9 January 2018

Health Sector Workers Network

By email: fyi-request-7004-403babd4@requests.fyi.org.nz

Official Information Act request

Thank you for your request for information dated 13 December 2017 for:

- all policy documents relating to restraint practices at Waikato DHB; and
- all instances of restraint for physical and mental health services for the period June 2016 to June 2017.

I **enclose** all the information which is covered by your request.

Yours sincerely

Sue Hayward
Chief Nursing & Midwifery Officer
Waikato DHB

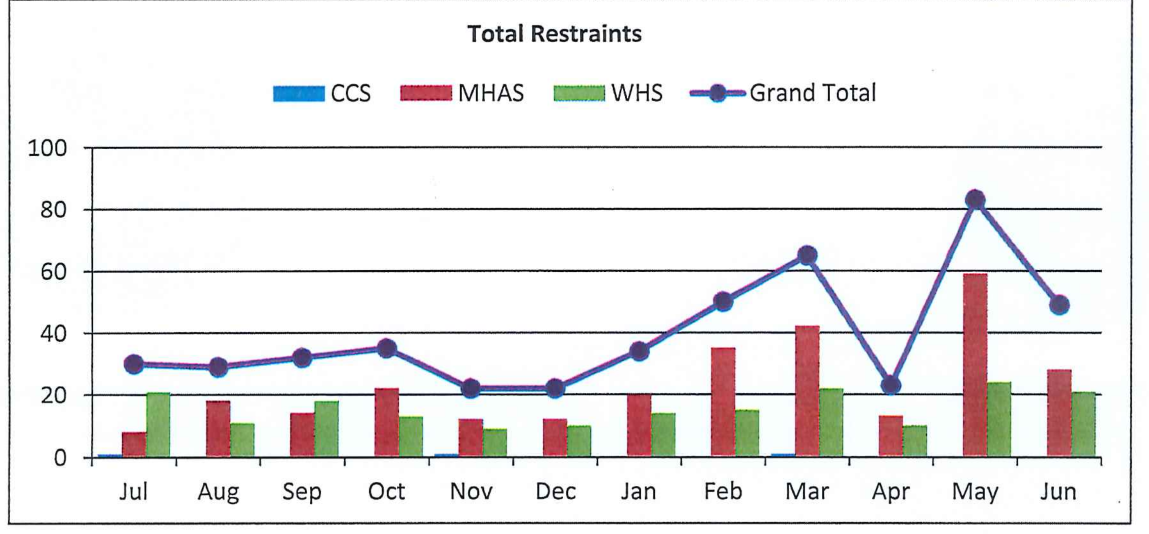
June 2016 to June 2017 statistical data captured on the Waikato DHB restraint register.

Restraints by hospital:

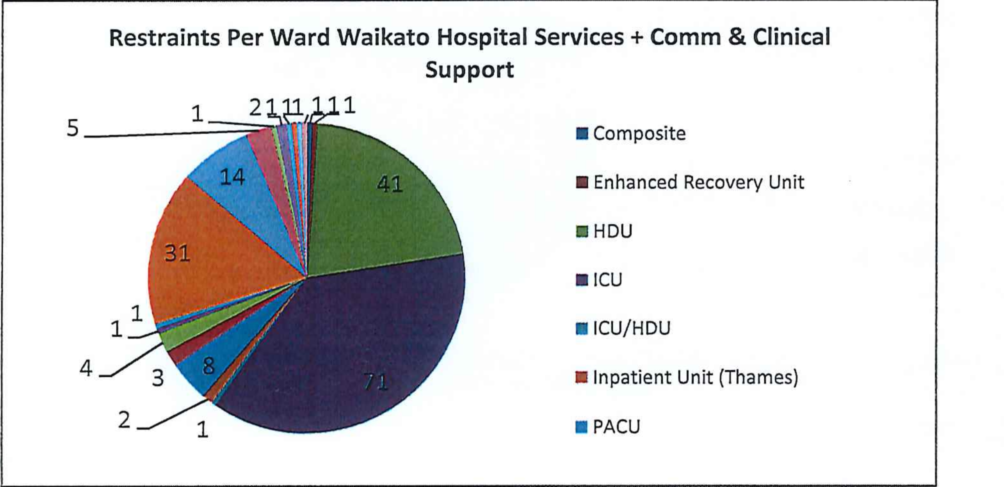
Waikato	182
Mental Health inpatient units (HRBC) + older persons OPR1	283
Thames Hospital	2
Community	1
Matariki Hospital based in Te Awamutu	5

