PART
TWO

Child Health BC
Provincial Least Restraint Guideline

Initial Management of Least Restraint in Emergent/Urgent Care Settings

Practical Summary and Tools

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:

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

Least Restraint: Children & Youth in the Emergent / Urgent Care Settings
Age 0 Days of Age – 19 Years of Age Less 1 Day

Purpose

To provide a least restraint/last resort approach to maximize safety in emergency situations. 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, and staff
- Disorganized approaches to safety events can prolong the trauma and may result in injury

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

Principles

Trauma Informed Practice

Trauma-informed practice takes into account an understanding of trauma in all aspects of service delivery and places priority on the individual's safety, choice and control (Harris & Fallot, 2001). A key aspect of trauma-informed services is to create an environment where service users do not experience trauma or further re-traumatization. This is supported, in part, through awareness of the wide-ranging impacts of trauma on an individual. This includes the ways in which trauma changes an individual's neurobiology and capacity for adaptive social functioning and emotional regulation, which often cause behaviors associated with a need for seclusion.

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. A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

Cultural Competence

Cultural competence refers to the ability to recognize and respect cultural difference and diversity. In the context of delivering care, cultural competence is necessary to facilitate effective communication between patients and providers; to ensure a system of care that responds to a variety of culturally-dependent beliefs, needs and practices; to ensure that care is trauma-informed; and to improve patient outcomes and provider experiences by reducing power imbalances that result from systemic inequality, discrimination, stigma, and/or stereotypes.

Clinicians and staff should undertake cultural safety training to improve their ability to establish positive partnerships with Indigenous clients seeking care. The San'yas Indigenous Cultural Safety Training Program, developed by the Provincial Health Services Authority (PHSA) Aboriginal Health Program, is an online training program designed to increase knowledge, enhance self-awareness, and strengthen the skills of those who work both directly and indirectly with Aboriginal people, and is an excellent resource for clinicians seeking to build their cultural competency. Please refer to the San'yas program website for more information.

Child/Youth/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 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 Centered

A family-focused approach that recognizes and supports families in their key role of providing ongoing care and support to children and youth. Client-centered and family-focused approaches are based on a philosophy that service delivery involves a partnership between those using and those providing services.

For more information on principles, please refer to: Trauma Informed Practice Guide http://bccewh.bc.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf This Guide was developed on behalf of the BC Provincial Mental Health and Substance Use Planning Council in consultation with researchers, practitioners and health system planners across British Columbia.

Key Recommendations

Emergency Restraint Use

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. 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 must be maintained at the "minimally sufficient level", and opportunities to "decrease the level" should ALWAYS be explored. Engagement should be maintained throughout the situation. The hierarchy of safety includes:

1. Engagement
2. Environmental supports
3. Oral medications
4. Isolation/ Seclusion
5. Injectable medications
6. Physical restraints

For further information, see Hierarchy of Safety (Appendix A)

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.

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.

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).

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.

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".

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.

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.

Scope

This document applies to all staff working in Emergency/Urgent Care settings who use emergency restraint with children & youth ages 0 days of age to 19 years of age less a day.

1.0 Procedure

1.1 Prior to Restraint

1.1.1 Review with patient/family members/caregivers:

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:

Must be attempted prior to initiating restraint. This should include **offering alternative prevention strategies.** Examples of prevention strategies include:

- Always treat the patient with respect.
- Approach in a quiet, calm and confident manner.
- Speak clearly and slowly.
- Ask them what they preferred to be called and their preferred pronoun.
- Always explain who you are and what you are doing.
- Acknowledge the patient's feelings and concerns.
- Provide frequent reassurance. Brief and frequent attendances will assist with this and may avoid unnecessary agitation.
- Protect the patient 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).
- Ensure child/youth's physical and psychological needs are met.
- Provide comfort items- could include: fidgets, ear plugs, warm drink, sleep masks, aroma therapy mist, Kleenex, lip balm, paper and pencils, snacks, books, comic books, relaxation techniques on cue cards, playing cards, greeting cards, blanket, stuffed animal etc.
- Sensory modulation (arts and crafts, music or sound therapy e.g. ipods, dvds).
- Encourage Walking, talking, writing, resting, crying, deep breathing.
- Music/music therapy- DVDs, ipods for music.
- Time alone.
- Spiritual practice.
- Minimize the number of staff attending the patient.
- For the confused/disoriented patient, keep an object familiar to them in view (e.g. a bag or an item of clothing).
- Correct perceptual errors and tell the patient what is real in a respectful manner.
- Accompany the person to and from places (e.g. toilet).

