



COLLEGE OF NURSES  
OF ONTARIO  
ORDRE DES INFIRMIÈRES  
ET INFIRMIERS DE L'ONTARIO

THE STANDARD OF CARE.

## Restraints Practice Standard A Nurse's Responsibilities

Copyright © College of Nurses of Ontario, 2006

The College of Nurses of Ontario presents the Restraints practice standard: A Nurse's Responsibilities.

## Ministry of Health and Long-Term Care's *Patient Restraints Minimization Act, 2001:*

- sets out when to use restraints;
- emphasizes the minimal use of restraints; and
- the College's *Restraints* practice standard is consistent with the Act.

Click here to access the [Patient Restraints Minimization Act](#)

Click here to access the College's [Restraints](#) practice standard

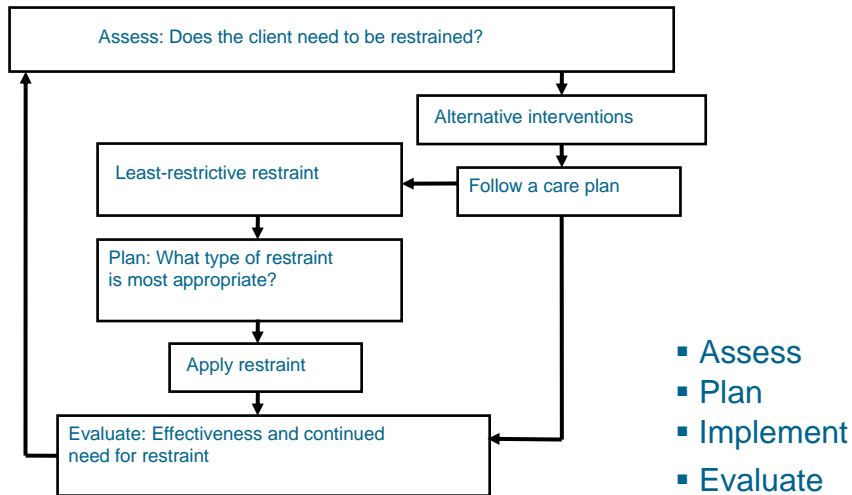


THE STANDARD OF CARE.

The Ministry of Health and Long-Term Care passed the Patient Restraints Minimization Act in 2001. The Act sets out when to use restraints on clients and emphasizes the minimal use of restraints. The College's Restraints practice standard is consistent with the Act, and encourages nurse education, ongoing client assessment, documentation, client consent and policy development.

To read the Act and the College's Restraints practice standard, click on the links.

## The process for deciding to use a restraint



The decision to use a restraint on a client, and a nurse's accountability in that decision, is often complex. By applying the decision process for deciding to use a restraint, nurses can provide the best possible client-centred care. The process can help you decide whether to use a restraint or try alternative interventions. Nurses must assess the client's needs first and then the need for a restraint. If it's determined that a restraint is necessary, nurses need to develop a plan for the client's care, implement the use of a restraint and evaluate the restraint's effectiveness.

## Decision process

Assess: Does the client need to be restrained?



The first step is to assess whether restraining a client is the most appropriate intervention. A thorough assessment may identify factors that are contributing to the client's behaviour; for example, consider the client's health status and medications. As well, environmental factors, such as a high level of noise, can cause stress and agitation in some clients.

## Decision process



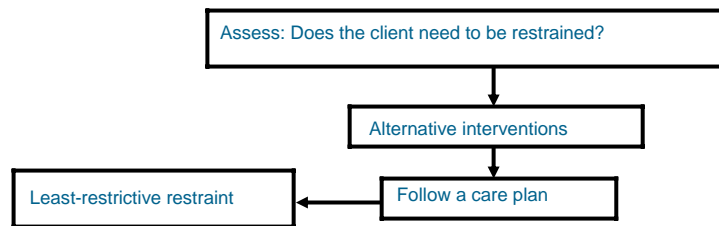
Assess: Does the client need to be restrained?

Alternative interventions

Follow a care plan

If possible, use alternative interventions rather than a restraint to address the difficult behaviour. An example of an alternative intervention would be providing a client with frequent toileting to decrease the client's level of agitation and risk of falling out of bed.

