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Compass Connections with Child Health BC

Part 1: Overview of the 2022 Provincial Least Restraint Guideline

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Island Health Regional Coordinator

Child Health BC

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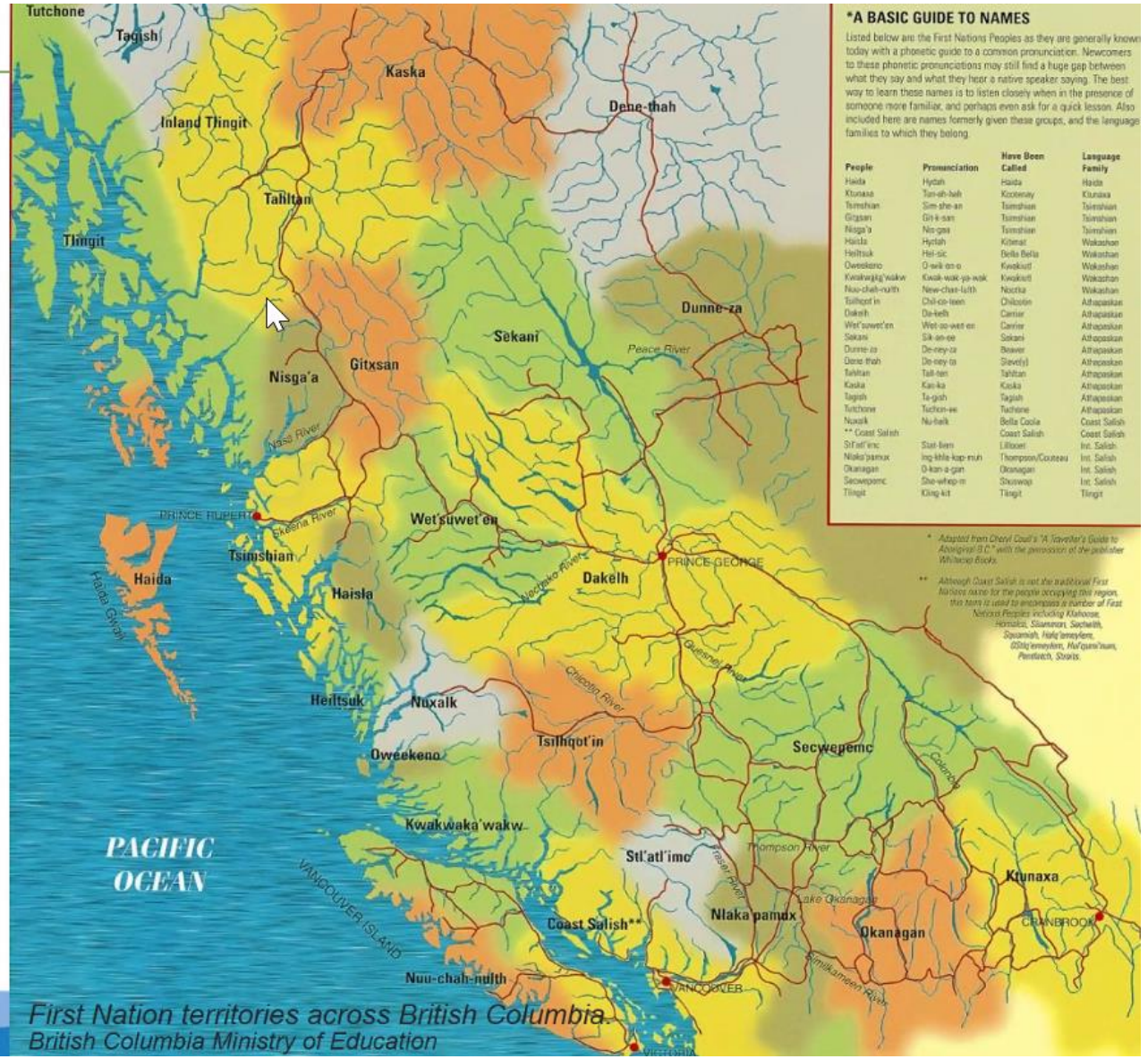
We acknowledge that today we are coming together from a number of locations from across BC. Collectively we acknowledge these homelands and recognize and respect the indigenous peoples presence, reminding us of the importance of establishing healthy and reciprocal relationships that are key to reconciliation.



First Nation territories across British Columbia.
British Columbia Ministry of Education

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Housekeeping

- Attendees are automatically muted and cameras are turned off
- Please submit questions for the speakers through the “Q&A” function and vote for the questions you want answered
- Please submit technical questions through the “Chat” function
- The webinar will be recorded and made available at compassbc.ca
- Specialist learners may apply for MOC Section 2 self-learning credits and family physician learners can apply for Mainpro+ self-learning at their respective colleges.

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Part 1 of a 3-part series

Join us **June 27th** 12-1pm for

PART 2:"Q&A on Chemical Restraint"

Join us **July 19th** 12-1pm for

PART 3:"Guidelines for Management & Resources to support CY with developmental disabilities in the ER"

Register at Compassbc.ca

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Objectives

1. Provide the background and overview of the Least Restraint Guideline
2. Review the Least Restraint approach and how to use the guideline (Hierarchy of Safety)
3. Outline the use of restraint and associated risks
4. Share available tools and resources

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Background and Overview

"This is an area of care that causes some of the most employee distress/injuries and contributes hugely to burnout in our ED. We really need better support for managing pediatric patients who pose high safety risks to themselves and others."

