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15 December 2017

Health Sector Workers Network
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Response to your request for official information

Dear Health Sector Workers Network

Thank you for your request for official information received 11 December 2017 by Nelson Marlborough Health (NMH)[1] where you seek the following information (enumerated for ease of reference). Please see our response directly below each of your questions.

1. ***Can you please provide all policy documents relating to restraint practices at Nelson/Marlborough DHB?***

Please see attached NMH *Restraint Minimisation and Safe Practice* policy, and NMH *Using Restraint / Enablers: Safe Practice* Procedure.

2. ***Are there instances in the last year (June 2016 to June 2017) of the use of mechanical restraints? (i.e. strapping arms to bed) this is also referred to as physical restraint.***

Mechanical restraints are not approved for use in NMH facilities.

3. ***Can you please provide this data for both physical and mental health services and identify the service associated with this data?***

Our restraint coordinator has confirmed that the above mentioned NMH policy and procedure apply to both physical and mental health service, noting that policies / procedures relating to seclusion are specific to mental health services only.

This data should be recorded in a Restraint Register and specify the type of restraint used (ie wrist strap) and the start and finish times of each individual mechanical/physical restraint. Obviously the presentation of this data should be anonymised for the protection of privacy.

As mechanical restraints are not an NMH approved form of restraint there are no related entries of restraint in the *Safety 1st* incident management system.

[1] Nelson Marlborough District Health Board

This response has been provided under the Official Information Act 1982. You have the right to seek an investigation by the Ombudsman of this decision. Information about how to make a complaint is available at www.ombudsman.parliament.nz or freephone 0800 802 602.

If you wish to discuss this decision with us, please feel free to contact Maree Nevill, OIA Coordinator at maree.nevill@nmdhb.govt.nz or phone 03 546 1522.

Yours sincerely

Eric Sinclair
Acting Chief Executive

Restraint Minimisation and Safe Practice

Purpose

The purpose of this policy is to ensure that in all Nelson Marlborough District Health Board (NMDHB) services:

- any use of restraint is minimised, planned and managed
- any use of enablers is authorised by the organisation, in line with current best practice and appropriately assessed and evaluated with regard for the safety, personal dignity, cultural, ethical and legal issues for health consumers.

Scope

This policy is for all NMDHB staff involved in situations where restraint of any type may be required or where approved enablers are in use. It is intended to be used in conjunction with the Using *Restraint and Enablers Safe Practice* procedure document.

Policy Statement

NMDHB undertakes to ensure:

1. That its services use restraint only :
    - as a last resort when other interventions have been unsuccessful
    - employing least restrictive options
    - employing approved methods of restraint
    - as a short-term safety measure
    - in appropriate circumstances and by appropriately-trained staff members
    - in ways that minimize adverse outcomes for the consumer, while protecting the safety, dignity, cultural needs and legal rights of all persons involved
2. That its services use enablers only:
    - following appropriate assessment and approval
    - in approved circumstances
    - with the informed consent of the consumer (refer to NMDHB Policies: Informed consent)

When this Policy does not apply

This policy does not apply where restraint is required by law for general safety reasons (e.g. the use of seat belts in cars and vans).

Definitions - Overview

Historically there has been widespread confusion regarding the difference between restraints and enablers and other terminology relating to restraint.

Enablers

- Enablers are devices, environmental features, furniture or items of equipment voluntarily used by a consumer following appropriate assessment and approval , that limit the normal freedom of movement with the intent of promoting independence, comfort and/or safety.
- For example, a consumer may voluntarily use:

- raised bedsides to assist their mobility in bed, to aid in the positioning of pillows for comfort or to prevent them falling from the bed
- a fixed tray in front of their chair to assist them to have a meal independently.
- 'time out' in an unlocked room or area where they are separated from others and from which they are not prevented from leaving. Timeout should be used for a limited time and with the intention of enabling the consumer to self soothe and regain control

- The use of enablers shall be:
  - approved by Restraint Advisory Group
  - voluntary and used with informed consent (refer to NMDHB Policies: Informed consent)
  - the least restrictive option to meet the needs of the consumer
  - implemented with the intention of promoting or maintaining consumer independence and safety.

