9758 Index

Restraint Minimisation and Safe Practice policy

Policy

The use of restraint is actively minimised in Specialist Mental Health Service (SMHS).

Where restraint is practiced, safe forms of assessment and treatment are emphasised, and all episodes are evaluated and monitored as part of a quality review process.

Purpose

To outline procedures that support the reduction of restraint use and to encourage use of least restrictive practices in SMHS.

Definitions

Restraint (as defined in NZS 8134:2008) is the use of any intervention by a staff member that limits a consumer's normal freedom of movement.

Personal restraint. Where a staff member uses their body to intentionally limit the movement of a consumer. For example where a consumer is held by a staff member.

Physical restraint. Where a staff member uses equipment, devices and furniture that limits the normal freedom of movement. For example where a consumer is unable to independently get out of a chair due to: the design of the chair, the use of a belt, or the position of a table or a fixed tray.

Environmental restraint. Where the staff member intentionally restricts a consumer's normal access to their environment. For example, locking devices on doors or denying their normal means or independent mobility (wheelchair).

Seclusion: Where a consumer is placed alone in a designated seclusion room, at any time and for any duration, from which they cannot freely exit.

Scope

All clinical staff

Relevant documentation

Legislation, standards and guidelines

Health and Disability Services, (Restraint Minimisation and Safe Practice) Standards NZS 8134.2:2008: section 2.1-2.3

Mental Health (CAT) Act 1992

Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003

Canterbury DHB policy and documents

Canterbury DHB Restraint Minimisation and Safe Practice policy

Speciality Mental Health Services

SMHS Restraint Minimisation Committee (RMC) Terms of Reference

Safety1st Restraint Register event

Safety1st Restraint Register report

Safety1st Behaviour & Safety form

Approval of forms of restraint

All forms of restraint used in SMHS and the associated procedures must be approved by the Canterbury DHB Restraint Approval and Monitoring Group (RAMG) following SMHS RMC recommendation. All approvals will be reviewed and renewed two yearly.

The following forms of restraint are approved for use in SMHS:

- Environmental restraint (Locking doors of open units)
- Seclusion
- Personal restraint: as per the approved Safe Practice and Effective Communication (SPEC) training

General restraint minimisation protocols

Assessment

Prior to using any restraint a thorough clinical assessment must occur. This includes:

- the consumer's current physical condition
- any known or possible medical disorders
- any contraindications or increased risk to the consumer
- any trauma related history.
- underlying causes, triggers or unmet need contributing to or driving the relevant behaviour

Attempts at less restrictive approaches

Less restrictive interventions will be attempted first, with restraint used only as last resort.

Examples of possible interventions include:

- Responding to underlying causes, triggers or unmet needs;
- Communication and De-escalation
- Family/whanau or carer involvement;
- Cultural Support;
- Sensory Modulation
- Use of the Personal Sensory Assessment

Legal issues

The legal status of the person being restrained must be known. Only people who are deemed patients under the Mental Health (Comulsory Assessment and Treatment) Act 1992 can be restrained. Voluntary patients who require restraint in emergency situations must have section 111 of the Mental Health Act actioned before restraint occurs.

Parental consent must be obtained for restraint on minors. Restraint may be used in children under 12 without invoking the Mental Health Act; however if seclusion is indicated for children, the Mental Health Act must be invoked.

During Restraint

Restraint will be used safely and respectfully and for the least amount of time possible.

During the restraint, the health and wellbeing of the consumer will be closely obsesrved as per SPEC training in order to detect and immediately cease the restraint in response to any signs of physical or mental distress.

Following restraint

Ensure the consumer's support and debriefing needs are appropriately met and documented in the clinical file.

Each episode of restraint must be evaluated as soon as possible following the episode ending with the restraint team and other staff involved. A review by the multi-disciplinary team (MDT) must be undertaken on the same day where possible. If after hours an MDT review must occur on the week day following the episode.

Wherever possible, participation of the consumer, their whanau/family/ carer, advocate, cultural advisor and Pukenga Atawhai (if appropriate) will be sought. If not involved, the reason should be noted.

Evaluation of restraints must include:

- Underlying causes and/or triggers of the patient behaviours that led to the restraint
- Atempted de-escalation strategies
- Other de-escalation strategies that could have bene used.
- Impact of the restraint episode on the consumer and other consumers on the unit, including whether appropriate advocacy/support was provided or facilitated;
- Appropriateness of the decision to use restraint.
- Safety, efficacy and effectiveness of interventions/and whether monitoring was adequate and maintained the safety of the consumer.
- Impact on staff
- Support needs of staff.
- Adherence to policy and procedure.
- Team practice and training issues.

The evaluation, with participation or information from the consumer and their whanau, family, or carer, informs the review and update of the consumer's treatment plan by the clinical team.

Documenting and Reporting restraint

Any clinician involved with restraints must document episodes in both consumer's clinical files and in the Safety 1st Incident Management system, and ensuring all restraint team members are identified.

Reporting and documenting episodes of restraint informs the consumers clinical record and enables monitoring and quality review of:

- The form of restraint used, the clinical indications and alternate interventions attempted, as well as any departures from the treatment plan (both helpful, and ineffective).
- The consumer's condition before, during and after the restraint episode.
- Any significant communication with the consumer, their whanau, family or carer, their advocate, or relevant others, detailing any verbal or written information given.
- Findings from consumer debriefing and evaluation.
- Any adverse outcomes associated with the restraint, and any incidents involving use of unapproved techniques must be reported.
- The Charge Nurse Manager or Clinical Team Co-ordinator or Duty Nurse Manager after hours must be informed of restraint episodes.

Restraint education

Clinical staff and authorisers will maintain an awareness of Restraint Minimisation and Safe Practice Standards, Canterbury DHB and SMHS restraint related policies, and best practice.

All staff that use restraint will be trained in the safe and appropriate use of restraint. This is taught through a four day *Safe Practice, Effective Communication* (*SPEC*), a course that is underpinned by least restrictive practice. *SPEC* focusses on communication and de-escalation skills training, as well as teaching breakaway techniques and standardised flexion-free restraint holds. Staff that use restraint must attend annual one day refresher course once they have received initial training.

A record of staff member's attendance will be maintained. Staff members and their managers must be aware of their training status, and be proactive in scheduling training.

The Training Unit will review the programme of restraint training in line with the National Directors of Mental Health Nursing Governence group two yearly.

Monitoring restraint trends

Restraint register

The divisional restraint register for SMHS is held within the Safety1st incident management system. Each new restraint event is added to the divisional register. The register is able to be accessed by senior clinicians and managers from each area enabling them to monitor and evaluate current restraint use in their area.

A monthly summary of seclusion usage is reported to Service Leadership Teams (SLT), for discussion at service level. SLTs report back to the Divisional Leadership Team .

Restraint Audit

All Restraint events are audited by units' Clinical Nurse Specialists and areas' Nurse Consultants. Nurse Consultants will audit and close the restraint register event in the Safety 1st incident management system. This ensures that every restraint event is independently examined to

ensure a focus on both quality of documentation and best practice. Each month the closure of a sample group of restraint register forms is audited by the Nurse Consultant and the areas Consumer Advisor. The results are then reported to the SMHS RMC group and the CDHB Restraint Approval and Monitoring Group.

SMHS involvement in reviews

SMHS will work to ensure that processes are consistent with other District Health Boards by participating in reviews when initiated.

Canterbury District Health Board
Te Poari Hauora ō Waitaha

RESTRAINT MINIMISATION & SAFE PRACTICE

Approved Restraint

Fall Out Chair or Bean Bag

CATEGORY OF RESTRAINT	Physical Restraint
APPROVED PRODUCTS	• **Fall Out Chair) if the intent is to restraint the patient** • **Bean Bag)**
APPROVED FOR	• Planned and Unplanned restraint events
INDICATIONS FOR USE	• Falls risk patient with cognitive impairment • Falls risk patient who is impulsive • Agitated patient AND • can not move from floor to standing OR • can not move out of a fall out chair
EPISODE DURATION FOR PLANNED RESTRAINT	• Maximum 7 days and must be reviewed & evaluated weekly at the Interdisciplinary Team Meeting

HOW IS THIS EPISODE REPORTED	• All Restraint Events are to be reported in Safety 1st Restraint Register form, documenting:
	  • the reason for restraint
	  • the type of restraint used
	  • the time the restraint was applied
	  • the time the restraint was removed
	  • the initiating clinician, and
	  • any adverse outcomes
	• Document the restraint event in the **body of the clinical note** identifying the restraint event using a **RESTRAINT** sticker. Comment on:
	• Precipitating behaviours prior to using restraint
	• Alternative strategies tried prior to restraint usage
	• All interventions during restraint episode including monitoring requirements.
	• Any communication with family
	• Criteria used for removing restraint
	• Document clinicians involved in initiating restraint and ongoing monitoring / termination of restraint
	• Any adverse outcomes for either staff or patient's
	• Evaluate the Clinical Restraint event in the **body of the clinical note** reflecting on:
	  • What could have been done to avoid the restraint event

