Restraint Minimisation & Safe Practice	
Type: policy	**HDSS Certification Standard** [optional]
Issued by: Restraint Approval Group	**Version:** 4.3
Applicable to: All	**Contact person:** Director of Area Mental Health Services (DAMHS)
Lead DHB: Hutt Valley DHB	

1.0 Purpose

To minimise the use of restraint in all its forms and when practised, to ensure it occurs with full regard for safety, personal dignity, cultural and legal requirements

2.0 Policy

Introduction

Restraint of a patient/tangata whaiora is an intervention that requires a clinical rationale, and is regarded as the last intervention when all other clinical interventions or calming/defusing strategies have not worked.

Restraint is a short-term technique used to manage, rather than modify, 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.

Hutt Valley DHB will ensure that its services implement restraint only:

- following approved minimisation procedures/early intervention strategies
- as a short-term measure
- in appropriate circumstances and by appropriately trained staff members
- in ways that minimise adverse outcomes for the patient/tangata whaiora, while protecting the safety, dignity, cultural needs and legal rights of all persons involved
- use restraint methods and techniques approved by the Restraint Approval Group
- trauma informed care is considered within training

3.0 Scope

This policy applies to all Hutt Valley DHB staff who:

- have direct patient/tangata whaiora contact as part of their work requirements
- have completed approved restraint training

4.0 Definitions

4.1 Restraint

Restraint is the implementation of any forcible control by a service provider that:

- limits the actions of a patient /tangata whaiora in circumstances in which the patient /tangata whaiora is at risk of injury or of injuring another person; or
- the intentional removal of their normal right to freedom

Restraint is defined in categories. These are:

- **Personal:** Service providers physically holding a patient/tangata whaiora.
- **Physical:** The use of equipment (mechanical restraints) and furniture
- **Environmental:** This form of restraint can range from a contained environment through to planned interventions that reduce the level of social contacts and/or environmental stimulation. eg: Locked ward or outdoor area that allows all other personal freedom, (including) their ability to continue all daily living functions and contact with staff and others.
- **Enablers:** The voluntary use of equipment by a patient/tangata whaiora to assist them in maintaining independence ie: wheelchair and other safety belts, vehicle interior security locks, vehicle seat belts, IV splints, orthopaedic equipment, chair trays, bed sides.

4.2 Seclusion is a form of restraint and is defined as the placing of a person, at any time and for any duration, alone in an area where s/he cannot freely exit. Seclusion can only be legally implemented under the Mental Health (Compulsory Assessment and Treatment) Act 1992. See Hutt Valley DHB Mental Health Service Seclusion Policy.

4.3 De-escalation is a complex process in which the highly aroused patient/tangata whaiora is re-directed 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 utilising skills and practical alternatives.

4.4 Use of medication is not supported as a means of restraint. All medications should be prescribed and used when indicated clinically/therapeutically with appropriate health professional advice to ensure the intervention is relevant and appropriate. This use does not equate to “chemical restraint”.

4.5 Safe Clinical Practice. There are a number of standard clinical procedures that require the holding of a limb or the person, and in some cases sedation, to ensure the clinical procedure can be carried out safely and effectively eg taking blood; cannulations/PICC lines; IM injections; IV injections; lumbar punctures; application and removal of plaster casts; traction, radiology procedures.

These clinical procedures require the patient/tangata whaiora and their family/whanau/parent/guardian (where appropriate) to consent and be fully informed and involved in the procedure wherever possible.

In a situation where there is resistance to the intended clinical intervention, the decision to proceed will be based on:

- ensuring that all other possible options have been explored
- parent/Guardian consent and wherever possible the active support of parents for children
- a clinical judgement that it necessary to give a planned, prescribed, essential treatment to an individual who is resisting and there is legal justification. See Section 11 of this Policy – Legal Consequences, and Hutt Valley DHB Policy – Self discharge against health professional advice.

These clinical interventions include safe /best practice procedures and are not determined to be restraint events.

4.6 Ethical and legal considerations

Practice is guided by ethical principles that include acting for the patient/tangata whaiora's good (beneficence), avoiding harm to the patient/tangata whaiora (nonmaleficence), avoiding harm to self and others and respecting the dignity of the patient/tangata whaiora and their human rights.

Any unauthorised restriction of a patients/tangata whaiora's freedom of movement may be seen as false imprisonment and may result in an action of assault. Ref: NZ Standards – Restraint Minimisation and Safe Practice Standard pg 18.

5.0 Roles and responsibilities

Compliance with the Restraint Minimisation and Safe Practice Standard is monitored by the establishment and maintenance of a Restraint Approval Group.

5.1 Restraint Approval Group (RAG) Terms of Reference

5.2 Purpose of the Restraint Approval Group

The purpose of the group is to approve restraint techniques and monitor Hutt Valley DHB's (HVDHB) compliance with the requirements of the New Zealand Health and Disability Services (Restraint Minimisation and Safe Practice) Standards (NZS 8134.2:2008).

5.3 Objectives

- Approve and evaluate restraint techniques that meet current best practice recommendations
- Approve the DHB Enabler Register
- Review restraint trends (through analysis of reportable events) and restraint usage at regular intervals in order to validate the appropriateness of techniques and identify alternative interventions
- Review restraint education and training
- Ensure appropriate access to training in supported

5.4 Accountability

The restraint approval group reports to the DHB's Clinical Council.
RAG is responsible and accountable for:

- Maintaining compliance with the requirements of the New Zealand Health and Disability Services (Restraint Minimisation and Safe Practice) Standards (NZS 8134.2:2008).
- Ensuring the Restraint Minimisation and safe practice policy is implemented and monitored and reviewed.

5.5 Membership

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

- Director of Area Mental Health Services (DAMHS)
- Medical representative
- Director of Nursing Representative
- Clinical Nurse Managers (or representatives)
- Te Roopu Whakatau trainer (or representative)
- Consumer advisor or representative (or equivalent role)

- Family advisor
- Maori health/pacific health representative
- 3 DHB Manual Handling co-ordinator (or representative)
- Domestic Services Manager
- Quality & Risk Advisor (or representative)

5.6 Quorum

A quorum will be 5 members or representatives.
Decision making will be by consensus.

5.7 Chairperson

The chair will be the Director of Area Mental Health Services (DAMHS)

5.8 Frequency of Meetings

The Restraint Approval Group will meet for a minimum of three meetings per year. Meetings will be no longer than one hour.

5.9 Agenda

The agenda will be sent out week prior to the meeting. Members must submit papers or items for the agenda to the chair/delegate prior to this.

5.10 Minutes

All meetings will be minuted. Minutes of the meeting will be sent out no more than seven days following the meeting. All members of the committee will receive a copy of the minutes.