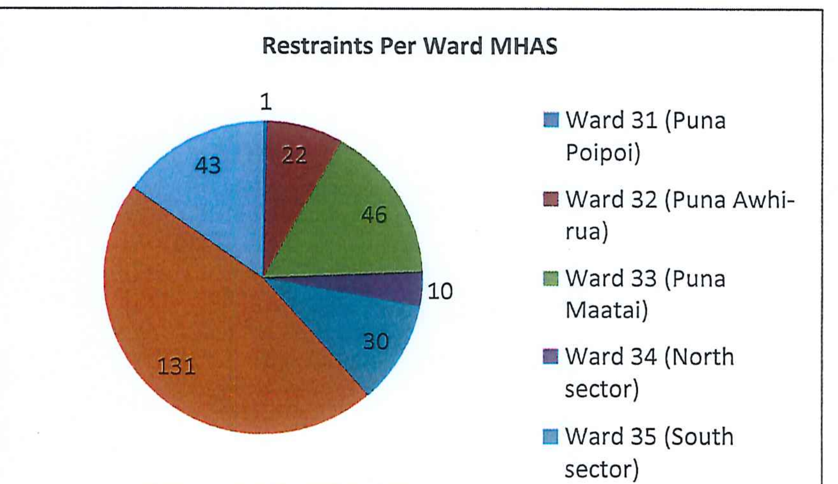
Month	CCS	MHAS	WHS	Grand Total
Jul	1	8	21	30
Aug		18	11	29
Sep		14	18	32
Oct		22	13	35
Nov	1	12	9	22
Dec		12	10	22
Jan		20	14	34
Feb		35	15	50
Mar	1	42	22	65
Apr		13	10	23
May		59	24	83
Jun		28	21	49
	3	**283**	**188**	**474**