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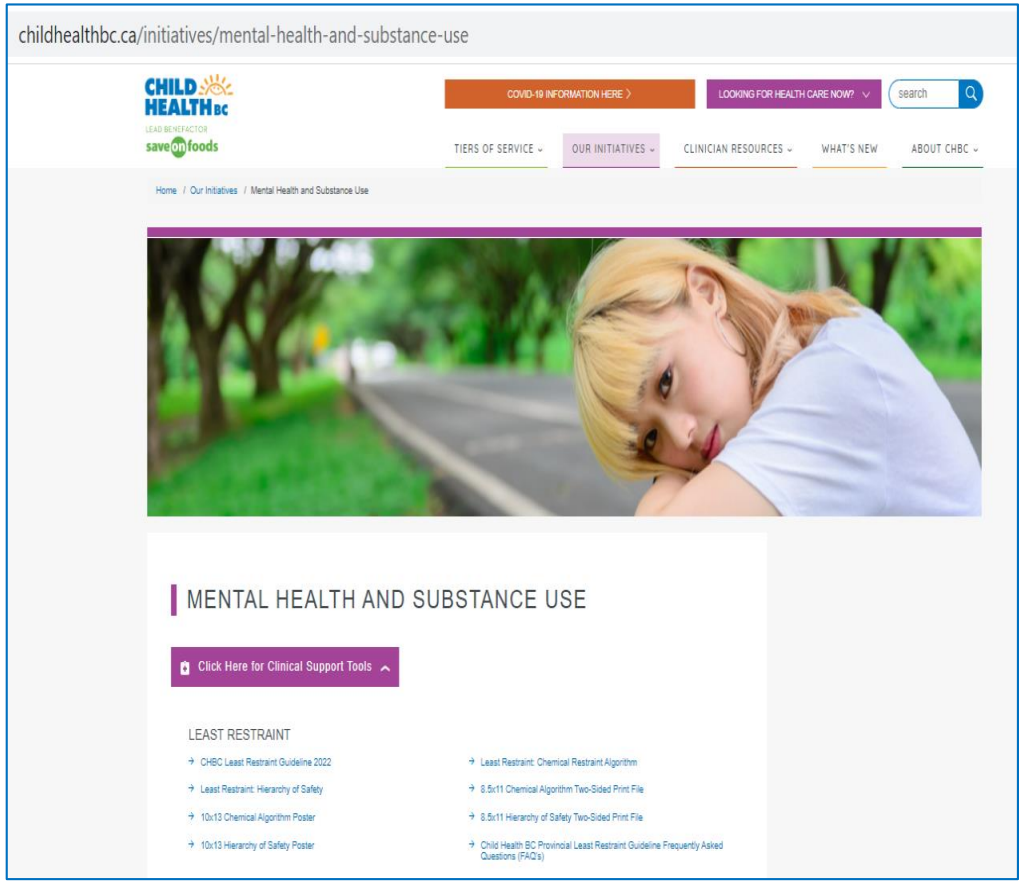
Background

- Request from the Health Authorities to expand the scope of the existing provincial guideline (2018) to include inpatient settings
- Guided consensus meetings with a provincial working group that included representatives from all Health Authorities, including First Nations Health Authority and youth & family with lived experience
- Guideline endorsed provincially April 2022



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Participants

Health Authority	Representatives
Vancouver Coastal	Liz Cave, RN, Carlile Brittany Gould, Educator, LGH Dr Dan Kalla, Emergency Physician, SPH
Northern Health	Damen DeLeenheer, Educator, Mental Health Chantelle Wilson, Manager, Specialized Services, Mental Health Fred Smith, Educator, Mental Health Jessica Manning, Pharmacy
Island Health	Susie Girling, Coord Crisis Services, VGH Jennifer Steele, Nurse Clinician, Ledger Fiona Crisp, Inpatient Coordinator, Ledger Kara Shebib, Pediatric CNL, VGH Caitlin Singbell & Carly Tarr, Peds RN's, NRGH Dr. Greg Culp, Emergency Physician, NRGH Dr Jennifer Balfour, Pediatrician, VGH Kyle Collins, C & A Pharmacist, VGH

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Participants

Health Authority	Representatives
Interior Health	Cindy Golbeck, MHSU Practice Lead Simono Ndebele, Manager, PIPU Andrea Antonishen, Manager, APU Erika Hayton, Patient Care Coord, KBRH Raj Chahal, Team Lead, PIPU Erin McFee, CNS, Peds Laura-lee Regnier, PCC, Pediatrics, KGH Dr. Ingrid Douziech, C & A psychiatrist Laura Beresford, C & A Pharamcist
Fraser Health	Paula Sandhu, Manager CY MHSU Sabina Choi, C & A Pharmacist Allison Fillion, CNE, CYMH Melissa Suzuki, CNE, CYMH Melissa Brown, CNE, Pediatrics Dr. Gilbert Lam, Pediatrician Dr. John Otasowie, C & A Psychiatrist

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Participants

Health Authority	Representatives
PHSA	Kyle Taylor, CNE, Healthy Minds Dean Elbe, C & A Mental Health Pharmacist Dr. Andrea Chapman, C & A Psychiatrist Dr. Martha Ignaszewski, C & A Psychiatrist Dr Susan Baer, C & A Psychiatrist Dr. Kelly Saran, C & A Psychiatrist Joanna MacKay, Consult Liaison Alice Virani, Director, Ethics Natasha Leech, Risk Specialists
Youth/Family Partners	Omar B. Jill T.
FNHA	Cynthia Russell, CNS, Mental Health