5.11 Reporting requirements

The RAG will provide the DHB clinical council with:

- Significant issues or trends as required
- Chairperson/delegate may attend the clinical council meeting to report on RAG progress as required

6.0 Restraint Register

The Restraint Minimisation and Safe Practice Standard and the Mental Health (CAT) Act,1992, s.122B: Use of Force, require all instances of restraint to be documented and maintained in a register for review and monitoring. Hutt Valley DHB will record all restraint events in a centralised Reportable Event register. Summary reports of restraint and Use of Force events will be provided to appropriate staff and to RAG for review.

Recording Restraint and Use of Force Events - staff will record all RAG approved restraint events (and any non approved restraint events) on the Reportable Event form in accordance with the Reportable Event procedures. Staff will also complete the Restraint Event Review form and identify any QI action to be taken.

Mental Health staff will record Use of Force (Mental Health (CAT) Act 1992) events on the Reportable Event form in accordance with the Reportable Event procedures and also complete the Restraint Event Review form and identify any QI action to be taken.

Restraint codes will identify Restraint and Use of Force events separately. Copies of Use of Force events will be available to the District Inspectors, and the DAMHS as required.

7.0 Staff Training - Restraint Minimisation and Safe Practice

Hutt Valley DHB will ensure staff are educated and appropriately trained in Restraint Minimisation and Safe Practice pertaining to their specific area of work.

The Restraint Approval Group will approve training packages and instructors.

Hutt Valley DHB will maintain staff records of initial training completed and required updates.

7.1 Hutt Valley DHB Restraint Minimisation and Safe Practice Education /Training Levels:

Level One	Orientation/education to HVDHB Restraint Minimisation and Safe Practice policy/procedures (will include orientation to approved restraint practices pertaining to the work area. eg bedrails, safety belts, bean bags etc as defined in the RAG Restraint Approval Register.	All HVDHB staff
Level Two	De-escalation –Training (education on a range of interventions that can be used to minimise the likelihood of more intensive intervention).	Managers identify staff in each department to attend.
Level Three	Calming and Restraint Training (Intensive response to situations requiring personal restraint methods – specific training and expertise required).	Approved HVDHB Orderlies/ Security Staff and MHS clinical staff working in Acute Services will attend Calming and Restraint training and refresher days as required.

8.0 Prevention and Early Intervention

8.1 General Principles: Sound clinical practice requires staff to:

- monitor the behaviour and activities of each patient/tangata whaiora and identifying risk
- attempt to prevent/de-escalate situations that might otherwise require actions of restraint
- take appropriate action to control the situation to minimise the possibility of injury.
- maintain, as far as possible, a safe environment for all the patient/tangata whaiora
- should personal restraint be required, only approved restraint methods as taught by HVDHB instructors are to be used.

8.2 Preventative and Alternative Strategies:

Alternatives to the use of restraints should always be considered first, some suggestions are listed below:

8.3 Increased supervision provided by staff, whanau, family or friends

- Ask family, friends or a volunteer to stay with the patient particularly when the patient needs one-to-one attention.
- Educate the family, friend or volunteer about appropriate interventions to manage the patient behaviour.
- Correct reversible causes of falls, especially for those patients who have been identified as high risk for falls.
- Provide increased nursing rounds for patients with a high risk of falls, dementia or a history of pulling out tubes, lines or catheters.
- Provide a nurse special.

8.4 Investigate reducing aggravating treatments

- Oral instead of IV.
- Removing drains and catheters.
- Try to eliminate the troublesome side effects of current medications with an alternative medication.

8.5 Environmental influences

- Modify the care environment – placement of equipment.
- Keep the call button accessible.
- Decrease or increase light.
- Place a bedside commode near the patient so that it can be easily and safely used when needed.
- Place patient closer to the nurses' station for closer monitoring.
- Keep bed in the lowest position or place mattress on floor.
- Decrease environmental stimuli and noise which tend to provoke behaviours.

8.6 Modify patient care

- Use long sleeved gowns or robes to hide catheter sites.
- Place briefs over a foley catheter.
- Keep IV solutions and tubing out of patient's field of vision.
- Overdress wounds and use abdominal binders to cover wound dressings whenever possible.
- Develop toileting routines to facilitate elimination and to reduce risk of falls.
- Carefully explain procedures and routines to reduce fear.

8.7 Diversion and physical activities

- Television, radio, music
- Exercise
- Involve the patient in conversation
- Patient education in the area of activities of daily living in order to promote self-care.
- Relaxation techniques

8.8 Suggested calming/defusing interventions

- Orientate patient to the environment.
- Talk to patient in a calm, firm and non-threatening manner. Should be consistency of approach by all staff ie avoid mixed messages and manipulation. Clear explanations should be given to questions at a level and manner appropriate to the patient.

- If appropriate encourage patient to verbally express his/her thoughts.
- Be accepting of the patient but not of their aggressive behaviour.
- If possible administer medication as prescribed.
- If appropriate take the patient for a walk.
- If appropriate have a punch bag or a similar piece of equipment available for the patient to use.
- Distract the patient by offering them an activity that they may enjoy eg warm bath or read newspaper, music.
- Provide the patient with time and space (cognitively impaired person may forget why they became aggressive).
- Develop a close rapport with the patient so that interactions can be more meaningful and effective.
- If possible arrange for a relative or close friend to come in and be with the patient.
- If the patient is demonstrating aggressive behaviour, remove excessive non-fixed items from the patient's immediate environment to avoid the potential for harm to the patient or to staff.

8.9 Management Planning

A patient/tangata whaiora identified as having "indications for restraint" is to, where practicable, have a management plan developed stating the possibility of physical restraint and identifying strategies to minimise the possibility of restraint occurring.

This plan must be developed in consultation with the multi-disciplinary team, with the patient/tangata whaiora and discussed (if possible) with the family/whanau and significant others as is appropriate.

9.0 Restraint Procedures

9.1 Initiating and ending restraint

The decision to initiate and end restraint should be made:

- By the most appropriate designated registered health professional
- When the environment is appropriate for successful initiation and discontinuation
- When adequate resources are assembled to ensure safe initiation and discontinuation
- When appropriate planning and preparation has occurred
- Ending restraint should occur in a gradual manner, following ongoing assessment and evaluation of outcomes to ensure the patient is re-integrated into the least restrictive environment.

9.2 Situations of Extreme Caution

When the use of restraint would threaten to compromise the well-being (Te Whare Tapa Wha) of the patient/tangata whaiora or others, consideration shall be given to the comparative risks of using restraint or not.