Total Number Of Restraints

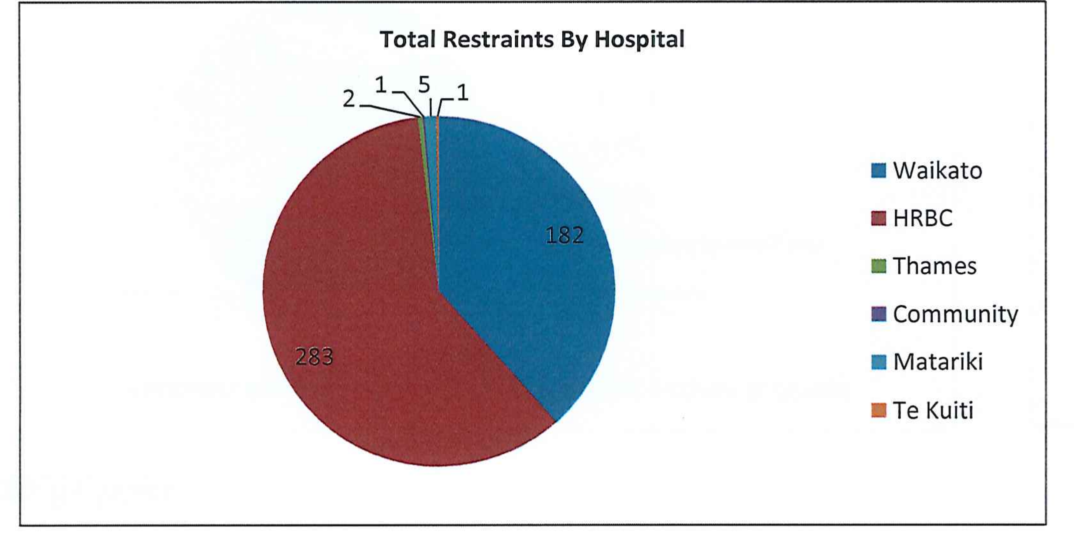


Restraints By Ward

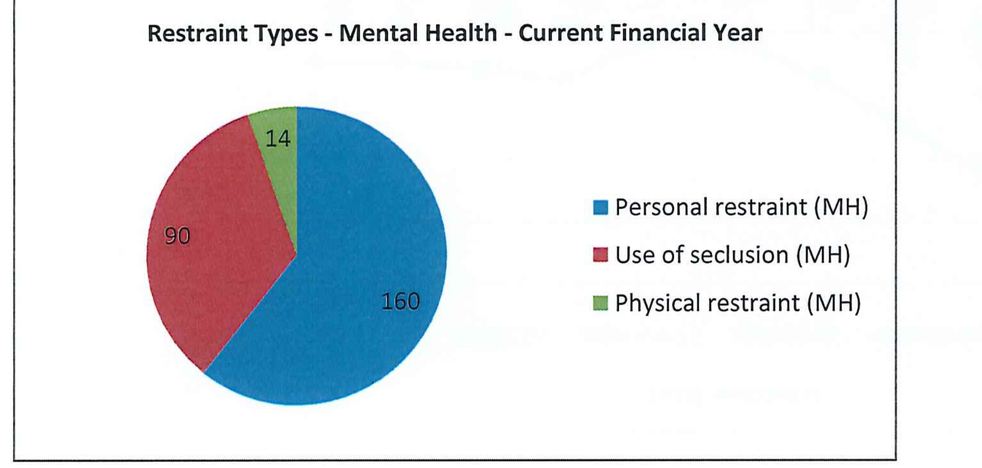


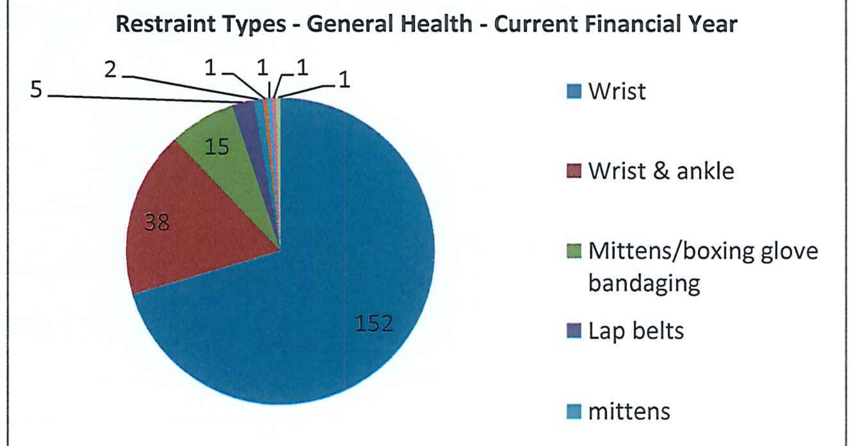


Restraints By Hospital

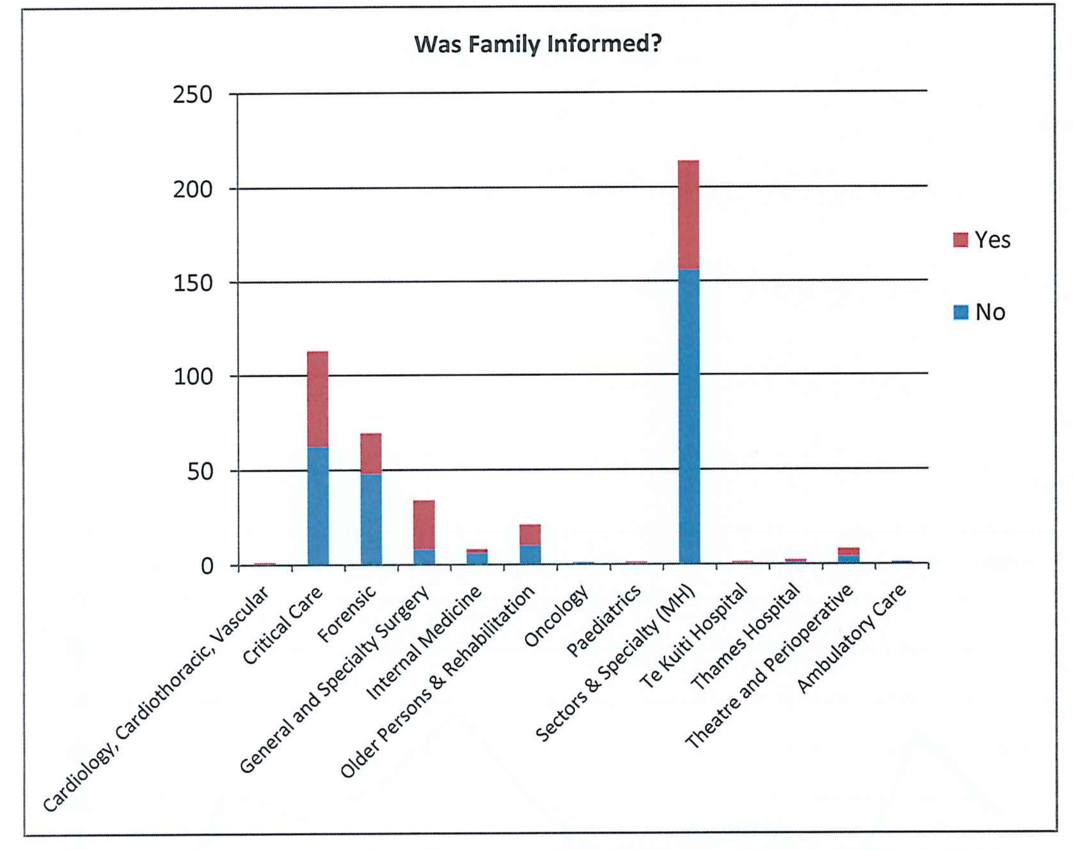


Restraint Types

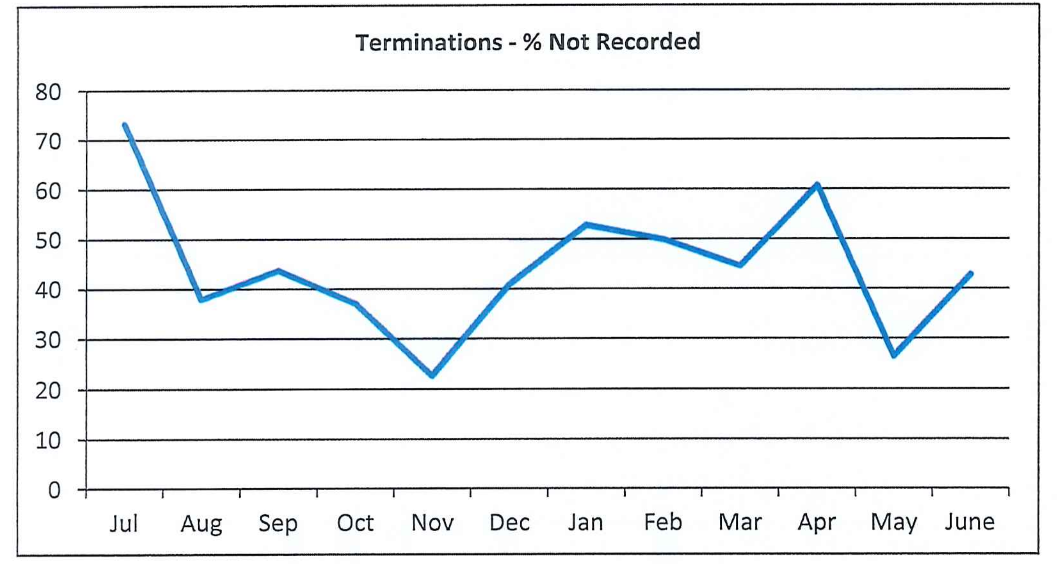




Was Family Informed



Termination



Restraint

Policy Responsibilities and Authorisation

Department Responsible for Policy	Nursing Service
Position Responsible for Policy	Chair Restraint Approval Committee
Document Owner Name	Colleen Hartley
Sponsor Title	Director of Nursing and Midwifery
Sponsor Name	Sue Hayward
Target Audience	Staff involved in restraint processes
Committee Approved	Restraint approval committee
Date Approved	
Committee Endorsed	
Date Endorsed	

