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Restraint minimisation and safe practice

Related documents

C&C DHB policies:

- *Use of seclusion* (Mental Health Services) – Staff to read in conjunction with this policy
- *Physical restraint* (Mental Health Services) – Staff to read in conjunction with this policy
- *Standard precautions*
- *Informed consent*
- *Reportable Events*
- *Security*
- *Maori Health Policy*
- *Cultural safety*

Restraint minimisation philosophy

C&C DHB is committed to the philosophy of reducing restraint in all its forms through encouraging the use of least restrictive practices allowing consumers to receive and experience services in the least restrictive manner

Restraint of a consumer is a serious intervention that requires clinical rationale and oversight. It must not be undertaken lightly and **should be considered only after exhaustion of other interventions** in a clinical setting, ie. de-escalation. Restraint should be applied only to enhance or maintain the safety of consumers, staff, or others.

Policy

Restraint is the use of any intervention that limits a consumer's normal freedom of movement.

Restraint should be perceived in the wider context of risk management and in itself is one of a number of strategies used by staff to limit or eliminate clinical risk and it is expected that:

- C&C DHB employees practice is guided by ethical principles that include the use of least restrictive practices; acting for the consumers good; avoiding harm to the consumer and respecting the dignity of the consumer and the consumers' rights.

- C&C DHB employees promote the interests, safety and well being of all involved

- C&C DHB employees follow specific restraint processes including approval , assessment, safe restraint use , evaluation, monitoring and quality review

Scope

All C&C DHB staff

For Mental Health Services and Intellectual Disability Services staff, this policy must be read in conjunction with the Mental Health Services Seclusion Policy.

This policy does not include the restraint of relatives or visitors (see C&C DHB policy, *Security*).

Definitions

Consumer

A person who uses/receives a health or disability service

Detention

The refusal to allow a person to leave.

De-escalation

A complex interactive process which the highly aroused consumer is redirected from an unsafe course of action towards a supported and calmer emotional state. This usually occurs through timely, appropriate and effective interventions and is achieved by using skills and practicable alternatives.

Enablers

Equipment, devices or furniture voluntarily used by a consumer following appropriate assessment that limits normal freedom of movement, with the intent of promoting independence, comfort and/or safety.

Interdisciplinary

A group of individuals with diverse training and backgrounds who work together collaboratively as an identified group to solve consumer problems that are too complex to be solved by one discipline or many disciplines in sequence.

Line Manager

For the purpose of this document the term ‘Line Manager’ is used to describe the person(s) with line management responsibilities for the area concerned i.e. the Manager, Team, Service or Clinical Leader and the Duty Manager after-hours.

Restraint

The use of any intervention by a service provider that limits a consumer’s freedom of movement.

(For interventions that limit a consumers freedom of movement voluntarily see definition of Enablers)

Personal restraint

Where a service provider uses their own body to intentionally limit the movement of a 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 consumers normal freedom of movement. For example where a consumer is unable to independently get out of a chair, the use of a belt, or the position of a table or fixed tray

Environmental restraint

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

Safe holding

Safe holding is the positioning of the child so that a procedure can be carried out in a safe and controlled manner, wherever possible it is with the consent of the child and parent/carer. Therefore, safe holding is set within the context of appropriate assessment and management of the child's needs.

Safe holding also includes immobilisation, which may be by splinting or by using limited force. It is the positioning and holding of an infant or child so that a medical procedure can be carried out in a safe and controlled manner. It is the method of helping children, with their permission, to manage a painful procedure quickly and effectively. Holding is distinguished from restraint by the degree of force required and the intention (refer to *Appendix 2*).

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

Indications

Legal obligations

- Every mentally competent adult has the right to determine what is done to his/her own body.
- The right to choose is absolute.
- All consumers have the right to refuse medical treatment under S11 NZ Bill of Rights Act 1990. That fact justifies the need to obtain consent from the consumer.

- The failure to obtain consent in situations where consent should have been obtained can result in common law claims of trespass to the person i.e. assault and battery, and sometimes false imprisonment.

Restraining the consumer without satisfactory justification would amount to false imprisonment and litigation against the hospital for damages could ensue.

NZ Bill of Rights Act 1990 (section 23)

A person compulsorily detained under any statute has rights under the NZ Bill of Rights Act. These rights include but are not limited to the right:

- to be informed of the reason for detention
- to consult a lawyer and to be informed of that right
- to have the validity of the detention determined without delay
- to be treated with humanity and respect.