Restraint

Restraint of a health consumer is an intervention that requires a clinical rationale, and is regarded as the last intervention when all other clinical interventions and calming/defusing strategies have been unsucessful.

Restraint is a short-term technique used to safely *manage,* rather than *modify*, safety issues related to behaviour, and is used in a *non-aversive* manner - that is, in ways that minimise distress, pain, or any sense of being penalised, in the person whose behaviour is being managed. As such, it should not be used as a threat to manage behaviour.

There are several types of restraints:

Environmental Restraint

Where a service provider intentionally restricts a consumers normal access to their environment, For example, where a consumers 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.

Personal Restraint

Where a service provider uses their own body to intentionally limit the movement of a consumer - e.g. where a consumer is held by a service provider.

Physical Restraint

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

Psychosocial /social restraint

Where a service provider uses "power control" strategies to manage a consumers behaviour – e.g. service user are being told to stay in their bedroom until told they can leave or where a service provider withdraws "privileges' such as activities and items as a consequence for non-compliance or threatens to do so

Seclusion

Where a consumer is placed alone in a room or area; at any time and for any duration, from which they cannot freely exit. It is a specific type of environmental restraint and can only be legally implemented for consumers who are under the Mental Health (Assessment and Treatment) Act (1992) or the Intellectual Disability Care and Rehabilitation Act (2003). Seclusion can only occur in approved and designated seclusion rooms.

Seclusion is not to be used as a component of a consumer's care plan, to modify unwanted behaviour. Seclusion may only be used to manage safety.

Restraint Episode

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

Definitions - Other

Chemical Restraint

The use of medication solely to ensure compliance and to render a person incapable of resistance. Such use of medication without a treatment objective, is not supported by the Standard and is not approved in NMDHB services.

The appropriate, prescribed use of medications to enable treatment is not classified or defined by the Standard as restraint.

Duty of Care

The duty to "take reasonable care to avoid acts or omissions which you can reasonably foresee would be likely to injure your neighbour".[(1)]

For the health professional, the 'neighbour' is usually the consumer, but professional accountability may include other consumers, colleagues, employers and the public generally.

Least restrictive option

That which keeps a consumer safe while restricting their rights and freedoms as little as possible.

The New Zealand Standard

NMDHB is subject to the requirements of the NZ Standard 8134.2:2008, *Health and Disability Services (Restraint Minimisation and Safe Practice) Standards* ("the Standard"). The information in this policy is intended only as a reference to the more detailed requirements of the Standard, and to specific procedures covered in training, which, while meeting the Standard, may differ from service to service.

Organisational Compliance with the Standard

Compliance with the Standard is ensured by the establishment and maintenance of a Restraint Advisory Group and the appointment of a NMDHB-wide Restraint Coordinator.

Role of the Restraint Advisory Group

The Restraint Advisory Group is responsible for ensuring ongoing compliance with of the Standard. The tasks of the Restraint Advisory Group include:

- Identification of training and education needs related to restraint minimization and safe practice within specific areas.
- Approval of restraint techniques and training which meet the requirements of the Standard. The approved techniques and training are listed in NMDHB *Restraint Inventory.*
- Approval of the use of enablers. The approved enablers are listed in NMDHB *Enabler Inventory*
- Review of instances of the use of restraint and seclusion (see *Restraint Register and Seclusion Reports).*

The Restraint Advisory Group is required to meet not less than 6-monthly and includes workplace representatives who are receive training and ongoing support for this role from the *Restraint Coordinator* . See Restraint Advisory Group *Terms of reference* for membership

Role of the Restraint Coordinator

The primary objective of the Restraint Coordinator position is to oversee all NMDHB systems and processes associated with the use restraint and its minimisation, in conjunction with the Restraint Advisory Group, in order to ensure that NMDHB services meet the requirements the *Restraint Minimisation and Safe Practice* Standard.

Refer to the job description for the Associate Director of Nursing – Mental Health, for further details.