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Key Updates

- Expanded scope to include all settings (ED and inpatient) where children and youth with mental health concerns are cared for
- Recommendations regarding documentation, reporting, debriefing and education and training
- Clarified language re: informed consent and Mental Health Act certification to reflect policy updates
- Simplified *Hierarchy of Safety* algorithm
- Expanded the guidance regarding chemical restraint to include:
  - ✓ pharmacological management
  - ✓ overview of medications including dosing recommendations, adverse effects and contraindications
- Significant input from youth and families with lived experience and a stronger focus on diversity, inclusion and the indigenous lens

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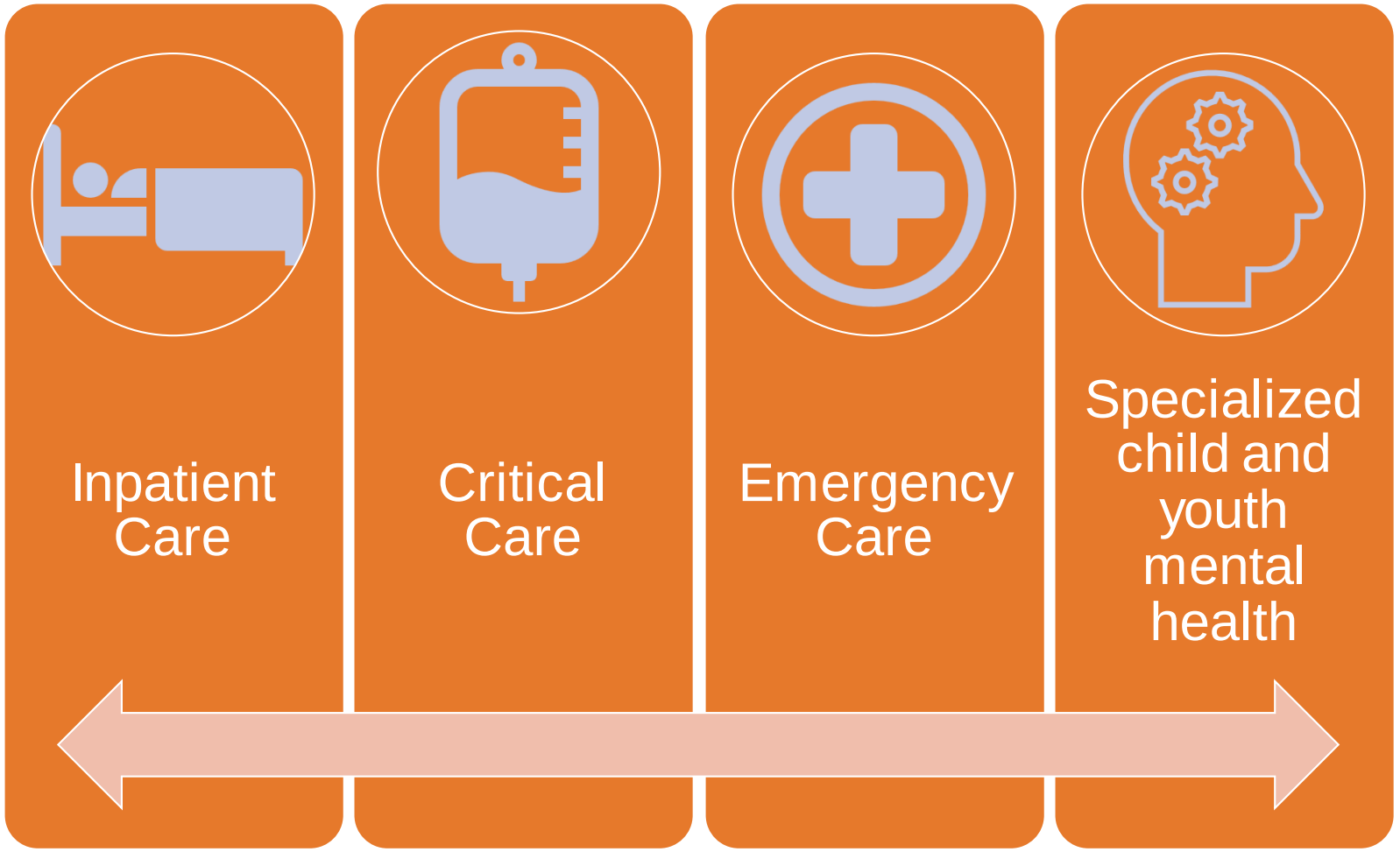
Scope

Patient Care Setting



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Using the Guideline: A least Restraint Approach

"It is very difficult to hold a child down and restrain them physically so that you can chemically restrain…it is traumatizing for the patient, staff and other patients on the unit and requires lots of time afterwards to check in and settle other patients on the unit."

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Trauma Informed Approach

- Everyone's safety is the priority!
- Compassion and safety are compatible with each other

"The room is scary for her."
and
"The room is safe for her."

"Restraints are traumatic."
and
"Restraints are needed for safety."