	• How the patient responded to the restraint event • What could be improved if this event if repeated • Adverse outcomes to patient or staff are reported on an Quality Improvement Event Reporting Form
POTENTIAL RISKS ASSOCIATED WITH USE i.e. what injury/harm (physical, cultural, psychological) to patient or staff may result from its use.	Psychological: • Fear, distress, agitation or confusion • Misinterpreting the reason for restraint • Isolation • Loss of dignity • Loss of contact with family/whanau • Loss of contact with the patient's culture • Loss of the familiar Physical: • Risks associated with reduced mobility • Increased patient dependence • Inability to carry out ADL's • Entanglement in appliance
ALTERNATIVES TO USING THIS INTERVENTION	Assessment: • Falls Assessment and implement appropriate strategies • Mental Status Examination • Cognitive Assessment • Nutrition Assessment • Continence Assessment • Medical Review • Nursing Assessment • Risk Assessment • Assess if the patient will benefit from a low stimulus or high stimulating environment • Sleep hygiene assessment Environmental /Sensory Strategies: • Ensure spectacles / hearing aides are used • Orientate patient to time, place & person • Ensure adequate lighting • Ensure that items that may be required by the patient are within easy reach • Move the patient to an area that facilitates easier observation • Remove non essential equipment from area to minimise risk of falls • Ensure regular contact with staff • Utilise Sensory Room (Ward K1) • Utilise Outdoors • Utilise activity box or programme of meaningful activity • Provide opportunity for physical activity • Re-establish routines • Review Non-restraint Alternatives (Section 5)

	Risk Minimisation Strategies: • Provide Intermittent Observation or use HA Specialling or family to sit with the patient if indicated • Utilise Chair exit or sensor mats • Utilise hip protectors Refer to "Restraint Free Options" (Section 5)
MONITORING REQUIREMENTS .	Monitoring requirements are based on Comprehensive Assessment however the minimum observation requirement is every 15 minutes. • Observation frequency is based on a comprehensive assessment including risk assessment tools and subsequent treatment plan. • Position checks and alterations as per need • Hygiene, nutrition, fluid & toileting as identified from assessment • Call bell if available or alternative means of calling for assistance. • Psychological / emotional support as per individual need • Regular medical reviews Note where the patient is to be located eg not in isolation
STAFF TRAINING	For comprehensive information regarding Restraint Training Requirements refer to Section 7 OPHSS Restraint Training Matrix.

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EPISODE DURATION FOR PLANNED RESTRAINT	• Maximum 7 days and must be reviewed & evaluated weekly at the Interdisciplinary Team Meeting

HOW IS THIS EPISODE REPORTED	• All Restraint Events are to be reported in Safety 1st Restraint Register form, documenting:
	  • the reason for restraint
	  • the type of restraint used
	  • the time the restraint was applied
	  • the time the restraint was removed
	  • the initiating clinician, and
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	• Document the restraint event in the **body of the clinical note** identifying the restraint event using a **RESTRAINT** sticker. Comment on:
	• Precipitating behaviours prior to using restraint
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	• Evaluate the Clinical Restraint event in the **body of the clinical note** reflecting on:
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POTENTIAL RISKS ASSOCIATED WITH USE i.e. what injury/harm (physical, cultural, psychological) to patient or staff may result from its use.	Psychological: • Fear, distress, agitation or confusion • Misinterpreting the reason for restraint • Isolation • Loss of dignity • Loss of contact with family/whanau • Loss of contact with the patient's culture • Loss of the familiar Physical: • Risks associated with reduced mobility • Increased patient dependence • Inability to carry out ADL's • Entanglement in appliance
ALTERNATIVES TO USING THIS INTERVENTION	Assessment: • Falls Assessment and implement appropriate strategies • Mental Status Examination • Cognitive Assessment • Nutrition Assessment • Continence Assessment • Medical Review • Nursing Assessment • Risk Assessment • Assess if the patient will benefit from a low stimulus or high stimulating environment • Sleep hygiene assessment Environmental /Sensory Strategies: • Ensure spectacles / hearing aides are used • Orientate patient to time, place & person • Ensure adequate lighting • Ensure that items that may be required by the patient are within easy reach • Move the patient to an area that facilitates easier observation • Remove non essential equipment from area to minimise risk of falls • Ensure regular contact with staff • Utilise Sensory Room (Ward K1) • Utilise Outdoors • Utilise activity box or programme of meaningful activity • Provide opportunity for physical activity • Re-establish routines • Review Non-restraint Alternatives (Section 5)

	Risk Minimisation Strategies: • Provide Intermittent Observation or use HA Specialling or family to sit with the patient if indicated • Utilise Chair exit or sensor mats • Utilise hip protectors Refer to "Restraint Free Options" (Section 5)
MONITORING REQUIREMENTS .	Monitoring requirements are based on Comprehensive Assessment however the minimum observation requirement is every 15 minutes. • Observation frequency is based on a comprehensive assessment including risk assessment tools and subsequent treatment plan. • Position checks and alterations as per need • Hygiene, nutrition, fluid & toileting as identified from assessment • Call bell if available or alternative means of calling for assistance. • Psychological / emotional support as per individual need • Regular medical reviews Note where the patient is to be located eg not in isolation
STAFF TRAINING	For comprehensive information regarding Restraint Training Requirements refer to Section 7 OPHSS Restraint Training Matrix.

Canterbury District Health Board
Te Poari Hauora ō Waitaha

RESTRAINT MINIMISATION & SAFE PRACTICE

Approved Restraint

Criss Cross Vest

APPROVED FOR	• Planned and Unplanned restraint events
INDICATIONS FOR USE	When a patient is at risk of harm to self or others due to: • Cognitive impairment • Impulsiveness • Agitation
POTENTIAL RISKS ASSOCIATED WITH USE i.e. what injury/harm (physical, cultural, psychological) to patient or staff may result from its use.	**Application Instructions - Posey Criss Cross Vest** **Checklist - Posey Criss Cross Vest** Psychological: • Fear, distress, agitation or confusion • Misinterpreting the reason for restraint • Isolation • Loss of dignity • Loss of contact with family/whanau • Loss of contact with the patient's culture • Loss of the familiar Physical: • Risks associated with reduced mobility • Increased patient dependence • Inability to carry out activities of daily living • Entanglement in appliance
MONITORING REQUIREMENTS	The extent and frequency of monitoring of the patient/consumer is to be documented in the patient's/consumer's clinical notes/treatment plan, and will be determined by: • the risks associated with their needs and • their response to restraint Each episode of restraint must be monitored and recorded using the appropriate documentation. Monitor as per the **divisional procedure** and in accordance with the requirements for specific types of restraint (including manufacturer's instructions). Monitoring includes, but is not limited to: • comfort and positioning (and alter as required) • hygiene, and toileting needs • nutrition and hydration

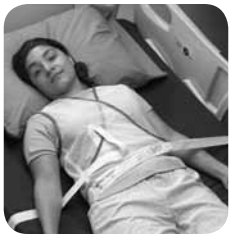
	• ensure call bell access is available, or alternative means of calling for assistance • cultural, psychological and emotional needs (provide support as indicated) • the ongoing need for restraint and the patient/consumers response to the restraint. • The patients physical status including the condition of the skin and circulation Observation frequency is based on comprehensive assessment, including risk assessment tools, and this is documented in the treatment plan Minimum observation requirement is every **15 minutes** including: • Position checks and alterations • Hygiene, nutrition, fluid & toileting • Ensuring the call bell, or an alternative means of calling for assistance, is accessible Regular medical reviews
PATIENT CARE DURING PHYSICAL RESTRAINT	• The patient must be repositioned at least two hourly, with range of movement exercises to be provided as clinically indicated • Restraints are to be released to check skin integrity and circulation (colour, warmth, pulse) • Psychological / emotional support to be provided as per individual need • The Patient is to be suitably located to enable ease of monitoring i.e. not in an isolated area of the ward

CRISS-CROSS VESTS

Applicable Products: REF **3311, 3331, 3341, 3390**

APPLICATION INSTRUCTIONS

DESCRIPTION OF PRODUCT: A versatile vest with tie ends. For bed or chair application. **Rx ONLY**



INDICATIONS FOR USE:

- Patients assessed to be at risk of injury from a fall.
- Patients requiring a positioning device to assist medical treatment.

