Child Health BC
Provincial Least Restraint Guideline

Initial Management of Least Restraint in Emergent/Urgent Care and Inpatient Settings

Practical Summary and Tools

JANUARY 2022

CHILD HEALTH BC

LEAD BENEFACTOR

save on foods

Table of Contents

How to cite the CHBC Provincial Least Restraint Guideline

We encourage you to share this guideline with others and we welcome their use as a reference. If referencing the full guideline, please cite as:

> Child Health BC. *Provincial Least Restraint Guideline; Initial Management of Least Restraint in Emergent/Urgent Care and Inpatient Settings*. Vancouver, BC: Child Health BC, January 2022.

Child Health BC acknowledges the contribution of the Provincial Least Restraint Working Group and patient/family partners.

Least Restraint: Children & Youth in the Emergent/Urgent Care and Inpatient Settings

Scope

This document applies to all staff and providers working in emergency/urgent care and inpatient settings (as determined by your Health Authority (HA)), for the use of emergency restraint specific to children and youth exhibiting unsafe behaviors related to a psychiatric or behavioral crisis. The focus of this guideline is children and youth, up to the age of 19 years of age less a day.

Restraint

Restraint is any method of restricting a child/youth's freedom of movement, physical activity, or normal access to their body. This guideline has sections dedicated to chemical restraint, seclusion and physical/mechanical restraint.

Forms of Restraint

Seclusion: A method of restraint involving involuntary confinement in a locked room, or any space from which free exit is denied. 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.

Chemical: Medication used to restrain (restrict movement, control behavior) a child/youth in emergencies and not in treatment for the condition. 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.

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. This should only be applied to prevent serious harm.

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

Purpose

- To provide guidance on a least restraint approach to address safety concerns in emergency situations for children and youth exhibiting unsafe behaviors related to a psychiatric or behavioral crisis
- To protect the safety of the child/youth, staff, providers and others
- To protect the developing autonomy of the child/youth, by providing direction for child/youth-centered care that avoids or minimizes restraints where possible
- To support the health and wellbeing of healthcare providers, staff, child/youth and family/caregiver(s) through the provision of information and tools that support ongoing competencies, sustainable practice and reduce stressors related to least restraint

- To ensure the least restrictive restraint suitable to achieve the intended outcome shall be used for the least amount of time
- To promote engagement and collaboration at every stage when possible, along the hierarchy of safety
- To use a developmentally appropriate, child/youth and family-centered, trauma-informed, culturally sensitive, gender-affirming, recovery-orientated and stigma free approach to least restraint
- To ensure the use of restraints complies with current legislation, professional standards and evidence informed practices
- To ensure that the principles of consent are applied appropriately and consistently in practice

Adverse Outcomes Associated with Restraint Use

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.

Alignments

This guideline complies with the requirements set out in British Columbia's:

- Provincial Violence Prevention Curriculum
- Mental Health Act
- Infant's Act

Guiding Principles

An approach to patient care that provides the safest, most necessary care is by definition compassionate.

- Safety always comes first
- Safety events can be traumatic to patients, families/caregivers, and staff
- Disorganized approaches to safety events can prolong the trauma and may result in injury
- Child/youth &/or family/substitute decision maker preference should be taken into consideration whenever possible

Trauma Informed Practice

Trauma-informed care should be incorporated into all aspects of service delivery with a goal of making patient's safety, choice and control a priority. Trauma-informed practice is built on understanding the prevalence and impact of trauma on patient's emotions and behaviors and, how trauma may influence a

patient's coping in the health care setting. It also requires an understanding of power relationships and the health care practitioner's unique role in promoting safe environments. An understanding of the ways in which trauma changes an individual's neurobiology, emotional regulation and capacity for adaptive social functioning is specifically relevant when faced with behaviors associated with restraint and seclusion.

For more information on principles, please refer to: Trauma Informed Practice Guide and Healing Families, Helping Systems: A Trauma-Informed Practice Guide for Working with Children, Youth and Families BC Ministry of Children and Family Development

Cultural Safety and Humility

Cultural safety is an outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the healthcare system. It results in an environment of inclusivity, free of racism and discrimination, where people feel safe when receiving health care.

Cultural Humility is a process of self-reflection with the intention to understand personal and systemic biases and to develop and maintain respectful processes and relationships based on mutual trust. Cultural humility involves humbly acknowledging oneself as a learner when it comes to understanding another's experience. Clinicians and staff should undertake cultural safety training to improve their ability to establish positive partnerships with Indigenous clients seeking care.
For more information about recommended cultural safety training please refer to: San'yas program website

Gender-Affirming Care

Gender-affirming care supports individuals to define and express their gender and sexual orientation for themselves and provides treatment that aligns with the individual's self-definition and expression. Individuals may identify their gender using language including cis, trans, Two-Spirit, non-binary, diverse, creative, and a variety of other terms. However, an individual of any age or developmental stage defines their gender, care providers should affirm their identity and the system should offer services that are accountable, transparent, anti-oppressive, trauma-informed, collaborative, person-centered, equitable and accessible.
For more information, please refer to: Trans Care BC

Child/Youth Centered Care

A philosophy that focuses on providing care according to the individual's understanding of well-being and quality of life. Treatment that is developmentally appropriate and emphasizes collaboration between clinicians and individuals receiving care, prioritizes individualized child/youth-specific care, and involves child/youth whenever possible as active agents in clinical decision-making.

Family/Caregiver Focused Care

An approach that recognizes and supports families/caregivers in their key role of providing ongoing care and support to children and youth. These approaches are based on a philosophy that service delivery involves a partnership between those using and those providing services and recognizes that family impacts the health, wellbeing, safety and healing process of children and youth.

Promoting a Safe and Healthy Workplace

An approach that creates a culture of safety through procedures, education, reporting of all safety events and working together to address safety concerns.

Stigma Reduction

Requires a change in behaviors and attitudes towards acceptance, respect and equitable treatment of people with mental health problems and mental illnesses. This happens by understanding that mental illness is not anyone's choice and recovery is possible.

Recovery Oriented

A model that emphasizes hope, autonomy and engagement in order for a child/youth experiencing mental illness and/or substance use to live a satisfying, meaningful and purposeful life despite the constraints of his/her illness.

Key Recommendations

The following are a summary of key recommendations. More specific and detailed procedures are outlined in Procedure and Guidelines sections below.

Emergency Restraint Use

Restraint use can result in adverse physical 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 all potential risks 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 Hierarchy of Safety Resources (Appendix A and B).

Engagement and De-escalation

Alternatives to restraint should be attempted prior to the use of restraints; including engagement strategies and methods to de-escalate. De-escalation refers to strategies that calm a patient who is experiencing a behavioral disturbance or crisis. Health care providers should have training in child and youth specific engagement and de-escalation strategies. Consult the Provincial Violence Prevention Curriculum.

Importance of Observed Behaviors

Behaviors can indicate something is not right. It is helpful to view behavior as a form of communication and a coping strategy, rather than a problem to be managed. All behavior has meaning; therefore, clinical care team members should observe and monitor for slight changes of behavior that indicate something is not right in the child/youth's world. The team should consider the following:

- What they are hearing and seeing
- What the child/youth is attempting to communicate

- Whether or not the child/youth is trying to get away from something or get to something of importance
- What can be done to make the child/youth feel safer
- What needs does the child/youth have that remain unmet

Consent

Obtain consent and authorization from child/youth or substitute decision-maker where possible. In keeping with the Infant's 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. Informed consent and discussion of rationale for treatment should be documented. It is important to verify understanding of the information by asking the child/youth to explain it back in their own words. 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 Infants Act, the health care provider will obtain informed consent from the patient. For further information please refer to your HA guidelines on informed consent.

Risk Assessment

An assessment of the child/youth should be undertaken prior to the use of emergency restraint including input from child/youth and family/caregiver, signs of medical instability, history of trauma, consideration of cognitive/learning or neurologic impairment, allergies, substance use, medical alerts, medical history (e.g., seizures, respiratory conditions, etc.). Complete as thorough an assessment as reasonable for the immediate situation with the expectation to complete a more detailed assessment as soon as possible afterwards. Risk assessment and management are central to preventing restraint, and ensuring that when it is delivered, it is done safely and appropriately.

Physician/NP Orders

A physician'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. Orders should never be written on a Pro Re Nata (PRN) basis. A physician/NP's order is not required to discontinue restraint.

Monitoring and Observation

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. Any concerning issues should be addressed. The team should regularly assess the need for continued use of restraints and discontinue as early as possible.

Documentation

Document the use of restraint. 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.