The Code of Health and Disability Services Consumers' Rights 1996

Right 2: Right to freedom from Discrimination

- Every consumer has the right to be free from discrimination on the grounds of age, gender, race, beliefs, marital or family status, employment, sexual orientation or disability; and

- Services should be delivered without coercion, harassment or any form of exploitation.

Right 3: Right to Dignity and Independence

- Services should be provided in a way that respects the dignity and independence of the individual

Legislation specifically related to restraint:

Criminal Procedure (Mentally Impaired Persons) Act 2003 sections 23; 24; 25; 34; 35; 38; 44

Mental Health (Compulsory Assessment & Treatment) Act (MHA), 1992, has specific powers to detain patients or proposed patients under the MHA.

Crimes Act, 1961, Sections 41,48, 62, 155, 156 and 157

Section 41 Prevention of suicide or certain offences –

Everyone is justified in using such force as may be reasonable and necessary in order to prevent the commission of suicide or commission of an offence which would be likely to cause immediate and serious injury to the person or property of any one, or in order to prevent any act being done which he believes, on reasonable grounds, would, if committed, amount to suicide or to any such offence.

Section 48 Self-defence and defence of another –

Everyone is justified in using, in defence of themselves or another, such force as, in the circumstances as they believe them to be reasonable to use**.**

Section 62 Excess of force -

Everyone authorised by law to use force, is criminally responsible for any excess, according to the nature and quality of the act that constitutes the excess.

Section 151 Duty to Provide the Necessities of Life

Everyone who has charge of any other person is under the legal duty to supply that person with the necessaries of life.

Section 157 Duty to Avoid Omissions Dangerous to Life

Everyone who undertakes to do any act, the omission of which may be dangerous to life, is under a legal duty to do that act.

Guidelines: Safe restraint practice

Personal restraint for problem behaviour

Where a service provider uses their own body to intentionally limit the movement of a consumer. A decision to initiate personal restraint may be made where there is immediate and/or imminent danger to the safety of the patient, staff or others, or when restraint is considered necessary for the purpose of administering a particular treatment.

The decision to initiate personal restraint should be made by either the clinician with the patient at the time of the incident, or the Consultant, RMO or Nurse in charge at the time.

Physical restraint for problem behaviour

Where a service provider uses equipment, devices or furniture that limits normal freedom of movement. For example, where a consumers normal access to their environment is intentionally restricted by having their normal means of independent mobility denied.

Physical restraint may be appropriate when an individual exhibits serious and on-going self-mutilatory behaviour e.g. use of hand cuffs. This type of restraint should only be used after clarifying the legal basis for restraint as a treatment procedure.

Record of this restraint must be kept in the restraint register. Restraint forms may be used or a more detailed management plan may be developed that includes the minimum information required on the restraint form.

Enablers

Equipment, devices or furniture, voluntarily used by a consumer following appropriate assessment, that limits normal freedom of movement, with the intent of promoting

independence, comfort and/or safety . For example lap safety belts used by individual wheelchair users to minimise the risk of them falling.

The use of enablers is documented in the individual's care plan / clinical record. The equipment used, the application of enablers and the clinical practices associated with these, are approved by the Service Restraint Approval Group. **A restraint form does not need to be completed for this form of restraint.**

Roles and responsibilities

Restraint Approval Group

C&C DHB will have a Restraint Approval Group (RAG) that will meet at least once every year (and more frequently if required). The terms of reference for this group are as follows:

- reports to the HHS C&C DHB Clinical Governance
- endorses restraint techniques
- reviews restraint trends and use of restraint usage at regular intervals in order to validate the appropriateness of techniques, ensure safety and identify alternative interventions
- updates Restraint Register
- reviews the C&C DHB restraint, minimisation and safe practice policy
- reviews the policy education, types of restraint training and implementation
- considers, monitors and approves methods of restraints commonly used in each service (both personal and physical).

The RAG will comprise of health professionals from various disciplines, including, but not restricted to:

- Medical
- Nursing
- Quality
- Mental Health
- Allied health professions
- consumer representation

Service Restraint Approval Group

- Identifies the types of restraints being used by clinicians in the service.
- Completes and maintains the Restraint Register.
- Submits the Restraint Register for endorsement to the Restraint Approval Group on an annual basis.
- Makes recommendations to the Restraint Approval Group on matters pertaining to restraint, eg. resourcing and training issues.
- Maintains a register of clinicians that are competent in using de-escalation techniques and the safe use of restraint.
- Can be a separate group or incorporated into the service quality group, risk management group – see terms of reference.