References

- Lord Atkin's 1932 judgement in Donoghue v Stevenson (frequently and currently cited in discussions on Duty of Care).
- NZS 8134.2.1:2008 Health and Disability Services (Restraint Minimisation and Safe Practice) Standards – Restraint Minimisation. Standards New Zealand, 2008.
- NZS 8134.2.2:2008 Health and Disability Services (Restraint Minimisation and Safe Practice) Standards – Safe Restraint Practice. Standards New Zealand, 2008.
- NZS 8134.2.3:2008 Health and Disability Services (Restraint Minimisation and Safe Practice) Standards – Seclusion - Standards New Zealand, 2008
- Seclusion in New Zealand Mental Health Services - Mental Health Commission, April 2004.
- Six Core Strategies Checklist: NZ adaption – Te Pou, 2013
- Towards restraint – free mental health practice: Supporting the reduction and prevention of personal restraint in mental health inpatient settings – Te Pou 2015

Associated Documents

NMDHB documents:

- NMDHB Approved Enabler Inventory
- NMDHB Approved Restraint Inventory
- NMDHB Policies : Falls prevention and management
- NMDHB Policies: Informed consent
- NMDHB Policies: Use of seclusion
- NMDHB Procedures: Using restraint and enablers
- NMDHB Procedures: Procedure for use of enabler
- NMDHB Restraint or enabler approval form
- NMDHB Restraint or enabler approval process flow chart
- *Restraint Advisory Group* Terms of Reference 2015
- *Restraint Coordinator* Position Description (with in ADON – MH position description 2014)

Using Restraint / Enablers: Safe practice

Purpose

The purpose of this procedure is to ensure:

- Any use of restraint is consistent with NMDHB policy: Restraint Minimisation and safe practice
- Any use of enablers is consistent with NMDHB policy: Restraint Minimisation and safe practice

Scope

This procedure is for all NMDHB staff involved in situations where restraint of any type or use of enablers may be required.

Definitions

See NMDHB Policy: Restraint Minimisation and safe practice

Restraint

Prior to the use of restraint:

Before any planned or proposed episode of restraint, clinical staff should consider the following points:

- possible alternative interventions/strategies
- consumer's physical and psychological health, gender, age and culture
- consumer's legal status and its implications
- consumer's Care Plan/Recovery Plan/Individual Lifestyle Plan directives
- degree of risk to the consumer, staff and the environment
- the experience of the individual undergoing restraint and the possible effects of restraint on the therapeutic relationship
- possibility of inappropriate behaviours being reinforced by the use of restraint
- desired outcome and criteria for ending restraint.

Indications for the use of restraint:

The use of planned restraint strategies is indicated:

- when an individual's behaviour indicates that they are seriously at risk of harm to self or others
- when all other alternatives have been attempted and proven to be unsuccessful
- when it is necessary to give a planned, prescribed treatment to an individual who is resisting and there is a legal "Duty of Care"[1] justification, and all other clinical interventions or calming/defusing strategies have failed
- when there are sufficient, appropriately trained personnel available to execute a restraint technique safely.

During the use of restraint:

During a restraint episode, the psychological and physical safety and wellbeing of both consumer and staff are to be subject to ongoing assessment and observation.

- In the event of a third party called to assist e.g. HCAs, orderlies, security or police the responsibility for the ongoing assessment, observation and care of consumer during the restraint lies with the team who called for assistance
- The frequency and level of observation and assessment is required to be appropriate to the level of risk associated with the restraint procedure and the setting in which it is occurring (HDSS 2008)

Cultural needs

Criterion 2.2.1(f) requires that culturally safe practice is maintained. A commitment to culturally safe practice is maintained by the Restraint Advisory Group and includes:

- Input from the office of General Manager: Maori Health and Whanau Ora including reviewing of training packages and related policies and procedures
- Input from a consumer representative or advisor including reviewing of training packages and related policies and procedures

Ending a restraint episode

- Restraint should cease at the earliest safe opportunity.
- Both consumers and staff involved in a restraint event should be debriefed, this being recorded on the online reportable event system and in the consumer's Clinical Record.
- Debriefing should be extended to include significant others (e.g. family, witnesses) when indicated. If a consumer is under the age of 18 family or designated representative need to be notified of restraint and given an opportunity to debrief.
- As part of a consumer debrief, advance directives should be considered if information learned at the debrief could prevent a future occurrence of the need for restraint.