Reporting

As 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. A 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

Post-incident debriefing is part of a cycle of continuous quality improvement. Offer debriefing with the child/youth, family/caregiver(s) 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.

Education and Training

Prior to implementation of least restraint interventions, health care providers are responsible for being competent about the:

- Alternatives to restraints
- Care needs of the patient being restrained; and
- Safe application, ongoing assessments required during restraint use and discontinuation of restraints.

All staff and providers caring for patients at risk for the use of restraints should receive education on appropriate restraint use and application.

1.0 Procedure

1.1 Prior to Restraint

1.1.1 Review the child/youth's history with the child/youth/family members/caregiver(s)

If possible, history of prior aggressive/suicidal/violent behavior including warning signs, triggers & calming strategies, prior hospitalizations, previous seclusion and/or restraint.

1.1.2 Engagement and de-escalation

Engagement and de-escalation should always be attempted prior to initiating restraint, including offering prevention strategies appropriate for your setting. Use prevention strategies, including but not limited to:

Communication strategies:

- Treat the child/youth with respect. Approach in a quiet, calm and confident manner. Speak clearly and slowly
- Explain who you are and what you are doing
- Ask preferred pronoun and use gender inclusive language
- Validate the child/youth's feelings and concerns
- Be transparent and communicative throughout all interactions
- Use every day words and terms the child can easily understand

Comfort and regulation strategies:

- Attend frequently and briefly (this may help avoid unnecessary agitation)
- Ensure their physical and psychological needs are met, including but not limited to toileting, nourishment, hydration, and pain management
- Provide comfort items that help with emotional and behavioural regulation, such as: warm drink, sleep mask, blankets, lip balm, paper and pencils, snacks, books, comic books, playing cards and stuffed animals

- Provide sensory modulation items such as: fidget toys, ear plugs, arts and crafts, music/relaxing sounds or digital media
- Offer suggestions for coping and emotional regulation, such as: relaxation techniques on cue cards, apps that provide specific regulation strategies
- Encourage active use of coping de-escalation strategies, such as: walking, talking, writing, resting, crying, and deep breathing
- Offer time alone and a quiet space
- Offer spiritual care or practice
- Offer music therapy
- Connection with family/support person

Environmental modification strategies:

- Protect the child/youth from accidental harm (e.g., do not leave them unattended on a bed without safety guards, lower the bed as close to the floor as possible)
- Modify the environment to create low stimulus environment e.g., reduce lighting, noise, reduce people in room, etc.
- Minimize the number of staff attending the child/youth
- Allow them to have familiar but non-dangerous personal items (own clothing)
- Accompany them to and from places (e.g., the toilet)

Follow Hierarchy of Safety (Appendix A and B).

1.1.3 Assess risk factors prior to considering restraint

- Check to see if there are alerts on child/youth's health record
- Assess risk factors for agitation and aggression including but not limited to:
  - Signs of medical instability
  - History of allergies/intolerances, dystonic reactions
  - Neurodevelopmental and neuropsychiatric issues such as: intellectual disabilities, autism, learning disorders, ADHD, learning or communication difficulties, neurological disorders, brain injury
  - Substance use and or substance intoxication/withdrawal
  - History of trauma

- Assess risk factors for complications
  For example:
  - a seizure disorder
  - a respiratory condition
  - morbid obesity
  - past and present alcohol and/or drug use
  - cardiac history
  - fractures
  - back and neck injuries
  - risk for aspiration (vomiting)
  - lower level of consciousness
  - certain medications (refer to the chemical restraint algorithm for more information- Appendix C)

1.1.4 Reasons restraint should NOT be used

- As a substitute for less restrictive alternatives
- As a disciplinary or punitive measure
- As a means of addressing disruptive or dysregulated behavior
- For convenience or to aid with management
- As a substitute for inadequate staffing, or staff training
- Solely to prevent damage to property
- Solely to prevent patient from leaving
- To obtain submission or compliance

1.2 Informed Consent & Certification

1.2.1 Consent to healthcare

Health care providers (HCP) must seek valid consent to health care before providing treatment:

- The Infants Act applies to anyone under the age of 19
- In British Columbia, a person who is under 19 years of age is considered a minor
- While there is a presumption of capability for an adult, there is no such presumption for a minor, unless assessed to have capacity by the Most Responsible Provider (MRP)
- Minors who lack capacity require the consent of a guardian(s) for such health care. However, a person under 19 years of age may consent to their own health care
- A minor may be deemed a mature minor and therefore capable of consenting to health care if a Health Care Provider (HCP) is satisfied that the minor understands the need for the health care; what the health care involves; and understands the benefits and risks of receiving the health care and the health care is in the best interest of the mature minor. If the MRP has any doubt as to whether the proposed health care is in a child/youth's best interests, obtain a second opinion as necessary
- HCPs are encouraged to involve children and youth in the discussions involving their health and treatment
- If the child/youth/family/substitute decision maker is not able to give consent, an explanation with rationale should be provided as soon as possible after the event.
- Please refer to your Health Authority specific guidelines and policies for consent to healthcare
  For further information: Consent to Healthcare: Procedure for Minors and Mature Minors

1.2.2 Exceptions to consent to health care

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 HCP confirms the first HCP's opinion about the need for health care and the patient's incapability

1.2.3 Certification / involuntary admission under the Mental Health Act

When a child/youth requires immediate treatment necessary to avert serious health consequences and/or risk of death, the patient can be admitted involuntarily to a designated facility and treated under the Mental Health Act if they meet specific criteria[1]

The Mental Health Act authorizes involuntary psychiatric admission to a designated facility for people who meet ALL four of the following criteria:

1. Is suffering from a mental disorder that seriously impairs the person's ability to react appropriately to his or her environment or to associate with others
2. Requires psychiatric treatment in or through a designated facility
3. Requires care, supervision and control in or through a designated facility to prevent the person's substantial mental or physical deterioration or for the person's own protection or the protection of others; and
4. Is not suitable as a voluntary patient

For further guidance regarding the Mental Health Act, please consult the Guide to the Mental Health Act.

Resources specific to the care of pediatric patients, for both providers and patients and families can be found at: Healthy Minds Learning where there is a Toolkit and a video for youth on being certified.

Use of Chemical Restraint with Children & Youth in Emergent/Urgent Care and Inpatient Settings

This section of the Clinical Practice Guideline on Least Restraint provides direction regarding the use of chemical restraint when providing health care services to children and youth who present to emergent/urgent care and inpatient settings.

2.0 Guideline

2.1 Initiating Chemical Restraint

2.1.1 Medical assessment

- Where possible, the child/youth shall be deemed medically stable by a physician or Nurse Practitioner (NP) prior to use of chemical restraint as an intervention. In the event where a child/youth cannot be deemed medically stable prior to restraint, rationale should be clearly documented

[1] A designated facility is a provincial mental health facility designated under the *Mental Health Act*, a public hospital or part of it, designated by the Minister of Health.

2.1.2 Physician/NP orders

- A physician/NP order for use of chemical restraint must be obtained prior to chemical restraint initiation. The order must specify the rationale for chemical restraint in relation to the child/youth's condition and/or plan of care
- Physician/NP's orders for chemical restraint of children/youth shall be time-limited and specific. If the situation remains unresolved after the specified length of time, a physician or NP must assess the child/youth and support treatment decisions
- Use of chemical restraint may not be ordered on a PRN (as needed) basis
- Oral/sublingual is the preferred route if child/youth is willing and able. Refer to Appendix C

2.1.3 Procedures for initiating chemical restraint

- Communicate with child/youth & caregivers about the reasons for using chemical restraint. In an emergency, this may not be entirely possible; however, rationale must be explained as soon as possible and documented
- Offer child/youth the option of other forms of restraint
- Conduct environmental safety check and assess patient's physical status; complete point of care risk assessment
- Allow child/youth to remain in their own clothes unless/until a physical exam is required and as long as the clothes are not assessed to be a safety risk
- Approach child/youth in a non-threatening manner. Ensure other staff members are present and aware of the situation and that a clear plan is in place
- Measure baseline vital signs (VS) and document as per HA standard
- Explain procedure and administer medication as ordered
- If using IM medication, offer child/youth oral/sub-lingual route again, prior to administering
- If voluntary restraint is not possible, follow HA/Site CODE WHITE procedures[2]
- If required, the patient may be held briefly in a recovery position in order for staff members to provide IM medication (see physical restraint guideline)
- Support child/youth to keep items of personal significance as long as they are not assessed to be a safety risk

2.2 Monitoring & Observation

In recognition that chemical restraint is a high risk intervention, best practice recommends that an RN or RPN be available within sight and sound at all times when a child/youth is sedated to:

- Continuously monitor for signs of physical and emotional/ psychological distress
- Assess vital signs at earliest opportunity when safe to do so and thereafter as per HA/Site standards or specific physician/NP orders
- Position patient on side or in recovery position
- Monitor patient and determine need for further medication
- Ensure child/youth's physical and psychological needs are met
- If more medication is needed or if medication was not effective, the physician/NP must follow up and evaluate patient.

