart for her valuable input in reviewing the guideline, associated tools and resources and education materials.

Procedure for Updating the Guideline

This guideline will be reviewed every three years (or earlier if new evidence is published) by a multidisciplinary provincial advisory group consisting of clinical experts in emergency and mental health. This guideline will be reviewed again in 2021.

Summary of Recommendations with Levels of Evidence

The following section will outline the key recommendations and assign a level of evidence based on the table below. This level of effectiveness rating scheme is based on the following: Ackley, B. J., Swan, B. A., Ladwig, G., & Tucker, S. (2008). Evidence-based nursing care guidelines: Medical-surgical interventions (p. 7). St. Louis, MO: Mosby Elsevier.

Level of evidence (LOE)	Description
Level I	Evidence from a systematic review or meta-analysis of all relevant RCTs (randomized controlled trial) or evidence-based clinical practice guidelines based on systematic reviews of RCTs or three or more RCTs of good quality that have similar results.
Level II	Evidence obtained from at least one well-designed RCT (e.g. large multi-site RCT).
Level III	Evidence obtained from well-designed controlled trials without randomization (i.e. quasi-experimental).
Level IV	Evidence obtained from well-designed case-control or cohort studies
Level V	Evidence from systematic reviews of descriptive and qualitative studies (meta-synthesis)
Level VI	Evidence from a single descriptive or qualitative study.
Level VII	Evidence from the opinion of authorities and/or reports of expert committees.

Recommendation	Level of Evidence	Evidence
Engagement and De-escalation Alternatives to restraint must be attempted prior to the use of restraints including engagement strategies and methods to de-escalate. Health care providers should have training in prevention and de-escalation strategies.	The papers supporting this recommendation were Level V	Systematic review of literature and evidence (Carubia et al., 2016; Cunha et al., 2016)
Consent Obtain consent and authorization from child/youth or substitution decision maker where possible. In British Columbia, children and youth under 19 years of age do not need parental consent to receive treatment. Capacity to consent is determined based on the capacity to fully understand the treatment and possible consequences of treatment. A patient under 19 seeking treatment who is determined able to understand the treatment and give consent should not require parental (or substitute decision-maker) permission or notification. Informed consent and discussion of rationale for treatment should be documented.	The papers supporting this recommendation were Level VII	Expert opinion and provincial consensus. Legislation: Mental Health Act: Guide to the Mental Health Act of BC Infants Act: The Infants Act of BC

Risk Assessment An assessment of risk should be undertaken prior to the use of emergency restraint including: signs of medical instability, history of trauma, consideration of cognitive/learning or neurologic impairment, allergies, poly-substance use, alerts, medical history (e.g. seizures, respiratory conditions, etc).	The papers supporting this recommendation were Level VI	Qualitative studies (Baren et al., 2008; Newberry & Wang, 2013)
Emergency Restraint Restraint is to be used when there is imminent risk to self and others. It should never be used as: • Discipline or punitive measure • Aid in management or substitute for inadequate staffing • Solely to prevent property damage or absconding	The papers supporting this recommendation were Level V	Systematic review of literature and evidence (Secure Rooms and Seclusion Standards and Guidelines: A Literature and Evidence Review, BC MoH, 2012)
Principles Approaches to the use of emergency restraint with children and youth should be developmentally-appropriate, child and youth-centered, trauma-informed, culturally appropriate, confidential, promote recovery, and include family involvement when appropriate.	The papers supporting this recommendation were Level V	Systematic review of literature and evidence (Secure Rooms and Seclusion Standards and Guidelines: A Literature and Evidence Review, BC MoH, 2012)
Physician Orders A physician's order must be obtained prior to use of restraint which includes reason for use and is time-limited. Orders should never be written "as needed".	The papers supporting this recommendation were Level VI	Qualitative studies (Sorrentino, 2004)
Monitoring and Observation Best practice recommends that a health care provider (RN or RPN) be available within sight or sound at all times. Regular re-assessment should include: safety and mental status, vital signs, signs of physical distress, physical and psychological needs, and need for continued use of restraint. Restraint removal should occur as early as possible.	The papers supporting this recommendation were Level VI	Qualitative studies (American Academy of Pediatrics, 1997; Hopper et al., 2012; Newberry & Wang, 2013)

