Winnipeg Regional Health Authority / Office régional de la santé de Winnipeg — Caring for Health / À l'écoute de notre santé	**REGIONAL PROGRAM** Applicable to all sites and facilities where the intended WRHA program services are delivered		Level: 1A
POLICY	Policy Name: **Restraints Minimization – Acute Care Facilities (Adult)**	Policy Number 110.000.025	Page 1 of 14
	Approval Signature: Milton Sussman	Section: CLINICAL SERVICES	
	Date: May 2017	Supersedes: May 2011 - Restraints (Least) in Acute Care Settings – Patient Safety	

1.0 PURPOSE:

1.1 To promote least restraint approaches to care.
1.2 To ensure that the use of Restraints in acute care facilities is appropriate and safe.
1.3 To recognize the patient experience by identifying expectations of care providers to include and support the patient as an equal partner in the provision of dignified, safe and respectful care.
1.4 To differentiate between what is a restraint and what is not a restraint, consistent with the goals and necessity of a given therapeutic intervention according to the specific patient situation.

2.0 DEFINITIONS:

2.1 Authorized Prescriber: Refers to a health care professional who is permitted to prescribe medications as defined by provincial and federal legislation, his/her regulatory college or association, and practice setting.
2.2 Emergent Restraint: A restraint used in a situation where occurrence of Patient behaviour poses an immediate/imminent danger to the Patient or others. Use of seclusion, 4-6 point restraints, and spit hoods/masks are always considered Emergent Restraints.
2.3 Health Care Team: Refers to the health care professionals and support staff who are directly involved in the Patient's care.
2.4 Non-Emergent Restraint: A restraint used in a situation to episodically ensure safety to patient and others, and where less restrictive methods of managing behaviour have been ineffective.
2.5 Nurse: Shall include Licensed Practical Nurse, Registered Nurse, and Registered Psychiatric Nurse.
2.6 Patient: Shall include Patient/client/resident
2.7 Restraint: Anything that restricts or reduces voluntary movement or freedom implemented to ensure safety of self, others or the physical environment. Restraint shall include:

2.7.1 Physical or Mechanical Restraint: A manual or physical device that the individual cannot remove and which restricts freedom of movement. Examples include 4-6 point Restraints, spit /hoods/masks, arm Restraints, hand mitts, soft ties, mobility restricting chairs that prevent rising (e.g. geri-chairs/ recliner chairs, tilt/recline wheelchairs, etc.), chair trays, seat and lap belts, and having all bed rails in the up position.

2.7.2 Chemical Restraint: Medication given for the specific and sole purpose of inhibiting severe and persistent behavioural and psychological symptoms which do not respond to non-pharmacological interventions and that may place the patient or others at risk and are not required to treat the Patient's medical or psychiatric symptoms.

This includes, but is not limited to;

- sedatives;
- hypnotics;
- antipsychotics;
- antidepressants, or;
- anxiolytic medications

When a psychotropic medication is being used in the absence of a diagnosis of a mental illness, it shall be considered a Chemical Restraint unless the medication is necessary to ensure immediate maintenance of life.

Example:

- If a psychotropic medication is being used on a regular basis to improve quality of life by decreasing a group of behavioural and psychiatric symptoms related to a diagnosis of dementia, then it is not considered a Chemical Restraint.
- If a psychotropic medication is used to sedate a critically ill patient in order to preserve life maintaining treatments (eg. endotracheal tube), then it is not considered a Chemical Restraint.
- If a psychotropic medication is being used to treat a diagnosed medical condition (eg. Delirium Tremens), then it is not considered a Chemical Restraint.

However:

- Where a diagnosis of dementia is present, and a psychotropic medication is being used on an as needed (PRN) basis for managing one specific behaviour from time to time, it is considered a Restraint (e.g. PRN to increase cooperation with a bath or decrease episodic agitation).
- If a psychotropic medication is being used on an as needed (PRN) basis to manage episodic acting out or aggressive behaviour towards staff or other patients it is considered a Restraint.