Restraint Training Co-ordinator

An appropriately skilled service provider who is responsible for ensuring that the New Zealand Standard *Restraint Minimisation and Safe Practice* (NZS 8134.0:2008) training is met.

Procedure: Safe restraint practice

Personal restraint and Physical restraint

Indications

Restraint may be appropriate when:

- there is legal basis for treatment **AND**
- the use of personal restraint is not possible or unrealistic **AND**
- a patient's behaviour indicates that he/she is a danger to self or others, eg. when a patient:
  - makes a serious attempt or act of self-harm
  - seriously compromises therapeutic environment
  - is violent and seriously damages property
  - is resisting necessary, planned, prescribed, essential treatment.

If an individual is in possession of a weapon:

- **Staff safety is paramount.**
- **Never** commence restraint if there is **significant** risk (all restraint is risk).
- **Stay calm.**
- **Dial – 777**, state 'security emergency' (refer to *Emergency procedure flip chart*).

Infection control

When restraining a consumer use Standard Precautions relating to blood, body fluid exposure.

Observation and care

- Any person undergoing restraint requires intensive assessment and continuous observation which reflects current accepted good practice. The frequency and level of observation and care during restraint should be appropriate to the level of risk associated with the procedure and setting in which this occurs.

Physical care

Personal restraint	*Physical restraint*
• Consumer's airway, pulse, skin colour (presence of cyanosis) • Bleeding • Other physical injuries or discomfort • Appropriate neurological observations	When a consumer is immobilised, the following must be assessed: • the extremities of any limbs mechanically restrained must be regularly assessed for signs of restricted blood flow (ask the patient about his/her comfort) • pressure area assessment and care should be taken with those body areas most at risk (eg. sacrum, heels, elbows) • great care must also be taken when physical restraints are used to restrict the torso (such restraint should pass across the ischial tuberosities and not allowed to move up to the abdomen and chest) • physically restrained limbs must be exercised at least two-hourly • special attention must be paid to providing opportunities for the patient to take food and drink and to void bladder and bowels • a range of motions should be carried out on restrained limbs to prevent cramp or loss of circulation (skin care to restrained limbs).

Psychological care

Assess:

- General mental state, including general assessment of alertness.
- Response to the physical or personal restraint event.

Communication

During the use of the physical or personal restraint, continuously communicate with the patient (if possible) the team members and significant others present.

Communicate (if possible) with the restrained patient, explaining:

- what is happening throughout the procedure
- why the physical or mechanical enabler restraint is required
- the range of options available for the patient in the circumstances
- the right that the patient has to access the services of an advocate throughout the restraint process.

Communication with the physical or personal restraint team members includes:

- checking the wellbeing of members, and
- checking with each member that their holds or personal restraint are applied safely.

Communication with other staff and significant individuals, eg. patients, visitors directly affected includes:

- advising them of the chosen course of action
- the need for that action
- how they might assist.

Other considerations

- Designated staff should be rotated to alleviate fatigue.

- If the restraint needs to be maintained over a prolonged period of time (longer than sixty minutes) safe removal of the patient to a suitable designated area may be required.

- Consideration must be given to involving family and whanau in the management of the patient.

Procedure: Safe holding of a child

For more information refer to Appendix 2 Child Health Service guideline, *Secure, safe holding of an infant/child*.

Personal restraint and physical restraint

Indications

- Safe holding or securing of a child should be a pro-active response to distress or non-compliance.
- Safe holding is set within the context of appropriate assessment of a child's needs.

Stage 1

Assess

- Is the procedure necessary?
- Does urgency prohibit alternative exploration that a child might not require holding?
- Know the development level of the child, including special needs.

Communication

- Gain the child's consent for any situation that is not an emergency
- Be pro-active and involve the child and parent in thinking about circumstances where a child may need to be held.
- Involve parents in decision-making and obtain verbal consent.
- Discuss if parent/s wish to stay or not, be involved or not – support the decision.

Stage 2

Preparation

- Explanation – is it age and developmentally appropriate (including special needs)?
- Is this an English speaking family? Is the vocabulary used too medically oriented?
- Has the child's pain history been taken into account?

Considerations

- Have you thought of play? Distractions? Alternative therapies?
- Has the child received adequate analgesia in time for it to be effective?