9.3 Considerations Prior to the Use of Restraint

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

- Patient/tangata whaiora's physical and psychological health
- Possibility that inappropriate behaviours may be reinforced by the use of restraint

- Patient/tangata whaiora's gender and culture
- Degree of risk to the consumer, to others and the environment
- Possible alternative interventions/ strategies
- The experience of the patient/tangata whaiora and the possible effects of restraint on the therapeutic relationship
- Desired outcome and criteria for ending restraint
- Patient/tangata whaiora's legal status and its implications

9.4 Initiating Personal Restraint

Guiding Principles

- The respect and dignity of individuals is maintained.
- The specific cultural needs of the patient/tangata whaiora during each stage of restraint are recognised and relevant cultural advice and or guidance is sought in order to maintain and practise cultural safety.
- Consideration is given to the legal rights and responsibilities of patient/tangata whaiora and staff, including the right for patients to access advocacy services.
- Personal restraint techniques will be approved by Hutt Valle DHB RAG and only used by identified staff training in the approved methods of personal restraint.
- The patient/tangata whaiora is kept informed of the reasons for the application of restraint and the process of restraint.
- The use of restraint is monitored.

9.5 Indications

Restraint may be appropriate when:

- There is a legal basis for treatment (See RMASP Std Section 10, page 6 for further guidance) and when the patient/tangata whaiora behaviour indicates that the patient/tangata whaiora is a danger to self or others
- Makes a serious attempt or act of self harm
- Seriously compromises the therapeutic environment
- Is violent and seriously damages property
- It is necessary to give a planned, prescribed, essential treatment to an individual who is resisting and there is legal justification. See Section 11 of this Policy – Legal Consequences, and Hutt Valley DHB Self-Discharge policy.
- The patient/tangata whaiora is in the possession of a weapon, consideration must be given to the intent and capability of the individual to use the weapon. Staff safety is paramount. Restraint should never be commenced if there is a significant risk for staff safety. In cases like this, don't hesitate - CALL THE POLICE.

Note: When restraining a patient/tangata whaiora perform hand hygiene before and after.

9.6 Observation and Care

Any patient/tangata whaiora undergoing personal or physical restraint requires intensive and continuous observation.

9.7 Personal Restraint - Care

9.8 Physical care
When the patient/tangata whaiora is immobilised, the following must be assessed:

- Patient airway, pulse, skin colour (ie. for presence of cyanosis)
- Bleeding
- Other physical injuries or discomfort
- Appropriate neurological observations
- Patient's position does not compromise their safety (ie positional asphyxia)

9.9 Psychological care

- General mental state, including general assessment of alertness
- Response to the personal restraint event
- Cultural safety and needs

9.10 Communication

During the use of the personal restraint, continuously communicate with the patient/tangata whaiora (if possible), the team members and significant others present.
Communications (if possible) with the restrained patient/tangata whaiora include explaining to the individual:

- what is happening throughout the procedure
- why the restraint is required, and
- the range of options available for the patient/tangata whaiora in the circumstances.
- the right that the patient/tangata whaiora has to access the services of an advocate throughout the restraint process

Communication with the personal restraint team members includes:

- checking the well-being of members, and
- checking with each member that their holds are applied safely.

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

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

9.11 Designated restraint staff are to 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/tangata whaiora to a suitable designated area may be required. Consideration must be given to involving family and whanau in the management of the patient/tangata whaiora e.g. Approved Environmental Restraint or Mental Health Service Seclusion Policy under Mental Health (CAT) Act (1992).

9.12 Initiating Physical Restraint

Indications

Restraint may be appropriate when:

- there is a legal basis for treatment (eg Crimes Act Provisions, MH Act)
- the use of personal restraint is not possible and is unrealistic
- an individual's behaviour indicates that s/he is a danger to self or others
- an individual makes a serious attempt or act of self harm
- an individual seriously compromises the therapeutic environment
- an individual is violent and seriously damages property
- it is necessary to give a planned, prescribed, essential treatment to an individual who is resisting. See Section 11 of this Policy – Legal Consequences

9.13 Observation and Care

Physical Care

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 their 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 mechanical restraints are used to restrict the torso (such restraint should pass across the ischial tuberosities and not be allowed to move up to the abdomen and chest). This is required to avoid complications such as positional aspyxia.
- mechanically 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 in the case of Mechanical Restraint).
- Check for muscle or ligament damage.
- Complete physical examination within each 24 hour period.

Psychological care
The following must be assessed:

- mental status.
- the response to the mechanical restraint event.
- cultural safety and needs

9.14 Communication
As for Personal Restraint.

9.15 Initiating Environmental Restraint

It is the responsibility of all Hutt Valley DHB staff to initiate the least restrictive and intrusive interventions. At times environmental restraint may offer the least restrictive and intrusive intervention or may be used a step down intervention following personal or physical restraint.

This may occur through the provision of an RAG approved locked area (eg ward/outdoor area) that does not limit the patient/tangata whaiora's personal freedom, nor their ability to continue all daily living functions and contact with staff and others.

9.16 Observation and Care

Psychological care

- general mental state
- charted observation levels/assigned responsibility
- cultural safety and needs

Communication

Communicate to the patient/tangata whaiora:

- why the environmental restraint is required, and
- the range of options available for the patient in the circumstances.
- the right that the patient/tangata whaiora has to access the services of an advocate throughout the restraint process

Communication with other staff and significant individuals eg. Patients/consumer, visitors directly affected, etc., should include:

- advising them of the chosen course of action,
- the need for that action, (eg Observation levels/responsibility)
- how they might assist.

9.17 Initiating Enablers

The patient /tangata whaiora will be fully informed regarding the purpose and use of the enabler and will voluntarily agree to its use

9.18 Ending Restraint

- All restraint events must be ended when assessment indicates there is a reduction in the patient/tangata whaiora's physical resistance, a change in the patient's attitude that indicates a willingness to comply, a regaining of their self control, or when the specific treatment has been completed.
- The patient/tangata whaiora's management/care plan must include details of post restraint management procedures for minimising risk. Review is to occur prior to repeat use of the restraint method used to ensure the intervention is the most effective and appropriate option.
- The ending of restraint must be done in a planned and controlled manner. Ending restraint may include whanau/family, parent/guardian in the process where appropriate.
- The restraint team leader remains with the patient/tangata whaiora to provide support
- The patient/tangata whaiora, whanau/family and others involved in care are informed of restraint ending and of the management plan in place
- The decision to end restraint must be justified subsequently to the patient/tangata whaiora's multidisciplinary team.

The decision to end personal restraint is to be made by:

- the staff member leading the restraint event
- the patient's medical officer or senior clinical nurse
- documentation must be completed

9.19 Specific Procedures for Ending Personal Restraint

- Staff involved move out of the patient/tangata whaiora's personal space, although remain ready to instigate restraint again if needed.
- The restraint team leader remains with the patient/tangata whaiora to provide support
- Reassurance is to be given to other observers informing them that the situation has been resolved.

9.20 Ending Use of Enablers

Where use of the enabler ceases staff will discuss the use of the enabler with the patient/tangata whaiora and have in place appropriate support/care plans that maximise the ongoing independence of the patient. Management Plans will incorporate how the patient/tangata whaiora may access the voluntary use of the enabler should this be required.