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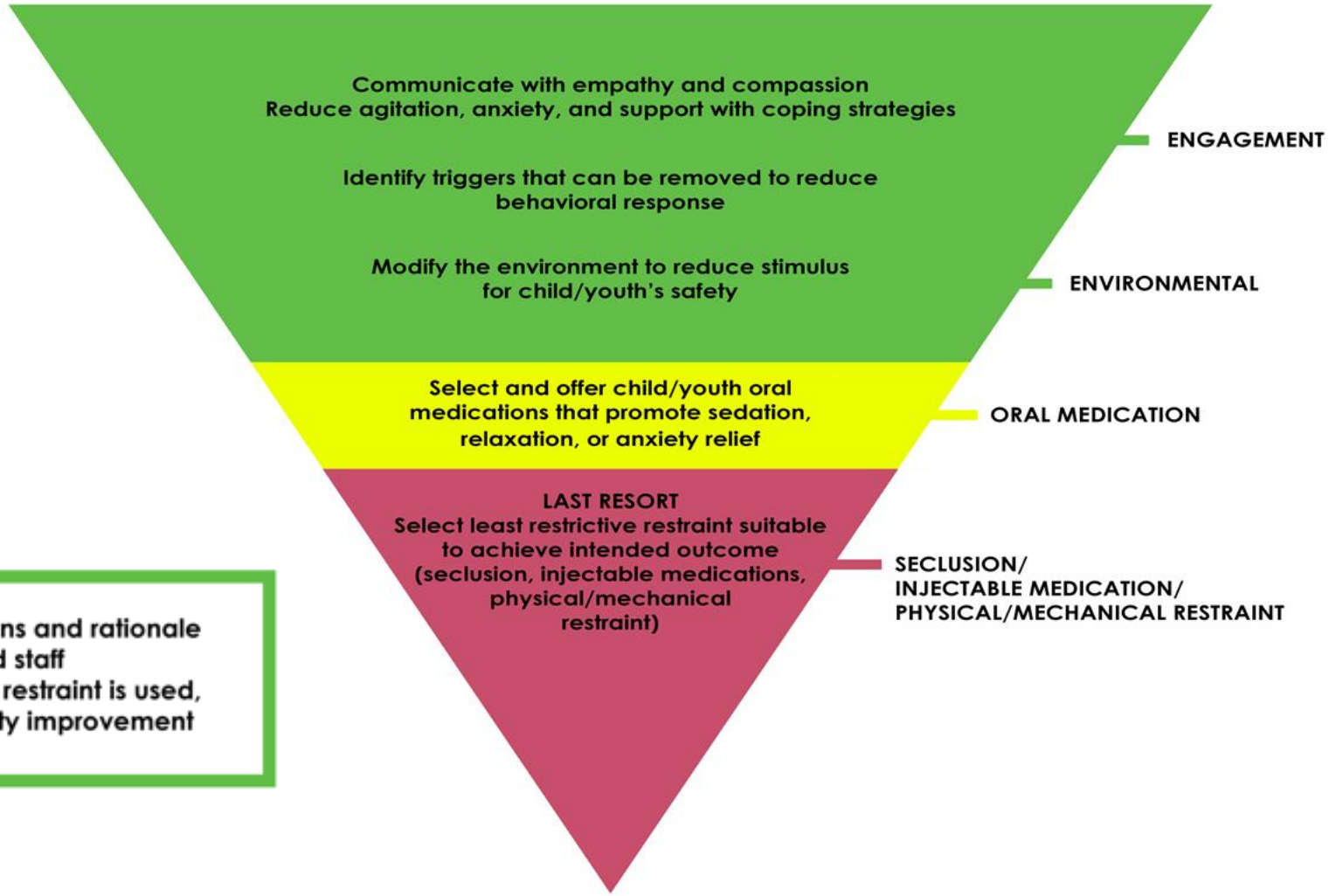
Safety is the Priority

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

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Hierarchy of Safety

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

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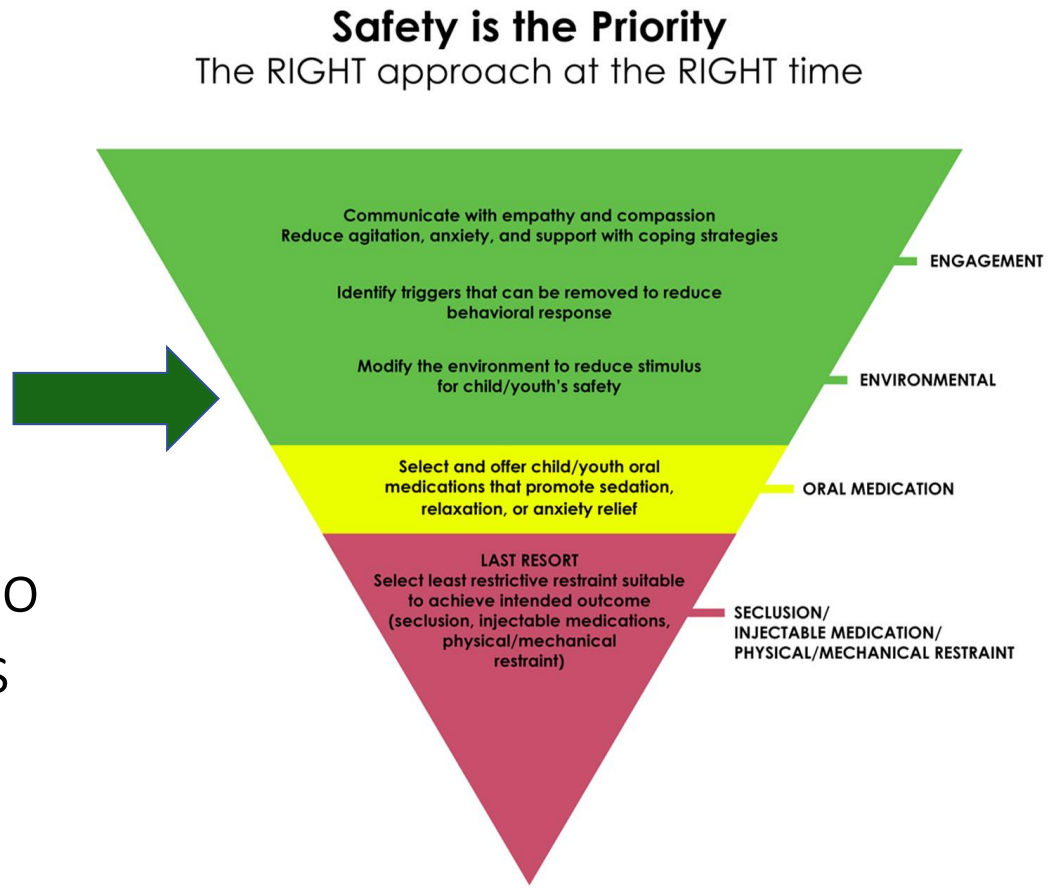
Engagement and Environmental Strategies