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Policy Review History

Version	Updated by	Date Updated	Summary of Changes
05	Colleen Hartley	10th March 2016	Policy reviewed and updated for currency in this practice environment. Changes to the documentation process. New restraint notification form designed to reflect the nursing process, with alignment to the Health and Disability standards. New audit tool designed and implemented to effectively evaluate care.
5.1	Colleen Hartley	November 2016	Addition of decision making grid for use of bed rails as enablers

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1. Introduction

1.1 Purpose

This policy sets out Waikato District Health Boards (Waikato DHB) standards in relation to the use of restraint. The intent of the policy is to maintain consumer safety and wellbeing and, where possible to limit the use of restraint in all its forms.

1.2 Background

"Restraint is a serious intervention that requires clinical rationale and oversight. It is not a treatment in itself but is one of a number of strategies used to limit or eliminate clinical risk.

Restraint should only be used in the context of ensuring, maintaining, or enhancing the safety of the consumer, service providers, or others", NZS 8134.2:2008 Health and Disability Services (Restraint Minimisation and Safe Practice) Standards (the standard).

Waikato DHB supports the reduction in the use of restraint in all its forms and encourages the use of least restrictive practices, as supported by NZS 8134.1: 2008, Health and Disability Services (core standards):

- consumer rights;
- effective and efficient organisational management;
- effective and efficient continuum of service delivery; and
- a safe and appropriate environment.

Waikato DHB considers that restraint minimisation and safe practice in Mental Health and Addictions Services is underpinned by 'Recovery' orientated service delivery. Use of medications is for therapeutic purposes only (refer definition, 'Abuse - chemical restraint').

1.3 Scope

This policy applies to ALL employees of Waikato DHB

1.4 Exclusions

This policy does not apply to:

- Safe Holding/Technical Positioning
  Safe holding which may be part of usual clinical procedures or clinical interventions or to briefly manage clinical symptoms (refer definitions)
- Domestic security
  Domestic security is the practice of locking external doors at night for general security (refer definitions)
- Locked Units
  Where a locked exit is a permanent aspect of service delivery to meet the safety needs of consumers who have been assessed as needing that level of containment (refer definitions).

- Use of restraint recommended and applied by law enforcement officers. i.e. police/prison officers, for reasons other than clinical treatment, is not covered by this policy as it does not fall under the Standard. The police/prison officer has full responsibility for safe law enforcement restraint

2. Definitions

Abuse	*Physical abuse* Infliction of physical pain, injury or force *Psychological/emotional abuse* Behaviour including verbal abuse which causes mental anguish, stress and fear *Sexual abuse* Sexually abusive and exploitative behaviours involving threats, force or the inability of the person to give consent *Chemical restraint* The use of medication, solely to ensure compliance or to render a consumer incapable of resisting
Advance Directive	A written or oral directive: a. By which a consumer makes a choice about a future health procedure; and b. That is intended to be effective only when not competent
Consumer	A person who uses / receives a health or disability service
Cultural Guidelines (Māori)	Waikato DHB recognises the specific cultural needs of Māori. Consideration should be given to cultural requirements whilst restraining tāngata whaiora / tūroro (refer Waikato DHB Tikanga Best Practice Guidelines and Waikato DHB Māori Health Policy)
Cultural safety	Practices which ensure that those receiving the service feel that their culture is respected
Culture	Culture includes, but is not limited to, age or generation; gender; sexual orientation; occupation and socio-economic status; ethnic origin or migrant experience; religious or spiritual belief; and disability
De-escalation	A complex interactive process in which the highly aroused consumer 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 service providers using skills and practical alternatives.
Domestic Security	Domestic security is the practice of locking external doors at night for general security and is not covered by the Standard. 'Night safety orders' are not covered by the Standard. 'Night safety orders' is a term used to describe the practice of locking the entry to a consumer's bedroom overnight at the request of the consumer or locking the entry to an inpatient unit or residential service at night for the general safety of all.