9.21 Debriefing

Patient/Tangata Whaiora Debriefing

As soon as practicable, the patient /tangata whaiora shall be offered a debriefing session. Wherever possible, whanau/ family and or advocate are to be present.

Where appropriate, a debrief is to occur with the patient and advocates, and whoever the patient requests to be present. For patients whose decision making processes are compromised by their current health status (ie dementia, intellectual disability sedation, delirium, mental disorder) strong consideration must be given to involving the welfare guardian, principal care giver and/or family member closely involved in the patient's care.

Staff Debriefing

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

Debriefing will be recorded on the reportable event system and will be monitored through the Event Reporting procedures and RAG review.

Debriefing will follow the Hutt Valley DHB Critical Incident Debriefing procedures.

10.0 Clinical Documentation - Reporting Requirements For Approved Restraint Events

Staff must report all RAG approved restraint events (and non approved events where this occurs) and also record the plan and process/event (in accordance with the HVDHB Restraint Minimisation and Safe Practice policy requirements) in the clinical file.

The Reportable Event must be completed for each restraint event and include:

- situation and the time restraint occurred and finished

- the means of the intervention including the type of personal, physical or environmental restraint used
- the restraint method used should be described, along with the reasons for using that method
- names of the staff/patient/tangata whaiora and others involved.

The Restraint Event Review must be completed for each restraint event reported using the reportable events system, and is to be reviewed by the Clinical Manager to ensure QI actions are implemented and signed off in the Unit/Service

Approved Safe Practice – Clinical Procedures and Enablers must be recorded in accordance with the Hutt Valley DHB Restraint Minimisation and Safe Practice policy requirements) in the clinical file.

Where the identified Safe Practice – Clinical Procedure is repeated, review will occur prior to each implementation in accordance with the Hutt Valley DHB Restraint Minimisation and Safe Practice policy requirements.

These RAG approved Safe Practice – Standard Procedure do not require the completion of a Reportable Event form.

10.1 Measurement Criteria

Approval and Monitoring of Restraints

Hutt Valley DHB Restraint Approval Group (RAG) will meet at least once every year (and more frequently if required). The terms of reference for this group are outlined in Section 5 of this policy.

Evaluation of the Use of Restraint

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

The review will occur using the HVDHB Restraint Event Review form and 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 patient/Tangata whaiora'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 documented on an Incident Form.
- the appropriateness of the intervention in this case, considering carefully other treatment options which would obviate the use of restraint.

Reviews will recommend strategies/suggestions for minimising the use of restraint and improving the practice of physical restraint where this is indicated

A restraint events summary and analysis/trends report will be provided to and reviewed at the 6 monthly RAG meetings.

11.0 References / Legal Consequences

Type	Title/Description
Legislation	Mental Health (Compulsory Assessment and Treatment) Act, 1992 and Amendment Act 1999 NZ Bill of Rights Code of Health and Disability Services Consumers Rights (1996)Criminal Justice Act 1985 Crimes Act 1961 Health & Disability Services (Safety) Act, 2001 Intellectual Disabilities Act, 2001
MOH Guideline	Guidelines to the Mental Health Act (Compulsory Assessment and Treatment) Act 1992 (April 2000) Guidelines for Clinical Risk Assessment and Management in Mental Health Services (1998) Night Safety Procedures June, 1995
NZ Standards	8141:2001 Restraint Minimization and Safe Practice 8143:2001 8143:2001 National Mental Health Sector 8134:2001 Health and Disability Sector Safety
Professional Code of Ethics	Medical, Nursing, Psychology, etc

11.1 Legal Consequences

Every mentally competent adult has the right to determine what is done to his/her own body. The right to choose is absolute. All patients have the right to refuse medical treatment. That fact justifies the need to obtain consent from the patient. The failure to obtain consent in situations where consent should have been obtained, can result in common law claims of trespass to the person ie. assault and battery, and sometimes false imprisonment.

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

Bill of Rights Act 1990 - A person compulsorily detained has rights under this Act. These rights include

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

The following legislation provides the basis for use of restraint:

Criminal Procedure (Mentally Impaired Persons) Act 2003; section 23, Inquiries about persons found unfit to stand trial or insane, section 24(2)(a), section 34(1)(a)(i), and section 35, Power of court to commit offender to hospital or facility on conviction, section 38(2)(c), Power of court to require assessment report, section 44(1), Detention pending hearing or trial section 169, Order for detention of defendant in hospital or secure facility

Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, section 136(5)(a), Application to mentally disordered persons.

Mental Health (Compulsory Assessment & Treatment) Act, 1992.

Crimes Act 1961, Section 41 Prevention of suicide or certain offences -

Everyone is justified in using such force as may be reasonable 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.

Crimes Act 1961, Section 48 Self-defence and defence of another

Every one is justified in using, in defence of himself or another, such force as, in the circumstances as he believes them to be, it is reasonable to use.

Crimes Act 1961, Section 151 Duty to Provide the Necessities of Life and Protect from Injury

Every one who has actual care or charge of a person who is a vulnerable adult and who is unable to provide himself or herself with necessaries is under a legal duty—

(a) to provide that person with necessaries; and

(b) to take reasonable steps to protect that person from injury

Crimes Act 1961, Section 157 Duty to Avoid Omissions Dangerous to Life

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

12.0 Appendices

1. Enablers
2. De-escalation Techniques
3. Use Of Bedrails
4. Use Of Safety Belt/Vest or Table
5. Use Of Bean Bags
6. Use Of Environmental Restraint
7. Use of Personal Restraint
8. Use of Physical Restraint
9. Use of Environmental Restraint (Dementia / Delirium Patients)
10. Paediatric Restraint
11. RAG Approval form – Restraint/Safe Practice /Enablers

12. Evaluation and Review of Personal/Physical Restraint Events

Appendix 1 **ENABLERS**

Type	**[ ] Restraint** **[ ] Safe Practice – Clinical Procedure** **[√] Enabler – (voluntary use)**
Purpose	To facilitate the maintenance of independence for patients.
Scope	All HVDHB clinical staff.
Staff education/ongoing training	Orientation to Restraint Minimisation and Safe Practice Policy Non Violent Crisis Intervention training, where available Orientation to RAG approved Enabler practice prior to implementation
Criteria for use of enablers	Patient requires specific equipment to maintain independence. Such equipment could include: • Positioning belts • Lateral trunk supports • Knee blocks • Pommels • Trays • Walking Frames • Lifting equipment and the use of slings
Before initiating use of enabler	• Full assessment of patient's ability to engage in activity of daily living must be undertaken. • Alternative equipment options must be considered and where appropriate trailed.
Consent	Explain need for use of enablers to the patient. Ensure this is a voluntary option for the patient/tangata whaiora and is discussed with the patient and where indicated, their whanau/family.
Procedure	As per policy requirements for enablers and identified service specific procedures.
Monitoring and evaluation	**NB** This monitoring regime applies only to patients who are receiving care within an HVDHB services. It does not apply to individual patients in external environments eg schools, own home. • Monitoring should be undertaken as a minimum two-hourly. • Monitoring is to include: – independence and functioning is being achieved – skin condition - patient comfort.