[2] According to the Provincial Violence Prevention Curriculum, a Code White "is a term to call for help when: equipment is being damaged; there is danger of physical harm to you or others; you and your co-workers do not have the ability to de-escalate the situation; you feel unsafe."

NOTE: Security Officers and Health Care Aides are NOT trained to make clinical decisions.

2.3 Following Chemical Restraint

- Ensure child/youth's physical and psychological needs are met
- Plan jointly regarding how to maintain safety and avoid further need for restraint and update care plan
- Complete medical assessment as per site process
- Observe the child/youth for a minimum of 30 minutes to ensure safety risk is no longer present

Please refer to Section 5 for information on debriefing and documentation following restraint

Use of Seclusion in Emergent/Urgent Care, and Inpatient Settings

This section of the Clinical Practice Guideline on Least Restraint provides direction regarding the use of seclusion when providing health care services to children and youth who present to emergent/urgent care, and inpatient settings.

3.0 Guideline

3.1 Seclusion is a Last Resort Option

- Short-term emergency measure of last resort
- Used only when all efforts to prevent the use of seclusion have failed

3.2 Initiating Seclusion

3.2.1 Medical assessment

- The child/youth shall be deemed medically stable by a physician or Nurse Practitioner (NP) prior to use of seclusion as an intervention. In the event where a child/youth cannot be deemed medically stable prior to seclusion, rationale should be clearly documented, and the child/youth shall be continuously monitored until they can be deemed medically stable

3.2.2 Physician/NP orders

- A physician/NP order for use of seclusion must be obtained prior to or immediately following seclusion initiation. The order must specify the rationale for seclusion in relation to the child/youth's condition and/or plan of care
- Physician/NP's orders for seclusion of children/youth shall be time-limited and specific. If the situation remains unresolved, a physician or NP must assess the child/youth and support treatment decisions. Every seclusion intervention requires a unique seclusion order
- Use of seclusion may not be ordered on a PRN (as needed) basis

3.2.3 Care plans

- If seclusion lasts more than one hour, a care plan shall be developed for the seclusion period. The care plan should include a plan for assessing the child/youth to determine if seclusion can be safely discontinued (a care plan is not required for seclusion in emergency departments). Care plans shall be timely, patient-centered, collaborative and individualized

- The care plan shall include risk assessments to be conducted, interventions and desired outcomes with the aim of assisting the person in regaining self-control. As part of this process, care plans shall include individualized engagement and de-escalation techniques that may prevent the use of seclusion. Reassuring the child/youth and family/caregiver that they are partners in care and explaining to them the reasons for the use of seclusion, the steps being undertaken while seclusion is initiated, and the ongoing care plan are critical for reducing fear and anxiety

3.2.4 Procedures for initiating seclusion

- Communicate with child/youth & family/caregiver(s) about the reasons for using seclusion. In an emergency, this may not be entirely possible; however, rationale must be explained as soon as possible and documented
- Ongoing communication with the child/youth (and their family, if present), about every step of the procedure is helpful to decrease anxiety and fear and to encourage cooperation
- Offer child/youth the option of entering the seclusion space voluntarily
- If voluntary entry is not possible, follow HA/Site CODE WHITE procedures
- Conduct environmental safety check and assess patient's physical status; complete point of care risk assessment
- Allow child/youth to remain in their own clothes unless/until a physical exam is required and as long as the clothes are not assessed to be a safety risk
- Support child/youth to keep items of personal significance as long as the items are not assessed to be a safety risk
- Hospital security staff shall follow facility-based policies and procedures regarding the role of security in the initiation of seclusion

3.3 Seclusion Spaces

When available, seclusion should occur in a room specifically designated for that purpose, i.e., a secure room. In settings without access to secure rooms, any space used for seclusion should at minimum be physically safe for children and youth, with any potentially dangerous equipment (sharp objects, potential ligatures), medications, chemicals or fluids out of reach or in locked cupboards.

3.4 Monitoring & Observation

In recognition that seclusion is a high risk intervention, best practice recommends that an RN or RPN be available within sight and sound at all times when a child/youth is secluded to:

- Continuously monitor for signs of physical and emotional/psychological distress
- Best practice recommends that patients shall receive direct, close observation (i.e., through the observation window) at minimum every 15 minutes, and more frequently or continuously if staff or the patient deem necessary. Close observation applies to patients whether sleeping or awake
- Document at regular intervals as per HA process (e.g., using a continuous monitoring or seclusion checklist)
- Assess vital signs at earliest opportunity when safe to do so and thereafter as per HA/Site standards or specific physician/NP orders
- Ensure child/youth's physical and physiological needs are met (i.e., toileting, nourishment, hydration, pain management, engagement)
- Review the need to continue seclusion throughout the intervention

- Assess and document potential for discontinuing seclusion (immediate risk of harm to self or others has passed) or rationale for continued seclusion

All health care workers (including LPNs and HCAs) may observe, but assessments must be performed by an RN, RPN, NP or physician. *NOTE: Security Officers and Health Care Aides are NOT trained to make clinical decisions.*

A minimum of two people is needed to enter seclusion room. Communicate with child/youth regarding entry and seek agreement when possible.

3.5 Discontinuing Seclusion

- Periods of seclusion shall end as quickly as possible, when a nurse and/or physician/NP on the clinical team determines that there is no longer any threat to any person's safety
- The clinical team shall implement a step-down process to end seclusion, unlocking or opening the door once they have determined it is safe to do so, enabling the child/youth to decide when they are ready to leave the room, and incorporating a period of observation to ensure that it is safe for the patient to return to the open unit
- Engage and assess the child/youth regarding their ability to remain safe
- A physician/NP's order is not required to discontinue seclusion, but they should be notified as soon as possible

3.6 Following Seclusion

- Ensure child/youth's physical and psychological needs are met
- Plan jointly regarding how to maintain safety and avoid further need for seclusion and update care plan
- Complete medical assessment/management as per site process

Please refer to Section 5 for information on debriefing and documentation following restraint

Use of Physical/Mechanical Restraint with Children & Youth in Emergent/Urgent Care and Inpatient Mental Health Settings

This section of the Clinical Practice Guideline on Least Restraint provides direction regarding the use of physical/mechanical restraint when providing health care services to children and youth who present to Emergent/Urgent Care and Inpatient Settings.

4.0 Guideline

4.1 Physical/Mechanical Restraint is a Last Resort Option

- Most associated with mortality and morbidity
- Most painful to the child/youth
- Most traumatic to child/youth, family/caregiver(s), and staff

4.2 Physical/Mechanical Restraint is Appropriate as an Intervention

- When immediate physical danger is present to self or others
- Other methods fail

4.3 Initiating Physical/Mechanical Restraint

4.3.1 Medical assessment

- The child/youth shall be deemed medically stable by a physician or Nurse Practitioner (NP) prior to use of physical/mechanical restraint as an intervention. In the event where a child/youth cannot be deemed medically stable prior to restraint, rationale is clearly documented, and the child/youth should be continuously monitored until assessed

4.3.2 Physician/NP orders

- A physician/NP order for use of physical/mechanical restraint should be obtained prior to or immediately following restraint initiation. The order must specify the rationale for physical/mechanical restraint in relation to the child/youth's condition and/or plan of care
- A physician/NP's order for physical/mechanical restraint shall be time-limited and specific. If the situation remains unresolved, a physician or NP must assess the child/youth and support treatment decisions. Every physical/mechanical restraint intervention requires a unique order
- Use of physical/mechanical restraint may not be ordered on a PRN (as needed) basis

4.3.3 Procedures for initiating physical/mechanical restraint

Restraint should only be performed by trained personnel (as per HA policies). Only HA approved methods and devices for children and youth may be used for holding a patient or when transferring patients to a seclusion room. Any devices used should be of appropriate size for children and youth.
Consult HA policies and procedures, the Provincial Violence Prevention Curriculum and Code White procedures for more information.