In the case of aggressive patients follow Hierarchy of Safety (Appendix A).

1.1.3 Assess risk factors prior to considering restraint.

Risk factors include (Mohr et al 2003):

- Any child/youth demonstrating signs of medical instability (including those experiencing withdrawal symptoms).
- Any child/youth with a known history of trauma, consider the potential for a history of trauma in its impact on current behaviours and interpretation of interventions.
- Consideration will be given to child/youth with cognitive/ learning/ neurological impairment (e.g. autism spectrum disorder) i.e. consult with caregiver regarding calming strategies/triggers, attempt to reduce environmental stimulation by moving child/youth to a quiet, calm, dim lit area if available.
- Environmental and resource considerations.
- Prior history of dystonic reactions.
- Allergies/intolerances.
- Potential unknown poly-substance use.
- Alerts that may currently be in place on child/youth's chart.
- Any child/youth with:
  - a seizure disorder
  - a respiratory condition. Could increase risk especially if the child/youth is placed face down (prone) during a physical restraint. The child/youth's airway must be unobstructed at all times.
  - morbid obesity
  - alcohol and drug use
  - cardiac history
  - fractures
  - back injuries
  - risk for aspiration (vomiting)
  - lower level of consciousness
  - certain medications

1.1.4 Reasons restraint should NOT be used:

- As a substitute for less restrictive alternatives.
- As a disciplinary or punitive measure or a means of addressing disruptive or dysregulated behavior.
- For convenience or to aid with management or as a substitute for inadequate staffing.
- Solely to prevent damage to property.
- Solely to prevent absconding.

1.2 Informed Consent & Certification

1.2.1 Consent to treatment:

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

- There is no minimum age of informed consent.
- The Infant Act applies to youth under the age of 19 (under the age of majority)
- Health care providers are encouraged to involve children and youth in the discussions involving their health and treatment.
- Where it is clear that the child or youth is competent to consent to treatment and that the treatment is in his/her best interest, as outlined in the Infants Act, the health care provider will obtain informed consent from the patient. **Infants Act: Consent of infants to medical treatment, Section 17.**
- http://www.bclaws.ca/civix/document/id/complete/statreg/96223_01
- If the minor is incapable of providing informed consent, the health care provider must obtain informed consent from the minor's parent or legal guardian. (Substitute decision maker - SDM).
- If patient/family/SDM is not able/available to give consent, an explanation with rationale should be provided as soon as possible after the event. It is important that the patient/family/caregiver receive an explanation as to why the treatment is necessary and they should be given the opportunity to respond to alternative methods when appropriate and safe.

1.2.2 Consent to medical care:

In a medical emergency, consent may not be needed to treat a child/youth — it depends on the situation. If a person's life or health is seriously threatened, and it appears that the person isn't capable of making healthcare decisions, healthcare providers may be able to treat the person without consent.

- Because they are dealing with a medical emergency, they may be able do whatever is necessary to try and save the person's life or health.
- Common law also recognizes that, in an emergency, where a person's life is at risk or where there may be serious harm to the person's health and where the individual is incapable of consenting to treatment, emergency treatment may be provided to a person of any age without that person's consent. Common law suggests that these emergency powers include the restraint of a person who is likely to cause serious harm to themselves or others.

1.2.3 Certification

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:

- 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;
- requires psychiatric treatment in or through a designated facility;
- 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
- is not suitable as a voluntary patient.

One Medical Certificate (Form 4) is required to provide legal authority for an involuntary admission for a 48-hour period. A Medical Certificate is completed by a physician who examines a person and finds that the person meets the involuntary admission criteria of the Mental Health Act. A second Medical Certificate by a different physician must be completed within 48 hours of admission, otherwise the patient must be discharged or admitted as a voluntary patient.

The Mental Health Act provides for compulsory treatment of all involuntary patients. The director may authorize treatment for patients who are mentally incapable of making a consent decision about the proposed treatment. Prior to treatment of involuntary patients, the Consent for Treatment (Involuntary Patient) form (Form 5) must be completed and signed.

http://www2.gov.bc.ca/gov/content/health/health-forms/mental-health-forms.