Documentation	Document need for enabler in the clinical notes. It is not necessary to complete a Reportable Event Form.
	RAG Approval Register No: 001
Issued Date	**May 2006; Restraint Approval Group**
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Version	**3**

Appendix 2 **DE-ESCALATION TECHNIQUES**

Type	**[ ] Restraint** **[v] Safe Practice – Clinical Procedure** **[ ] Enabler – voluntary**
Purpose	Minimise the likelihood of escalation of disruptive behaviours. Management of difficult situations in a positive proactive manner.
Scope	All HVDHB staff
Staff education/ ongoing training	Orientation to Restraint Minimisation and Safe Practice Policy Non Violent Crisis Intervention Training This internationally recognised programme promotes early recognition and intervention for persons with disruptive behaviours. Emphasis is placed upon verbal diffusion, de-escalation and limit setting. Proactive management can prevent situations escalating. Some breakaway techniques are learned to assist you should you find yourself in a potentially dangerous situation. Orientation to RAG approved de-escalation practice prior to implementation. ** MHS Inpatient Unit staff complete de-escalation training within their Core training requirement for Calming and Restraint
Criteria for use of de-escalation techniques	In accordance with approved HVDHB de-escalation training approved by RAG

Consent	Where de-escalation is indicated the clinicians involved will explain and inform the patient/tangata whaiora and their whanau/family throughout the process and record this in the clinical notes. Where ever possible consent will be gained to a care/management plans that minimises the likelihood of restraint events occurring.
Procedure	In accordance with the restraint Minimisation and Safe practice policy and procedures and the HVDHB approved training programme techniques/practices.
Monitoring & Evaluation	As per policy, Section 8 Measurement Criteria
Documentation	All acts of verbal, physical aggression and or harassment must be reported in the clinical notes and reported through the HVDHB Event Reporting system.
	RAG Approval Register No: 002
Issued Date	**May 2006; Restraint Approval Group**
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Version	**3**

Appendix 3 **USE OF BEDRAILS**

Type	**[ ] Restraint** **[√] Safe Practice – Clinical Procedure** **[ ] Enabler – voluntary**
Purpose	To prevent patient injury. The intent of the policy and procedures is to reduce the use of restraint in all its forms and to ensure that, when practised, it occurs in a safe and respectful manner.
Scope	All HVDHB Clinical staff
Staff education/ongoing training	Orientation to Restraint Minimisation and Safe Practice Policy Non Violent Crisis Intervention training, where available Orientation to RAG approved Use of Bed Rails Safe Practice procedure prior to implementation.
Criteria for use of bedrails	1.Patient/tangata whaiora requires bed rails to stop patient from falling, rolling or getting out of bed and preventing falls *that have occurred* or are *likely to occur.* 2.Patient/tangata whaiora getting out of bed will affect treatment ie patient is attached to medical devices which could cause injury if the patient was to get out of bed unsupervised.
Before initiating use of bedrails	Assess the situation as to the need for bedrails and ensure the following has occurred: • Beds are kept at the lowest level • Review if use of monitors would be effective • Review placement in ward ie place near nurses' station • Assessment of why falling • Investigate what patient was going to do prior to fall and initiate plan to prevent occurring ie if patient needed to go to the toilet then toilet more frequently. • Assess staffing levels ie are there enough staff for supervision of patients? Obtain special nurse if required. • Investigate any medical reason for fall – confusion, decreased BP.

Consent	Where a Safe Practice procedure is indicated the clinicians involved will explain and inform the patient/tangata whaiora and where possible consent will be gained from the patient to a care/management plan that defines the specific Safe Practice procedure planned.
Monitoring & Evaluation	• As per care plan for individual patient • Ensure bed rails are applied safely ie patient is not trying to climb over • Assess if use of bed rails is making the patient agitated. • Review need for bed rails regularly as per policy. For long-term care this could be done less frequently.
Documentation	Document the planned use of bed rails in the clinical notes. Refer to Patient Falls and Prevention and Management policy It is not necessary to complete a Reportable Event Form.
Debriefing	A debriefing need only be held in exceptional situations. It is not necessary, for example, when bedrails are used as a component of a fall prevention programme.
	RAG Approval Register No: 003
Issued Date	**May 2006; Restraint Approval Group**
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Appendix 4 **USE OF SAFETY BELT/VEST OR TABLE**

Type	**[ ] Restraint** **[√] Safe Practice – Clinical Procedure** **[ ] Enabler – voluntary**
Purpose	To prevent patient injury when sitting in chair. The intent of the policy and procedures is to reduce the use of restraint in all its forms and to ensure that, when practised, it occurs in a safe and respectful manner.
Scope	All registered medical and nursing staff.
Staff education/ ongoing training	Orientation to Restraint Minimisation and Safe Practice Policy Non Violent Crisis Intervention training, where available Orientation to RAG approved use of safety belt/vest or table Safe Practice procedure prior to implementation
Criteria for use	Patient requires safety belt or table placed in front of them to prevent patient from getting out of chair unsupervised and therefore prevent risk of a fall.
Before initiating use of safety belt/table	Assess the situation as to the need for the safety belt or table and ensure the following has occurred: • Assessment of reasons for falling • Investigate what they were going to do prior to fall and initiate plan to prevent occurring ie if patient needed to go to the toilet then toilet more frequently. • Assess staffing levels ie are there enough staff for supervision of patients. Obtain special nurse if required. • Investigate any medical reason for fall – confusion, decrease BP. • Review placement in ward ie place near nurses' station

Procedures	As per policy requirements and in accordance with product use information
Approved Products	**Safety Belt** **Safety Vest** **Table**
Consent	Where a Safe Practice procedure is indicated the clinicians involved will explain and inform the patient/tangata whaiora and where possible consent will be gained from the patient to a care/management plan that defines the specific Safe Practice procedure planned.
Monitoring/ evaluation	• Assess if use of belt/table is making the patient agitated. • Review patient as per policy • Review need for belt regularly at least each duty. For long-term usage this could be done less frequently. • Ensure belt/table are applied safely ie patient is not trying to climb out of restraint.
Documentation	Document in the clinical notes need for safety belt/table and record checks/reviews undertaken. Refer to Patient Falls and Prevention and Management policy It is not necessary to complete a Reportable Event Form.
	RAG Approval Register No: 004
Issued Date	**May 2006; Restraint Approval Group**
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Appendix 5	**USE OF BEAN BAGS**
Type	**[ ] Restraint** **[√] Safe Practice – Clinical Procedure** **[ ] Enabler – voluntary**
Purpose	To ensure the provision a safe, comfortable positioning - for example dementia patients, in extreme situations. The intent of the policy is to reduce the use of restraint in all its forms and to ensure that, when practised, it occurs in a safe and respectful manner.
Scope	All HVDHB clinical staff
Staff education/ongoing training	Orientation to Restraint Minimisation and Safe Practice Policy Non Violent Crisis Intervention training, where available Orientation to the RAG approved Use of Bean Bags Safe Practice procedure prior to implementation.
Criteria for use of bean bag	• A patient who climbs out of chair and in doing so increases his/her potential for injury through a fall. • Compromising others' safety eg lying on floor, tripping wandering patients. • Alternative strategies (see Section 6.2) have been unsuccessful.
Before initiating use of bean bag	• Assess the situation as to the need for use of a beanbag and ensure assessment, as to why patient is falling out of chair or agitated, has been undertaken. • Assess/consider use of alternative strategies *(See Section 6.2 & 6.3 in Policy)*
Procedure	As per policy requirements for and identified service specific procedures.
Consent	Where a Safe Practice procedure is indicated the clinicians involved will explain and inform the patient/tangata whaiora and where possible consent will be gained from the patient to a care/management plan that defines the specific Safe Practice procedure planned.
Monitoring and evaluation	Planned reviews during and at the end of the procedure.