2.7.3 Environmental Restraint: A barrier to free personal movement which serves to confine a Patient to specific areas. Examples include:

- Removal of a mobility aide such as a cane, walker, or wheelchair
- Isolation – limiting a Patient to a particular environment (e.g. confining a Patient to his/her room) or excluding a Patient from an area to which they want to go
- Seclusion - voluntary or involuntary confinement of a Patient alone in room locked from the outside for care, nursing and treatment

2.8 Substitute Decision-Maker: a third party identified to participate in decision-making on behalf of a patient/resident/client who has been determined to lack decision-making capacity, concerning a proposed procedure(s),treatment(s), or investigation(s). The task of a Substitute Decision-Maker is to faithfully represent the known preferences or, if the preferences are not known, the best interests of the incapable patient/resident/client. The following, in order of priority, may act as Substitute Decision-Maker(s):

2.8.1 Proxy named in a Health Care Directive;
2.8.2 A committee of both property and personal care appointed by:
a) The court under section 75(2) of The Mental Health Act (Manitoba);
b) An order under section 61(1) of The Mental Health Act (Manitoba); or
c) A Substitute Decision-Maker for Personal Care appointed under The Vulnerable Persons Living with a Mental Disability Act (Manitoba). A committee or a Substitute Decision-Maker for Personal Care may be an individual(s) or the Public Trustee.

2.8.3 Family, friends, and others. This category does not have binding legal authority to make decision. In the absence of a third party with binding legal authority, the following principles may provide guidance. Within this context, such a Substitute Decision-Maker must have the support of all interested and available parties. Such a person will usually, but not necessarily, be a close relative, who speaks for all. The listing contained in The Mental Health Act (Manitoba) is guidance and is as follows in order of preference:

a) The adult relatives being of whole blood is preferred to relatives of the same description of the half-blood. The elder or eldest of two or more relatives described in any clause is preferred to the other of those relatives, regardless of gender:
- Spouse or common-law partner;
- Son or daughter;
- Father or mother;
- Brother or sister;
- Grandfather or grandmother;
- Grandson or granddaughter;
- Uncle or aunt;
- Nephew or niece

b) A supportive friend when family is unavailable or non-existent, or if the patient requested while competent.

c) On occasion, an existing power of attorney may be most appropriate to fulfill this role, since such an individual, although limited to property decisions, has obviously been placed in a position of trust.

For the Responsible Party or Authorized Designate to feel confident in identifying a Substitute Decision-Maker from family, friends, and others it will be necessary, within reason, to:

a) Understand relationships, dynamics, hierarchy, and values;
b) Ascertain that there exists acceptance from involved family/friends in the designation of the Substitute Decision-Maker;
c) Clarify as necessary the role of the Substitute Decision-Maker for all interested parties

If this is not possible, the Responsible Party or Authorized Designate shall act in the best interests of the patient/resident/client. The Responsible Party or Authorized Designate may refer to conflict resolution resources such as ethics services, mediation with family/friends or referral to the Public Trustee or courts if apparent dissension among family/friends cannot be resolved.

3.0 **POLICY:**

3.1 Based on the judgment of the Health Care Team, a Restraint may be used for the protection of the Patient who is at imminent risk of harm to self or others.

3.2 Given that Patients routinely move between acute care and longterm care sectors in the healthcare system, as much consistency as possible shall exist for policies which address situations occurring in either sector, and promote safe transitions.Therefore the Manitoba Health background information from the **Ministerial Guidelines for the Safe Use of Restraints in Personal Care Homes** shall be followed in acute care:

Restraint(s) can be employed when required in the clinical management of a Patient. The use of any Restraint poses an inherent risk to a person's physical safety and psychological well-being. The psychological/emotional effect of loss of liberty is often underestimated. Controlling a Patient's freedom in any way is a Restraint and carries with it a responsibility on the part of the care providers to exercise a high degree of forethought, caution and attention.

3.3 Any form of Restraint shall be used judiciously in the context of the overall clinical management of the Patient. Restraint shall be implemented only after careful assessment has determined that it is an appropriate form of treatment and then only to the extent necessary to manage the care of the Patient appropriately. With any use of Restraint, there shall be ongoing review of the clinical status of the Patient, including current risk/benefit analysis, in order to ensure:

a) that this particular form of Restraint continues to be clinically necessary in light of all other options to manage the Patient's behaviour; and,
b) that it is used only to the extent necessary to accomplish an appropriate therapeutic goal in the context of the overall clinical management of the Patient.

3.4 A Restraint shall be:

3.4.1 Used only after all other options to address the safety risks for the patient and others in the immediate environment have been thoroughly attempted;
3.4.2 The least restrictive possible restraint;
3.4.3 Used over the shortest period of time needed;
3.4.4 Applied in accordance with the manufacturer's directions where applicable; and
3.4.5 Applied in a manner that can be easily removed by staff.