For further guidance regarding the Mental Health Act, see the Guide to the Mental Health Act at:
http://www.health.gov.bc.ca/library/publications/year/2005/MentalHealthGuide.pdf

[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.

Use of Seclusion in Emergent / Urgent Care 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 & youth who present to Emergency/Urgent care settings.

2.0 Guideline

2.1 Initiating Seclusion

2.1.1 Medical Assessment

Where possible, the child/youth shall be deemed medically stable by a physician, nurse (RN), Registered Psychiatric Nurse (RPN) 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 is clearly documented.

2.1.2 Physician Orders

A physician order for use of seclusion must be obtained within one hour of seclusion initiation. The order must specify the rationale for seclusion in relation to the child/youth's condition and/or plan of care.

** In smaller (Tier 1 or 2) sites, the first order may be given by phone. Physician assessment should be undertaken as soon as possible.*

Physician's orders for seclusion of children/youth shall be valid for a maximum of 1 hour. If the situation remains unresolved, a physician, psychiatrist or NP must attend in-person to assess the child/youth and support treatment decisions.

Use of Seclusion may not be ordered on a PRN (as needed) basis.

2.1.3 Procedures for Initiating Seclusion

- Communicate with child/youth & caregivers 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 Health Authority (HA)/Site CODE WHITE procedures. "Code White" is a term that is used to call for help when workers perceive themselves or others to be at risk of being harmed from someone who may become or is violent.
- Conduct safety check, as per HA guidelines and allow child/youth to remain in his/her street clothes unless/until a physical exam is required and as long as the clothes pose no safety risk.
- Support child/youth to keep personal items of personal significance as long as the items pose no safety risk.

2.2 Seclusion Spaces

When available, seclusion should occur in a room specifically designated for that purpose, i.e. a secure room (MoH, 2014).

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

2.3 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:

a) Continuously monitor for signs of physical distress.
b) Document at regular intervals as per Health Authority process (e.g. using a continuous monitoring or seclusion checklist).
c) Assess vital signs at earliest opportunity when safe to do so and thereafter as per emergency/urgent care settings protocol or orders.
d) Ensure child/youth's physical and physiological needs are met (i.e. toileting, nourishment & hydration, pain management, engagement).
e) Assess and document potential for discontinuing seclusion (immediate risk of harm to self or others has passed) or rationale for continued seclusion.

NOTE: Security officers and Health Care Aides are NOT trained to make clinical observations.

A minimum of two people (i.e. 2 staff members, or 1 staff member plus one supporting professional e.g. police, security) are needed to enter seclusion room. Communicate with child/youth regarding entry and seek agreement when possible.

2.4 Discontinuing Seclusion

- **Inform child/youth of what is required** so that they can be safely released from the room/space.
- **Prior to terminating seclusion, open the door/space.** 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 seclusion.

2.5 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.
- Complete medical assessment/ management as per site process.

2.6 Debriefing

- Debriefing is recommended for child/youth, family/caregivers and all staff involved in a seclusion event. The purpose is to rebuild trust and relationship, promote emotional and physical safety, enable learning and reduce future use of restraint/seclusion.
- The debrief/discussion with child/youth/family/caregiver (either together or separately) should be completed as soon as the child/youth is able to engage.

Use of Chemical Restraint with Children & Youth in the Emergent / Urgent Care 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 & youth who present to Emergency/Urgent care settings.

3.0 Guideline

3.1 Initiating Chemical Restraint

3.1.1 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 is clearly documented.

3.1.2 Physician Orders

A physician 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.
** In smaller (Tier 1 or 2) sites, the first order may be given by phone. Physician assessment should be undertaken as soon as possible.*

3.1.3 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.**
- If voluntary restraint is not possible, **follow Health Authority (HA)/Site CODE WHITE procedures. "Code White"** is a term that is used to call for help when workers perceive themselves or others to be at risk of being harmed from someone who may become or is violent.
- **Conduct safety check, as per HA guidelines and allow child/youth to remain in his/her street clothes** unless/until a physical exam is required and as long as the clothes pose no safety risk.
- **Obtain physician order.** Oral/sublingual is the preferred route if child/youth is willing and able. Refer to Appendix B.
- 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.
- Support child/youth to keep items of personal significance as long as they pose no safety risk.
- **Measure baseline vital signs** (VS) and document as per health authority standard.
- Identify patient, explain procedure and administer medication as ordered.
- 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).
- 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. "Code White" is a term that is used to call for help when workers perceive themselves or others to be at risk of being harmed from someone who may become or is violent.