CONTRAINDICATIONS:

- **DO NOT** use on a patient who is or becomes highly aggressive, combative, agitated, or suicidal.
- **DO NOT** use on patients with: ostomy, colostomy, or G-tubes; hernias, severe Cardio Obstructive Pulmonary Disease (COPD); or with post-surgery tubes, incisions or monitoring lines. These could be disrupted by a restraint.

POSEY CRISS-CROSS VESTS

REF **3311** Breezeline Mesh, S-XL
REF **3331** Cotton, S-L
REF **3341** Poly/Cotton, S-L
REF **3390** Breezeline Mesh with Sleeves, S-XL

ADVERSE REACTIONS

- Severe emotional, psychological, or physical problems may occur: if the applied device is uncomfortable; or if it severely limits movement. If symptoms of these problems ever appear for any reason, get help from a qualified medical authority and find a less restrictive, product or intervention.

APPLICATION INSTRUCTIONS:

⚠WARNING Make sure patient wears proper undergarments to protect skin.

⚠CAUTION Before use, check device for damage. Discard if you have any questions about patient safety.

1. Place the device on the patient with the "V" neck in front.
2. Position the straps in front of the patient and feed the strap from the patient's left side through the slot in the vest on the patient's right side.
3. Secure straps to the wheelchair or bed frame, out of the patient's reach (See below).
4. Slide an open hand (flat) between the device and the patient to ensure proper fit. The device must be snug, but not interfere with breathing.

⚠WARNING

- **A restraint applied incorrectly or worn backwards may result in serious injury or death from suffocation, chest compression or patient escape.**
- **NEVER criss-cross straps directly behind the patient. Straps may loosen if the patient rotates.**
- **Make sure straps cannot slide, loosen, or tighten if the patient pulls on them, or if the bed or chair seat position is adjusted. The patient may suffocate if the straps tighten. If the straps loosen, serious injury or death may occur from: patient escape; or from chest compression or suffocation if the patient becomes suspended in the restraint.**

FOR WHEELCHAIR USE:

a. Position the patient as far back in the seat as possible with the buttocks against the back of the chair.
b. Bring the straps over the hips at a 45-degree angle and pass down between the seat and the wheelchair sides (fig. 1).
c. Criss-cross the straps, and use quick-release ties to attach straps to the opposite side kick spurs, out of the patient's reach (fig. 2).
d. If the chair has an adjustable seat, secure straps to a movable part of the chair frame, out of the patient's reach.

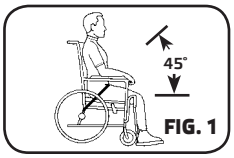


FIG. 1


FIG. 2

FOR BED USE:

a. Secure straps with quick-release ties to a movable part of the bed frame at waist level, out of the patient's reach.

NOTE: This device **DOES NOT** allow the patient to roll from side-to-side or sit up in bed. If greater range of motion is desired, see Posey Catalog for other options.

⚠ ADDITIONAL WARNINGS:

Heed these warnings to reduce the risk of serious injury or death:

BED SAFETY

- **ALWAYS use Hospital Bed Safety Workgroup (HBSW) (http://www.fda.gov/cdrh/beds/modguide.html) compliant side rails in the UP position and fill ALL gaps to reduce the risk of entrapment.**
- **Use side rail covers and gap protectors to help prevent the patient's body from going under, around, through or between the side rails. A failure to do so may result in serious injury or death if a patient becomes suspended or entrapped. Posey offers a full range of side rail pads and/or gap protectors to cover gaps.**
- **There is a risk of chest compression or suffocation if the patient's body weight is suspended off the mattress or chair seat. Use extreme caution with chair cushions. If a cushion dislodges, straps may loosen and allow the patient to slide off the seat (figs. 3, 4, and 5).**
- **Monitor per facility policy to ensure that the patient cannot slide down, or fall off the chair seat or mattress and become suspended or entrapped (figs. 3, 4, and 5).**


FIG. 3


FIG. 4


FIG. 5

- **STOP USE AT ONCE: if the patient has a tendency to slide forward or down in the device; or is able to self-release.**

NOTE: A restraint with a pelvic piece will reduce the risk of sliding, or of the patient pulling the device over his or her head. See Posey Catalog.

ADDITIONAL SAFETY AND LAUNDERING INSTRUCTIONS ON OTHER SIDE

Posey Company • 5635 Peck Road, Arcadia, CA 91006-0020 USA • www.posey.com
Phone: 1.800.447.6739 or 1.626.443.3143 • Fax: 1.800.767.3933 or 1.626.443.5014

EC REP MDSS GmbH
Schiffgraben 41
D-30175 Hannover, Germany

Posey® Safety Information for the Use of Posey Torso and Limb Restraining Products

⚠ WARNING: ALWAYS Monitor patients per facility policy.

Improper application or use of any restraint may result in serious injury or death.

RX ONLY. NOT FOR HOME USE. Federal law (USA) restricts this device to sale by or on order of a physician. For use in a licensed healthcare facility only.

STAFF TRAINING: Staff must have on going training and be able to demonstrate competency to use this device in accord with: Posey instructions; your facility policies and state and federal regulations (Federal Register, Part IV, 42 CFR Part 482.13(e)(5) and (f)(6); Posey offers inservice training aids at no charge. Contact Posey online at www.posey.com or call toll-free at 1.800.447.6739 (press 5).

SELECTING THE RIGHT POSEY PRODUCT: Refer to the Posey catalog to help select the right device to meet individual patients' needs.

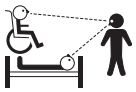
BEFORE APPLYING ANY RESTRAINT:

- Make a complete assessment of the patient to ensure restraint use is appropriate.
- Identify the patient's symptoms and, if possible, remove the cause. You may need to: cater to individual needs and routines; increase rehabilitation and restorative nursing; modify the environment; or increase supervision.
- Use a restraint only when all other options have failed. Use the least restrictive device, for the shortest time, until you find a less restrictive alternative. Patients have the right to be free from restraint.
- Obtain informed consent from the patient or guardian prior to use. Explain the reason for restraint use to the patient and/or guardian to help ensure cooperation.
- A restraint must only be used in accord with the patient's Individualized Care Plan (ICP). The ICP is an assessment by an interdisciplinary team, which may include, but is not limited to: PT, OT, Nursing, the Physician, and Social Services. The ICP should include: restorative nursing; patient release; and pressure sore prevention.

NOTE: Just as patient behavior is not 100% predictable, no product is 100% foolproof. Patient safety requires regular reassessment and monitoring per facility policy. A product that worked in the past may be inappropriate if the patient's mental or physical health status changes. NEVER apply any product that you feel is unsafe. Consult with the proper medical authority if you have questions about patient safety.

⚠ ADDITIONAL WARNINGS:

1. **ALWAYS monitor patient per facility policy. Be aware that constant monitoring may be required for:**
   - Aggressive or agitated patients; and
   - Patients deemed at risk of aspirating their vomit. This includes patients in the supine position, or who are not able to sit up. If the patient vomits, he or she could aspirate the vomit and suffocate.
   - Be prepared to intervene at the first sign of danger. Such patients require frequent review and evaluation of their physical and psychological status.



2. **NEVER alter or repair this product. ALWAYS Inspect before each use:** Check for broken stitches or parts; torn, cut or frayed material; or locks, buckles, or hook and loop fasteners that do not hold securely. DO NOT use soiled or damaged products. Doing so may result in serious injury or death. Dispose of damaged products per facility policy for BIOHAZARDOUS material.

3. **ALWAYS secure straps, to a movable part of the bed or chair frame, out of the patient's reach, using quick-release ties (see drawing below) or buckles.** These allow easy release in the event of an accident or fire. Test to make sure straps cannot tighten, loosen, or slip and create excess slack. If this occurs, the patient may slide off the chair or bed, increasing the risk of serious injury or suffocation. Restraint release is an important part of facility fire and disaster drills. Straps can be cut with scissors in an emergency.

4. **NEVER use Posey products on toilets, or on any chair or furniture that does not allow proper application as directed in the Application Instructions. DO NOT use at home.**

5. **NEVER expose this product to open flame, fire, smoking materials, or high heat sources.** Some products may melt or ignite and burn. The facility smoking/no smoking policy should be strictly enforced.

6. **NEVER use a Posey product as a seat belt in a moving vehicle. Posey products are not designed to withstand the force of a crash or sudden stop.**

LAUNDERING INSTRUCTIONS (if applicable):

- Fasten all buckles and locks to reduce risk of damage during wash and dry cycles. DO NOT put buckles or locks through extractors. For maximum life, launder in a laundry bag.
- Before laundering, zip up and turn the product inside out to protect zipper.
- Hook and loop fasteners may collect lint after repeated use or laundering, reducing grip strength. Fasten the "hook" to the "loop" before laundering to help prevent lint buildup. As needed, use a stiff- bristle brush to remove lint from the "hook" side.
- These products, other than foam products, can be machine washed under CDC* guidelines for material soiled with blood or bodily fluid.