Documentation	Document need for use of bean bags in the clinical notes. Refer to Patient Falls and Prevention and Management policy It is not necessary to complete a Reportable Event Form.
	RAG Approval Register No: 005
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Appendix 6	**USE OF ENVIRONMENTAL RESTRAINT**
Type	**[v] Restraint** **[ ] Safe Practice – Clinical Procedure** **[ ] Enabler – voluntary**
Purpose	To prevent patient injury and potential injury to other persons.
Scope	All HVDHB staff
Staff education/ ongoing training	Orientation to Restraint Minimisation and Safe Practice Policy Non Violent Crisis Intervention training, where available Orientation to RAG approved environmental restraint practice prior to implementation.
Criteria for use of environmental restraint	Protection of patient and others is required eg dementia patients. Refer also to policy - Section 6. **NB** If there is a suspicion that the patient is suffering from a mental health illness, seclusion is to be implemented as per the Mental Health (Compulsory Assessment and Treatment) Act 1992.
Consent	Where ever possible consent will be gained to a care/management plans that minimises the likelihood of restraint events occurring. Where restraint is indicated the clinicians involved will explain and inform the patient/tangata whaiora and their whanau/family throughout the process and record this in the clinical notes.
Procedure	As per policy requirements for Environmental Restraint and identified service specific procedures.
Monitoring & Evaluation	Planned reviews during and at the end of the procedure.
Documentation	Document the planned use of environmental restraint in the clinical notes. Complete a Reportable Event Form and Restraint Review Form
Debriefing	Where indicated to occur in accordance with HVDHB Critical Incident Debriefing procedures
	RAG Approval Register No: 006
Issued Date	**May 2006; Restraint Approval Group**
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Appendix 7 **USE OF PERSONAL RESTRAINT**

Type	**[√] Restraint** **[ ] Safe Practice – Clinical Procedure** **[ ] Enabler – voluntary**
Purpose	To prevent patient/tangata whaiora injury and/or potential injury to other persons.
Scope	HVDHB staff trained in approved Calming and Restraint Method.
Staff education/ ongoing training	Orientation to Restraint Minimisation and Safe Practice Policy Non Violent Crisis Intervention training, where available Training in the RAG approved restraint practice prior to implementation Clinical Manager/Team leader training related to their role/ responsibilities in requesting restraint support.
Criteria for use of personal restraint	Protection of patient/tangata whaiora and/or others is required **NB** If there is a suspicion that the patient is suffering from a mental *health* illness, seclusion is to be implemented as per the Mental Health (Compulsory Assessment and Treatment) Act 1992.
Consent	Where ever possible consent will be gained to a care/management plans that minimises the likelihood of restraint events occurring. Where restraint is indicated the clinicians involved will explain and inform the patient/tangata whaiora and their whanau/family throughout the process and record this in the clinical notes.
Procedure	As per approved training programme
Approved Personal Restraint Method	Calming and Restraint training – specified holds only
Monitoring & Evaluation	As per policy, Section 8 Measurement Criteria

Documentation	As per policy, Section 7 Clinical Documentation Complete a Reportable Event Form and Restraint Review Form
Debriefing	Where indicated, to occur in accordance with HVDHB Critical Incident Debriefing procedures
	RAG Approval Register No: 007
Issued Date	**May 2006; Restraint Approval Group**
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Approved	**Restraint Approval Group**
Version	**3**

Appendix 8	USE OF PHYSICAL RESTRAINTS
Type	**[√] Restraint** **[ ] Safe Practice – clinical procedure** **[ ] Enabler – voluntary**
Purpose	To prevent patient injury and to ensure safety of clinical procedures where there is an ongoing risk that the patient may remove clinical equipment eg central venous lines, naso-gastric tubes and arterial lines.
Scope	All HVDHB clinical staff
Staff education/ongoing training	Orientation to Restraint Minimisation and Safe Practice Policy Non Violent Crisis Intervention training, where available Orientation to RAG approved Use of Soft restraints procedures prior to implementation.
Criteria for use of	Restraint may be appropriate when: • there is a legal basis for treatment (eg Crimes Act Provisions MH Act) • an individual's behaviour indicates that s/he is a danger to self or others • an individual makes a serious attempt or act of self harm • an individual seriously compromises the therapeutic environment • an individual is violent and seriously damages property it is necessary to give a planned, prescribed, essential treatment to an individual who is resisting. See Section 11 of this Policy – Legal Consequences
Before initiating use of Soft Restraint	Ensure prevention/alternative strategies (less restrictive) have been considered /tried and documented
Procedure	To be carried out in accordance with Physical Restraint procedures Section 6.5.2 of the policy
Approved Physical Restraint Products	**Approved Restraint Products** Soft Wrist/Ankle:. To be used as per product instructions Soft Body Belt: To be used as per product instructions Body Belt - ED
Consent	Where ever possible consent will be gained to a care/management plans that minimises the likelihood of physical restraint events occurring. Where restraint is indicated the clinicians involved will explain and inform the patient/tangata whaiora and their whanau/family throughout the process and record this in the clinical notes.
Monitoring & Evaluation	As per Section 8 - Measurement Criteria
Documentation	As per policy, Section 7 Clinical Documentation Complete a Reportable Event Form and Restraint Review Form
Debriefing	Where indicated, to occur in accordance with HVDHB Critical Incident Debriefing procedures