- Conduct environmental safety check and assess patient's physical status; complete point of care risk assessment
- Communicate with child/youth and caregivers about the reasons for using physical/mechanical restraint. If this is not possible, document the rationale and procedure as soon as possible
- Offer child/youth the option of other forms of restraint (e.g., voluntary chemical restraint, voluntary seclusion)
- If voluntary restraint is not possible, follow HA/Site CODE WHITE procedures
- Approach the child/youth according to the following:
    - Ensure other staff members are present and aware of the situation
    - Have a clear plan
- Use a non-threatening manner
- Allow child/youth to remain in their own clothes unless there is a safety risk or until a physical exam is required
- Support child/youth to keep items of personal significance as long as the items are not assessed to be a safety risk
- Conduct the restraint in a safe, skilled and efficient manner, respecting the rights and dignity of the child/youth
- Assess vital signs at earliest opportunity when safe to do so and thereafter as per HA/Site standards or specific physician/NP orders
- In physically restraining a child/youth the health care providers should:
    - Position the patient comfortably using correct body alignment principles

- Ensure the patient is able to communicate with staff
- Ensure patient's lungs and airway are unobstructed at all times:
  - A respiratory condition could increase the risk during a physical restraint. The child/youth's airway must be unobstructed/protected at all times
  - Do not put pressure on a child/youth's upper back or neck
  - Ensure the child/youth is able to rotate their head
  - Observe for obstruction of airway or altered breathing
  - Prone positioning is an unsafe practice and has the highest risk of mortality and therefore should not be used

- Mechanical restraints should be used in a manner that allows for quick release in an emergency situation (e.g., codes) and according to the manufacturer specifications and HA training/procedures

4.4 Monitoring & Observation

In recognition that physical/mechanical restraint is a high-risk intervention, best practice recommends that an RN or RPN be available, within sight and sound, when a child/youth is restrained to continuously monitor for signs of physical distress. All health care workers (including LPNs and HCAs) may observe, but assessments must be performed by an RN, RPN, NP or physician.

Ongoing actions include, but are not limited to:

- Monitor:
  - Airway and breathing
  - Pain/discomfort
  - Skin condition at point of contact with restraint and in areas prone to break down due to reduced ability for position changes
  - Proper body alignment/joint mobility
  - Circulation/sensation of restrained extremities
- Provide direct, close observation
- Address any concerns and immediately consider discontinuing restraint and implementing other safety measures
- Document at regular intervals as per HA process (e.g., using a continuous monitoring checklist)
- Assess vital signs at earliest opportunity when safe to do so and thereafter as per HA/Site standards or specific physician/NP orders
- Ensure child/youth's physiological and psychological needs are met
- Assess and document potential for discontinuing restraint (immediate risk of harm to self or others has passed) or rationale for continued restraint

NOTE: Security Officers and Health Care Aides are NOT trained to make clinical decisions.

4.5 Discontinuing Physical/Mechanical Restraint

- An RN/RPN or other member of the clinical team should discontinue restraint when it is determined that there is no longer an immediate safety concern and decision is made to terminate
- Prior to terminating, engage and assess the child/youth regarding their ability to remain safe

- Determine that child/youth is no longer an immediate safety concern and decision is made to terminate restraint
- Inform the child/youth of what is required so that they can be safely released from the restraint
- A physician/NP's order is not required to discontinue physical/mechanical restraint, but they should be notified as soon as possible

4.6 Following Physical/Mechanical Restraint

- Engage with child/youth and offer comfort measures (e.g., toilet, water)
- Plan jointly regarding how to maintain safety and avoid further need for restraint
- Complete medical assessment/ management as per site process
- Observe the child/youth for a minimum of 30 minutes to ensure safety risk is no longer present

Please refer to Section 5 for information on debriefing and documentation following restraint

The following sections apply to all forms of restraint use

5.0 Documentation

5.1 Documentation

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. The child/youth's 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.

5.2 Reporting

As 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. A 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.

6.0 Debriefing

Debrief with the child/youth, family/caregiver(s) 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(s) (either together or separately) should be completed as soon as the child/youth is able to engage and documented in the health record
- Staff debrief/discussion will include a thorough assessment of factors leading to 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/caregiver(s) as appropriate to inform ongoing care and quality improvement

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

7.0 Definitions

7.1 Behavioral Emergency

An acute situation when an individual is displaying behavior that indicates there is imminent danger or serious harm or death to self or others. The behavior is directed at someone, there is no time to talk or de-escalate and the clinical care team member needs to get out and get help immediately.

7.2 Least Restraint

A standard of care that focuses on mitigating restraint use by implementing individualized measures to address behaviors that interfere with safety of the client, staff and others. A practice of least restraint requires that other interventions are considered and/or implemented prior to using a restraint. When restraint use is necessary to ensure the safety of the client and others, the restraint that applies the least amount of restriction will be implemented for the shortest duration possible.

7.3 Emotional Crisis

An emotional crisis is a process during which a person's coping skills and abilities are significantly challenged by a combination of internal and external events. In an emotional crisis, there is no change from the person's baseline behavior, there is not a threat to self and others, the behavior is not directed at anyone and there is time to de-escalate.

7.4 Restraint

Restraint is any method of restricting a child/youth's freedom of movement, physical activity, or normal access to their body. The definition of restraint excludes treatment uses and refers to restraint used for controlling behaviors that are either harmful to the child/youth or others (e.g., aggression), or are interfering with necessary medical treatments.

7.5 Forms of Restraint

Seclusion: a method of restraint involving involuntary confinement in a locked room, or any space from which free exit is denied. 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.
Chemical: medication used to restrain (restrict movement, control behavior) a child/youth in emergencies and not in treatment for the condition. 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.
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. This should only be applied to prevent serious harm.
Mechanical: involves the implementation of devices or appliances to physically restrain the patient.

CHILD/YOUTH IS EXHIBITING UNSAFE BEHAVIOUR (Imminent Risk to Self or Others)
When use of restraints cannot be prevented, the hierarchy of safety must be maintained
1. Engagement **2.** Environmental Supports **3.** Oral Medications **4.** Seclusion / Injectable Medications / Physical/Mechanical Restraints

WHEN CHILD/YOUTH FIRST PRESENTS
- Support emotional, social and cultural safety by building rapport
- Ask the child and family what coping strategies work best for them and possible interventions if things become unsafe
- Problem solve together the types of supports and activities you can offer for distraction and self-soothing
- Decrease environmental stimulation (noise, lights, crowds of people) and remove clutter

ENGAGEMENT (ONGOING)
- Check in frequently
- Use simple, direct language and soft voice
- Be clear that your role is to support them and to keep everyone safe
- Ask for their input and provide choice when possible
- If something cannot change because it is a safety issue, let them know why
- Be consistent, predictable and calm

ALWAYS:
ASSESS
DOCUMENT
MONITOR

If not effective, utilize **ENVIRONMENTAL SUPPORTS** such as a quiet area/room, distraction tools, or monitored room

Consider **ORAL MEDICATIONS** that promote anxiety relief, relaxation or sedation

If not effective, CONSIDER USE OF RESTRAINTS
ONLY WHEN THERE IS IMMINENT RISK TO SELF OR OTHERS. Restraint should never be used as:
- A disciplinary or punitive measure
- A convenience or as a substitute for inadequate staffing
- Solely to prevent property damage or absconding

Truly a last resort option: Use the LEAST RESTRICTIVE restraint suitable to achieve the intended outcome for the LEAST AMOUNT OF TIME
- Must follow Health Authority/Site procedures
- May not be ordered as a PRN
- Assess risk factors prior to considering restraint
- Type of restraint used should take into consideration previously discussed individualized safety plans

Mental Health Act

OBTAIN APPROPRIATE CONSENTS and authorization from child/youth, family or temporary substitute decision maker when possible. If certification is required follow process as per the Mental Health Act. Obtain physician order as appropriate.