3.5 Restraint use shall require:

3.5.1 A comprehensive interprofessional assessment of the Patient prior to application/ re-application of Restraints;
3.5.2 An order by an Authorized Prescriber;
3.5.3 Verbal informed consent from the Patient, family and/or Substitute Decision-Maker in non-emergent situations. See WRHA Policy 110.000.005 Informed Consent (for Procedures, Treatments, and Investigations). In emergent situations, the Patient or family/substitute decision-maker shall be notified as soon as possible or at least within 24 hours, and does not have the right to refuse use of the restraint.
3.5.4 An individual plan of care specific to the needs of the Patient, including steps to mitigate the potential negative impact of the Restraint use; and
3.5.5 Ongoing reassessment and documentation.

3.6 Restraints shall **NOT** be:

3.6.1 A standing order;

3.6.2 Used as a fall prevention strategy, for example while the Patient is on a commode or toilet;

3.6.3 Used in the form of bed rails inhibiting free movement, except as in 3.5;

3.6.4 Used in the form of seclusion except for Mental Health Program or Emergency Program (see relevant WRHA Seclusion Practice Guidelines);

3.6.5 Jackets, vests, and triangular pelvic Restraints;

3.6.6 Devices manufactured for use other than as a Restraint i.e. sheets, gait/transfer belts;

3.6.7 Altered from the manufactured variety of Restraint;

3.6.8 Used as coercion, punishment, convenience, or retaliation;

3.6.9 Applied at patient or caregiver request;

3.6.10 Strapping mechanisms except: 4-6 point Restraints and spit hoods/masks which shall only be used as an Emergent Restraint and shall require one to one constant care observation; or wrist to waist restraints/ankle hobbles as used in Forensics in the Mental Health Program or by law enforcement agencies.

3.7 While the use of restraints shall be limited whenever possible, the following circumstances are **NOT** considered restraints:

3.7.1 Devices that limit mobility or temporarily immobilize, but are required specifically for safe Patient care (e.g. transport or in the performance of surgical or invasive/diagnostic procedures);

3.7.2 Bed rails when required specifically for safe Patient monitoring in the peri-operative period when the Patient has not yet returned to their pre-operative level of consciousness. This may include but is not limited to Post-Anesthetic Care Units (PACU), intensive care (ICU), and Emergency Department (ED);

3.7.3 A front closing seat belt or a lap tray that can be removed by a Patient;

3.7.4 A chair/device to enable appropriate seating, positioning and enhanced function, such as mobility restricting chairs (e.g. tilt/recline wheelchairs, tilt commodes) and other positioning devices (e.g. chin straps, chest/torso/leg straps) when recommended in an interprofessional assessment;

3.7.5 Isolation for the sole purposes of infection control;

3.7.6 Electronic location bracelets (e.g.Wanderguard®/Roam Alert®) bed/chair check systems, secured units;

3.7.7 The use of brakes on a wheelchair for safety, (e.g. brakes are not a Restraint when staff are providing assistance or care to the Patient, to keep the person close enough to the table so they can feed themselves, to keep the chair from rolling away during transfers, or to enhance the Patient's ability to participate in an activity) ;

3.7.8 Handcuffs, shackles and/or other restraints applied by the police or as requested by the justice system (However, the Health Care Team continues to be responsible to ensure safe and appropriate care) and;

3.7.9 Medications given where life would be threatened within seconds or minutes if the patient were to interrupt treatment.

3.8 Emergent Use of Restraints

3.8.1 A Restraint may be applied in an emergent situation, when in the judgment of the Nurse, the urgency and severity of the case warrants it.

3.8.2 A Restraint applied in an Emergent Situation shall:

3.8.2.1 Be used as outlined in 3.2;

3.8.2.2 Be a last resort to protect the safety of the Patient or others;

3.8.2.3 Be reassessed as soon as reasonably possible and at maximum within 24 hours after the initiation;

3.8.2.4 Not be used beyond the immediate episode;

3.8.2.5 Include a full assessment as per 4.1 if continued use is required;

3.8.2.6 Require a patient be observed every 15 minutes for the first 2 hours and be observed at least every 30 minutes for the duration of the Restraint use; or

3.8.2.7 Require a Patient be observed constantly, one to one, and have oxygen and suction available at the bedside if a 4-6 point Restraint or a spit hood/mask is used.