Ready to proceed?

- Is the child ready to proceed? If not, go back to Stage I.

Other considerations

- There should be skilled use of minimum pressure and appropriate techniques, such as wrapping and splinting, with explanations for each technique.
- When it is not possible to obtain the child's consent, the child is comforted and given clear explanation of why restraint is necessary.

Restraint documentation guidelines

Appropriate, accurate recording of the restraint event must occur. This includes a reportable event and a restraint form: (see Appendix 1 *Restraint form*)

- the situation and time it occurred
- the means of the intervention including the type of personal or physical restraint used
- the restraint method used should be described, along with the reasons for using that method
- names of the staff/patient/others involved
- details documented in consumer medical record

Restraint approval and monitoring guidelines

Restraint guiding principles (includes ethical and legal)

- Acting for the consumers good
- Avoiding harm to the consumer
- Avoiding harm to self and others
- Respecting the dignity of the consumer
- Respecting the consumer's human rights
- Respecting the consumer's individual cultural beliefs
- Consideration is given to the legal rights and responsibilities of consumers and staff, including the right for consumers to access advocacy services.
- All restraint techniques used will enhance least restrictive practice and safety of the consumer

- The consumer is kept informed of the reasons for the application of restraint and the process of restraint.

- The use of restraint is monitored

Monitoring requirements should be as follows:

Use of any form of restraint should be monitored by an interdisciplinary team (clinicians, consumer representatives and other relevant stakeholders) who have appropriate level of knowledge and skills (Restraint Approval Group or equivalent). This interdisciplinary team will ensure that methods of restraint are used in a safe and therapeutic manner.

Approval requirements should be as follows:

The C&C DHB Restraint Approval Group must approve the use of all forms of restraints.

Ending restraint procedure

The restraint event must be ended when there is a reduction in the consumer's physical resistance, a change in the consumer's attitude that indicates a willingness to comply, a regaining of their self control, or when the specific treatment has been completed.

The ending of restraint must be done in a planned and controlled manner.

Personal restraint

- The decision to end personal restraint should be made by:
  - the staff member leading the restraint team who should ensure that the restraint team remains nearby should the patient require restraining again
  - the patient's medical officer or senior clinical nurse.
- Staff involved move out of the consumer's personal space, although remain ready to instigate restraint again if needed.
- The restraint leader remains with the consumer to provide support
- Reassurance is to be given to other observers informing them that the situation has been resolved.

Physical restraint

- The decision to end physical restraint must be justified subsequently to the patient's interdisciplinary team.
- Prior to the removal of physical restraint, a management/care plan must be developed which details procedures which may include repeat use of restraint (should they again exhibit the behaviour previously requiring restraint).

Use of restraint – evaluation procedure

As with any consumer intervention, restraint must be evaluated for its effectiveness following each event. A clinical review should occur as soon as possible to review the reasons for the physical restraint and its outcome. This could include the consumer and their family/whanau. The time scale for the review will vary according to each incident.

Where appropriate an immediate debrief should occur with the staff and any significant others involved, as soon as the event is under control.

Where appropriate, a debriefing should occur with the consumer and advocates, and whomever the consumer requests to be present. For incompetent consumers, strong consideration must be given to involving the welfare guardian, principal care giver and/or family member closely involved in the patient's care.

The review should include:

- how the restraint was applied
- whether or not the restraint used achieved its objectives, both short and long term
- the outcome of the restraint from the consumer's perspective (and initiate a further investigation if requested by the patient)
- the outcome from a staff support and staff debriefing perspective
- any injury to any party arising as a possible result of the application of the restraint technique. This would be a reportable event (see reportable event policy)
- the appropriateness of the intervention in this case, considering carefully other treatment options which would obviate the use of restraint.

On the basis of this, the review would recommend strategies/suggestions for improving the practice of physical restraint.

References

Department of Health June 1993. *Procedural Guidelines For Physical Restraint* - Mental Health Policy Section.

Health and Disability Services (Restraint Minimisation and Safe Practice) Standards (NZS 8134:2008).

Guidelines for Medical Practitioners Using Seclusion. Section 71(2) Mental Health (Compulsory Assessment and Treatment Act 1992).

The Code of Health and Disability Consumers' Rights 1996.

Health and Safety in Employment Act 1992 .

Human Rights Act 1993.

NZ Bill of Rights Act 1990.