- **Document assessments, interventions and rationale**
- **Debrief with child/youth, family and staff**
- **Initiate a review process whenever restraint is used, to minimize future use and for quality improvement to minimize future use**

INJECTABLE MEDICATIONS
- Offer voluntarily first and communicate reasons for using
- May require physical restraint during injection
- Should be planned as a team prior to use
- Follow Health Authority/Site CODE WHITE procedures
- If the situation remains unresolved, a physician or NP must assess the child/youth and support treatment decisions

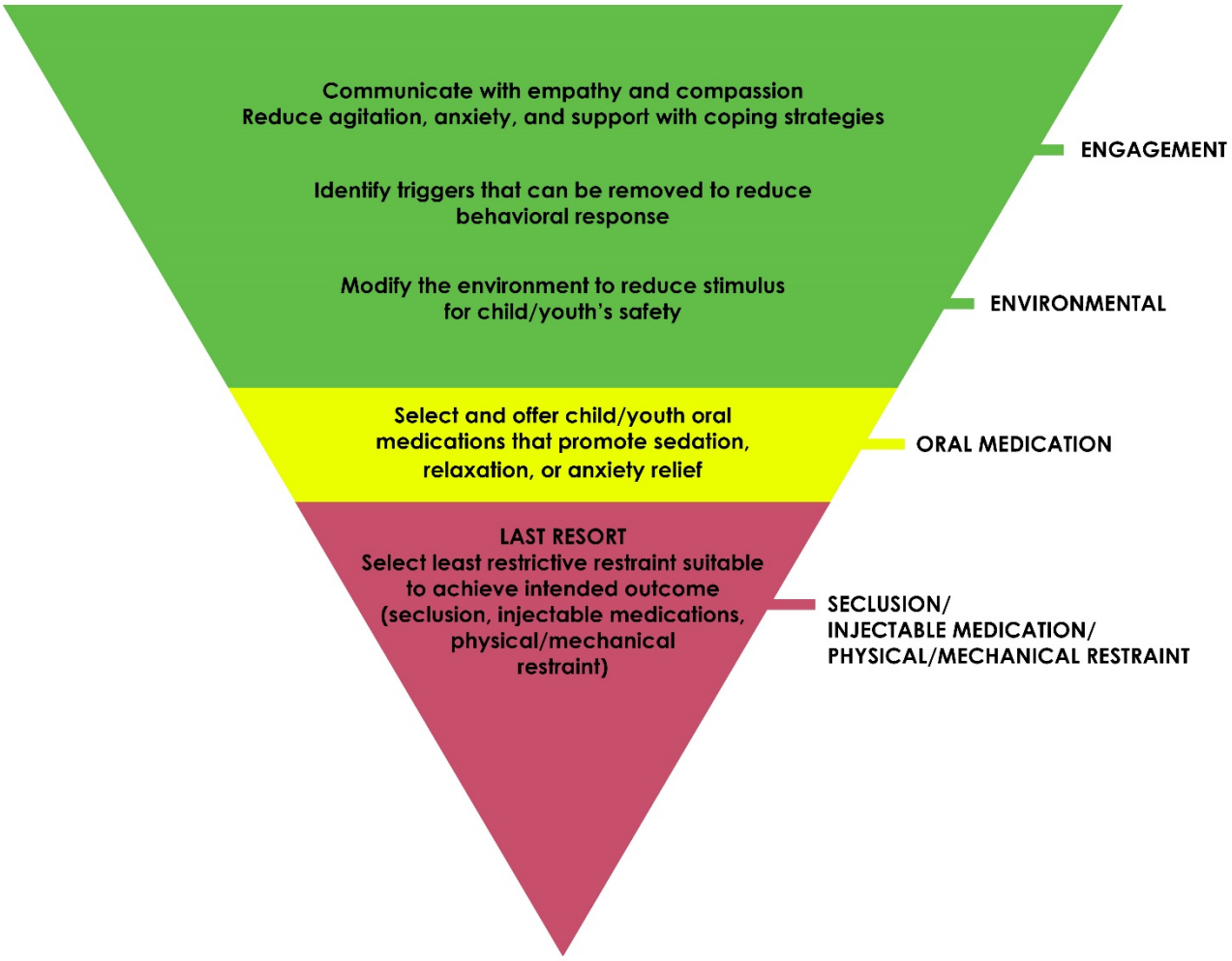
SECLUSION
- Where available, seclusion should occur in a room specifically designed for that purpose
- In most cases a patient requiring seclusion must be involuntarily admitted under the Mental Health Act
- Offer child/youth the option of entering the seclusion space voluntarily
- If the situation remains unresolved, a physician or NP must assess the child/youth and support treatment decisions

PHYSICAL/MECHANICAL
- Most associated with mortality & morbidity; most painful to patient; and most traumatic to patient, family and staff
- Physical/mechanical restraint should only be performed by trained personnel (as per HA policies)
- Only Health Authority approved methods and devices for children and youth, may be used
- If the situation remains unresolved, a physician or NP must assess the child/youth and support treatment decisions. Every physical/mechanical restraint intervention requires a unique order

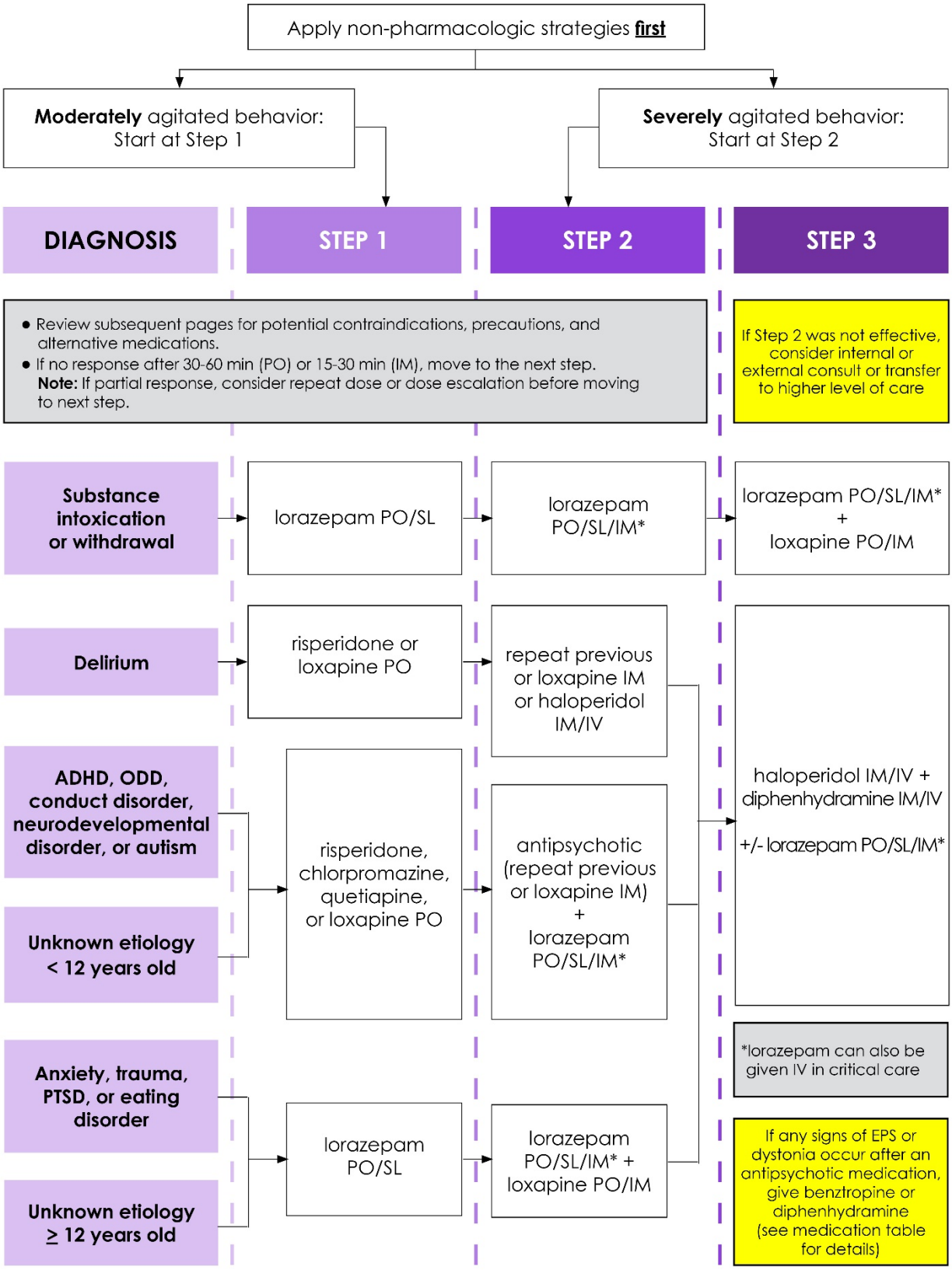
MONITORING AND OBSERVATION AS PER HEALTH AUTHORITY GUIDELINES
- Best practice recommends that a health care provider (RN or RPN) be available within sight and sound at all times
- Regular re-assessment should include assessment of vital signs, signs of physical and psychological distress, and mental status changes
- The team should regularly assess the need for continued use of restraints and discontinue as early as possible

Safety is the Priority

The RIGHT approach at the RIGHT time



- Document assessments, interventions and rationale
- Debrief with child/youth, family and staff
- Initiate a review process whenever restraint is used, to minimize future use and for quality improvement



Created by Sarah Leung, BScPharm, ACPR2(Ped)