- For non-contaminated material, use lower temperature wash and dry cycles to extend product life.
- For foam products:

⚠WARNING

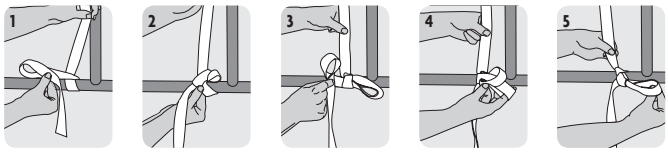
Test Zippers or hook and loop fasteners before each use. DISCARD device if it does not fasten securely.

STORAGE AND HANDLING:

- This device is designed for use in normal indoor environments.
- This device may be stored in ambient warehouse temperatures at normal humidity levels. Avoid excess moisture or high humidity that may damage product materials.

*www.cdc.gov

How to Tie the Posey Quick-Release Tie



1. **Wrap the strap once around a movable part of the bed frame leaving at least an 8" (20 cm) tail. Fold the loose end in half to create a loop and cross it over the other end.**
2. **Insert the folded strap where the straps cross over each other, as if tying a shoelace. Pull on the loop to tighten.**
3. **Fold the loose end in half to create a second loop.**
4. **Insert the second loop into the first loop.**
5. **Pull on the loop to tighten. Test to make sure strap is secure and will not slide in any direction.**
6. **Repeat on other side. Practice quick-release ties to ensure the knot releases with one pull on the loose end of the strap.**

Sizing Table for Posey Products

ALWAYS use the proper size product. Products that are too small or large may compromise patient comfort and could result in severe injury or death.

BINDING COLOR	SIZE	WEIGHT lb. (kg.)	CHEST in. (cm)
White	X-Small	60-115 (27-52)	25-32 (64-81)
Red	Small	112-160 (51-73)	31-37 (79-94)
Green	Medium	135-203 (61-92)	35-40 (89-102)
Yellow	Large	160-225 (73-102)	38-44 (97-112)
Blue	X-Large	180-247 (82-112)	42-48 (107-122)
Black	XX-Large	220-275 (100-125)	46-55 (117-140)
Yellow/Black	XXX-Large	265-305 (120-138)	54-60 (137-152)
Blue/Black	XXXX-Large	295-340 (133-154)	58-64 (147-163)

Posey Belts are not color-coded, but are sized according to this table.
Flame-retardant fabric is available on request.
Patient weight and size are a general indicator only. Consider individual physical characteristics to choose the right product for each patient. Refer to product label for specific sizing information.

Posey Company • 5635 Peck Road, Arcadia, CA 91006-0020 USA • www.posey.com
Phone: 1.800.447.6739 or 1.626.443.3143 • Fax: 1.800.767.3933 or 1.626.443.5014

EC REP MDSS GmbH
Schiffgraben 41
D-30175 Hannover, Germany

I9200B REV B 092412

Criss-Cross Vests
3311, 3331, 3341, 3390
CHECKLIST

Posey®

Facility		Contact	
Facility Name		Name	
Street Address		Title	
City/State/Zip		Nursing Unit	
Instructor		Date	
Signature			

Description	Competency Level	Date	Comments
Competency Level Definition - (1) Needs remediation and re-evaluation, (2) Performs skill with accuracy under supervision, (3) Performs skill with accuracy independently			
APPLICATION INSTRUCTIONS: 1. Place the device on the patient with the "V" neck in front.			
2. Position the straps in front of the patient and feed the strap from the patient's left side through the slot in the vest on the patient's right side.			
3. Secure straps to the wheelchair or bed frame, out of the patient's reach.			
4. Slide an open hand (flat) between the device and the patient to ensure proper fit. The device must be snug, but not interfere with breathing.			
FOR WHEELCHAIR USE: 1. Position the patient as far back in the seat as possible with the buttocks against the back of the chair.			
2. Bring the straps over the hips at a 45-degree angle and pass down between the seat and the wheelchair sides.			

Rx ONLY

Before use, make sure to read the instructions accompanying the product. A copy of the instruction sheet is included with the product and can also be downloaded at www.posey.com.

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Description	Competency Level	Date	Comments
Competency Level Definition - (1) Needs remediation and re-evaluation, (2) Performs skill with accuracy under supervision, (3) Performs skill with accuracy independently			
3. Criss-cross the straps, and use quick-release ties to attach straps to the opposite side kick spurs, out of the patient's reach.			
4. If the chair has an adjustable seat, secure straps to a movable part of the chair frame, out of the patient's reach.			
FOR BED USE: 1. Secure the straps with quick-release ties to a movable part of the bed frame at waist level, out of the patient's reach.			

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Canterbury District Health Board
Te Poari Hauora ō Waitaha

RESTRAINT MINIMISATION & SAFE PRACTICE

Approved Restraint

Soft Belt (Posey)

APPROVED FOR	• Planned and Unplanned restraint events
INDICATIONS FOR USE	When a patient is at risk of harm to self or others due to: • Cognitive impairment • Impulsiveness • Agitation
POTENTIAL RISKS ASSOCIATED WITH USE i.e. what injury/harm (physical, cultural, psychological) to patient or staff may result from its use.	Application Instructions • Posey Soft Belt Restraint Checklist: • Posey Soft Belt Checklist pdf
MONITORING REQUIREMENTS	The extent and frequency of monitoring of the patient/consumer is to be documented in the patient's/consumer's clinical notes/treatment plan, and will be determined by: • the risks associated with their needs and • their response to restraint Each episode of restraint must be monitored and recorded using the appropriate documentation. Monitor as per the **divisional procedure** and in accordance with the requirements for specific types of restraint (including manufacturer's instructions). Monitoring includes, but is not limited to: • comfort and positioning (and alter as required) • hygiene, and toileting needs • nutrition and hydration • ensure call bell access is available, or alternative means of calling for assistance • cultural, psychological and emotional needs (provide support as indicated) • the ongoing need for restraint and the patient/consumers response to the restraint. • The patients physical status including the condition of the skin and circulation Observation frequency is based on comprehensive assessment, including risk assessment tools, and this is documented in the treatment plan

	Minimum observation requirement is every **15 minutes** including: • Position checks and alterations • Hygiene, nutrition, fluid & toileting • Ensuring the call bell, or an alternative means of calling for assistance, is accessible Regular medical reviews
PATIENT CARE DURING PHYSICAL RESTRAINT	• The patient must be repositioned at least **two hourly**, with range of movement exercises to be provided as clinically indicated • Restraints are to be released to check skin integrity and circulation (colour, warmth, pulse) • Psychological / emotional support to be provided as per individual need • The Patient is to be suitably located to enable ease of monitoring i.e. not in an isolated area of the ward

SOFT BELT

Applicable Products: REF **4125C**

APPLICATION INSTRUCTIONS

DESCRIPTION OF PRODUCT: A pelvic holder to prevent sliding. For chair use only.

Rx ONLY

POSEY SOFT BELT

REF **4125C** Chair use only; 4½"W x 16½" (11 cm x 42 cm) belt pad w/6 foot (2 m) straps

INDICATIONS FOR USE:

- Patients assessed to be at risk of injury from a fall.
- Patients needing a positioning device for added safety while in a chair.
- Patients who have a tendency to slide down in a chair.

CONTRAINDICATIONS:

- **DO NOT** use on a patient who is or becomes highly aggressive, combative, agitated, or suicidal.
- **DO NOT** use on patients with: ostomy, colostomy, or G-tubes; hernias, severe Cardio Obstructive Pulmonary Disease (COPD); or with post-surgery tubes, incisions, catheters, or monitoring lines. These could be disrupted by a restraint.

ADVERSE REACTIONS

- Severe emotional, psychological, or physical problems may occur: if the applied device is uncomfortable; or if it severely limits movement. If symptoms of these problems ever appear for any reason, get help from a qualified medical authority and find a less restrictive, product or intervention.

APPLICATION INSTRUCTIONS:

⚠WARNING Make sure patient wears proper undergarments to protect skin.

⚠CAUTION Before use, check device for damage. Discard if you have any questions about patient safety.

1. Lay the device on the chair with the narrow side to the back of the chair.
2. Bring the ends of the connecting straps on the narrow end, down behind the chair, and secure out of the patient's reach (fig. 1).
3. Position the patient as far back in the seat as possible, with the buttocks against the back of the chair.
4. Bring the wide part of the pelvic holder up between the patient's legs.
5. Bring the ends of the connecting straps on the wide end, down between the seat and wheelchair sides at a 45-degree angle (fig. 2).
6. Criss-cross the straps and use quick-release ties to attach the straps to the opposite side kick spurs, out of the patient's reach (fig. 3).
7. If the chair has an adjustable seat, secure straps to a movable part of the chair frame, out of the patient's reach.
8. Check that the straps are secure and will not change position, loosen, or tighten if the patient pulls on them, or if the chair is tilted or adjusted.