3.2 Monitoring & Observation

In recognition that chemical restraint is a high risk intervention, a RN, RPN or NP shall be available within sight and sound at all times when a child/youth is restrained to:

a) Monitor as per health authority guidelines.
b) Position patient on side or in recovery position.
c) Monitor patient and determine need for further medication.
d) If more medication is needed or if medication was not effective, the physician must follow up and evaluate patient.

NOTE: Security officers and Health Care Aides are NOT trained to make clinical observations.

3.3 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.
- 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.

3.4 Debriefing

- Debriefing is recommended for child/youth, family/caregivers and all staff involved in a restraint event. The purpose is to rebuild trust and relationship, promote emotional and physical safety, enable learning and reduce future use of restraint.
- Debrief/discussion with child/youth/family/caregiver (either together or separately) should be completed as soon as the child/youth is able to engage.
- 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.

Use of Physical / Mechanical Restraint with Children & Youth in the Emergent / Urgent Care 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 & youth who present to Emergency/Urgent Care settings.

4.0 Guideline

4.1 Physical/Mechanical Restraint is Appropriate as an Intervention:

- When immediate physical danger is present,
- Other methods fail.

4.2 Physical/Mechanical Restraint is a Last Resort Option:

- Most associated with mortality and morbidity,
- Most painful to the patient,
- Most traumatic to patient, family, and staff.

4.3 Initiating Physical/Mechanical Restraint

4.3.1 Medical Assessment

Where possible, 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.

4.3.2 Physician Orders

A physician order for use of physical/mechanical restraint should be obtained prior to physical/mechanical 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. In an emergency situation, physical/mechanical restraint may be used without a physician’s order however an order must be obtained within one hour of the restraint.

** In smaller (Tier 1 or 2) sites, the first order may be given by phone. Physician assessment should be undertaken as soon as possible.*

A physician’s order for physical/mechanical restraint is valid for a maximum of 1 hour. If the situation remains unresolved, a physician, psychiatrist or NP must attend in-person to assess the child/youth and support treatment decisions.

Use of physical/mechanical restraint may not be ordered on a PRN (as needed) basis.

4.3.3 Procedures for Initiating Physical/Mechanical Restraint

- **Communicate with child/youth & caregivers about the reasons for using physical 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.**
- If voluntary restraint is not possible, **follow Health Authority (HA)/Site CODE WHITE procedures. "Code White"** is a term that is used to call for help when workers perceive themselves or others to be at risk of being harmed from someone who may become or is violent.
- **Conduct safety check, as per HA guidelines and allow child/youth to remain in his/her street clothes** unless/until a physical exam is required and as long as the clothes pose no safety risk.
- **Offer child/youth the option of other forms of restraint** e.g. voluntary chemical restraint, voluntary seclusion.
- **Obtain physician order** including rationale in relation to patient's condition and/or plan of care.
- 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.
- Support child/youth to keep items of personal significance as long as the items pose no safety risk.
- **Assess vital signs at earliest opportunity** when safe to do so and thereafter as per emergency department protocol or orders.
- Apply physical/mechanical restraint in a safe, skilled and efficient manner, respecting the rights and dignity of the child/youth. **Restraint should only be performed by trained personnel (as per Health Authority policies).**
- In physically restraining a child/youth the health care providers should:
  - Position the patient comfortably using correct body alignment principles.
  - Consider the use of sedation and/or analgesia to promote comfort and reduce patient emotional distress.
  - Apply mechanical restraints according to the manufacturer's instructions. Only Health Authority approved devices will be used.
  - Provide patient with a means of communicating with staff (call bell, other alarm).
  - Ensure patient's lungs and airway are unobstructed at all times by:
    - Not putting pressure on a patient's upper back or neck.
    - Ensuring that patient is able to rotate his/her head unless the restraint is intended to prevent head injury.
    - Maintaining and protecting the child and youth's airway as well as observing for obstruction of airway or altered breathing.
  - Only Health Authority approved holds may be used for holding a patient or when transferring patients to the Seclusion Room.
  - If child/youth is required to be in a temporary face down position **(necessary for a clinical procedure only)**, observe airway and breathing during this period of time (Prone positioning is not considered safe practice and has the highest risk of mortality).