		Antipsychotics (2nd generation)			Antipsychotics (1st generation)				Non-antipsychotic agents		
		quetiapine	risperidone	olanzapine	loxapine	haloperidol	methotrimeprazine	chlorpromazine	lorazepam	clonidine	diphenhydramine
PATIENT FACTORS	↑ QTc interval?	✗	!	✓	!	✗	!	!	✓	✓	!
	Hypotensive/ ↑ falls risk?	✗	!	! (PO) ✗ (IM)	✓	✓	✗	✗	!	✗	!
	Anticholinergic delirium?	✗	✓	✗	!	✓	✗	✗	✓	!	✗
	Seizures/ ↑ seizure risk?	!	!	!	✓	✓	!	✗	✓	✓	!
	Eating Disorder?	!	!	!	✓	✗	!	!	✓	!	✓
	Developmental disorder/autism	✓	✓	✓	✓	✗	✓	✓	! [d]	✓	! [d]
	Opioid use/ respiratory depression?	!	!	!	!	!	!	!	✗	✓	!
		quetiapine	risperidone	olanzapine	loxapine	haloperidol	methotrimeprazine	chlorpromazine	lorazepam	clonidine	diphenhydramine
DRUGS FACTORS	Routes/Dosage Forms	PO (TABLET)	PO (TABLET, LIQUID)	PO (TABLET, ODT) IM[a,b]	PO (TABLET) IM	PO (TABLET) IM/IV	PO (TABLET) IM/IV	PO (TABLET)	PO/SL (TABLET) IM	PO (TABLET, LIQUID)	PO (TABLET, LIQUID) IM
	EPS risk	+	++	+	++	++++	+	+	↓EPS	n/a	↓EPS
	Sedation properties	+++	++	++	+	+	+++	+++	++[d]	++	++[d]
	Useful as a PRN to treat acute agitation	✓	✓	✗ (PO/ODT) ✓ (IM)	✓	✓	✓	✓	✓	✗	✓
	Time to onset of action	~30-60 min	~60-75 min	~15 min(IM) ~6 hr (PO/ ODT)	~30 min (all forms)	~15 min (IM) ~3-20min (IV) ~2 hr (PO)	~30 min (IM) [c] ~15 min (IV) [c] ~1 hr (PO)	~30-45 min	~20-30 min (all forms)	~30-60 min	~30-45 min (PO) ~15-30 min (IM)
	Duration of action	~4-6 hr	~12-24 hr	~2 hr (IM) ~12-24 hr (PO)	~12 hr	~4-12 hr	~2-4 hr	~4-6 hr	~6-8 hr	~3-4 hr	~4-6 hr

✓ optimal choice
! caution
✗ less optimal choice

a Peak serum level 5 times higher with IM form compared to PO
b IM form **CONTRAINDICATED** within 1 hr of parenteral benzodiazepine
c Peak serum level 2 times higher with IM/IV form compared to PO
d Note: ↑ risk of paradoxical agitation

Abbreviations: EPS extrapyramidal symptoms; IM intramuscular; IV intravenous, ODT oral dissolving tablet; SL sublingual; PO oral

Table updated January 2022
Dr. Dean Elbe, PharmD, BCPP, Dr. Andrea Chapman, MD, FRCPC, Dr. Kelly Saran, MD, FRCPC, Joanna McKay, RN

NAME	USUAL DOSE (FOR ACUTE EPISODE)	ACTION	ADVERSE EFFECTS	CONTRAINDICATIONS
Benztropine	**EPS:** 0.5-1 mg/dose PO/IM Max: 0.1 mg/kg/24h or 6 mg/24h **Acute dystonia:** 1-2 mg/dose IM/IV	Anticholinergic	Sedation, dry mouth, blurred vision, tachycardia, constipation, urinary retention.	**Avoid:** Age < 3 years (use diphenhydramine), anticholinergic delirium **Caution:** Ileus, narrow angle glaucoma
Chlorpromazine	0.5-1 mg/kg/dose PO (round to nearest 12.5 mg) Max: 50 mg/dose	FGA, low potency	Postural hypotension, tachycardia, QTc prolongation, lowered seizure threshold. Less risk of EPS vs. haloperidol, but more anticholinergic effects.	**Avoid:** Seizure disorders, anticholinergic delirium **Caution:** Cardiac conditions, other QTc prolonging medications
Clonidine	1 mcg/kg/dose PO Max: 50 mcg/dose	Alpha-2 agonist	Dizziness, hypotension, bradycardia.	**Avoid:** Hypotension, bradycardia **Caution:** Anticholinergic delirium
Diphenhydramine	1 mg/kg/dose PO/IM/IV (round to nearest 5 mg). Max: 50 mg/dose. Given with haloperidol to prevent dystonic reaction. Use IM/IV route for treating acute dystonia.	Anticholinergic, used to treat agitation or EPS/dystonia	Sedation, dry mouth, blurred vision, tachycardia, constipation, urinary retention. QTc prolongation in high doses. Paradoxical excitation can occur; more common in younger children and those with neurodevelopmental disorders.	**Avoid:**: Anticholinergic delirium **Caution:** Ileus, narrow angle glaucoma
Haloperidol	0.025-0.075 mg/kg/dose PO/IM/IV Max: 5 mg/dose	FGA, high potency	High incidence of EPS and dystonic reactions in children and adolescents. IM route may have higher risk of dystonia, and IV route may have higher risk of QTc prolongation. Hypotension, lowered seizure threshold. Minimal anticholinergic effects.	**Avoid:** Cardiac conditions (particularly arrhythmias or prolonged QTc), other QTc prolonging medications **Caution:** Seizure disorders
Lorazepam	0.025-0.1 mg/kg/dose PO/SL/IM (round to nearest 0.25 mg) Max: 2 mg/dose (higher doses may be required for stimulant overdose or substance withdrawal; max single dose 4 mg)	Benzodiazepine	Confusion, mild cardiovascular suppression. Higher risk of respiratory depression when combined with opioids. Paradoxical excitation can occur; more common in younger children and neurodevelopmental disorders.	**Avoid:** Respiratory depression **Caution:** Patients taking opioids
Loxapine	0.1-0.2 mg/kg/dose PO/IM (round to nearest 2.5 mg) Max: 25 mg/dose	FGA, moderate potency	Moderate incidence of EPS and dystonic reactions, moderate anticholinergic effects.	**Caution:** Cardiac conditions, seizure disorders, other QT prolonging medications, anticholinergic delirium
Methotrimeprazine	**Child:** 0.125 mg/kg/dose PO **Adolescent:** 2.5-10 mg/dose PO **Child & Adolescent:** 0.06 mg/kg/dose IM/IV (round to nearest 2.5 mg)	FGA, low potency	Sedation, anticholinergic effects, postural hypotension. Less risk of EPS vs. haloperidol, but more anticholinergic effects.	**Avoid:** Hypotension, anticholinergic delirium **Caution:** Seizure disorders, cardiac conditions, other QTc prolonging medications
Olanzapine	2.5-10 mg/dose IM Max: 3 doses or 20 mg/24h, given 2-4 h apart (onset of PO route too slow for PRN use in acute agitation)	SGA	Postural hypotension (monitor before each IM dose), anticholinergic effects, lowered seizure threshold, akathisia. Minimal risk of QTc prolongation.	Do NOT combine IM route within 1 hour of parenteral benzodiazepine; reported cases of respiratory depression and death. **Avoid:** Hypotension, anticholinergic delirium **Caution:** Seizure disorders
Quetiapine	**Child:** 12.5-50 mg/dose PO **Adolescent:** 25-100 mg/dose PO	SGA	Sedation, dizziness, postural hypotension, tachycardia, QTc prolongation, anticholinergic effects, lowered seizure threshold. Lower risk of EPS than other agents.	**Avoid:** QTc prolongation, hypotension, anticholinergic delirium **Caution:** Cardiac conditions, other QTc prolonging medications, seizure disorders
Risperidone	**Child:** 0.125-0.5 mg/dose PO **Adolescent:** 0.25-1 mg/dose PO	SGA	Postural hypotension, EPS (in higher doses), lowered seizure threshold, akathisia. Minimal risk of anticholinergic effects.	**Caution:** Seizure disorders, cardiac conditions, CYP2D6 inhibitors (e.g. fluoxetine) – consider dose reduction with repeat/regular dosing of risperidone

EPS – Extrapyramidal symptoms; FGA – First generation antipsychotic; SGA – Second generation antipsychotic

Appendix D: Disclaimer

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 E: Working Group Members

This group would like to acknowledge the many other health care professionals and patients and families with lived experience 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 listed below.