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. N.B. Both enablers and restraint limit the normal freedom of movement of the consumer. Where the intent is to promote independence, comfort and safety, and the intervention is voluntary, this constitutes an enabler. The use of enablers should be the least restrictive option to safely meet the needs of the consumer.
Evaluation	A formal process for determining the extent to which the planned or desired consequences of an action are attained. The organisation routinely assesses service delivery to groups of people who have prolonged or frequent engagement with the health and disability sector
Good practice	The current accepted range of safe and reasonable actions that result in efficient and effective use of available resources to achieve quality outcomes, and minimise risk for the consumer. Current accepted good practice should also reflect standards for service delivery where these exist. This may include but is not limited to: a. Codes of practice; b. Research/evidence/experience-based practice; c. Professional standards; d. Good practice guidelines; e. Recognised/approved guidelines; and f. Benchmarking.
Informed consent	As in the Code of Health and Disability Services Consumers' Rights 1996 (the Code), informed consent is a process rather than a one-off event, involving effective communication, full information, and freely given, competent consent (Rights 5, 6 and 7 respectively). A signature on a consent form is not, of itself, conclusive evidence that informed consent has been obtained.
Locked units	• In a 'locked unit' the locked exit is a permanent aspect of service delivery to meet the safety needs of consumers who have been assessed as needing that level of containment. • Although by definition the locking of exits constitutes environmental restraint the requirements of the Standard are not intended to apply to the locking of exits in 'locked units', where the unit: a. Is clearly designated a 'locked unit'; b. Has clear service entry criteria against which consumers are assessed prior to entry; c. Can ensure consumers using the service continue to meet the service criteria following entry; and d. Can ensure any consumer that does not meet the service criteria has the means to independently exit the unit at any time. In the absence of any of the above points, the locking of exit doors should be treated as environmental restraint.
Multidisciplinary	Members from various disciplines who work together to determine goals, evaluate outcomes, and make recommendations.
Recovery	Recovery is defined as the ability to live well in the presence or absence of one's mental illness (or whatever people choose to name their experience). 'Blueprint for mental Health Services in New Zealand: How things need to be' (Mental Health Commission).

Restraint	The use of any intervention by a service provider that limits a consumer's normal freedom of movement. (For interventions that limit a consumer's 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 consumer's normal freedom of movement. For example: where a consumer is unable to independently get out of a chair due to: the design of the chair, the use of a belt, or the position of a table or fixed tray. *Environmental* Where a service provider intentionally restricts a consumer's normal access to their environment. For example, where a consumer's normal access to their environment is intentionally restricted by locking devices on doors or by having their normal means of independent mobility (such as a wheelchair) denied. *Seclusion* Where a consumer is placed alone in a room or area, at any time and for any duration, from which they cannot feely exit.
Restraint Approval Committee (Waikato DHB)	The Restraint Approval Committee (Waikato DHB) reviews the use of and monitors restraint at least quarterly and reports information to Board of Clinical Governance. The Restraint Approval Committee reviews and approves all proposed changes to restraint use / type across the DHB and this includes systems and processes. The Restraint Approval Committee shall review any staff or consumer concerns related to the use or misuse of restraint. The Restraint Approval Committee shall review the use of restraint based on data and audits obtained from the Quality and Patient Safety service (refer section 4.3).
Restraint episode	A restraint episode refers to a single restraint event, or, where restraint is used as a planned regular intervention and is identified in the consumer's service delivery plan, a restraint episode may refer to a group of restraint events.
Review	A formal process of updating and amending or re-planning based on evaluation of outcomes.
Safe holding / technical positioning	Safe-holding which may be part of usual clinical procedures or possible clinical interventions, e.g. plaster casts, IV splints, paediatric limb splints, positioning and support during procedures, or to briefly manage clinical symptoms. Safe-holding, supporting and the positioning of a consumer so that a procedure can be carried out in a safe and controlled manner with their

	consent, is not considered a form of restraint Safe-holding, when the consumer is not competent/fully conscious short-term, i.e. emerging from general anaesthetic is acceptable when used for immediate consumer safety and therapeutic purposes and is within accepted clinical practice. Under these circumstances, this is not considered restraint, as this an expected post-anaesthetic recovery room nursing intervention
Seclusion	Refer definition of restraint above
Whānau / family	The family or an extended family/group of people who are important to the person who is receiving the service.

3. Policy Statements

- The Waikato DHB policy for restraint management is that:
- All methods and equipment for restraint will be approved by the Waikato DHB Restraint Approval Committee
- Unauthorised use of restraint may be considered unlawful
- Authorised restraint is an approved, skilled intervention that may be used to prevent individuals from harming themselves, endangering others or seriously compromising the therapeutic environment
- Restraint is to be used only after all less restrictive interventions have been attempted and found inadequate
- Local procedures for use of restraint in clinical areas shall reflect robust clinical decision-making processes, and meet Māori cultural requirements
- Local procedures for use of restraint in clinical areas shall reflect robust clinical decision-making processes, and meet all cultural requirements for the person having them applied
- Where any form of restraint is used there must be appropriate documentation in the clinical record, and appropriate monitoring of the consumer's clinical outcome
- Use of medication for restraint without valid clinical indications is considered to be an abuse and is not supported by Waikato DHB
- Seclusion and restraint shall not be used by providers for punitive reasons; or as a component of consumer's treatment plan to modify unwanted behaviour. Seclusion may only be used to manage safety
- Where restraint is used as an enabler, it shall be voluntary and only be used following appropriate assessment. Enabler use shall be monitored and evaluated.

4. Policy Processes

4.1 Roles and Responsibilities

All Staff

The requirements of legislation, external standards and relevant professional codes of practice are met throughout episodes of restraint to ensure consumer rights are protected and use of restraint is actively minimised.

The use of **enablers** must be **voluntary** and be the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.

Clinicians

Employees using restraint must be trained in the use of restraint and shall have completed the appropriate self-directed learning package

Staff must recognise the consumer may have increased need to access advocacy and support during restraint, ensure consumers are informed of this right, and facilitate this access where the need is identified or requested.