4.3.4 Monitoring & Observation

In recognition that physical/mechanical restraint is a high risk intervention, best practice recommends that a **RN, or RPN shall be available within sight and sound at all times** when a child/youth is restrained.

a. Continuously monitor for signs of physical distress including but not limited to:
   - Airway and breathing
   - 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
   - Proper application of restraint and adjust if necessary
   - Circulation/sensation of restrained extremities

b. If physical distress is present, address concerns and immediately consider discontinuing restraint and implementing other safety measures.

c. Document at regular intervals as per Health Authority process (e.g. using a continuous monitoring checklist).

d. Assess vital signs at earliest opportunity when safe to do so and thereafter as per emergency department protocol or orders.

e. Ensure child/youth's physiological and psychological needs are met (i.e. toileting, nourishment & hydration, pain management, engagement).

f. 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 observations.

4.3.5 Discontinuing Physical/Mechanical Restraint

- **Inform child/youth of what is required** so that they can be safely released from the restraint.
- **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.

4.3.6 Following Physical/Mechanical Restraint

- Engage with child/youth in a warm manner and offer comfort measures such as toilet, water, etc.
- 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.

4.3.7 Debriefing

- Debriefing is recommended for child/youth, family/caregivers and all staff involved in a restraint event. The purpose is to rebuild trust and relationship, promote emotional and physical safety, enable learning and reduce future use of restraint.
- The debrief/discussion with child/youth/family/caregiver (either together or separately) should be completed as soon as the child/youth is able to engage.
- Staff debrief/discussion will include a thorough assessment of factors leading to restraint, a reflection on possible alternative interventions (pre/during/post) and a review of adherence to guidelines/policies.

5.0 Documentation

5.1 Documentation

Follow site procedures for documentation of event including monitoring, assessment, interventions and discontinuation.

5.2 Reporting

Due to high risk nature of restraint, agency Patient Safety and Learning System (PSLS) reporting is **recommended** for all events.

6.0 Definitions

6.1 Least Restraint

A standard of care that focuses on mitigating restraint use by implementing individualized measures to address behaviours 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 (Amdam, 2006; College & Association of Registered Nurses of Alberta, 2009; College of Nurses of Ontario, 2009).

6.2 Restraint

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

6.3 Forms of Restraint

- Environmental/Seclusion- a method of restraint involving involuntary confinement in a locked room, or any space "from which free exit is denied" (Mayers et al., 2010, p. 61). In emergency/urgent care settings, this definition applies to all rooms or spaces used for the purpose of seclusion including secure rooms, isolation rooms, or any alternately labelled room or space.
- Chemical- medication used to restrain (restrict movement, control behavior) of child/youth/youth in emergencies and not in treatment for the condition (Dorfman & Kastner, 2004).
- Physical/Mechanical- any human intervention or device that is applied to limit mobility (Dorfman, 2000).

7.0 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. http://foundrybc.ca/

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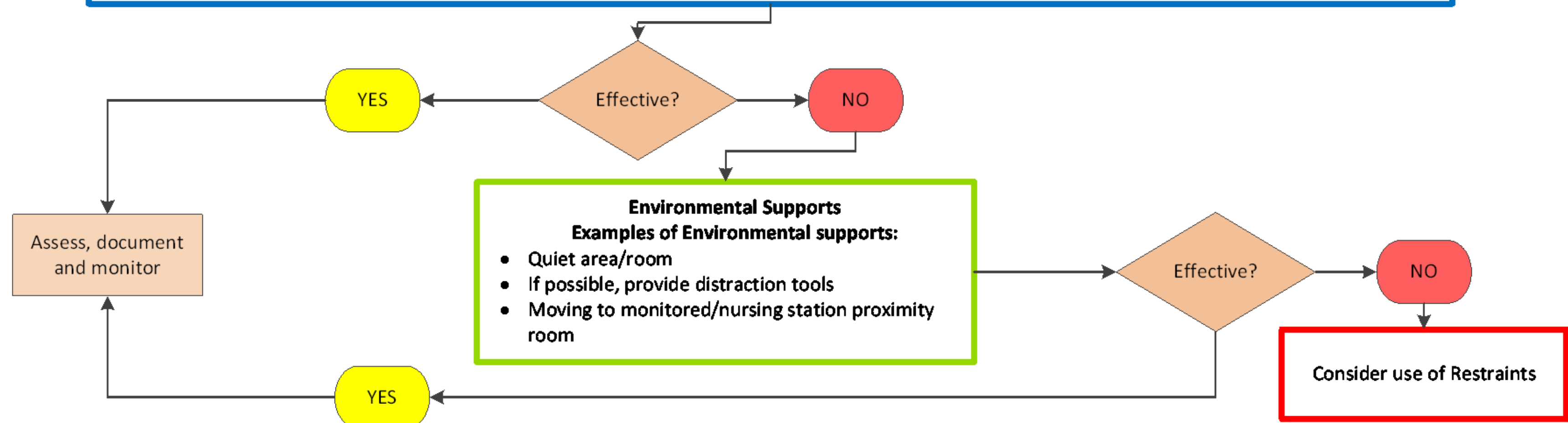
PATIENT IS EXHIBITING UNSAFE BEHAVIOUR (Imminent Risk to Self or Others)