2017-2018 Original Guideline Working Group

Health Authority	Name	Position
Provincial Health Services	Andria Ryomoto	Clinical Resource Nurse. Child Mental Health In-patient unit
Provincial Health Services	Christy Hay	Program Manager Emergency
Provincial Health Services	Sharlynne Burke	In-patient Program Director , Child, Youth and Reproductive Mental Health
Provincial Health Services	Shawna Wilwand	Nurse Clinician, Child & Adolescent Psychiatric Emergency
Provincial Health Services	Jennifer Kendrick	Clinical Supervisor, Pharmacy Department
Provincial Health Services	Dean Elbe	Clinical Pharmacy Specialist, Child & Adolescent Mental Health
Provincial Health Services	Kendra Sih	Clinical Pharmacy Specialist
Provincial Health Services	Jennifer Toomey	Nurse Clinician, Provincial Youth Concurrent Disorders
Provincial Health Services	Kim Wong	Senior Practice Lead, Child, Youth and Reproductive Mental Health
Provincial Health Services	Jenny Lindstrom	Nurse Educator, Child, Youth and Reproductive Mental Health
Provincial Health Services	Dr. Tyler Black	Psychiatrist, Child And Adolescent Psychiatric Emergency Unit (CAPE)
Provincial Health Services	Lorelei Faulkner	Professional Practice Leader
Provincial Health Services	Cynara Radley	Senior Practice Leader, Mental Health
Provincial Health Services	Dr. Ran Goldman	Division Head, Pediatric Clinical Pharmacology, Pediatrics
Child Health BC	Dr. Maureen O'Donnell	Executive Director
Child Health BC	Theresa McElroy	Regional Coordinator
First Nations Health	Christine Westland	Clinical Nurse Specialist, Mental Health and Substance Use
First Nations Health	Cindy Preston	Health Benefits Pharmacist Lead
Fraser Health	Charlene Cena	Clinical Nurse Specialist, Pediatric Emergency
Fraser Health	Dr. Shruthi Eswar	Child and Adolescent Psychiatrist
Fraser Health	Claire MacLeod	Pharmacist, Pediatric
Fraser Health	Sabina Choi	Pharmacist, Pediatrics
Interior Health	Micheline Wiebe	Clinical Nurse Specialist, Emergency & Trauma
Interior Health	Carla Mantie	Practice Lead MH & Substance Use
Interior Health	Ingrid Douziech	Child & Adolescent Psychiatry
Interior Health	Dr. Paul Dagg	Clinical Director - Tertiary Mental Health
Interior Health	Jennifer Farough	Nurse
Interior Health	AJ Brekke	Network Director, Emergency & Trauma Services

Health Authority	Name	Position
Interior Health	Debra Salverda	Team Lead and Knowledge Coordinator for South Okanagan MHSU
Interior Health	Leala Tomlinson	Nurse
Interior Health	Dr. Shannon Wires	Pediatrician
Northern Health	Darlene Fjellgaard	Clinical Nurse Educator
Northern Health	Darren Johnson	Nurse Pediatrics
Northern Health	Mary Morrison	Manager, Youth Services And Eating Disorders and Community Services Management
Northern Health	Dr. Patrick Rowe	Head, Emergency Medicine, UNBC
Providence Health	Talena Hale	Clinical Nurse Leader
Vancouver Coastal Health	Heather Epp	Nurse
Vancouver Coastal Health	Dale Handley	Clinical Planner
Vancouver Coastal Health	Michelle Connell	Trauma Coordinator, Clinical Group
Vancouver Coastal Health	Susanne Scott	Interim Manager Acute Services Sea-to-Sky, Squamish Whistler and Pemberton
Vancouver Coastal Health	Catherine Marshall	Clinical Nurse Educator, Richmond Emergency
Vancouver Coastal Health	Justin Scott	Registered Nurse-Emergency
Vancouver Coastal Health	Tanis Evans	Manager, Carlile Youth Concurrent Disorders Centre, Youth Mental
Vancouver Coastal Health	Peter Ramsay	Patient Care Supervisor, Lion's Gate Hospital
Island Health	Kathleen (Kitty) Murray	Clinical Nurse Educator
Island Health	Susie Girling	Coordinator Of Crisis Services
Island Health	Dr. Rex Bowering	Child And Adolescent Psychiatrist
Island Health	Dr. Fawad Elahi	Child And Adolescent Psychiatrist
Island Health	Dr. Chris McCollister	Pediatrician, West Coast General Hospital

2020-2022 Guideline Review and Update Working Group

Health Authority	Name	Position
Provincial Health Services	Kyle Taylor	Clinical Resource Educator. Healthy Minds
Provincial Health Services	Dean Elbe	Child and Adolescent Pharmacist
Provincial Health Services	Dr. Andrea Chapman	Child and Adolescent Psychiatrist
Provincial Health Services	Dr. Martha Ignaszewski	Child and Adolescent Psychiatrist
Provincial Health Services	Dr Susan Baer	Child and Adolescent Psychiatrist
Provincial Health Services	Dr. Kelly Saran	Child and Adolescent Psychiatrist
Provincial Health Services	Joanna MacKay	Consult Liaison Nurse, Psychiatry
Provincial Health Services	Alice Virani	Director, Ethics
Provincial Health Services	Natasha Leech	Risk Specialist

Health Authority	Name	Position
First Nations Health	Cynthia Russell	Clinical Nurse Specialist, Mental Health and Substance Use
Fraser Health	Paula Sandhu	Mental Health Substance Use Practice Lead
Fraser Health	Allison Fillion	Clinical Nurse Educator, Mental Health and Substance Use
Fraser Health	Melissa Suzuki	Clinical Nurse Educator, Mental Health and Substance Use
Fraser Health	Sabina Choi	Pharmacist, Pediatrics
Fraser Health	Dr Gilbert Lam	Child & Adolescent Psychiatrist
Fraser Health	Dr John Otasowie	Child & Adolescent Psychiatrist
Interior health	Cindy Golbeck	Mental Health and Substance Use Practice Lead
Interior Health	Simono Ndebele	Manager, PIPU
Interior Health	Ingrid Douziech	Child & Adolescent Psychiatrist
Interior Health	Andrea Antonishen	Manager, Adolescent Psychiatry Unit
Interior Health	Erika Hayton	Patient Care Coordinator, Kootenay Boundary Regional Hospital
Interior Health	Raj Chahal	Team Lead, PIPU
Interior Health	Erin McFee	Clinical Nurse Specialist, Pediatrics
Interior Health	Laura-lee Regnier	Patient Care Coordinator, Kelowna General Hospital
Interior Health	Laura Beresford	Child and Adolescent Pharmacist
Northern Health	Damen DeLeenheer	Educator, Mental Health
Northern Health	Chantelle Wilson	Manager, Specialized Services, Mental Health
Northern Health	Fred Smith	Educator, Mental Health
Northern Health	Jessica Manning	Pharmacy
Vancouver Coastal Health	Liz Cave	Nurse, Carlile
Vancouver Coastal Health	Brittany Gould	Educator, Lion's Gate Hospital
Vancouver Coastal Health	Dr Dan Kalla	Emergency Physician, St Paul's Hospital
Island Health	Jennifer Steele	Nurse Clinician, Ledger House
Island Health	Susie Girling	Coordinator, Crisis Services
Island Health	Fiona Crisp	Inpatient Coordinator, Ledger House
Island Health	Kara Shebib	Clinical Nurse Leader, Pediatrics
Island Health	Dr. Greg Culp	Emergency Physician, Nanaimo Regional General Hospital
Island Health	Dr Jennifer Balfour	Pediatrician, Victoria General Hospital
Island Health	Kyle Collins	Child and Adolescent Pharmacist
	Jill Townsend	Family Partner
	Omar Bseiso	Patient Partner

8.0 Additional 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. Alberta Health Services: Restraint as a Last Resort Toolkit- Information for Health Professionals
   https://www.albertahealthservices.ca/info/Page15702.aspx

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

6. 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

7. 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

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

9. BC Mental Health Act Toolkit
   www.healthymindslearning.ca

10. Provincial Violence Prevention Curriculum
    Provincial Violence Prevention Curriculum

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

12. San'yas program website

13. Cultural humility. First Nations Health Authority. Published 2020
    https://www.fnha.ca/wellness/wellness-and-the-first-nations-health-authority/cultural-safety-and-humility

14. http://foundrybc.ca/

15. BC Children's Hospital (2019). *2019 ONCAIPS-BC Provincial Child & Adolescent Inpatient Mental Health Standards.* BC Children's Hospital, Child and Adolescent Psychiatry.

http://www.bcchildrens.ca/mental-health-services-site/Documents/BC-ONCAIPS%20Standards%202019.pdf

16. Agency for Healthcare Research and Quality, Guide to Patient and Family Engagement in Hospital Quality and Safety, Agency for Healthcare Research and Quality, 2017. https://www.ahrq.gov/patient-safety/patients-families/engagingfamilies/howtogetstarted/index.html

17. Ballantyne, M et al. Canadian Paediatric Nursing Standards. 2017. https://paednurse.ca/resources/Documents/FINAL-Paediatric%20Nursing%20Standards%20September%202017.pdf

18. Child Health BC. Pediatric Foundational Competencies Online Course. https://www.childhealthbc.ca/clinician-resources/formal-learning

19. BC Children's Hospital. Pediatric Foundational Competencies (formerly CAPE tools). 2020 (Draft)

20. First Nations Health Authority, First Nations Health Council, First Nations Health Director's Association. Anti-Racism, Cultural Safety & Humility Framework. April 22, 2021. https://www.fnha.ca/Documents/FNHA-FNHC-FNHDA-Anti-Racism-Cultural-Safety-and-Humility-Framework.pdf.