	RAG Approval Register No: 008
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Appendix 9	USE OF ENVIRONMENTAL RESTRAINT (Dementia / Delirium Patients)
Type	**[√] Restraint** **[ ] Safe Practice – clinical procedure** **[ ] Enabler – voluntary**
Purpose	Manage dementia, delirium or challenging behaviour
Scope	All HVDHB clinical staff working with psycho-geriatric patients
Staff education/ongoing training	Orientation to Restraint Minimisation and Safe Practice Policy Non Violet Crisis Intervention training, where available Orientation to RAG approved Psycho-geriatric restraint policy prior to implementation.
Criteria for use of Restraint	Protection of patient and others as required
Consent	Where a Safe Practice procedure in indicated the clinicians involved will explain and inform the patient/tangata whaiora and where possible consent will be gained from the patient to a care/management plan that defines the specific Safe Practice procedure planned.
Methods of Restraint Approved	The types of acceptable environmental restraint to minimise risk: • Minding at distance • Supervised wandering • Redirecting the patient • Reducing stimuli • Quiet environment room Where practicable, consistency in use of staff should be considered. This enables both the patient and the carer to develop a rapport, the staff member is then better able to gauge the triggers of challenging behaviour.
Limitation	If behaviour escalates, there are difficulties in containment and the environment and facility are not safe, the patient is non responsive to re-direction or becomes physically challenging, the patient should be medically reassessed. This reassessment should include development of a comprehensive nursing care plan, review of medication, consideration given to complex case protocol. Senior clinicians from all disciplines should involved in decisions about the on-going management of the patient.
Monitoring and Evaluation	Monitoring and evaluation to occur as per the care/management plan for the individual patient and reviewed on a daily basis.
Medication Administration	In all cases where there is difficulty administering medication, consultation between clinicians and family is required to agree to an alternative solution.
Calling for Non-Clinical Assistance	Orderlies/Security staff should only be called in a situation when a patient is in imminent danger to themselves or others. Mental Health consultation and assistance may need to be requested.
Documentation	Document the planned use of environmental restraint in the clinical notes.

	Complete a Reportable Event Form and Restraint Review Form.
Related HVDHB Documents	Special nursing policy Minder care plan policy
	RAG Approval Register No: 009
Issue Date	November 2007; Restraint Approval Group
Review Date	May 2016; Restraint Approval Group
Approved	Restraint Approval Group
Version	3

Appendix 10 **PAEDIATRIC RESTRAINT**

Type	**[√] Restraint** **[ ] Safe Practice – clinical procedure** **[ ] Enabler – voluntary**
Purpose	Manage the appropriate methods of restraining neonates, infants and children by health professionals.
Scope	All HVDHB clinical staff working with patients under 16yrs
Staff education/ongoing training	Orientation to Restraint Minimisation and Safe Practice Policy Non Violet Crisis Intervention training, where available Orientation to RAG approved Paediatric Restraint policy prior to implementation.
Criteria for use of Paediatric Restraint techniques	Undergoing medical treatment can be emotionally and psychologically difficult for a child. It is important to prepare children for a medical procedure by communicating what will happen and why. HVDHB Children's Ward is committed to the benefits of play in the Hospital. Play and/or distraction techniques: • Lessen stress and anxiety • Helps children's understand their medical condition and what will happen • Assists with coping strategies and with treatment • Children's feel more confident and in control • Aids in assessment and diagnosis • Speeds recover and rehabilitation Paediatric restraint should be used in conjunction with play and/or distraction techniques. Restraint is limited to procedures where the safety of the patient and/or clinician requires part of the body to be held to enable clinical investigation and/or treatment.
Consent	Before commencing any procedure, clinical staff will explain to the family / whanau the rational supporting the decision to restrain the child and seek their consent.
Methods of Restraint Approved for Paediatric Patients	The types of acceptable physical restraining for paediatric patients are: Age appropriate devises used for safety: • Cot-sides on bed • Cots/Incubators – for use whilst sleeping/resting and for recovery use and for temperature management • High handles on doors/gates at the end of the ward • Highchairs with five-point safety harness • Pushchairs with five-point safety harness and brakes • Baby chairs /Car-seats with five-point harness • Wheelchairs with lap belts or five-point harnesses Specific restraint used in Clinical Practice: • Splint on limbs to secure cannulas. Splints may at time be covered to

	prevent the child removing their IV line. • Splint on limbs to prevent the child from touching affected areas after surgery • Use of bolsters/pads within wheelchairs to facilitate safety and positioning of the child. • Use of comfort positioning and distraction • Mitten on hands to prevent skin trauma and pulling out of tubes.
Personal Restraint Limitation	Personal restraint (physically holding a paediatric patient) is limited to the holding of a limb or other body part (including the head and trunk) to enable safe and effective patient assessment or application of treatment techniques.
Acceptable Personal Restraint Techniques with Consent	The types of personal restraint that may be required to use with infants and children as part of evidence-based clinical practice including: Holding or immobilising a body part for a clinical intervention e.g. • Insert a cannula for treatment or blood tests • Administer intramuscular injections • Insert suction catheters, pass a naso-gastric tube • Radiology examination e.g. x-ray • Dressing changes e.g. burns • Lumbar punctures or postural drainage • Taking clinical observations e.g. obtaining a temperature • Total body wrapping for the insertion of tubes so to minimise the risk of the tube being pulled out • Total body wrapping of the child for eye drop administration Gloves or mittens may be put on the child to prevent the child from pulling at tubes or scratching themselves. These must be removed at regular intervals for short period of time to allow freedom of movement and inspection of the hands/fingers. Parents may help hold their own child if they are willing and able.
Monitoring and Evaluation	Monitoring will be through continuous observation and communication to the child and their family / whanau.
Medication Administration	Holding and immobilising a child and forcing them to swallow medicines against their wishes should be avoided. Helping the child understand why they must have the medication and what will happen if they do not, should be attempted. Parents/care givers may have developed strategies at home that can also be used in hospital. Wherever possible medication administration should be delivered in the same method and time used at home.
Calling for Non-Clinical Assistance	Orderlies staff should only be called in a situation when a child is in imminent danger to themselves or others. Mental Health consultation and assistance should be requested when mental health issued have been identified or are suspected.

Documentation	Document the planned use of paediatric restraint in the clinical notes. Complete a Reportable Event Form and Restraint Review Form.
Debriefing	Where indicated, to occur in accordance with HVDHB Critical Incident Debriefing procedures
	RAG Approval Register No: 0010
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Appendix 10 a

Safety on the Children's Ward

Kia Ora and Welcome

We understand that having your child in the hospital can be stressful for you and your family. We would like to make your stay as pleasant and safe as possible for you and your family. We would therefore appreciate it if you could take the following precautions to ensure a safe environment is maintained for you, your family and other children and family in the ward.