- **Engagement and de-escalation should always be attempted prior to initiating restraint, including offering prevention strategies appropriate for your setting.**
- A collaborative plan with child/youth/family input is important to develop as soon as possible, before a crisis occurs.
- Identify options to support the child/youth to manage in your setting, e.g. distraction tools and reduced stimulus.
- Oral medications may also be offered as the next step as appropriate.



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Restraint and Risk Considerations

"During my pediatric training, I do not recall any specific training in managing unsafe behaviours of children and youth. I only recall chaotic situations where my supervisors were stressed and quickly 'had to do something' to manage a dangerous situation."

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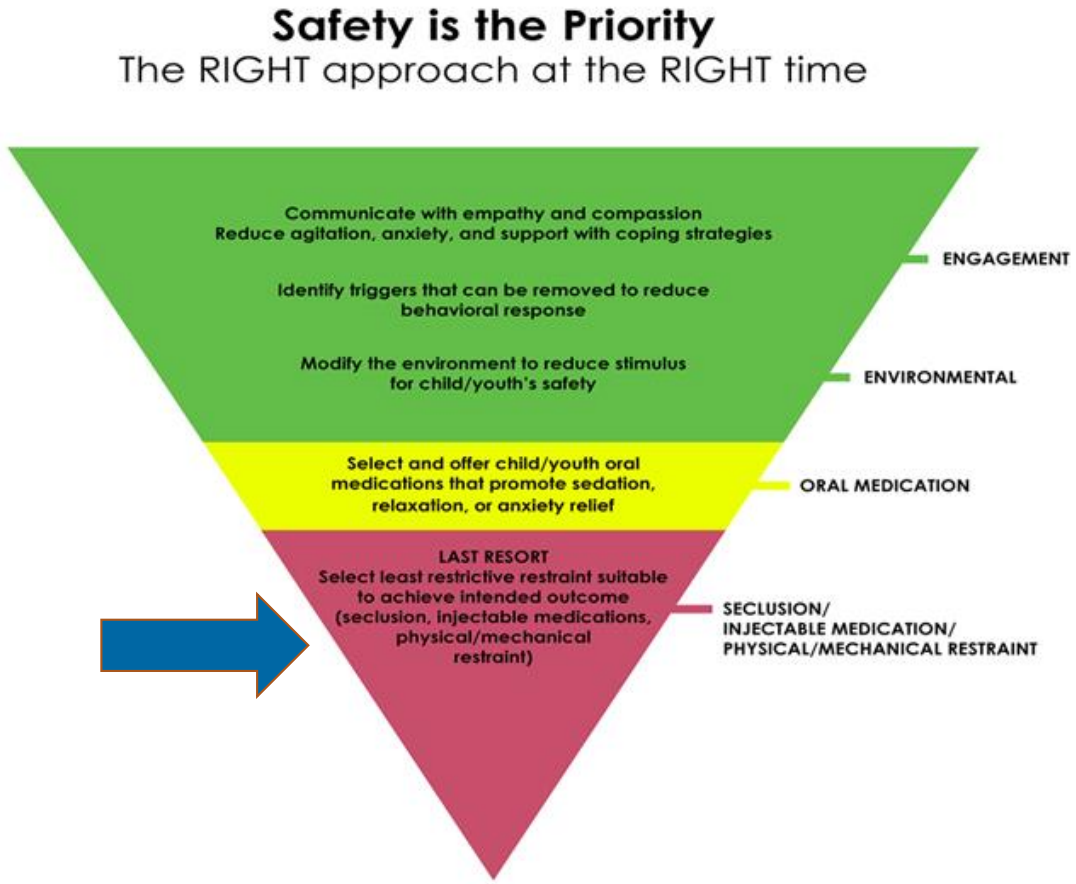
What is Restraint?

Restraint is any method of restricting a child/youth's freedom of movement, physical activity, or normal access to their body.

Forms of Restraint: Seclusion, Chemical, Physical and Mechanical

- Last resort options.
- Can result in adverse physical and psychological outcomes for the child/youth and staff.



For questions about medications physicians can call BCCH 604 875 2345 and ask for the psychiatrist on call 24 hours a day