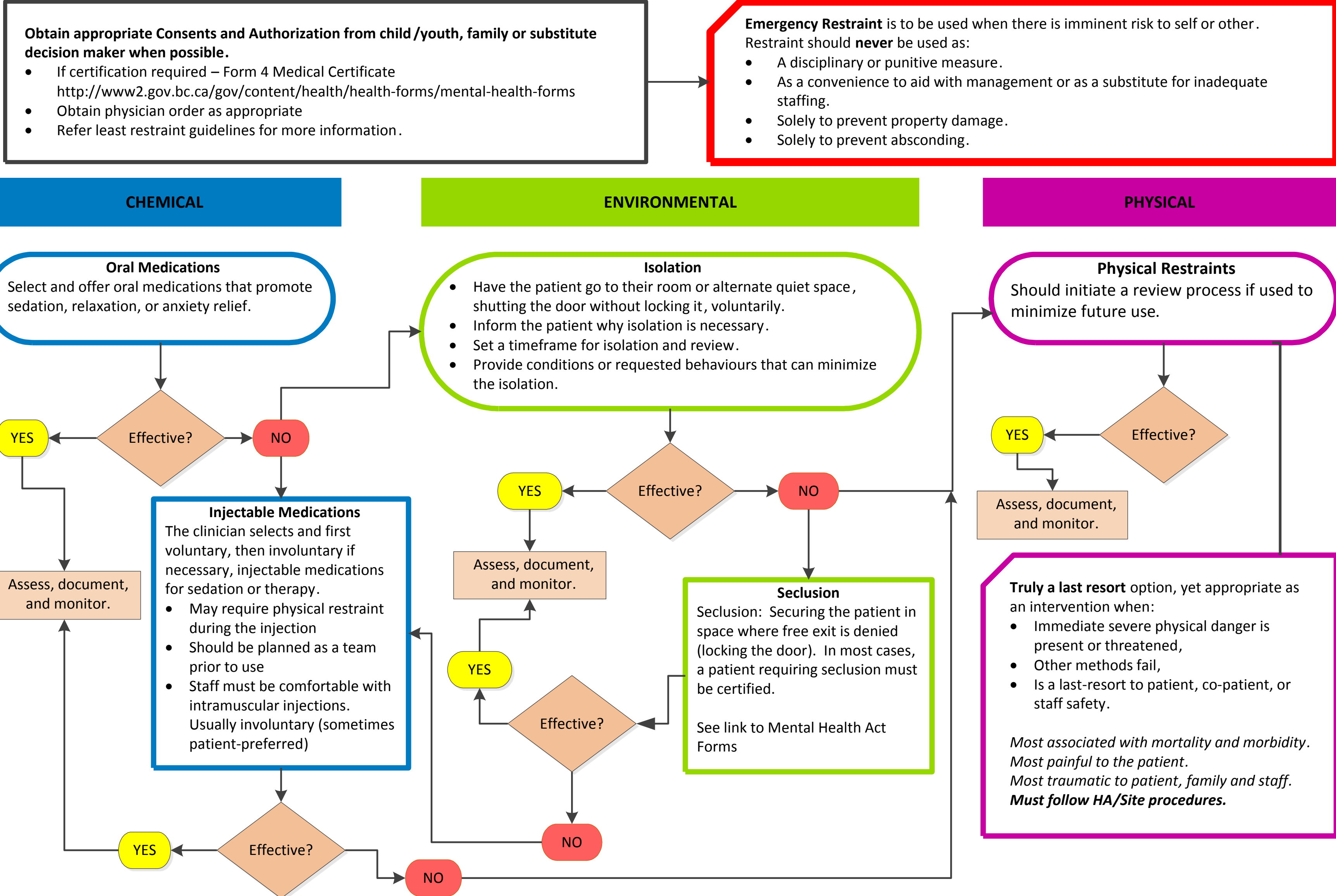
When Child/Youth First Presents

- Remove as much clutter as possible and replace with safe activities that can be used for distraction and self-soothing.
- Support emotional, social and cultural safety by building rapport and asking about the things that are important for that child and family
- Ask the child when they are calm what works for them when they are having a hard time coping Problem solve together they types of supports you can offer in the hospital if they start to feel overwhelmed
- Check in frequently and look for ways to optimize the situation.

Engagement (ongoing)