All use of restraint shall be documented based on:

- promotion of the safety of all involved
- effective risk assessment and clinical decision making
- focus on de-escalation and the minimisation / elimination of restraint
- best practice healthcare to the consumer and be free from discrimination, coercion, harassment, sexual, financial or other exploitation.
- respect the specific cultural needs of the consumer
- not unnecessarily compromise the consumer's dignity, privacy, confidentiality, self-respect, treatment and recovery
- be documented on the Waikato DHB Restraint Event Notification (REN) Use form T1738HWF
- when any injury occurs due to the restraint process log the incident in Datix, the Waikato DHB electronic Risk Management System

Relevant cultural advice and / or guidance is sought in order to maintain and practice cultural safety (see Tikanga Best Practice guidelines 2118).

Staff must ensure that each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration and outcome of the restraint.

Appropriate and timely communication with the consumer and their whānau /family of all decisions relating to restraint intervention must occur.

Each episode of restraint shall be evaluated in collaboration with the consumer; and whanau / family if appropriate.

Evaluation methodology may include the documentation / record review; interviews with staff, consumer and Māori; visual inspections; and consumer service provider, Māori and linked services / family / whanau questionnaires (NZS 8134.0: 2008, p.17).

Managers and Clinical Leadership

The service philosophy on restraint is congruent with Waikato DHB policy, and is effectively communicated to all staff.

Line managers/ Charge Nurse and Midwife Managers (CNM/CMM) are responsible to ensure individual compliance of their staff to the Restraint policy.

Restraint Approval Committee
Review the use and monitoring of restraint, concerns raised about restraint, and quality data on restraint use and practice.

4.2 Use of enablers

Enablers are equipment, devices or furniture **voluntarily** used by a consumer that limits normal freedom of movement with the intent of promoting independence, comfort and / or safety e.g. lap belts, bed rails

Enablers should be the least restrictive option to safely meet the needs of the consumer and must only be used following appropriate assessment.

Documentation may indicate consumer agreement and show evidence the use of the enabler has been monitored and evaluated for effectiveness e.g. care plan.

Bed Rails
Bed rails attach to the side of beds and are intended to help reduce the risk of accidentally slipping or rolling off the bed. Bed rails may also enable patient movement in and around the bed and be used for security.

Using bedrails increases the risk of bruising, skin tears, entrapment and inducing agitated behaviour. They generally do not avert a determined patient from getting off the bed and may contribute to an increased falls risk it they are used as a form of restraint, to that end the Waikato DHB views bed rails to be used as enablers. They are not a form of restraint.

In order to guide the clinician in the use of bedrails, the decision grid below outlines the recommend use.

This grid is to be used with clinician discretion, as part of a clinical assessment and documented appropriately in the patient care plan.

Bed Rail Decision Guide			
The Patient is:	Immobile	Require assistance to mobilise	Independent with mobilisation
Orientated & Alert	May be used	May use with care	Not Recommended
Drowsy	May be used	May use with care	Not Recommended
Confused & Disorientated	Not recommended	Not Recommended	Not Recommended
Unconscious	May be used	N/A	N/A

Auckland City Hospital & National Patient Safety Agency, Using Bedrails Safely and Effectively: London NPSA, 2007

4.3 Use of restraint

4.3.1 Indications for use of restraint

Restraint may be considered as one of a range of possible interventions in the care setting. The following are situations where restraint may be appropriate:

- When a consumer's condition or behaviour indicates an immediate and ongoing high risk of serious self-harm (either deliberate or unintentional)
- When a consumer's behaviour poses immediate and ongoing serious risk to others e.g. when an individual makes, or is likely to make a sustained or serious attack on another person
- When a consumer seriously compromises the therapeutic environment e.g. by damage to property, social milieu or relationship with other consumers or staff
- When it is necessary to give essential clinical treatment to an individual who is refusing treatment, and the treatment has been deemed to be clinically necessary by a registered health professional (preferably in consultation with the clinical team) e.g. consumers admitted under the Mental Health Act, patients with head injuries, etc. See Waikato DHB Informed Consent policy regarding impaired competence
- When there is legal support to carry out the prescribed treatment against the consumers' will

4.3.2 Consideration prior to use of restraint

Use of restraint must be considered as the option of last resort. Services shall ensure **rigorous comprehensive assessment** of consumers is undertaken; and care processes reflect the intent of ensuring patient safety and wellbeing which actively minimises the use of restraint.

The following factors must be considered prior to the use of restraint:

- the consumer's physical and psychological health and intellectual capability
- Clinical conditions that may cause behavioural changes must be considered prior to the use of restraint e.g. pyrexia, pain levels, dehydration, continence, etc.
- possible alternative intervention/strategies
- awareness of the consumer's gender i.e. it is desirable to have any form of restraint carried out by a staff member of the same gender
- awareness of the consumer's culture and cultural values
- the degree of risk to the individual, others and the environment
- existing advanced directives
- whether the consumer has been restrained in the past and, if so, an evaluation of these episodes,
- any history of trauma or abuse which may have involved the consumer being held against their will
- identified desired outcome and criteria for ending restraint (this is to be explicit and as much as practicable made clear to the consumer).

Restraint must always be used in a manner that maximises the safety of the consumer and others. It must involve the use of the minimum level of force necessary to achieve and maintain safe control.