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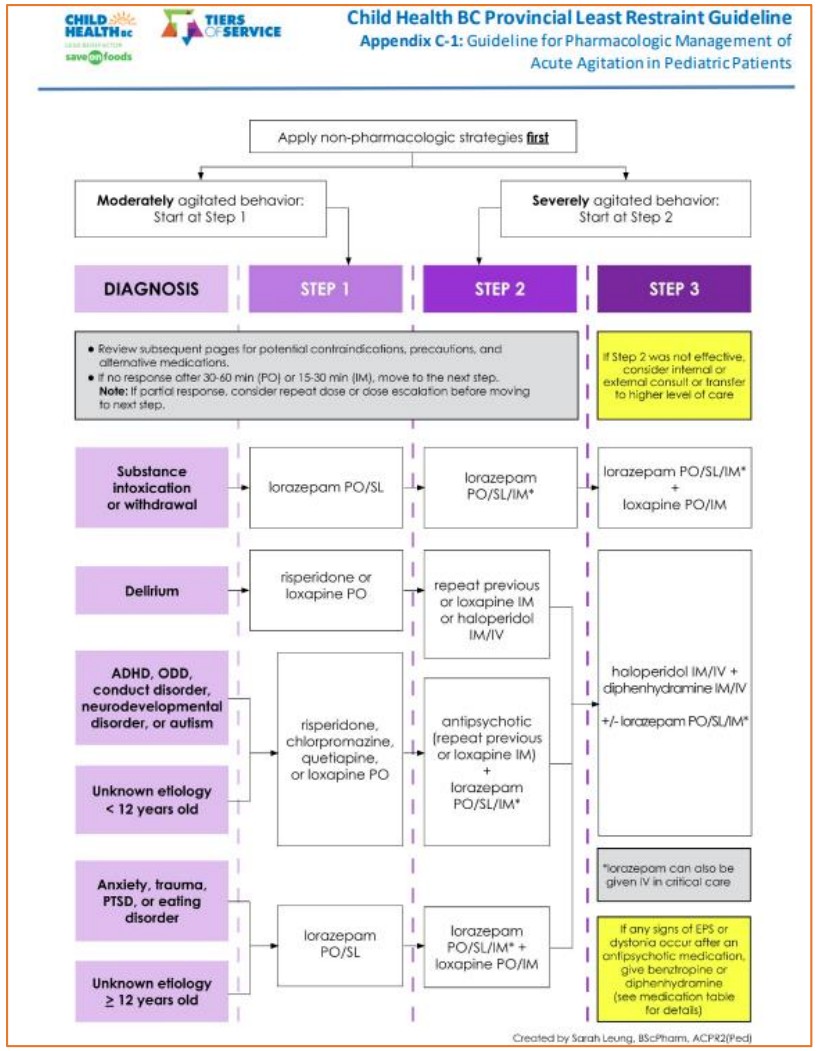
Chemical Restraint



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Child Health BC Provincial Least Restraint Guideline
Appendix C-1: Guideline for Pharmacologic Management of Acute Agitation in Pediatric Patients

Apply non-pharmacologic strategies **first**

Moderately agitated behavior: Start at Step 1

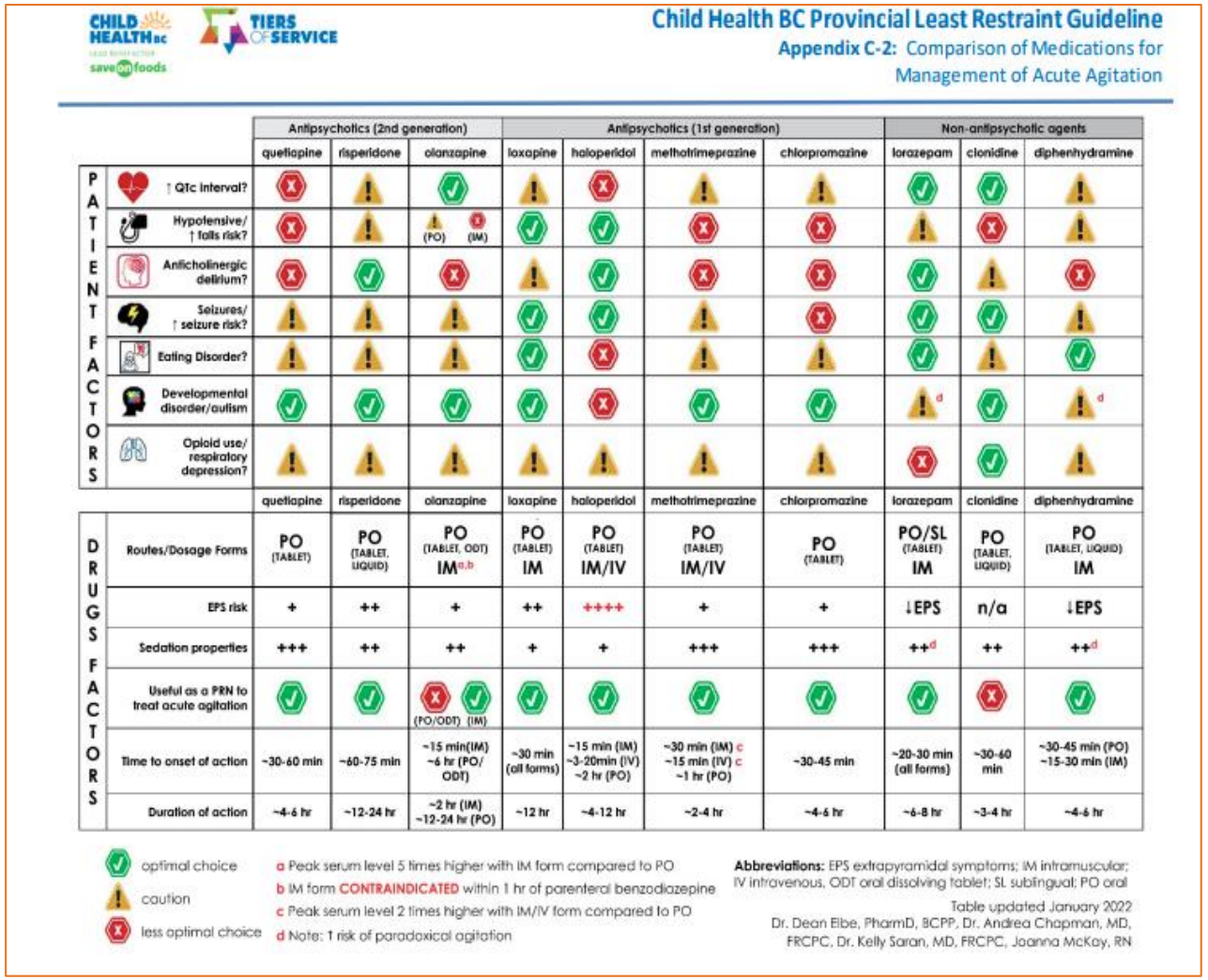
Severely agitated behavior: Start at Step 2