Restraint register form Appendix 1

Consumer details

Name: _____ Date of birth: _____
(or use hospital label)
NMPI: _____ MHA status _____

Location of incident: _____

Date: _____ **Time commenced:** _____ **Duration of restraint:** _____

Type of restraint required: _____

Personal ☐ Physical ☐ Environmental ☐ Enablers ☐

Name of staff involved: _____
_____

Any injuries to consumer or staff *(if yes describe, complete an incident report)* _____
_____

Description of incident: *(include reason for restraint, explanation given to consumer, nature of mental state disturbance, indications for the use of restraint, other interventions used, success of intervention)*

_____
_____
_____
_____
_____
_____

Reportable Events form number: _____ **(Attach copy to register form entry)**
Detail action required as a result of incident, in consumer's management plan and in staff policy.
Summary and recommendations from post restraint review and for future restraint events (if any).

_____
_____
_____
_____
_____

Family informed (date, time and by whom) _____
_____
_____

Register entry completed by:
Name: _____ Signature: _____
Designation: _____

Reviewed by:
Responsible clinician: _____ Signature: _____
Team Leader/CNS _____ Signature: _____

_____

Appendix 2

Child Health Services: Secure safe holding of infant/child – guideline

Introduction

Standard 9 (9.7 and 9.8) of the New Zealand Standards for the Welfare of Children and Young People in HealthCare facilities states:

> "All invasive procedures in the conscious child/adolescent are accompanied by adequate analgesia and appropriate psychological preparation and support. Physical restraint will be kept to a minimum".

Staff in the Child Health Service does not use restraint to modify or control behaviour. The only intention is to fulfil their duty of care, which is to:

- give the most effective care
- keep the infant/child safe from harm.

Procedures are often frightening to a child, but being held still can also be distressing. Physical restraint should be used rarely and only to prevent a child harming himself or herself or others, for this reason the Child Health Service believes it to be 'safe holding'.

Environmental restraint considerations as set out in this document relate to the practices used by Capital and Coast Health to ensure the safety of their paediatric population within the hospital environment.

Definitions

Safe Holding

The positioning of the child so that a procedure can be carried out in a safe and controlled manner. Wherever possible it is with the consent of the child and parent/carer. Therefore, safe holding is set within the context of appropriate assessment and management of the child's needs. Safe holding also includes immobilisation, which may be by splinting or by using limited force. It is the method of helping children, with their permission, to manage an unknown, frightening or painful procedure quickly and effectively. *Holding is distinguished from restraint by the degree of force required and the intention.*

However, no child should be so held without considering why, when and how this should happen.

Parent

Parent in this guideline includes but is not limited to the biological parent, caregiver, guardian, grandparent or nominated support person for the child, it is used to refer to the infant/child's personal adult companion at the time of the procedure.

Infant/child/children

Infant/child/children refers to those aged up to 16 years. However it is recognised that these guidelines have application for young people over the age this age.

Young person

Young person is a general term used to describe persons under the age of 19 years. It is recognised that both physical and emotional maturity has huge variation which will impact on the application of these guidelines.

Indications

Good decision-making about restraint, safe holding or containing requires that there is an ethos of caring and respect for the child's rights and that restraint, holding or containing without the child's consent are a last resort and not the first line of intervention.

Anxiety and fear about procedures can be minimised by adequate and correct preparation. Children should be adequately prepared before a procedure (see C&C DHB *Guidelines for preparing and promoting coping strategies for children and young people*). Before the event, it is often known whether the child will be, or may become non-compliant.

Safe holding should be a pro-active rather than a reactive response to distress or non-compliance. There should be an anticipation and prevention of the need for holding through information giving, encouragement, distraction and, if necessary, sedation (see *Paediatric Oral Sedation* policy). Safe holding is set within the context of appropriate assessment of the child's needs. If the child needs to be held, either to complete a procedure which cannot be abandoned, or where the child needs to be held for safety reasons (eg. lumbar puncture) explanation of safe holding and the obtaining of consent should be included in the preparation before the procedure is begun.

Restraint procedure

Stage 1

- The guideline, *Preparation and promotion of coping strategies for children and young people* should be read.
- There should be careful consideration of whether the procedure is really necessary and whether urgency prohibits the exploration of alternatives that would not require the child to be held.
- The developmental level of the child, including those with special needs, needs to be known, and in all but the very youngest children, the child's assent or consent obtained, for any situation which is not an emergency.
- The health professional should be proactive and involve the child and parent in thinking about circumstances where the child may need to be held.
- If a child is thought to require holding the decision needs to be made by someone with experience in dealing with children.