De-escalation techniques or other alternative interventions or strategies must be considered as outlined in the Self-directed learning package. If the behaviour is threatening and presents a high level of danger to staff or public safety then security / emergency response team / police intervention shall be considered and accessed as appropriate.

4.3.3 Education and training in restraint

All staff will have knowledge of "The Code of Health and Disability Service's Consumers Rights 1996", including assisting patients to access the information.

All staff shall have knowledge of scopes of practice, relevant legislation, Waikato DHB relevant policies and procedures including knowledge of the Tikanga Best Practice Guidelines and other cultural considerations.

Practice and training in use of restraint should ensure that any techniques are firmly grounded in the context of good clinical practice (refer appropriate clinical training manuals).

All employees using restraint must be trained and have completed the appropriate self-directed learning packages; and specific trainings as appropriate to service area. This information is to be included in ward/unit orientation. These resources shall be approved by the Waikato DHB Restraint Approval Committee.

All staff using restraint shall update the self-directed learning package every three years and submit evidence of completion to CNM / CMM / Nurse Educator (NE) / Team Leader

It is the responsibility of the Line Manager / CNM / CMM to ensure that individual records of restraint training and education are held for all staff as per current tracking process.

4.3.4 Initiating and using restraint

The order to use restraint must be made by a registered health professional.

It shall be documented in the patient's clinical record and on the Restraint Event Notification (REN) FormT1738HWF.

Upon initiation of restraint, a Waikato DHB Use of Restraint Event Notification (REN) Form is completed and scanned to Quality and Patient Safety. All other processes are to be followed.

Only techniques of restraint approved by the Waikato DHB Restraint Approval Committee may be applied.

Restraint is initiated **only** when adequate resources are assembled to ensure safe initiation and use.

Family and / or consumer advocate may be consulted to advocate for the consumer.

Requirements for documentation in the clinical record must be met.

Use of seclusion must not occur outside Mental Health Inpatient Services (refer 5.0 Seclusion).

Where a consumer requires one-to-one supervision or constant observation, the requirements of Mental Health Risk: The Assessment and Management of Consumers/Tāngata Whaiora at Risk of harm to self or others procedure (5241).

Policy 1811 "Suicidal or deliberate self-harm thoughts or behaviour management of patients must be complied with.

In an emergency situation, any person may apply approved restraint under the direction of a registered health professional.

4.3.5 Monitoring and care during restraint

Waikato DHB Restraint policy and procedures inform and guide services in ensuring adequate and appropriate observation, care, dignity, respect, and on-going assessment occurs to minimise the risk of physical and psychological harm to consumers during restraint.

The frequency and level of observation and assessment should be appropriate to the level of risk associated with the restraint procedure, and setting in which it is occurring. They should reflect current accepted good practice and the requirements of the standard.

Monitoring of physical restraint is recorded as per approved procedure, using the reverse side of the Waikato DHB Restraint Event Notification (T1738HWF).

Monitoring forms approved by the Waikato DHB Restraint Approval Committee outside this process are. ICU Monitoring Sticker, Seclusion Record / Monitoring form (A1029MHF).

Re-evaluation and documentation of the continuing need for restraint use shall occur at each monitoring time as stated in the restraint procedure.

If there is any clinical, physical or psychological deterioration noted, the consumer must be reassessed by a registered health professional, appropriate action and treatment given.

A Waikato DHB Incident report form (109481) must be completed if the consumer suffers an adverse event.

4.3.6 Restraint procedures

All restraint devices and processes must be approved by the Restraint Approval Committee along with other relevant DHB document processes before the restraint can be used.

Every area / service using restraint must:

- use approved restraint procedures
- **where there is no relevant restraint procedure, the service must develop the procedure for the use of restraint, using the Waikato DHB Procedure template (available from the intranet),**

Restraint procedures shall identify:

- description of types of restraint used
- how the consumer's personal and cultural needs will be met
- standards for maintaining effective and timely communication – where clinically appropriate - with the consumer and their family / whānau - during and after restraint
- documentation and monitoring associated with each type e.g. ICU Restraint Monitoring sticker, e-Seclusion Authority form (and Monitoring and Review Mental Health and Addictions Service only) and standard REN T1738HWF

4.3.7 Terminating restraint

Restraint termination is the responsibility of a registered health professional.

Restraint termination occurs following assessment of the consumer and a decision that restraint is no longer required.

Restraint termination must ensure the safety and dignity of the consumer and the staff at all times.

- Upon termination of restraint, completion of "the termination" section on the REN, (questions 5, 6, and 7) is required.
-
- One copy of the REN is to be retained on the ward and one copy placed in the clinical notes.

However, and notwithstanding the above requirements in an emergency situation **any** staff member may remove a consumer from their restraint.

4.4 Documentation and evaluation of restraint use

4.4.1 Documentation of restraint

All use of restraint shall be documented in the consumer's clinical record and include:

- the reasons for the restraint
- the alternatives tried or attempted prior to restraint use
- the type of restraint and equipment used
- risks associated with the use of restraint and strategies to minimise these
- the names of all staff, consumers and others involved in the restraint process are documented on the REN
- a record of restraint monitoring
- notification of family / whānau / significant others of the need for restraint
- evaluation of restraint use and consumer/family whānau response to use of restraint as appropriate

- the alternatives implemented / attempted prior to restraint
- the observations made.