3.9 Chemical Restraints shall:

3.9.1 Require an assessment to rule out readily correctible causes;

3.9.2 Be discontinued as soon as behaviour indicates;

3.9.3 Be ordered by an Authorized Prescriber as the least invasive medication administration route and in the lowest dosage required for effectiveness;

3.9.4 Include thorough documentation of the patient behaviour and effectiveness of the drug used;

3.9.5 Only be reordered following an in person review by the Authorized Prescriber;

3.9.6 For an Emergent Restraint:

3.9.6.1 Be ordered as a one-time administration. NOTE: In person review by an Authorized Prescriber, including a full assessment of antecedent factors, behaviour observed and consequences is required for continued use.

3.10 Staff applying any form of Restraint shall receive education in the prevention, use, monitoring and documentation of Restraint use and shall be familiar with this policy.

4.0 **PROCEDURE:**

4.1 Assessment

4.1.1 The Health Care Team, in consultation with the Patient, family and/or the Substitute Decision-Maker, performs a thorough assessment when a concern is identified.

4.1.2 Include a review of all antecedent factors, behaviour observed, and consequences. (See Appendix A: Risk Assessment of Behaviours That May Require Restraint).

4.1.3 Document detailed findings of the assessment in the patient's health record.

4.2 Plan of Care is developed by the Health Care Team, in accordance with an obtained order. The Plan is communicated to, and kept easily accessible for the Health Care Team, and shall include the following:

4.2.1 Use supportive interventions (i.e. non-restraint strategies) to address the issues identified in the assessment.

4.2.2 Consider the use of a restraint as a last resort when other alternatives have been exhausted. (See Appendix B: Alternatives to Restraints).

4.2.2.1 A Nurse may initiate the use of a Physical, Mechanical or Environmental Restraint following a Patient assessment as per 4.1. An order is to be obtained within 24 hours.

4.2.2.2 An Authorized Prescriber may initiate the use of a Chemical Restraint following a Patient assessment as per 4.1.

4.2.3 Name and designation of person initiating Restraint use.
4.2.4. Reason Restraint required.
4.2.5 Type of Physical, Mechanical or Environmental Restraint and method of application, as applicable, or type of Chemical Restraint.
4.2.6 Frequency and/or length of time the Restraint is to be applied (i.e. continuously, intermittently or when necessary);
4.2.7 Frequency of Patient monitoring for safety, respiratory status, hydration status, somnolence, emotional status, assessment of circulatory impairment, movement and skin integrity of restrained limbs:
- 4.2.7.1 At a minimum monitoring shall occur every two hours;
- 4.2.7.2 Shall be based on Patient's unique circumstances and type of restraint;
- 4.2.7.3 Use of more than one Restraint may require more frequent monitoring; and
- 4.2.7.4 One to one constant care is required for Patients with 4-6 Point Restraints and/or who have a spit hood/mask restraint, due to the increased risk of the patient's physical and emotional status being affected. Oxygen and suction are to be readily available when patient is in 4-6 Point Restraints or has a spit hood/mask.

4.2.8 Frequency of removal of physical or mechanical restraint. A restraint shall be removed for a minimum of 10 minutes every 2 hours in order to provide opportunity for repositioning, ambulating, toileting, exercising and other care as required. To vary from the above stated frequency, consider:
- 4.2.8.1 Patient's current condition (eg. change in level of consciousness, prevention of physical injury, observation for skin breakdown, circulatory impairment, hypotension, confinement anxiety or confusion);
- 4.2.8.2 Restraint being used, and
- 4.2.8.3 Reason for the restraint.

4.2.9 Interventions to be implemented:
- 4.2.9.1 To resolve the issue for which the Restraint was initiated; and
- 4.2.9.2 To promote return of independence and self-control.

4.2.10 Frequency of reassessment of the need for the Restraint, as per 4.5

4.3 Consent

A regulated health professional who is a member of the Health Care Team can obtain consent. In non-emergent situations obtain verbal informed consent and document in the Patient's health record. See WRHA Policy 110.000.005 Informed Consent (for Procedures, Treatments, and Investigations). In emergent situations, notify the Patient or family/Substitute Decision-Maker as soon as possible or at least within 24 hours, and document. Note, the Patient or family/Substitute Decision-Maker does not have the right to refuse use of the restraint.

Order

4.4 Order

4.4.1 Obtain and document an order within 24 hours of initiation of a Restraint. Note: All Chemical Restraints require an order prior to initial administration of the medication.