- There are a number of possible management strategies available before holding should be deemed necessary, these include the presence of the child's parents and if applicable, the use of sedation.

- Use of distraction therapy should always be used, eg. ceiling train, bubbles, dolls. stories.

If the child does require holding, involve the parents in the decision and obtain verbal consent. Discuss parental presence and involvement if they wish to be present and involved. If the parents do not wish to be present, they should be supported in their decision.

Pre-restraint preparation

- All explanations should be age appropriate – what level of understanding does the child appear to have in relation to age, stage of development and past experience? Ask the child to explain what is about to happen so that misconceptions can be explained correctly.

- Have you considered that the procedure may be unpleasant, if so have you taken measures to reduce this as much as possible?

- If the family is not English speaking, ensure they understand what is happening, if they do not, where possible, find someone to translate what is happening.

- Does the child understand the vocabulary – ensure that the explanation is not too medically orientated. Remember not to use jargon and to use simple explanations using words and connotations that the child will understand.

- Ensure that the environment is suitable for the procedure – remember that the child's bed is their 'safe space' and should never be used for anything unpleasant.

- Ensure that only necessary equipment is used and present. Unnecessary equipment may frighten the child.

- If appropriate/possible – make sure that the child is comfortable with the person carrying out the procedure.

- If the child has special needs – ensure that they been adequately prepared.

- Has the child's pain history been taken into account? Have the child's past hospital experiences been taken into account?

Considerations

- Have you thought of play?

- Have you thought of distraction?

- What alternative therapies are available?

- If appropriate, has the child received adequate analgesia, which has been given adequate time to become effective?
- If the child has received sedation, is it effective?
- Are there appropriate other professionals involved?

Ready to proceed?

- Is the child ready to proceed, if Yes, proceed to Stage 2.
- If not, go back to stage 1.

Stage 2

- If restraint is necessary, it must be performed expertly to minimise undue stress to the child and family. There should be skilled use of minimum pressure and appropriate techniques, such as wrapping and splinting, with explanations for each technique.
- If possible give the child some choice (for example which arm for a vene-puncture). If the child is able to have some control over the event, they may be able to better cope with it.
- Is help required to restrain the child? Using additional personnel may minimise distress. Do not ask the parents to restrain the child – they are there to comfort and not to assist.
- Only recognised restraint techniques should be used, these are identified in the attached restraint register.
- All nurses are taught the correct procedure for safe holding on joining Child Health.
- Have the parents and the child been informed of what will happen and given their consent?
- When it is not possible to obtain the child's consent, the child is comforted and given a clear explanation of why holding/restraint is necessary.
- Following the event, record what is necessary in the patient records. This should cover all aspects of the pre-restraint assessment and the restraint/holding practices used.

Environment

Wherever there are children, modification of the environment, rather than restraint of the child is preferable to ensure safety. However, there are occasions when physical barriers are necessary to prevent the children leaving or harming themselves.

Modifications/barriers in Child Health:

- adults modify their actions (regarding hot drinks for example) to enable children to move freely through the ward
- small children are nursed in cots which must always have the sides raised fully when the child is in the cot – the child should never be left in the cot without the sides raised
- medicines, lotions, detergents are confined to one area, which is not accessible to children – these service rooms have high door handles and the doors are kept closed
- a low gate (click latch, not locked) secures playroom area in ward 19 for protection of the children from activity in the ward, eg. theatre or laundry delivery trolley
- ward doors are controlled with a timed automatic closing ability so that they cannot be accidentally left open; this prevents young children wandering out of the ward area
- ward doors are locked at night to restrict entry to the clinical area from unauthorised persons.

References

Royal College of Nursing (1999). Restraining, Holding still and containing children: Guidelines for good practice. Royal College of Nursing, London.

Guidelines for therapeutic holding for children undergoing clinical procedures. Alder Hey – Royal Liverpool Children's N.H.S. Trust 2003

The United Nations Convention on the rights of the child.(2000) Office of the Commissioner for children.

Jeffery, K (2002). Therapeutic restraint of children: it must always be justified. *Paediatric Nursing*, *14*(9) 20–22.

Robinson, S & Collier, J (1997) Holding children still for procedures. *Paediatric Nursing*, *9(*4) 12–14.

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