DIAGNOSIS	STEP 1	STEP 2	STEP 3
• Review subsequent pages for potential contraindications, precautions, and alternative medications. • If no response after 30-60 min (PO) or 15-30 min (IM), move to the next step. **Note:** If partial response, consider repeat dose or dose escalation before moving to next step.			If Step 2 was not effective, consider internal or external consult or transfer to higher level of care
Substance intoxication or withdrawal	lorazepam PO/SL	lorazepam PO/SL/IM*	lorazepam PO/SL/IM* + loxapine PO/IM
Delirium	risperidone or loxapine PO	repeat previous or loxapine IM or haloperidol IM/IV	haloperidol IM/IV + diphenhydramine IM/IV +/- lorazepam PO/SL/IM*
ADHD, ODD, conduct disorder, neurodevelopmental disorder, or autism	risperidone, chlorpromazine, quetiapine, or loxapine PO	antipsychotic (repeat previous or loxapine IM) + lorazepam PO/SL/IM*	
Unknown etiology < 12 years old			
Anxiety, trauma, PTSD, or eating disorder	lorazepam PO/SL	lorazepam PO/SL/IM* + loxapine PO/IM	
Unknown etiology ≥ 12 years old			

*lorazepam can also be given IV in critical care

If any signs of EPS or dystonia occur after an antipsychotic medication, give benztropine or diphenhydramine (see medication table for details)

Created by Sarah Leung, BScPharm, ACPR2(Ped)



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Child Health BC Provincial Least Restraint Guideline
Appendix C-2: Comparison of Medications for Management of Acute Agitation

		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 Eibe, PharmD, BCPP, Dr. Andrea Chapman, MD, FRCPC, Dr. Kelly Saran, MD, FRCPC, Joanna McKay, RN

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Restraint Use in Emergencies

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 & family preference taken into consideration whenever possible.

- Restraint is only to be used in emergency situations where there is immediate/imminent risk of harm to self or others
- Assess risk factors prior to considering use of restraint
- Must have a physician order & should NOT be ordered as a PRN (includes all types of restraint: chemical, seclusion and physical/mechanical restraint)
- Explain to child/youth/family the rationale for restraint use

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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

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Adverse Outcomes Associated with Restraint Use

- 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

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Documentation and Reporting

- 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.
- Patient response to restraint shall be tracked, documented, and reviewed to assist further decision-making.
- As restraint is considered a patient safety event, it is recommended that all events be reported through agency Patient Safety and Learning System (PSLS).

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De-Briefing

- The purpose of de-briefing is to rebuild trust and relationship, promote emotional and physical safety, enable learning and reduce future use of restraint.
- Offer debriefing with the child/youth, family/caregiver(s) and all staff involved in a restraint event.
- Post-incident debriefing is part of a cycle of continuous quality improvement.

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Tools and Resources

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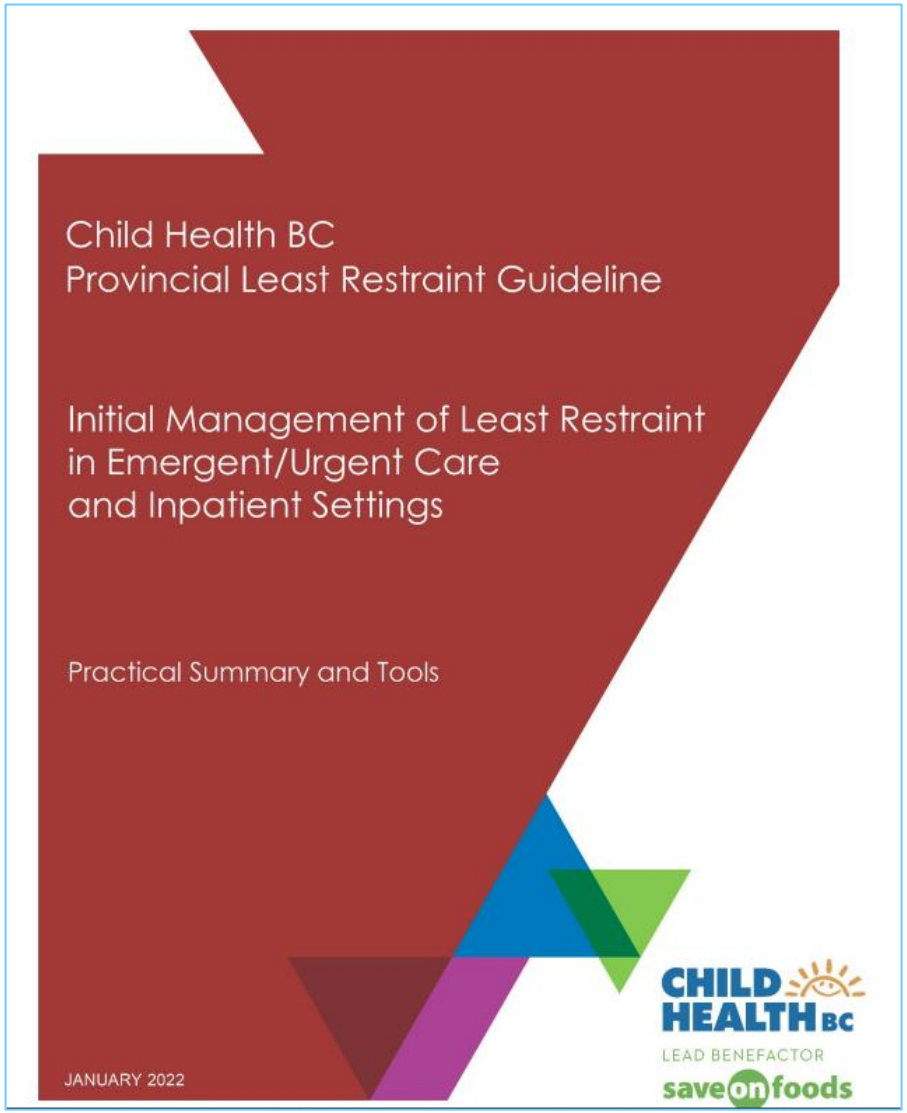