4.4.2 Include the following:

4.4.2.1 Type of Restraint to be used;

4.4.2.2 Reason required;

4.4.2.3 Frequency of monitoring required;

4.4.2.4 Signature and designation of health care professional, as applicable; and

4.4.2.5 Discontinuation/reassessment date.

4.4.3 Obtain a new order:

4.4.3.1 If Restraint is intended for a different behaviour;

4.4.3.2 If a different Restraint is required; or

4.4.3.3 When reassessment occurs and a decision is made that the use of the Restraint shall be continued.

4.5 Reassessment

4.5.1 The HealthCare Team reassesses the Patient to determine whether a Restraint can be discontinued:

4.5.1.1 At minimum every 72 hours or as per 4.6 for an Emergent Restraint; and

4.5.1.2 More often where indicated in the individual plan of care.

4.5.2 Include the following:

4.5.2.1 Date of reassessment;

4.5.2.2 An assessment of the need for continued use of the Restraint;

4.5.2.3 Changes to the plan of care; and

4.5.2.4 The Patient's response to the use of the Restraint, including any side effects.

4.6 Emergent Use of Restraints

4.6.1 Shall follow the policy as per 3.6, when in the judgment of the Nurse, a Restraint is necessary for the protection of a Patient who is at imminent risk for harm to self or others.

4.6.2 Complete a full assessment as per 4.1 if continued use of a Restraint is required.

4.6.3 Observe the Patient:

4.6.3.1 Every 15 minutes for the first 2 hours and at least every 30 minutes for the duration of the Restraint use

4.6.3.2 For Patients with 4-6 Point Restraints and/or who have a spit hood/mask restraint, use one to one constant care and keep oxygen and suction readily available.

4.7 Chemical Restraints:

4.7.1 Follow the policy as per 3.7.

4.7.2 Determine the frequency of monitoring required for safety, respiratory status, hydration status, somnolence and emotional status keeping in mind the peak effect of the medication administered.

4.7.3 A Chemical Restraint can only be considered 'removed' when the effects of the medication are no longer present.

4.8 Documentation in the Patient health record

4.8.1 For a non-emergent Restraint document in the Patient health record:

- 4.8.1.1 Reason for and type of Restraint;
- 4.8.1.2 Assessment and reassessment for the use of a Restraint as per 4.1 and 4.5; include any interventions taken to avoid use of a Restraint;
- 4.8.1.3 An order by an Authorized Prescriber within 24 hours;
- 4.8.1.4 Indication that discussion by the Direct Patient Care Provider(s) with the Patient and/or Substitute Decision-Maker includes the details of the plan of care;
- 4.8.1.5 Verbal consent of the Patient or Substitute Decision-Maker or refusal of Patient and/or Substitute Decision-Maker's consent for Restraint use, if applicable, as well as the reasons for such refusal;
- 4.8.1.6 Monitoring of Patient comfort and safety;
- 4.8.1.7 Care provided during Restraint use;
- 4.8.1.8 Any observations made at the time of care; and
- 4.8.1.9 The Patient's response to the use of the Restraint and interventions to resolve the issue for which the Restraint was initiated.

4.8.2 For an Emergent Restraint document:

- 4.8.2.1 Description of the reason the Restraint is required;
- 4.8.2.2 Type of Restraint used;
- 4.8.2.3 Name and designation of person initiating and/or ordering the Restraint;
- 4.8.2.4 Time Restraint applied and frequency of monitoring;
- 4.8.2.5 Monitoring of Patient comfort and safety;
- 4.8.2.6 Observations and Patient response;
- 4.8.2.7 Care provided during Restraint use, including frequency of removal;
- 4.8.2.8 Notification or attempts at notification of family and/or Substitute Decision-Maker; and;
- 4.8.2.9 When reassessment is to occur.

4.8.3 The Restraint Assessment and Use Form, and accompanying guidelines are available on line under **Regional Health Records Forms** - http://home.wrha.mb.ca/hinfo/rhc.php

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Appendix A: Risk Assessment of Behaviours That May Require Restraint

Keep in mind all behaviour has meaning and there are almost always multiple reasons for behaviour (Putting the P.I.E.C.E.S.™ Together, 2008).

Antecedents

- Patient's diagnosis;
- Mental status (underlying delirium, psychosis);
- Unmet comfort needs (e.g. pain, toileting, thirst, hunger, boredom, loneliness, constipation);
- Possible impact of medication;
- Psychosocial issues which may impact on the Patient's behaviour (e.g. anxiety, depression, previous traumas);
- Circumstances leading up to the behaviour (e.g. consider whether staff behaviour was a trigger, was the behaviour an attempt to communicate?).