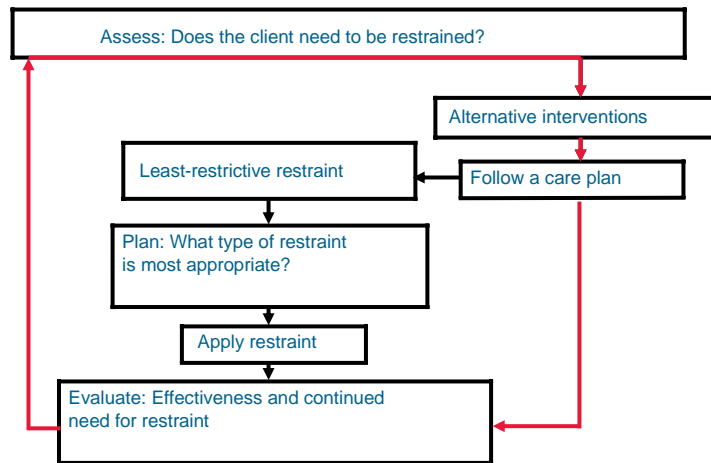
## Decision process



After exhausting alternative interventions and determining that a restraint is required, choose the least-restrictive form of restraint. The less restrictive the restraint, the less invasive it is for the client. For example, it's less invasive to allow a client to walk around in a secure unit than it is to restrain the client to a chair.

Before using a restraint, discuss with the health care team the options and risks associated with different types of restraints. Nurses should obtain client consent to use a restraint, except in emergency situations in which there is a serious threat of harm to the client or others.

## Decision process



After you have obtained consent, develop an individualized plan of care with the client, the client's family and the multidisciplinary health care team. Once the restraint is applied, evaluate its effectiveness and whether there's a continued need for the restraint.

## Document:

- assessment;
- collaboration;
- plan of care;
- consent obtained; and
- ongoing assessment.



When developing a plan of care for either alternative interventions or the use of a restraint, document your assessment, the collaboration between the appropriate parties, the plan of care and when consent was obtained. Continue to assess the use of the restraint and document your decisions.

## Test your knowledge



Test your knowledge of restraints by applying the decision process to the following scenarios.

## Scenario 1

Margaret, 72, has left-sided weakness due to a stroke and is a client in a long-term care facility. She has fallen numerous times while attempting to walk to the washroom by herself. The nursing staff has suggested to Margaret that she call for assistance when she needs help, yet Margaret does not call for assistance. The nursing staff has also suggested to Margaret that the side rails be up when she's in bed to protect her from falling out. Margaret does not want this plan of care.

Margaret, 72, has left-sided weakness due to a stroke and is a client in a long-term care facility. She has fallen numerous times while attempting to walk to the washroom by herself. The nursing staff has suggested to Margaret that she call for assistance when she needs help, yet Margaret does not call for assistance. The staff has also suggested that the side rails be up when she's in bed to protect her from falling out. Margaret does not want this plan of care.

**Should the nurses put up the side rails to protect Margaret's safety?**

- a) Yes
- b) No

## Discussion

The correct answer is no, the nurses should not put up the side rails without Margaret's consent. Clients have the right to make decisions about their care and treatment. Nurses must obtain client consent before using any restraint. The nurses should consider alternatives to restraints. Could a walker be placed near Margaret's bed to assist her with ambulation? Can the furniture be arranged so that Margaret's bed is closer to the washroom, decreasing the distance she needs to walk?

The correct answer is no, the nurses should not put up the side rails without Margaret's consent. Clients have the right to make decisions about their care and treatment. Nurses must obtain client consent before using any restraint. The nurses should consider alternatives to restraints. Could a walker be placed near Margaret's bed to assist her with ambulation? Can the furniture be arranged so that Margaret's bed is closer to the washroom, decreasing the distance she needs to walk?

## Scenario 2

Nine-year-old Jennifer has undergone surgery that requires her to be intubated for a number of hours. She is agitated and trying to pull out the tube. Her parents have tried to calm their daughter by talking to her and playing her favourite music, but with no success. The nurses are concerned that Jennifer will pull out the intubation tube. They speak with her parents and obtain consent to apply wrist restraints.

Nine-year-old Jennifer has undergone surgery that requires her to be intubated for a number of hours. She is agitated and trying to pull out the tube. Her parents have tried to calm their daughter by talking to her and playing her favourite music, but with no success. The nurses are concerned that Jennifer will pull out the intubation tube. They speak with her parents and obtain consent to apply wrist restraints.

Is this an appropriate use of restraints?