21. Health Standards Organization (HSO). First Nations, Metis, and Inuit Cultural Safety and Humility (Draft for Public Review). HSO 75000:2021 (E). https://healthstandards.org/files/40-Standard-PRDraft-CSH-23June2021.pdf (accessed Nov 28, 2021).

22. Compass Mental Health: Supporting Providers: http://www.bcchildrens.ca/health-professionals/clinical-resources/mental-health/compass-1-855-702-7272

23. Trans Care BC: http://www.phsa.ca/transcarebc/gender-basics-education

9.0 References

Amdam, L. (2006). Restraint-free in residential care – A worldwide goal. In Caring: The Newsletter of the Advocates of Care Reform, Summer 2006. Retrieved April 4, 2012 from http://www.acrbc.ca/pdf/ACR-Summer.06.pdf
https://www.mentalhealthcommission.ca/English/what-we-do/stigma-and-discrimination

Baren JM, Mace SE, Hendry PL, Dietrich AM, Goldman RD, Warden DR. (2008). Children's Mental Health Emergencies-Part 2: Emergency Department Evaluation and Treatment of Children with Mental Health Disorders. Pediatric Emergency Care. 24(7): 485-498.

B.C. Representative for Children and Youth. Detained: Rights of children and youth under the Mental Health Act. Victoria, BC: Representative for Children and Youth, 2021. https://rcybc.ca/wp-content/uploads/2021/01/RCY_Detained-Jan2021.FINAL_.pdf

Brown University (2005). Using pediatric chemical restraints in the ER: Protocol and safety concerns; 7(5): 1-7.

Carubia B, Becker A & Levine H. (2016). Child Psychiatric Emergencies: Updates on Trends, Clinical Care, and Practice Challenges. Curr Psychiatry Rep. 18(41): 1-8.

Clinical Practice Guidelines for the care of children and adolescents in New South Wales Health acute care facilities, 2010.

College of Nurses of Ontario. (2009). *Practice Standard: Restraints.* Retrieved from http://www.hqontario.ca/Portals/0/modals/qi/en/processmap_pdfs/resources_links/restraints%20cno.pdf

College of Registered Psychiatric Nurses of British Columbia (CRPNBC) (2008, January 24). *The use of physical restraint & seclusion as Psychiatric Nursing interventions: A position statement.* Vancouver, BC. Retrieved April 5, 2012 from https://www.bccnm.ca/RN/learning/consent/Pages/restraint_seclusion.aspx

Cunha M et al. (2016). Chemical and physical restraint of patients. Procedia - Social and Behavioral Sciences; 217: 389 – 399

Darby C, Cardwell P. (2011). Restraint in the Care of Children. Emergency Nurse. 19(7): 14-17

Davidson JE, Aslakson RA, Long AC, et al. Guidelines for Family-Centered Care in the Neonatal, Pediatric, and Adult ICU. Critical care medicine. 2017; 45:103-128

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.

Dorfman DH & Kastner B (2004). The Use of Restraint for Pediatric Psychiatric Patients in Emergency Departments. Pediatric Emergency Care. 20 (3): 151-156.

Dorfman DH & Mehta, SD (2006). Restraint Use for Psychiatric Patients in the Pediatric Emergency Department. Pediatric Emergency Care. 22(1): 7-12.

Griffey RT, Wittels K, Gilboy N, et al. (2009). Use of a computerized forcing function improves performance in ordering restraints. Ann Emerg Med; 53(4):469Y476.

Grupp-Phelan J, Mahajan P, Foltin GL, Jacobs E, Tunik M, Sonnett M, Miller S, Dayan P and the Pediatric Emergency Care Applied Research Network. (2009). Referral and Resource Use Patterns for Psychiatric-Related Visits to Pediatric Emergency Departments. Pediatric Emergency Care. 25(4): 217-220.

Hamm MP, Osmond M, Curran J, Scott S, Ali S, Hartling L, Gokiert R, Cappelli M, Hnatko G, Newton AS. (2010). A Systematic Review of Crisis Interventions Used in the Emergency Department Recommendations for Pediatric Care and Research. Pediatric Emergency Care; 26 (12): 952-962.

Harris M, Fallot RD. (2001) A Trauma Informed Approach to Screening and Assessment. New Directions for Mental Health Services, Issue 89.

Hopper SM, Babl FE, Stewart CE, Woo JW. Aggression management in a children's hospital setting Med J Aust; 196 (3): 198-201.

Joint Commission on Accreditation of Healthcare Organizations. Comprehensive Accreditation Manual for Hospitals. Refresher Course. January 2005.

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.

McQueen A, Cress C, Tothy A. (2012). Using a Tablet Computer During Pediatric Procedures: A Case Series and Review of the ''Apps''. Pediatric Emergency Care. 28(7): 712-714.

Mohr WK, Petti TA, Mohr BD. (2003) Adverse Effects Associated With Physical Restraint. Canadian Journal of Psychiatry; 48(5): 330-337

Muralidharan S1, Fenton M. (2006) Containment strategies for people with serious mental illness. Cochrane Database Syst Rev. Jul 19; (3):CD002084.

Newberry JA, Wang NE (2013) Emergency Department Management of the Agitated Pediatric Patient. Pediatric Emergency Medicine Reports. Accessed Sept 16 from: https://www.ahcmedia.com/articles/63642-emergency-department-management-of-the-agitated-pediatric-patient

Newlove T. An Introduction to Trauma Informed Practice. Presented at: Provincial Health Services Authority; June 16, 2020. https://mediasite.phsa.ca/Mediasite/Play/e408eb95e5f748a3a563cf35f441cef41d

Nicholas, DB; Zwaigenbaum L, Muskat B, Craig WR, Newton AS, Cohen-Silver J, Sharon RF,

Greenblatt A, Kilmer C. (2016). Toward Practice Advancement in Emergency Care for Children With Autism Spectrum Disorder;137(s2):e20152851S

Nielson Simon, Bray Lucy, Carter Bernie, Kiernan Joann (2020) Physical restraint of children and adolescents in mental health inpatient services: A systematic review and narrative synthesis. Journal of Child Health Care, Vol. 0(0)1-26

Provincial Quality, Health and Safety Standards and Guidelines for Secure Rooms in Designated Mental Health Facilities under the BC Mental Health Act, Aug 2014.

Provincial Violence Prevention Curriculum https://www.safecarebc.ca/programs/provincial-violence-prevention-curriculum-peer-facilitator-training/

Secure Rooms and Seclusion Standards and Guidelines: A Literature and Evidence Review, BC MoH, 2012).

Sheridan, DC, Spiro DM, Fu R, Johnson KP, Sheridan JS, Oue AA, Wang W, Van Nes, R, Hansen ML. (2015). Mental Health Utilization in a Pediatric Emergency Department. Pediatric Emergency Care. 31 (8): 555-559.

Sorrentino A. (2004). Chemical restraints for the agitated, violent, or psychotic pediatric patient in the emergency department: controversies and recommendations. Curr Opin Pediatr 16:201–205.

Uspal NG, Rutman LE, Kodish I, Moore A, Migita RT. Use of a Dedicated, Non–Physician-led Mental Health Team to Reduce Pediatric Emergency Department Lengths of Stay. ACADEMIC EMERGENCY MEDICINE; 23(4): 440-447.

Weiss EM, et al. Deadly restraint: a Hartford Courant investigative report. Hartford Courant 998; October 11 – 15.

Zun, LS. (2005). Use of Restraint and Seclusion in the Emergency Department. Psychiatric Times. Accessed on September 19, 2016 from: http://www.psychiatrictimes.com/articles/use-restraint-and-seclusion-emergency-department