Behaviour

- A detailed description of the behaviour;
- Environment in which the behaviour occurred (where, who was present);
- Time of day the behaviour occurred.

Consequences

- What happened immediately after the incident?
- What interventions improved or aggravated the behaviour?
- Alternatives that have been tried and exhausted;
- Benefits to the Patient of using a Restraint (safety, protection from harm, provision of required treatment e.g. tracheostomy, feeding tube, central line);
- Burdens to the Patient of using a Restraint (risk of harm from restraint use including death, loss of independence, self-control and dignity);
- Any additional ethical aspects of restraining the Patient; and
- Consideration of the Patient's medical condition that may contraindicate the use of a particular type of Restraint.

Appendix B: Alternatives to Restraints

- Refer to the Registered Nurses' Association of Ontario best practice guideline: Promoting Safety: Alternative Approaches to the Use of Restraints. Available at http://rnao.ca/bpg/guidelines/promoting-safety-alternative-approaches-use-restraints
- Refer to alternatives presented in learning modules, for example: P.I.E.C.E.S.™ training, Non-Violent Crisis Intervention™, or Safety for All: Caring for People with Dementia in Acute Care Settings
- Consider calming strategies from 6 Core Strategies including: having the patient use deep breathing, talking to peers, spiritual practices, reading, and art activities such as drawing or coloring, journaling, eating, exercising, bathing, using music or having personal space. Also if the patient is at risk for or has been aggressive ask the patient when they are calm what triggers their anger/anxiety and integrate this into a care plan. If patient has a cognitive impairment consider asking family and friends what they have experienced as triggers for the persons aggression

QUICK REFERENCE TABLE TO RESTRAINT MINIMIZATION POLICY

*Refer to 110 000 025 Restraint Minimization Policy Acute Care Facilities (Adult) for full details
* Seclusion shall follow relevant WRHA clinical practice guidelines; Emergency and Mental Health Programs only

	Non-Emergent		Emergent		
	Physical/Mechanical Restraint	**Chemical Restraint**	**Physical/Mechanical Restraint**	**4-6 Point Restraints**	**Chemical Restraint**
Assessment	Antecedent factors, behaviour observed, and consequences	Antecedent factors, behaviour observed, and consequences	Imminent risk for harm to self or others	Imminent risk for harm to self or others	Rule out correctable cause, verify behaviour is due to mental illness
Frequency of Monitoring	Minimum every two hours, and based on situational circumstances	Minimum every two hours, and based on situational circumstances	Every 15 minutes for first two hours and every 30 minutes for duration	One to one constant observation	Determine based on safety, respiratory status, somnolence and peak effect of medication
Frequency of Removal of Restraint	Minimum of 10 minutes every 2 hours	N/A	Minimum of 10 minutes every 2 hours	Minimum of 10 minutes every 2 hours	N/A
Order	Obtained within 24 hours	Obtained prior to initiation	Obtained within 24 hours	Obtained within 24 hours	Obtained prior to initiation; one time only administration
DISCONTINUE RESTRAINT USE AS SOON AS POSSIBLE					
Reassessment to Discontinue	Minimum every 72 hours	Minimum every 72 hours	Within 24 hours full assessment of antecedent factors, behaviour observed, and consequences	Within 24 hours full assessment of antecedent factors, behaviour observed, and consequences	Continued use requires in person review by Authorized Prescriber; full assessment of antecedent factors, behaviour observed, and consequences
Consent	Verbal informed consent	Verbal informed consent	Notify family within 24 hours; cannot refuse use	Notify family within 24 hours; cannot refuse use	Notify family within 24 hours; cannot refuse use
Documentation	Reason, type of restraint, assessment and reassessment plan, order, indication of verbal consent, plan of care, observations, interventions, and patient response	Reason, pharmaceutical agent given , assessment/reassessment plan, order, indication of verbal consent, plan of care, observations, interventions, and patient response/effectiveness of agent	Reason, type of restraint, assessment and reassessment plan, order, indication of notification, plan of care, observations, interventions, and patient response	Reason, type of restraint, assessment and reassessment plan, order, indication of notification, plan of care, observations, interventions, and patient response	Reason, pharmaceutical agent given, assessment/ reassessment plan, order, indication of notification, plan of care, observations, interventions, and patient response