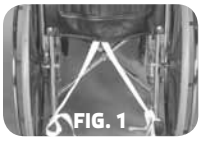


FIG. 1

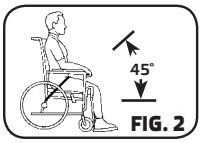


FIG. 2

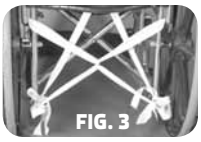


FIG. 3

APPLICATION INSTRUCTIONS: (PLASTIC INCONTINENCE SHIELD):

1. Insert the pelvic straps through the shield starting at the widest part and pull the shield up until it rests on the foam pelvic piece.

⚠WARNING

Heed these warnings to reduce the risk of serious injury or death:

- **Monitor skin conditions in the groin area frequently. If the patient slides down or forward, pelvic straps may damage the skin.**
- **There is a risk of chest compression or suffocation, if the patient's body weight is suspended off the chair seat. Use extreme caution with chair cushions. If a cushion dislodges, straps may loosen and allow the patient to slide off the seat (fig. 4).**
- **Monitor per facility policy to ensure that the patient cannot slide down, or fall off the chair seat and become suspended (fig. 4).**

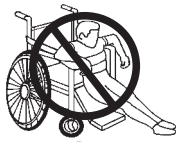


FIG. 4

- **STOP USE AT ONCE: if the patient has a tendency to slide forward or down in the device; or is able to self-release.**

ADDITIONAL SAFETY AND LAUNDERING INSTRUCTIONS ON OTHER SIDE

Posey Company • 5635 Peck Road, Arcadia, CA 91006-0020 USA • www.posey.com
Phone: 1.800.447.6739 or 1.626.443.3143 • Fax: 1.800.767.3933 or 1.626.443.5014

EC REP MDSS GmbH
Schiffgraben 41
D-30175 Hannover, Germany

I92100 040609

Posey® Safety Information for the Use of Posey Torso and Limb Restraining Products

⚠ WARNING: ALWAYS Monitor patients per facility policy.

Improper application or use of any restraint may result in serious injury or death.

RX ONLY. NOT FOR HOME USE. Federal law (USA) restricts this device to sale by or on order of a physician. For use in a licensed healthcare facility only.

STAFF TRAINING: Staff must have on going training and be able to demonstrate competency to use this device in accord with: Posey instructions; your facility policies and state and federal regulations (Federal Register, Part IV, 42 CFR Part 482.13(e)(5) and (f)(6); Posey offers inservice training aids at no charge. Contact Posey online at www.posey.com or call toll-free at 1.800.447.6739 (press 5).

SELECTING THE RIGHT POSEY PRODUCT: Refer to the Posey catalog to help select the right device to meet individual patients' needs.

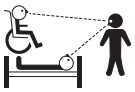
BEFORE APPLYING ANY RESTRAINT:

- Make a complete assessment of the patient to ensure restraint use is appropriate.
- Identify the patient's symptoms and, if possible, remove the cause. You may need to: cater to individual needs and routines; increase rehabilitation and restorative nursing; modify the environment; or increase supervision.
- Use a restraint only when all other options have failed. Use the least restrictive device, for the shortest time, until you find a less restrictive alternative. Patients have the right to be free from restraint.
- Obtain informed consent from the patient or guardian prior to use. Explain the reason for restraint use to the patient and/or guardian to help ensure cooperation.
- A restraint must only be used in accord with the patient's Individualized Care Plan (ICP). The ICP is an assessment by an interdisciplinary team, which may include, but is not limited to: PT, OT, Nursing, the Physician, and Social Services. The ICP should include: restorative nursing; patient release; and pressure sore prevention.

NOTE: Just as patient behavior is not 100% predictable, no product is 100% foolproof. Patient safety requires regular reassessment and monitoring per facility policy. A product that worked in the past may be inappropriate if the patient's mental or physical health status changes. NEVER apply any product that you feel is unsafe. Consult with the proper medical authority if you have questions about patient safety.

⚠ ADDITIONAL WARNINGS:

1. **ALWAYS monitor patient per facility policy. Be aware that constant monitoring may be required for:**
   - Aggressive or agitated patients; and
   - Patients deemed at risk of aspirating their vomit. This includes patients in the supine position, or who are not able to sit up. If the patient vomits, he or she could aspirate the vomit and suffocate.
   - Be prepared to intervene at the first sign of danger. Such patients require frequent review and evaluation of their physical and psychological status.



2. **NEVER alter or repair this product. ALWAYS Inspect before each use:** Check for broken stitches or parts; torn, cut or frayed material; or locks, buckles, or hook and loop fasteners that do not hold securely. DO NOT use soiled or damaged products. Doing so may result in serious injury or death. Dispose of damaged products per facility policy for BIOHAZARDOUS material.

3. **ALWAYS secure straps, to a movable part of the bed or chair frame, out of the patient's reach, using quick-release ties (see drawing below) or buckles.** These allow easy release in the event of an accident or fire. Test to make sure straps cannot tighten, loosen, or slip and create excess slack. If this occurs, the patient may slide off the chair or bed, increasing the risk of serious injury or suffocation. Restraint release is an important part of facility fire and disaster drills. Straps can be cut with scissors in an emergency.
4. **NEVER use Posey products on toilets, or on any chair or furniture that does not allow proper application as directed in the Application Instructions. DO NOT use at home.**

5. **NEVER expose this product to open flame, fire, smoking materials, or high heat sources.** Some products may melt or ignite and burn. The facility smoking/no smoking policy should be strictly enforced.

6. **NEVER use a Posey product as a seat belt in a moving vehicle. Posey products are not designed to withstand the force of a crash or sudden stop.**

LAUNDERING INSTRUCTIONS (if applicable):

- Fasten all buckles and locks to reduce risk of damage during wash and dry cycles. DO NOT put buckles or locks through extractors. For maximum life, launder in a laundry bag.
- Before laundering, zip up and turn the product inside out to protect zipper.
- Hook and loop fasteners may collect lint after repeated use or laundering, reducing grip strength. Fasten the "hook" to the "loop" before laundering to help prevent lint buildup. As needed, use a stiff- bristle brush to remove lint from the "hook" side.
- These products, other than foam products, can be machine washed under CDC* guidelines for material soiled with blood or bodily fluid.

- For non-contaminated material, use lower temperature wash and dry cycles to extend product life.
- For foam products:

⚠WARNING

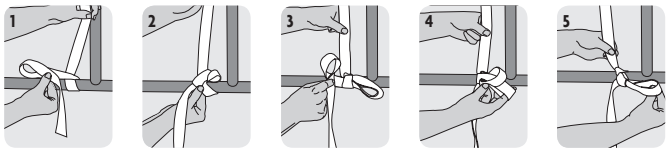
Test Zippers or hook and loop fasteners before each use. DISCARD device if it does not fasten securely.

STORAGE AND HANDLING:

- This device is designed for use in normal indoor environments.
- This device may be stored in ambient warehouse temperatures at normal humidity levels. Avoid excess moisture or high humidity that may damage product materials.

*www.cdc.gov

How to Tie the Posey Quick-Release Tie



1. **Wrap the strap once around a movable part of the bed frame leaving at least an 8" (20 cm) tail. Fold the loose end in half to create a loop and cross it over the other end.**
2. **Insert the folded strap where the straps cross over each other, as if tying a shoelace. Pull on the loop to tighten.**
3. **Fold the loose end in half to create a second loop.**
4. **Insert the second loop into the first loop.**
5. **Pull on the loop to tighten. Test to make sure strap is secure and will not slide in any direction.**
6. **Repeat on other side. Practice quick-release ties to ensure the knot releases with one pull on the loose end of the strap.**

Sizing Table for Posey Products

ALWAYS use the proper size product. Products that are too small or large may compromise patient comfort and could result in severe injury or death.

BINDING COLOR	SIZE	WEIGHT lb. (kg.)	CHEST in. (cm)
White	X-Small	60-115 (27-52)	25-32 (64-81)
Red	Small	112-160 (51-73)	31-37 (79-94)
Green	Medium	135-203 (61-92)	35-40 (89-102)
Yellow	Large	160-225 (73-102)	38-44 (97-112)
Blue	X-Large	180-247 (82-112)	42-48 (107-122)
Black	XX-Large	220-275 (100-125)	46-55 (117-140)
Yellow/Black	XXX-Large	265-305 (120-138)	54-60 (137-152)
Blue/Black	XXXX-Large	295-340 (133-154)	58-64 (147-163)

Posey Belts are not color-coded, but are sized according to this table.
Flame-retardant fabric is available on request.
Patient weight and size are a general indicator only. Consider individual physical characteristics to choose the right product for each patient. Refer to product label for specific sizing information.