Bedside

- Ensure cot-sides are up at all times to avoid injuries and falls.
- Inform your nurse if you have to leave the ward, in case we need consent for treatment or your child becomes upset
- Children and siblings are to be supervised by an adult 16 years and above at all times.
- Only one caregiver or parent may stay overnight.
- During the daytime, the curtains around the bedside should remain open, unless a health professional is with you and your child or there is a specific need for privacy e.g. breast feeding/nappy changes
- In isolation rooms, blinds should be kept open for the same reasons

Pre-operative

- If your child is going to theatre, the anaesthetist sometimes prescribes medication to calm and relax your child.
- If your child has had medication he or she may be drowsy and therefore should be in a bed with the cot-sides up, and under direct supervision of a parent or caregiver. This is to ensure safety from falls and injuries

Post-operative

- When your child returns from theatre he or she would be drowsy and tired.
- Ensure that cot-sides or bedrails are up at all times.
- Child should be supervised at all times.
- If you have to leave the ward, ensure that you inform your nurse.
- Please discuss with your nurse before feeding your child.

Isolation

Sometimes children are cared for in isolation. There are different types of isolation, some are to protect the child in isolation, and others are to protect other children in the ward. When in isolation no siblings or visitors are allowed, to prevent them from becoming unwell or spreading the infection. Please follow the isolation precaution sign outside your Childs door. We will give you more information if your child is admitted into an isolation room

Siblings and Visitors

- Siblings are allowed to visit from 3pm-5pm only.
- Siblings need to be supervised by a parent or caregiver at all times.

Timeout

It is important for you to have timeout. We have a parent room which you can have to have hot drinks. No hot drinks are allowed in the ward for the safety of your child and other children in the ward. This room is for adults only

Appendix 10a

Paediatric Restraint

Undergoing medical treatment can be emotionally and psychologically difficult for a child. It is important to prepare children for a medical procedure by communicating what will happen and why. HVDHB Children's Ward is committed to the benefits of play in the Hospital. Play and/or distraction techniques:

- Lessen stress and anxiety
- Helps children's understand their medical condition and what will happen
- Assists with coping strategies and with treatment
- Children's feel more confident and in control
- Aids in assessment and diagnosis
- Speeds recover and rehabilitation

The types of acceptable physical restraining for paediatric patients are:
Examples of age appropriate devises used for safety (but not limited to):

- Cot-sides on bed
- Cots/Incubators – for use whilst sleeping/resting and for recovery use and for temperature management
- High handles on doors/gates at the end of the ward
- Highchairs with five-point safety harness
- Pushchairs with five-point safety harness and brakes
- Baby chairs /Car-seats with five-point harness
- Wheelchairs with lap belts or five-point harnesses

Paediatric restraint may be used in conjunction with play and/or distraction techniques. Restraint is limited to procedures where the safety of the patient and/or clinician requires part of the body to be held to enable clinical investigation and/or treatment.

Before commencing any procedure, clinical staff will explain to you and your family/whanau the rational supporting the decision to restrain the child and seek your consent.

During your child's stay, we may have to perform certain procedures.

For example: Specific restraint that may be used in Clinical Practice (but not limited to):

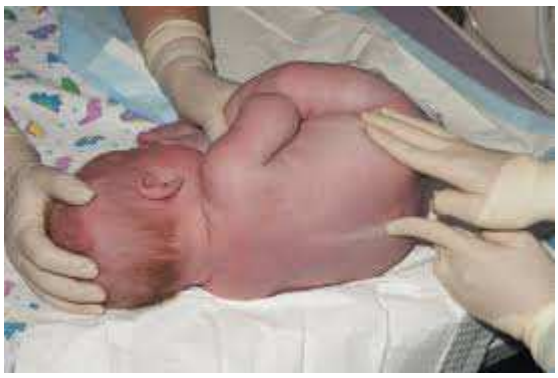
- Splint on limbs to secure cannulas. Splints may at time be covered to prevent your child removing their IV line.
- Splint on limbs to prevent your child from touching affected areas after surgery
- Use of bolsters/pads within wheelchairs to facilitate safety and positioning of your child.
- Use of comfort positioning and distraction
- Mitten on hands to prevent skin trauma and pulling out of tubes.For these medical procedures your child will need to sit or lie still, and they may need some help to achieve this. We immobilise or limit movement to enable safe and effective treatment.

Personal restraint (physically holding a paediatric patient) is limited to the holding of a limb or other body part (including the head and trunk) to enable safe and effective patient assessment or application of treatment techniques.

The types of personal restraint that may be required to use with infants and children as part of evidence-based clinical practice including (but not limited to):
Holding or immobilising a body part for a clinical intervention e.g.

- Insert a cannula for treatment or blood tests
- Administer intramuscular injections
- Insert suction catheters, pass a naso-gastric tube
- Radiology examination e.g. x-ray
- Dressing changes e.g. burns
- Lumbar punctures or postural drainage
- Taking clinical observations e.g. obtaining a temperature
- Total body wrapping for the insertion of tubes so to minimise the risk of the tube being pulled out
- Total body wrapping of the child for eye drop administration

Insertion of intravenous line



Lumbar puncture

Gloves or mittens may be put on your child to prevent them from pulling at tubes or scratching themselves. These will be removed at regular intervals for short period of time to allow freedom of movement and inspection of the hands/fingers.

As parents, you may help hold your own child if you are willing and able.
You are welcome to be present during the procedure. All attempts will be made to minimise distress to your child including involving the play therapist to provide distraction (if available).

We will continuously communicate to you, your child and their family/whanau. Your child will be continuously monitored throughout the procedure by continuous observation.

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Appendix 11 HVDHB RAG APPROVAL FORM

Type	**[ ] Restraint** **[ ] Safe Practice – clinical procedure** **[ ] Enabler – voluntary**
Purpose	
Scope	
Staff education/ongoing training	
Criteria for use of ……..	
Before initiating use of …….	
Procedure	
Consent	
Monitoring & Evaluation	

Documentation	
Debriefing	
Issued Date **Review Date** **Approved Date**	**RAG Approval Register No:**

Appendix 12

Restraint/Enabler/Safe Clinical Practice Consent Form

Intervention: _____

Type ( ) Restraint
( ) Enabler - Voluntary
( ) Safe Clinical Practice

Purpose: (e.g. to prevent patient being injured or causing injury to another person)
_____

_____

_____

I consent to use restraint /enabler/safe clinical practice measure for my _____
(please circle one)

_____

Patient Name (Stickie Label)

I understand the explanation provided of the risk/s involved with using and not using the restraint/enabler/safe clinical practice (please circle one).

Signature: _____ Witness: _____
(Patient/ EPOA/Next of Kin)

Date: _____ Date: _____

Appendix 13

Restraint Monitoring Form

(24-Hour Period)

Name of Patient: _____ Date: _____

Form of Restraint: _____

Frequency of Checks: _____

Time Applied	Time Removed	Intervention/s	ABC*	Food / Fluid	Toileting	Positioning Note: at least every 2 hours	Skin Care e.g. Pressure Area	Environmental Safety	Psychological Care	Comment/s	Staff Name, Designation and Signature

Note: * ABC – Airway, Breathing and Circulation Complete physical examination within each every 24 hour period (to be documented in the Intervention/s section). CNM to review and then email form to Quality Team **daily at 7am**.