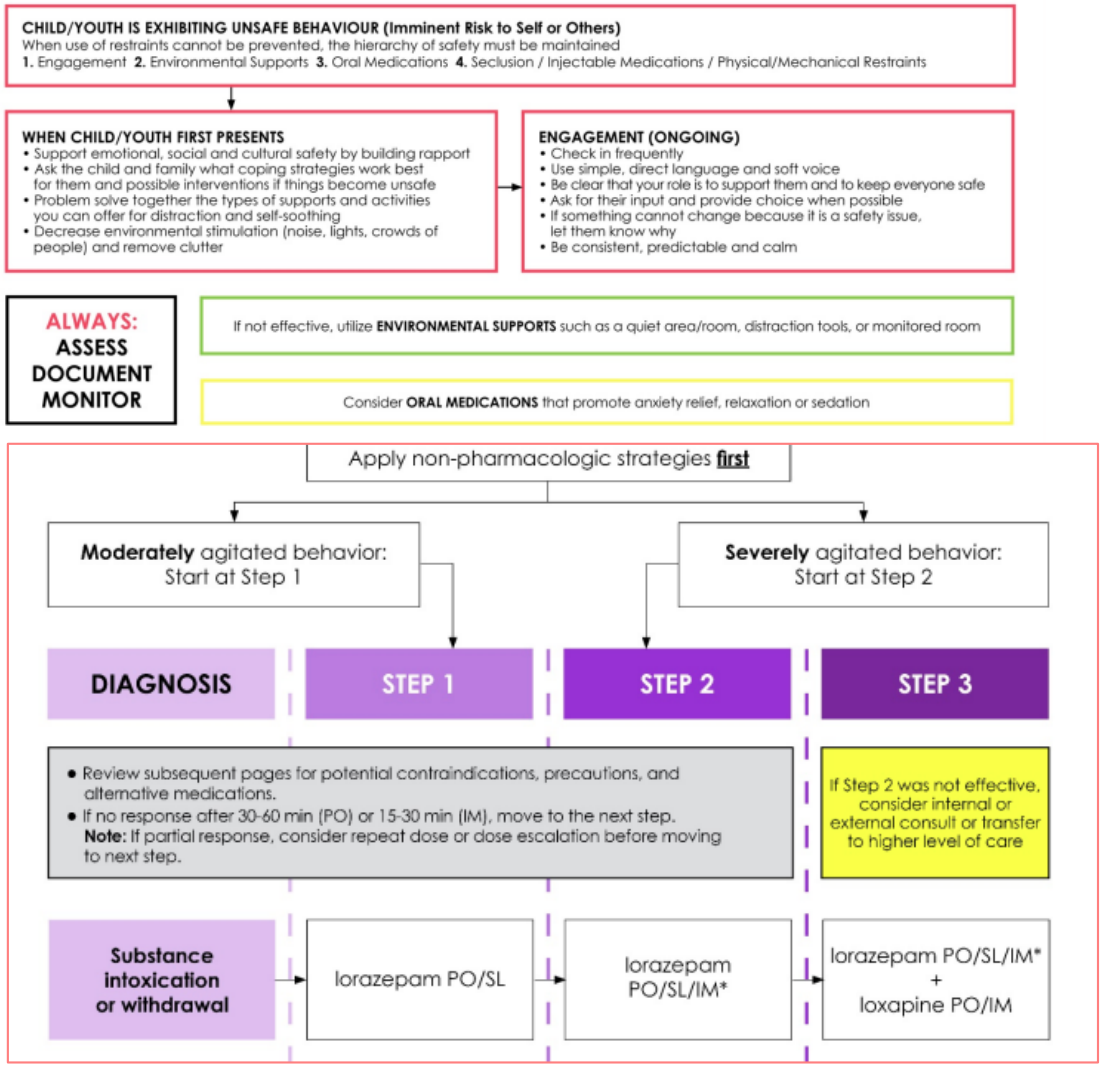

In conclusion, here are some questions to ask yourself when considering use of the Least Restraint Guideline:

1) What are, if any, the potential harms and benefits associated with the care?
2) What effect does the care have on the individual and/or family?
3) What are, if any, the ways to minimize potential harm?
4) Have the caregivers been consulted? What are their thoughts? Do they mind?

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Thank you!

Join us next on July 27th 12-1pm for Session 2: Q&A on Chemical Restraint

Guidelines available at childhealthbc.ca
(https://www.childhealthbc.ca/news/chbcs-provincial-least-restraint-guideline-update)