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Schiffgraben 41
D-30175 Hannover, Germany

I9200B REV B 092412

Soft Belt 4125C
CHECKLIST

Posey®

Facility		Contact	
Facility Name		Name	
Street Address		Title	
City/State/Zip		Nursing Unit	
Instructor		Date	
Signature			

Description	Competency Level	Date	Comments
Competency Level Definition - (1) Needs remediation and re-evaluation, (2) Performs skill with accuracy under supervision, (3) Performs skill with accuracy independently			
APPLICATION INSTRUCTIONS: 1. Lay the device on the chair with the narrow side to the back of the chair.			
2. Bring the ends of the connecting straps on the narrow end, down behind the chair, and secure out of the patient's reach.			
3. Position the patient as far back in the seat as possible, with the buttocks against the back of the chair.			
4. Bring the wide part of the pelvic holder up between the patient's legs.			
5. Bring the ends of the connecting straps on the wide end, down between the seat and wheelchair sides at a 45-degree angle.			
6. Criss-cross the straps and use quick- release ties to attach the straps to the opposite side kick spurs, out of the patient's reach.			

Rx ONLY

Before use, make sure to read the instructions accompanying the product. A copy of the instruction sheet is included with the product and can also be downloaded at www.posey.com.

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Description	Competency Level	Date	Comments
Competency Level Definition - (1) Needs remediation and re-evaluation, (2) Performs skill with accuracy under supervision, (3) Performs skill with accuracy independently			
7. If the chair has an adjustable seat, secure straps to a movable part of the chair frame, out of the patient's reach.			
8. Check that the straps are secure and will not change position, loosen, or tighten if the patient pulls on them, or if the chair is tilted or adjusted.			
APPLICATION INSTRUCTIONS: **(Plastic Incontinence Shield)** 1. Insert the pelvic straps through the shield starting at the widest part and pull the shield up until it rests on the foam pelvic piece.			

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Soft Limb Restraint Policy

Contents

Purpose/Policy

Staff will maintain patient and others safety involved in the application of soft limb restraint devices approved by the Restraint Monitoring and Approval Group.

Scope

Clinicians and personnel authorised to apply, monitor or review any form of approved restraint, or provide education or training in regard to restraint purposes.

Decision/Authority to use

The decision to apply this restraint must be made by a Clinician - e.g. Registered nurse or Medical Officer.

Definitions

Approved Clinician
A registered nurse or medical officer who meets the requirements for education/training and competency to order to, apply or monitor this type of restraint

Associated documents

Restraint Minimisation and Safe Practice Policy

Monitoring Physical Restraint Form C240330

Use of Restraint Form C240190

CDHB Legal and Quality Manual

Safety First Incident Management System

Authorised Limb holders

The authorised limb holder approved for use in this division is:

The PC WRAPAROUND LIMB HOLDER CT/40
Oracle no. **120265**

These can be obtained by ICU if an area requires a limb holder urgently

Education/Training

Clinicians should be familiar with the CDHB Restraint Minimisation and Safe Practice Policy and Nursing staff should have successfully completed the Restraint Minimisation Self Learning Package via the Health Learn Website.

Clinician staff applying restraints must have read the manufactures instructions on applying the restraint before use.

Assessment to Use

The decision to use soft limb restraint must include a risk assessment which identifies the probability of harm to patient/staff or visitors, and after other interventions or management have failed to maintain a safe environment.

To prevent a patient whose consciousness or cognition is impaired so they are unable to remember or follow instructions to prevent them from interfering with medical equipment which may seriously compromise their safety.

When the patient is confused or disoriented to the degree that he/she is not responsible for safe decision making and may seriously compromise their safety by interfering with medical equipment.

Risk Associated with using this Restraint

- Restricted blood flow to the extremities
- Bruising, damage to skin integrity of the area where strap applied.
- Nerve damage
- Dislocation
- Loss of range of motion movements
- Pressure areas
- Anxiety, agitation
- Loss of dignity

Prior to Use

Minimally, the following should be done and documented in the patient's clinical record:

- An assessment of the patient's physical status, including the condition of the skin and circulatory status.
- Assessment of toileting and hygiene needs and the provision of necessary care to meet these needs.
- Assessment of nutritional and hydration needs and the provision of necessary nutrition and hydration.
- Assessment of comfort needs and the provision of necessary comfort measures.

Consultation should occur with the family/whanau at the earliest opportunity.

Monitoring and Reporting Requirements

Each episode of restraint must be monitored using the Monitoring Physical Restraint Form C240190

Consideration must be given to releasing the restraints to check skin integrity as clinically indicated.

The patient must be repositioned at least two hourly.

The decision to use restraint, assessment, strategies used prior to restraint and consultation of whanau family and other staff must be documented on the Use of Restraint form as per the CDHB Restraint Minimisation and Safe Practice Policy

Ending the Restraint

The episode of restraint ends when the patient is no longer at risk of seriously compromising their safety by interfering with medical equipment or the patient has restored decision-making capacity and elects to have them removed.

After restraint has ceased an:

Evaluation of the episode must be commenced preferably by the clinician who ordered the restraint.

A debriefing session should be offered to the patient/family/whanau and clinical staff who were involved in the restraint. Debriefing should centre on ascertaining the effect of the restraint on individuals and providing support for those affected.

The evaluation is completed on the Use of Restraint form.

Medical review must be completed for any adverse events while the patient is being restrained and an ACC form completed where harm has occurred.

Once the episode of restraint has ended, a copy of the Christchurch Hospital 'Use of Restraint Form' must be faxed to the Nursing Co-ordinator –Quality and Risk, Department of Nursing on 80844 for entry into the Safety First incident management system

Date and time that restraints were discontinued are to be recorded on the 'Use of Restraint Form' and Monitoring Physical Restraint Form

Reviewing the Restraint

At the end of the episode of restraint, an evaluation of the restraint needs to be completed by an approved staff member and documented on the reverse of the Christchurch Hospital 'Use of Restraint Form'. This needs to be completed within 48 hours from the time the restraint was discontinued and then faxed to 80844.

Measurement or evaluation

Biyearly Christchurch Campus Restraint Episode Audits

Safety First review

Policy Owner	Christchurch Campus Restraint Minimisation Committee
Policy Authoriser	Director of Nursing Christchurch Campus
Date of Authorisation	February 2017

Restraint Minimisation and Safe Practice

Table of Contents

Policy

Restraint is a serious clinical intervention used only as a last resort to protect patients/consumers, others, or property, from harm.

The Canterbury DHB (CDHB) will meet the Restraint Minimisation and Safe Practice Standard NZS 8134.2:2008 and all other relevant legislation.

- The CDHB is committed to:
- Reducing the use of all forms of restraint
- Ensuring that all restraint use is clinically justified
- Ensuring restraint occurs for the least amount of time possible

- Ensuring restraint only occurs in a safe and respectful manner under the direction and supervision of the most appropriate Health Professionals

Purpose

To determine CDHB responsibilities and overarching processes in relation to restraint.

Scope/Audience

The restraint of patients/consumers within CDHB Hospital and Specialist Services under the direction and supervision of a CDHB staff member who is registered with an authorising body.

Staff other than health professionals defined above may participate in restraint episodes but only under the direction and supervision of the most appropriate Health Professional.

Associated documents

- CDHB Restraint Minimisation and Safe Practice SharePoint site
  - CDHB Restraint Minimisation and Safe Practice Self Directed Learning Package
  - CDHB Restraint Minimisation and Safe Practice Resource/Guidance
  - CDHB Restraint Minimisation and Safe Practice Responsibilities
  - Older Person's Health and Rehabilitation Restraint Minimisation and Safe Practice Resource
  - Child Health Restraint Minimisation and Safe Practice Self Directed Learning Package
  - NZS 8143.2:2008 Restraint Minimisation and Safe Practice standard
  - Specialist Mental Health Services Restraint and Seclusion policy and procedure
- Psychiatric Services for Elderly and Specialist Mental Health Services Seclusion Observation forms
- Physical Restraint Monitoring forms

Definitions

Restraint

The use of any intervention, by a service provider, that limits a patient's/consumer's normal freedom of movement.

Episode of Restraint

For the purposes of restraint documentation and evaluation, a restraint episode refers to a single restraint event, or, where restraint is used as a planned regular intervention and is identified in the consumer's service delivery plan, a restraint episode may refer to a grouping of restraint events.

Chemical Restraint – PLEASE NOTE Chemical restraint is not condoned by the CDHB and is considered abuse.

The use of medication solely for the purpose of limiting a patient's/consumer's freedom of movement or to render them incapable of resistance is considered chemical restraint.