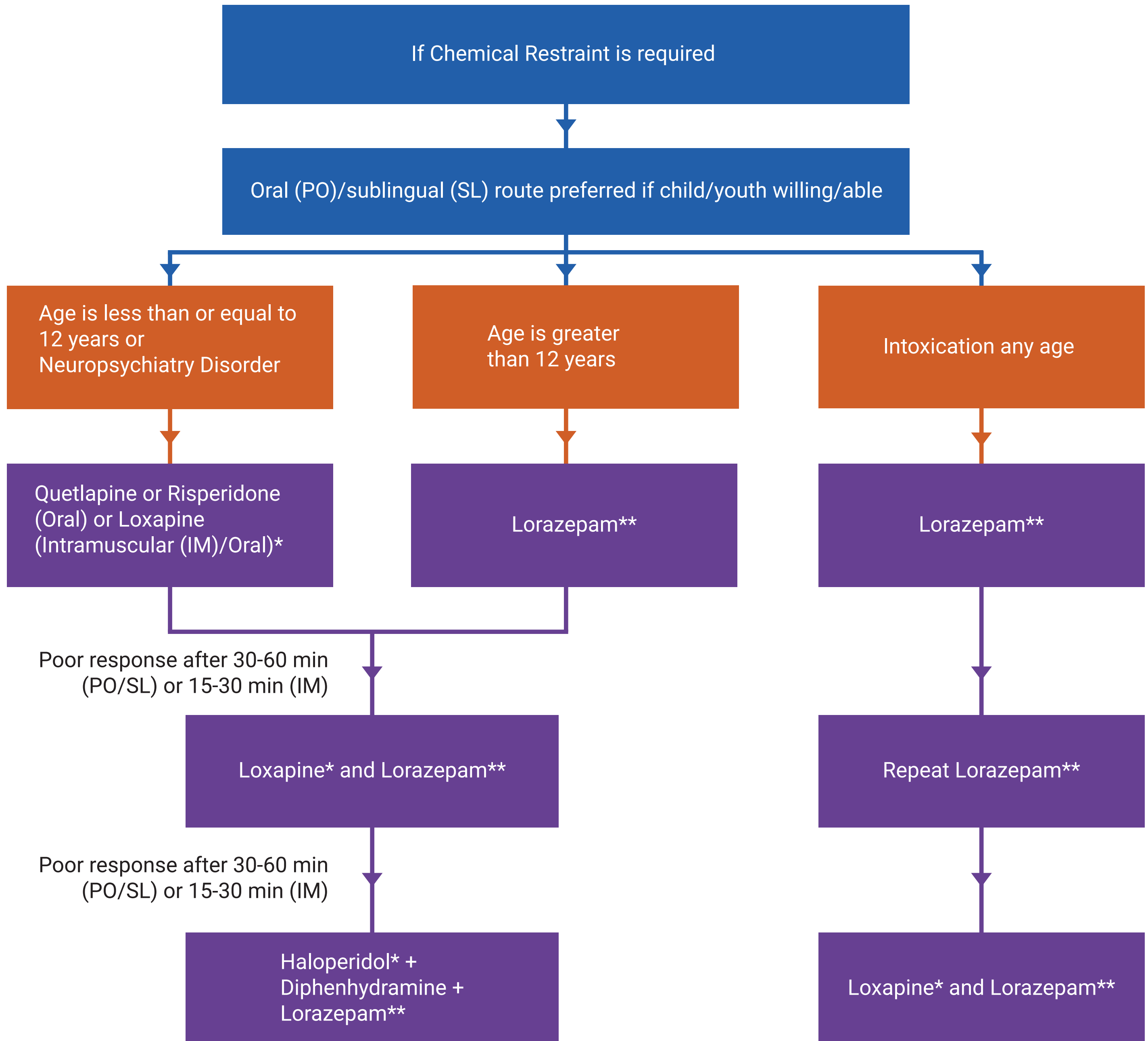
- Use of communication, empathy, compassionate care, and meeting needs to reduce agitation, anxiety, and behavioural concerns. Be clear that your role is there to support them and to keep everyone safe.
- Let them know you are willing to work with them and are open to hearing their ideas
- Ask for their input in the plan of care and provide choice when possible.
- If something can't change because it is a safety issue, let them know the reasons why.
- Be consistent, predictable and calm.
- Model appropriate behaviours and ways of coping.
- Focus on safety and managing in the moment (coping strategies)