- a) Yes
- b) No

## Discussion

The correct answer is yes, this is an appropriate use of restraints. Alternative interventions were tried, but were not successful. Now the nurses should explain to Jennifer why she needs wrist restraints, monitor her for the risk of injury that the restraints present and discontinue using the restraints as soon as possible.

The correct answer is yes, this is an appropriate use of restraints. Alternative interventions were tried, but were not successful. Now the nurses should explain to Jennifer why she needs wrist restraints, monitor her for the risk of injury that the restraints present and discontinue using the restraints as soon as possible.

### Scenario 3

Carol, a community nurse with a nursing agency, is visiting Samuel, an 85-year-old client, at his home. During the shift changeover, Carol reviews the client's chart and notes that Graham, the nurse from the previous shift, had used a bed sheet to secure Samuel to a chair. When Carol asks Graham for his rationale, Graham explains that Samuel was unsteady on his feet and he was concerned that Samuel might fall.

Carol, a community nurse with a nursing agency, is visiting Samuel, an 85-year-old client, at his home. During the shift changeover, Carol reviews the client's chart and notes that Graham, the nurse from the previous shift, had used a bed sheet to secure Samuel to a chair. When Carol asks Graham for his rationale, Graham explains that Samuel was unsteady on his feet and he was concerned that Samuel might fall.

**What strategies would you implement to prevent this from happening?**

## Discussion

Carol should engage in a private discussion with Graham and ensure that he is aware of the legislation on the minimal use of restraints. Graham may be unaware that the client must give his consent for a restraint to be applied. Carol and Graham should also explore why Samuel is unsteady on his feet. Is this a new symptom that requires investigation? The health care team needs to ask Samuel and his family for their input on Samuel's current health and plan of care.

Carol should engage in a private discussion with Graham and ensure that he is aware of the legislation on the minimal use of restraints. Graham may be unaware that the client must give his consent for a restraint to be applied. Carol and Graham should also explore why Samuel is unsteady on his feet. Is this a new symptom that requires investigation? The health care team needs to ask Samuel and his family for their input on Samuel's current health and plan of care.

## Scenario 4

Joe, an RN, is working the night shift in a busy emergency department. Police officers arrive with a client in handcuffs who is agitated and shouting profanities. Joe approaches the client to assess the laceration on his scalp and check his neurological status. Because the client is handcuffed, Joe feels that a thorough assessment is not possible and asks the officers to remove the handcuffs. The officers are understanding but refuse. In their assessment, the client may be a danger to others.

Joe, an RN, is working the night shift in a busy emergency department. Police officers arrive with a client in handcuffs who is agitated and shouting profanities. Joe approaches the client to assess the laceration on his scalp and check his neurological status. Because the client is handcuffed, Joe feels that a thorough assessment is not possible and asks the officers to remove the restraints. The officers are understanding but refuse. In their assessment, the client may be a danger to others.

How should Joe handle this situation?

- a) Remove the restraint because it's against legislation to apply restraints.
- b) Discuss with the police an alternative method of performing the assessment while ensuring the safety of others.

## Discussion

The correct answer is B. The decision to use a restraint was made by the police officers, not the nurse. The officers have determined that there is a risk of harm to others if the client is not restrained. Because the handcuffs impede Joe from assessing the client, Joe needs to discuss with the officers alternative options. These include administering a chemical restraint to calm the client or waiting for the client to calm down on his own before assessing him.

The correct answer is B. The decision to use a restraint was made by the police officers, not the nurse. The officers have determined that there is a risk of harm to others if the client is not restrained. Because the handcuffs impede Joe from assessing the client, Joe needs to discuss with the officers alternative options. These include administering a chemical restraint to calm the client or waiting for the client to calm down on his own before assessing him.

**A client is ordered Ativan 1-2 mg S/L q4h PRN for agitation. Before the nurse administers the medication, the nurse should:**

- a) Check the order against the MAR.
- b) Explore the meaning behind the client's behaviour.
- c) Consider and implement alternative interventions.
- d) Obtain consent from the client and/or the client's substitute decision-maker.
- e) Apply a physical restraint.

## Restraints learning module

1. Guiding Principles
2. An Overview
3. A Nurse's Responsibilities

Click here to access the College's [Restraints](#) practice standard.



You have now completed Chapter 3. To work through another chapter in this module, close this presentation and return to the Learning Centre.

To ask a College Practice Consultant a question, click on the “Contact” button in the top right-hand corner of your screen.

Click on the link to access the College's Restraints practice standard.