Categories of Restraint:

Personal Restraint

Where a service provider uses their own body to intentionally limit the movement of a patient/consumer. For example, where a consumer is held by a service provider.

Physical Restraint

Where a service provider uses equipment, devices or furniture that limits the patient's/consumer's normal freedom of movement. For example, where a patient/consumer is unable to independently get out of a chair due to: the design of the chair; the use of a belt; or the position of a table or fixed tray.

Environmental Restraint

Where a service provider intentionally restricts a patient's/consumer's normal access to their environment. For example, where a patient's/consumer's normal access to their environment is intentionally restricted by locking devices on doors or by having their normal means of independent mobility (such as a wheelchair) denied.

Seclusion

Where a patient/consumer is placed alone in a room or area, at any time and for any duration, from which they cannot freely exit.

Seclusion is a specific type of Environmental Restraint and can only be legally implemented for patients/consumers who are under the Mental Health (Compulsory Assessment and Treatment) Act1992 or the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003. Seclusion only occurs in approved and designated seclusion rooms.

Exclusions to this Policy

1. The use of Enablers which are equipment, devices or furniture, voluntarily used by a patient/consumer following appropriate assessment, that limits normal freedom of movement, with the intent of promoting independence, comfort and/or safety.

   Please note: Both enablers and restraint limit a patient's/consumer's normal freedom of movement; it is not the properties of the equipment, device or furniture that determines whether or not it is an enabler or restraint but rather the intent of the intervention and more importantly whether it is voluntarily used by the consumer/patient.

   An enabler can become a restraint if it is not removed when the consumer/patient requests i.e. the enabler ceases to be voluntarily used.
2. Environmental isolation and/or detainment of patients/consumers for infection prevention and control purposes. Refer to the Canterbury DHB intranet for Volume 10, Infection Prevention and Control manual.
3. The restraint of patients/consumers who are prisoners for security purposes. Refer to the Canterbury DHB intranet Volume 11, Patients who are Prisoners policy.
4. The restraint of patients/consumers being transported and subject to specific provisions under The Mental Health (Compulsory Assessment and Treatment) Act 1992 or The Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003.

Clinical Responsibilities

The following are clinical activities and decisions which are to be undertaken by the most appropriate Health Professional/s:

- Undertaking a Restraint Minimisation and Safe Practice Assessment
- Making the decision to use restraint
- Monitoring and documenting the consumer's/patient's health and wellbeing during the restraint episode
- Monitoring the consumer's/patient's ongoing need for restraint and ensuring restraint is used for the least amount of time
- Making the decision to cease using restraint
- Undertaking an evaluation of the restraint episode in collaboration with the patient/consumer, including future options to avoid restraint
- Reporting the restraint episode on the CDHB Incident Management System 'Safety 1st (in services where 'Safety 1st ' is yet to be deployed staff are to report restraint on their

divisional restraint reporting form until such time as Safety 1st is deployed).

- Documenting the restraint episode in Safety 1st and in patient's/consumer's clinical record

Divisional Responsibilities

The following reponsibilites are largely undertaken by the division Restraint Monitoring Committees:

- Maintaining approved Restraint Minimisation and Safe Practice procedures - approval is through the CDHB Restraint Approval and Monitoring Group
- Promoting the intent of the Restraint Minimisation and Safe Standards and CDHB policy
- Monitoring compliance with the Restraint Minimisation and Safe Practice Standard and CDHB policy
- Providing or facilitating approved education appropriate to clinical settings - approval is through the CDHB Restraint Approval and Monitoring Group
- Providing representation on the CDHB Restraint Approval and Monitoring Group
- Monitoring the use of restraint in the division
- Providing bi-annual reports on the use of restraint to the CDHB Restraint Approval and Monitoring Group

Corporate Responsibilities

The following responsibilities are largely undertaken by the CDHB Restraint Approval Monitoring Group and the CDHB Nurse Co-ordinator Restraint Minimisation and Safe Practice

- Organisational-wide restraint Minimisation and Safe Practice policy
- The approval and review of all forms of restraint, restraint education, restraint policy and restraint procedures across the CDHB.
- Maintaining an approved restraints database and 2 yearly review
- Providing Restraint Minimisation and Safe Practice advice and leadership
- Assisting in the review of restraint issues/adverse events
- Ensuring appropriate Restraint Minimisation and Safe Practice guidance is readily available
- Monitoring and Quality review of restraint use

Measurement/Evaluation

- Evaluation of every episode of restraint
- Monitoring of restraint data by the divisional Restraint Monitoring Committees
- Biannual Divisional Restraint Monitoring Committee reports to RAMG
- Biannual reports to the Clinical Board supplied by the Nurse Co-ordinator Restraint Minimisation and Safe Practice on behalf of the Restraint Approval and Monitoring Group
- Safety 1st reports

References

- NZS 8143.2:2008 Restraint Minimisation and Safe Practice standard
- The Mental Health (Compulsory Assessment and Treatment) Act 1992
- The Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003
- Memorandum of Understanding between the Ministry of Justice and the Ministry of Health

Policy Owner	Restraint Approval and Monitoring Group
Policy Authoriser	Chief Medical Officer or Executive Director of Nursing on behalf of Clinical Board
Date of Authorisation	January 2015

Sensory modulation protocol

Purpose

To support staff to use sensory modulation as a treatment modality.

Scope

Clinicians

Students on clinical placement under the supervision of a registered staff member, subject to sensory modulation training.

Definitions

Sensory Modulation is described as the capacity to regulate and organise the degree, intensity, and nature of responses to sensory input in a graded and adaptive manner. This allows the individual to achieve and maintain an optimal range of performance, and adapt to challenges in daily life.

Sensory room: A therapeutic treatment environment that is equipped with sensory based tools which supports the consumer to recognise his/her own individual sensory preferences, thereby aiming to support the individual to be orientated, grounded and safe. Dedicated sensory room equipment needs to remain in the sensory room. Other sensory equipment may be provided for use outside of the room.

Comfort room: A therapeutic environment equipped with a range of furniture and sensory based resources that can be used with safety by the individual in an unsupervised manner. Examples of these are shared lounges, high care areas and outpatient waiting rooms.

Relevant documents

CDHB Infection prevention and control Policy: Decontamination of equipment

SMHS Weighted blanket guidelines

SMHS Advanced Directives guidelines

Personal Safety assessment

Occupational therapy Adolescent/ Adult Sensory Profile Assessment

Treatment plan

Clinical record

Crisis plan

Risk assessment

References

Te Pou o te Whakaaro Nui (2011). Sensory modulation in mental health clinical settings: A review of the literature. Auckland. Te Pou o te Whakaaro Nui.

Champagne, T., Stromberg,N. (2004). Sensory approaches in inpatient psychiatric settings: innovative alternatives. Journal of Psychosocial Nursing and Mental Health Services, 42(9), 34-44

Training

Sensory modulation training is provided by SMHS approved trainers, and is coordinated by the SMHS training unit. Training is given as part of an overall implementation plan to ensure that staff are able to embed sensory modulation into their area.

Staff should be orientated to the use of sensory modulation equipment and designated spaces within the environment.

Equipment often used in sensory modulation

A variety of equipment can assist proprioceptive, vestibular, tactile, olfactory, gustatory, auditory and visual sensory systems. Equipment can include:

- bean bags, rocking chairs, glider rockers
- reading materials
- relaxation and exercise videos
- music for listening to and/or playing
- weighted items, such as lap blankets, full blankets, arm and wrist weights
- therapy balls and exercise bands
- lavender or citrus room spray aromas

Sensory modulation resources will be available 24hrs a day.

Opportunities for the use of sensory modulation

Treatment interventions include:

- educating and supporting the consumer in self-awareness, and developing personal strategies for promoting wellbeing and recovery
- calming during high levels of arousal, distress, or agitation
- alerting or activating during periods of inactivity or low mood
- supporting debriefing of the consumer following a restraint event

Precautions for the use of sensory modulation

Diagnostic considerations include, but are not limited to:

- allergies
- epilepsy and seizure history
- respiratory problems
- cardiac problems
- muscular-skeletal conditions
- medication changes or side effects
- pregnancy
- breastfeeding
- trauma history
- environmental responses (e.g lighting, background noise)

Use of sensory modulation equipment

An Occupational Therapist can provide guidance in the use of sensory modalities.

Staff must follow the guidelines in the use of weighted blankets prior to use.

When using essential oils, consider other consumers nearby as they may not be able to tolerate essential oils, and may cause distress or increased agitation.

Infection prevention and control cleaning procedures (CDHB policy: Decontamination of equipment) must be followed after use of equipment.

Sensory rooms

The sensory room is a treatment space, and must remain locked when not in use. Where therapeutically indicated a sensory room may have a dual function as a comfort space. A comfort space may be left unlocked if the environment is organised to be risk neutral.