Documentation and Reporting Document use of restraint including monitoring, assessment, interventions and discontinuation. As the use of restraint is a high risk procedure, report event using the PSLS system. Evidence has shown that monitoring the use of restraints results in reduction.	The papers supporting this recommendation were Level IV	Cohort studies (Griffey et al., 2009)
Seclusion/Environmental Restraint When available, seclusion should occur in a room specifically designed for that purpose. In Emergency/urgent care settings without access to secure rooms, any space used for seclusion should at minimum be physically safe for children with any potentially dangerous equipment (sharp objects, potential ligatures), medications, chemicals or fluids out of reach or in locked cupboards.	The papers supporting this recommendation were Level VII	Expert opinion and provincial consensus (Provincial Quality, Health and Safety Standards and Guidelines for Secure Rooms in Designated Mental Health Facilities under the BC Mental Health Act,2014)
Chemical Restraint Chemical sedation may be considered however, overall there is weak evidence supporting the use of medications as an intervention in children and youth and therefore use should be conservative. Offer medications that promote sedation relaxation or anxiety relief. Chemical restraint should be offered as a voluntary treatment option first. Oral medications should be offered prior to intramuscular. Risks associated with chemical restraint include: interfering with assessment/diagnosis, medication risks and side effects, interactions with other drugs (e.g. alcohol or other substances) the patient may have used.	The papers supporting this recommendation were Level VI	Qualitative studies (Dorfman, 2000; Sorrentino, 2004; Carubia et al., 2016)
Physical Restraint Restraint can involve both physical and chemical interventions to be effective and can be used separately or jointly. Physical restraint may be used to facilitate chemical restraint or seclusion. Only approved mechanical devices will be used. Restraint should only be performed by trained health care providers. Supine position is preferred with pediatric patients. Prone is not considered safe practice. Patients need to be monitored closely for respiration, and vomiting/aspiration. There are significant risks associated with physical restraint including: asphyxia, aspiration, falls, neurovascular damage, injuries and rhabdomyolysis. Therefore, physical restraint should only be considered when other methods fail.	The papers supporting this recommendation were Level VI	Qualitative studies (Baren et al., 2008; Dorfman, 2000; Mohr et al., 2003)

Appendix A: Acknowledgements

This group would like to acknowledge the many other health care professionals who contributed to the development of this guideline by sharing their expert opinion and by acting as reviewers. In addition to the working group members, Dr. Jana Davidson, Vice-President Medical Affairs & Psychiatrist in Chief, Children's & Women's Mental Health Programs, PHSA, Associate Clinical Professor, Dept of Psychiatry, University of British Columbia and Head of the Division of Child & Adolescent Psychiatry at UBC and Cynthia Russell, RN, MN(c), Clinical Nurse Specialist – Mental Health, First Nations Health Authority reviewed and provided input into the guidelines.

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Appendix B: Applicability

Educational materials to support the implementation of this guideline were created by Child Health BC with the input of provincial partners.

The resource toolkit for staff and physicians includes:

- Child & Youth Mental Health & Substance Use Resources, January 2018.
- Key Ingredients of Child and Youth Mental Health and Substance Use Presentation by Dr. Jana Davidson, Vice-President Medical Affairs & Psychiatrist in Chief, Children's & Women's Mental Health Programs: http://mediasite.phsa.ca/Mediasite/Play/29d6522fc24d1fa8ad6516fdbe9a80 1d
- Caring for Children & Youth with Mental Health & Substance Use Concerns booklet January 2018.

Implementation strategies may vary between health authorities and individual sites with the consideration of factors such as: educational needs, service population, geographical location, operational structure and available resources.

Appendix C: Editorial Independence

There are no conflicts of interest to report.

i. Disclaimer

Child Health BC develops evidence-based clinical support documents that include recommendations for the care of children and youth across British Columbia. These documents are intended to give an understanding of a clinical problem, and outline one or more preferred approaches to the investigation and management of the problem. These documents are for guidance only and not intended as a substitute for the advice or professional judgment of a health care professional, nor are they intended to be the only approach to the management of a clinical problem. Healthcare professionals should continue to use their own judgment and take into consideration context, resources and other relevant factors. Neither Provincial Health Services Authority nor Child Health BC assume any responsibility or liability from reliance on or use of the documents.

Appendix D: Resources

Resources

1. The Kelty Mental Health Resource Centre
http://www.keltymentalhealth.ca/

2. FamilySmart Resources:
http://www.familysmart.ca/resources/

3. Learning Links
https://learninglinksbc.ca/

4. Comprehensive Trauma Informed Practice Guide:
http://bccewh.bc.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf

5. Healing Families, Helping Systems: A Trauma-Informed Practice Guide for working with children, youth and families
http://www2.gov.bc.ca/assets/gov/health/child-teen-mental-health/trauma-informed_practice_guide.pdf

6. Mental Health Act: Guide to the Mental Health Act of BC is available @
http://www.health.gov.bc.ca/library/publications/year/2005/MentalHealthGuide.pdf

7. Mental Health Act Forms
http://www2.gov.bc.ca/gov/content/health/health-forms/mental-health-forms.

8. Infants Act: The Infants Act of BC is available @
http://www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/00_96223_01

9. San'yas program website

10. Foundry offers young people ages 12-24 health and wellness resources, services and supports – online and through integrated service centres in six communities across BC.
http://foundrybc.ca/

11. Appraisal of Guidelines for Research and Evaluation II Instrument (AGREE II) http://www.agreetrust.org/resource-centre/agree-reporting-checklist/

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