Obtain appropriate Consents and Authorization from child /youth, family or substitute decision maker when possible.
If certification required – Form 4 Medical Certificate http://www2.gov.bc.ca/gov/content/health/health-forms/mental-health-forms
Obtain physician order as appropriate
Refer least restraint guidelines for more information.
Emergency Restraint is to be used when there is imminent risk to self or other. Restraint should never be used as:
A disciplinary or punitive measure.
As a convenience to aid with management or as a substitute for inadequate staffing.
Solely to prevent property damage.
Solely to prevent absconding.
CHEMICAL
ENVIRONMENTAL
PHYSICAL
Oral Medications
Select and offer oral medications that promote sedation, relaxation, or anxiety relief.
Effective?
YES
NO
Assess, document, and monitor.
Injectable Medications
The clinician selects and first voluntary, then involuntary if necessary, injectable medications for sedation or therapy.
May require physical restraint during the injection
Should be planned as a team prior to use
Staff must be comfortable with intramuscular injections. Usually involuntary (sometimes patient-preferred)
Effective?
YES
NO
Isolation
Have the patient go to their room or alternate quiet space, shutting the door without locking it, voluntarily.
Inform the patient why isolation is necessary.
Set a timeframe for isolation and review.
Provide conditions or requested behaviours that can minimize the isolation.
Effective?
YES
NO
Assess, document, and monitor.
Seclusion
Seclusion: Securing the patient in space where free exit is denied (locking the door). In most cases, a patient requiring seclusion must be certified.
See link to Mental Health Act Forms
Effective?
YES
NO
Physical Restraints
Should initiate a review process if used to minimize future use.
Effective?
YES
Assess, document, and monitor.
Truly a last resort option, yet appropriate as an intervention when:
Immediate severe physical danger is present or threatened,
Other methods fail,
Is a last-resort to patient, co-patient, or staff safety.
Most associated with mortality and morbidity.
Most painful to the patient.
Most traumatic to patient, family and staff.
Must follow HA/Site procedures.

CHILD HEALTH BC — LEAD BENEFACTOR save on foods | TIERS OF SERVICE

Use of Chemical Restraint with Children and Youth in Emergency Departments



First-Line Medications – low-dose antipsychotic (Loxapine, Quetiapine, or Risperidone) or Benzodiazepine (Lorazepam) for sedation:

- Lorazepam 0.025-0.1 mg/kg/dose PO/SL/IM (round to nearest 0.25 mg; max 2 mg/dose)
- Loxapine 0.1-0.2 mg/kg/dose PO/IM (round to nearest 2.5 mg; max 25 mg/dose)
- Quetiapine 12.5-50 mg/dose PO (child) or 25-100 mg/dose PO (adolescent)
- Risperidone 0.125-0.5 mg/dose PO (child) or 0.25-1 mg/dose PO (adolescent)

Rescue Medications – high-potency antipsychotic (Haloperidol) and anticholinergic medication:

- Diphenhydramine or Benztropine
- Haloperidol 0.05-0.1 mg/kg/dose IM (round to nearest 0.5 mg; max 5 mg/dose)
- Diphenhydramine 1 mg/kg/dose IM (max 50 mg/dose) for EPS or dystonia
- Benztropine 0.5-1 mg/dose PO/IM for EPS or dystonia. May repeat once in 30 min

*If any signs of extrapyramidal (EPS) symptoms or dystonia, administer Diphenhydramine or Benztropine.

** Watch for signs of paradoxical reactions.

Adapted from BCCH Emergency Department Management of Agitation or Aggression.

Appendix C: 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.