The staff member responsible for unlocking the room is responsible for ensuring it is returned to its neutral state following use.

Sensory rooms should have facility for observation.

Each use of the room should be time limited and should be used within a timeframe of approximately 30 mins.

The room is available for individual or small group sessions.

Trained staff must initially supervise the consumer using the room. In some instances the consumer may eventually be able to use the room unsupervised, if this is indicated by the treatment plan.

Before using the room:

- the consumer must be fully orientated to the space and function of the equipment by a trained clinician
- a sensory assessment or profile must be completed by the clinician. The assessment or profile must be documented on the consumer's clinical file and be part of his/her treatment plan.

Procedure

1. The use of sensory modulation for the consumer should be reflected in the treatment plan, crisis plan, personal safety assessment and risk assessment for the individual. These should be regularly reviewed, along with the consumers advance directives.
2. Identify the level of arousal of the individual.
3. Use clinical judgement to determine which sensory modalities are safe to use at the time of intervention.
4. Discuss with consumer directly what is helpful to him/her.
5. Use clinical judgement to decide whether to remain in the room/space with the consumer.
6. Upon completion of activities encourage the consumer to reflect on what was useful (using the 'I have tried it' tool if appropriate).
7. Following each session document in the consumer's clinical notes. This must include what items were used, and the observed or reported effect.
8. Update treatment plan, crisis plan, personal safety assessment and risk assessment as required.

Restraint Minimisation and Safe Practice policy

Policy

The use of restraint is actively minimised in Specialist Mental Health Service (SMHS).

Where restraint is practiced, safe forms of assessment and treatment are emphasised, and all episodes are evaluated and monitored as part of a quality review process.

Purpose

To outline procedures that support the reduction of restraint use and to encourage use of least restrictive practices in SMHS.

Definitions

Restraint (as defined in NZS 8134:2008) is the use of any intervention by a staff member that limits a consumer's normal freedom of movement.

Personal restraint. Where a staff member uses their body to intentionally limit the movement of a consumer. For example where a consumer is held by a staff member.

Physical restraint. Where a staff member uses equipment, devices and furniture that limits the normal freedom of movement. For example where a consumer is unable to independently get out of a chair due to: the design of the chair, the use of a belt, or the position of a table or a fixed tray.

Environmental restraint. Where the staff member intentionally restricts a consumer's normal access to their environment. For example, locking devices on doors or denying their normal means or independent mobility (wheelchair).

Seclusion: Where a consumer is placed alone in a designated seclusion room, at any time and for any duration, from which they cannot freely exit.

Scope

All clinical staff

Relevant documentation

Legislation, standards and guidelines

Health and Disability Services, (Restraint Minimisation and Safe Practice) Standards NZS 8134.2:2008: section 2.1-2.3

Mental Health (CAT) Act 1992

Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003

Canterbury DHB policy and documents

Canterbury DHB Restraint Minimisation and Safe Practice policy

Speciality Mental Health Services

SMHS Restraint Minimisation Committee (RMC) Terms of Reference

Safety1st Restraint Register event

Safety1st Restraint Register report

Safety1st Behaviour & Safety form

Approval of forms of restraint

All forms of restraint used in SMHS and the associated procedures must be approved by the Canterbury DHB Restraint Approval and Monitoring Group (RAMG) following SMHS RMC recommendation. All approvals will be reviewed and renewed two yearly.

The following forms of restraint are approved for use in SMHS:

- Environmental restraint (Locking doors of open units)
- Seclusion
- Personal restraint: as per the approved Safe Practice and Effective Communication (SPEC) training

General restraint minimisation protocols

Assessment

Prior to using any restraint a thorough clinical assessment must occur. This includes:

- the consumer's current physical condition
- any known or possible medical disorders
- any contraindications or increased risk to the consumer
- any trauma related history.
- underlying causes, triggers or unmet need contributing to or driving the relevant behaviour

Attempts at less restrictive approaches

Less restrictive interventions will be attempted first, with restraint used only as last resort.

Examples of possible interventions include:

- Responding to underlying causes, triggers or unmet needs;
- Communication and De-escalation
- Family/whanau or carer involvement;
- Cultural Support;
- Sensory Modulation
- Use of the Personal Sensory Assessment

Legal issues

The legal status of the person being restrained must be known. Only people who are deemed patients under the Mental Health (Comulsory Assessment and Treatment) Act 1992 can be restrained. Voluntary patients who require restraint in emergency situations must have section 111 of the Mental Health Act actioned before restraint occurs.

Parental consent must be obtained for restraint on minors. Restraint may be used in children under 12 without invoking the Mental Health Act; however if seclusion is indicated for children, the Mental Health Act must be invoked.

During Restraint

Restraint will be used safely and respectfully and for the least amount of time possible.

During the restraint, the health and wellbeing of the consumer will be closely obsesrved as per SPEC training in order to detect and immediately cease the restraint in response to any signs of physical or mental distress.

Following restraint

Ensure the consumer's support and debriefing needs are appropriately met and documented in the clinical file.

Each episode of restraint must be evaluated as soon as possible following the episode ending with the restraint team and other staff involved. A review by the multi-disciplinary team (MDT) must be undertaken on the same day where possible. If after hours an MDT review must occur on the week day following the episode.

Wherever possible, participation of the consumer, their whanau/family/ carer, advocate, cultural advisor and Pukenga Atawhai (if appropriate) will be sought. If not involved, the reason should be noted.

Evaluation of restraints must include:

- Underlying causes and/or triggers of the patient behaviours that led to the restraint
- Atempted de-escalation strategies
- Other de-escalation strategies that could have bene used.
- Impact of the restraint episode on the consumer and other consumers on the unit, including whether appropriate advocacy/support was provided or facilitated;
- Appropriateness of the decision to use restraint.
- Safety, efficacy and effectiveness of interventions/and whether monitoring was adequate and maintained the safety of the consumer.
- Impact on staff
- Support needs of staff.
- Adherence to policy and procedure.
- Team practice and training issues.

The evaluation, with participation or information from the consumer and their whanau, family, or carer, informs the review and update of the consumer's treatment plan by the clinical team.

Documenting and Reporting restraint

Any clinician involved with restraints must document episodes in both consumer's clinical files and in the Safety 1st Incident Management system, and ensuring all restraint team members are identified.

Reporting and documenting episodes of restraint informs the consumers clinical record and enables monitoring and quality review of:

- The form of restraint used, the clinical indications and alternate interventions attempted, as well as any departures from the treatment plan (both helpful, and ineffective).
- The consumer's condition before, during and after the restraint episode.
- Any significant communication with the consumer, their whanau, family or carer, their advocate, or relevant others, detailing any verbal or written information given.
- Findings from consumer debriefing and evaluation.
- Any adverse outcomes associated with the restraint, and any incidents involving use of unapproved techniques must be reported.
- The Charge Nurse Manager or Clinical Team Co-ordinator or Duty Nurse Manager after hours must be informed of restraint episodes.

Restraint education

Clinical staff and authorisers will maintain an awareness of Restraint Minimisation and Safe Practice Standards, Canterbury DHB and SMHS restraint related policies, and best practice.

All staff that use restraint will be trained in the safe and appropriate use of restraint. This is taught through a four day *Safe Practice, Effective Communication* (*SPEC*), a course that is underpinned by least restrictive practice. *SPEC* focusses on communication and de-escalation skills training, as well as teaching breakaway techniques and standardised flexion-free restraint holds. Staff that use restraint must attend annual one day refresher course once they have received initial training.

A record of staff member's attendance will be maintained. Staff members and their managers must be aware of their training status, and be proactive in scheduling training.

The Training Unit will review the programme of restraint training in line with the National Directors of Mental Health Nursing Governence group two yearly.

Monitoring restraint trends

Restraint register

The divisional restraint register for SMHS is held within the Safety1st incident management system. Each new restraint event is added to the divisional register. The register is able to be accessed by senior clinicians and managers from each area enabling them to monitor and evaluate current restraint use in their area.

A monthly summary of seclusion usage is reported to Service Leadership Teams (SLT), for discussion at service level. SLTs report back to the Divisional Leadership Team .

Restraint Audit

All Restraint events are audited by units' Clinical Nurse Specialists and areas' Nurse Consultants. Nurse Consultants will audit and close the restraint register event in the Safety 1st incident management system. This ensures that every restraint event is independently examined to

ensure a focus on both quality of documentation and best practice. Each month the closure of a sample group of restraint register forms is audited by the Nurse Consultant and the areas Consumer Advisor. The results are then reported to the SMHS RMC group and the CDHB Restraint Approval and Monitoring Group.

SMHS involvement in reviews

SMHS will work to ensure that processes are consistent with other District Health Boards by participating in reviews when initiated.