As part of a staff debrief, further training and/or review of procedures should be considered if an adverse event occurred, such as a staff injury, or if there were any issues with how the restraint episode was conducted

Reporting a restraint episode

The use of restraint is considered an adverse event and requires reporting and investigating.

- Any episode of restraint as outlined in this procedure including seclusion is to be reported on the *Restraint Register* via the online reportable events system
- In the event of a third party being called to assist e.g. HCAs, orderlies, security, police the responsibility for reporting lies with the team who called for assistance.

Investigation and Review of restraint episodes

Each reported episode of restraint is investigated and reviewed within the area or team in which it occurred. This process includes:

- Staff members involved
- Coordinator/Team leader or equivalent person as designated by manager

Following investigation and review, the Coordinator/Team leader completes the Restraint management component of online register.

- Any required actions resulting from the review are actioned by the appropriate persons and recorded as a departmental or area-specific Quality Improvement activity.
- It is recommended that the general use of restraint and seclusion within a specific area is discussed at team meetings.
- The use of restraint is an adverse event and requires open disclosure to families/ guardians (refer: NMDHB Policy: Open Disclosure).

Restraint Register

NMDHB maintains a *Restraint Register* via its online reportable events system

- All restraint episodes are monitored by Restraint Coordinator via online reporting system. Suggestions and recommendations are communicated to team leader/ coordinator as necessary.
- The Director of Area Mental Health Services and District Inspectors (for consumers detained under the Mental Health Compulsory Assessment and Treatment Act (1992)) receives notification of the use of seclusion.
- Summaries of restraint episodes are reviewed quarterly by the *Restraint Advisory Group.*

Restraint Inventory

NMDHB will maintain an Approved *Restraint Inventory* listing approved restraint training, techniques and instructors.

- Only restraint training approved by the Restraint Advisory Group will be listed. No other restraint types, methods or techniques will be used in NMDHB services
- Only restraints techniques approved by the Restraint Advisory Group will be listed. No other restraint types, methods or techniques will be used in NMDHB services.
- Only instructors approved by Restraint Advisory Group will provide training
- The *Restraint Inventory* will be updated and reviewed annually by the Restraint Advisory Group.

Enablers

NMDHB will maintain an *Approved Enabler Inventory*

Enabler approval process

Approval for the use of enablers is required

- Prior to the general use of an enabler in a particular area (e.g bed rails used in Medical Unit)
- Prior to the use of a specific enabler with a specific client

To gain approval for the use of an enabler the *Enabler Approval Process* is followed and *Enabler Approval Form* is completed. These are available from the *Restraint Coordinator*

Requests for the use of enablers within the NMDHB are approved by the Restraint Advisory Group

Enabler use

- Each area / unit will have its own list of Approved Enablers.
- These enablers will be reviewed annually by the Restraint Advisory Group.
- Use of Approved Enablers will be in line with current best practice evidence and will include a specific procedure document providing guidance for use of a specific enabler.
- Informed Consent for the use of enablers is documented in the consumer's Clinical Record (refer to NMDHB Policies: Informed consent).

Reporting and recording enabler use

- The use of enablers with individual health consumers will be recorded in their assessment, Care Plan and Clinical Record.
- The use of enablers with individuals will be reviewed and evaluated regularly, in line with relevant best practice for the particular practice setting.
- If the above conditions are met, there is no requirement to report the use of enablers as a reportable event.

References

1 Lord Atkin's 1932 judgement in *Donoghue v Stevenson* (frequently and currently cited in discussions on *Duty of Care).*

- NZS 8134.2.1:2008 Health and Disability Services (Restraint Minimisation and Safe Practice) Standards – Restraint Minimisation. Standards New Zealand, 2008.
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