Restraint use must be documented on the REN form T1738HWF and monitoring must be documented on the reverse

Restraint use must be documented on all associated forms i.e. those specific to clinical area, and those generic to Waikato DHB Quality and Patient processes (refer Associated Documents).

4.4.2 Evaluating and review of restraint

Each episode of restraint shall be evaluated:

General Health:

- whether the desired outcome was achieved
- whether observations and monitoring were adequate and maintained the safety of the consumer

Mental Health and Addictions:

in collaboration with the consumer, and where appropriate their family / whānau

This review shall consider:

- future options to avoid the use of restraint
- whether the consumer's service delivery plan (or crisis plan) was followed
- any review or modification required to the plan
- whether the desired outcome was achieved
- whether restraint was the least restrictive option to achieve the desired outcome
- the duration of the episode and whether this was the least amount of time required
- the impact the restraint had on the consumer including any issues or injuries. Any such injuries should be notified via the incident reporting system (refer Waikato DHB Incident Management policy)
- whether appropriate advocacy / support was provided or facilitated
- whether observations and monitoring were adequate and maintained the safety of the consumer
- any suggested changes or additions required to restraint training for staff.

It is the CNMs or line managers responsibility to ensure overall restraint use is evaluated, including:

- Staff compliance with policies, procedures and certification
- All interventions for restraint minimisation were tried prior to the appropriate restraint device being applied
- Reporting adverse outcomes

An annual audit of restraint use will take place through the Restraint Advisory Committee audit process. This form may be found on the intranet. The purpose of this audit will be to identify whether:

- Changes to the procedures are required
- Additional training or education is needed
- Changes to existing devices is required

A collated report and recommendations to be provided to the Restraint Approval Committee from the Directorate on an annual basis for endorsement.

4.4.3 Evaluating and review of restraint by the Restraint Approval Committee

The Waikato DHB Restraint Approval Committee reviews the use and monitoring of restraint at least quarterly and reports any red flags through to the Board of Clinical Governance.

The Restraint Approval Committee shall review any staff or consumer concerns relating to the use or misuse of restraint.

The Restraint Approval Committee shall review the use of restraint based on data obtained from the Quality and Patient Safety, Mental Health and Addictions Service Seclusion data and audits.

- This shall include but not be limited to:
- extent of restraint use and trends
- organisations progress in reducing restraint
- staff compliance with restraint policies and procedures
- whether additional training or education needed or changes to existing training are required
- any learnings from evaluations.

4.4.4 Restraint use process

Complete Restraint Event Notification form (REN) with the clinical details as requested to question 4.

Scan the Restraint Notification Form to Quality and Patient Safety To comments@waikatodhb.health.nz

Initiate monitoring of the restraint event as described on the Restraint Event Notification form by turning over the form

At completion of the restraint episode ensure the remainder of the Restraint Event Notification form is completed

Copy both sides of the form One copy is filed in the clinical record and the other copy is filed on the ward in the restraint folder for audit purposes

4.5 Seclusion

Safe use of seclusion

Seclusion (refer definition Appendix B) can only be legally implemented subject to the conditions specified in the Mental Health (Compulsory Treatment and Assessment) Act 1992 and the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003.

All seclusion use occurs only when there is an assessed risk to the consumer, to other consumers, service providers or other.

Mental Health and Addictions Service staff will comply with the Use of Seclusion procedure.

Approved seclusion rooms

The seclusion room must: (Health and Disability Standard 3.2)

- Provide adequate lighting, room temperature and ventilation
- Allow the observation of the consumer and allow the consumer to see the head and shoulders of the staff member
- Provide a means for the consumer to effectively call for attention
- Contain only furniture and fittings chosen to avoid the potential for harm

4.6 Cultural considerations for Māori

See definitions, and Tikanga Best Practice guidelines

5. Audit

5.1 Indicators

- Review of restraint use at Waikato DHB occurs at least quarterly by the Restraint Approval Committee and any red flags escalated to the Board of Clinical Governance
- 85% of staff in areas where restraint is used have completed the self-directed learning programme
- All restraint episodes are documented in the clinical record or care plan

5.2 Tools

Restraint use is audited and monitored through the annual audit Programme in October each year using the Waikato DHB audit tool approved by the Restraint Approval Committee

It is the responsibility of the Line Manager/CNM to ensure that records of training are maintained, inclusive of percentage of staff with current training in restraint as per current process.

New clinical staff are provided with the self-directed learning package at Waikato DHB orientation and are required to complete the Moodle training and hand their certificate of completion to their line manager/CNM/CMM/NE within 3 months of starting on the Ward/Unit.

6. Legislative Requirements

6.1 Legislation

Waikato DHB must comply with the following legislation (this list is not exclusive):

- Health and Safety in Employment Act 1992 and Amendments Act 2002
- Health and Disability Services (Safety) Act 2001 and amendments
- Human Rights Act 1993
- Code of Health and Disability Services Consumer's Rights 1996
- Mental Health (Compulsory Assessment and Treatment) Act 1992
- Criminal Procedures (Mentally Impaired Person) Act 2003 and amendments
- Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003
- Protection of Personal and Property Rights Act 1988 (PPPR Act)
- Privacy Act 1993
- Treaty of Waitangi Act 1992.
- Crimes Act 1961 and amendment
- The New Zealand Bill of Rights Act 1990
- Health Practitioners Competence Assurance Act 2003

6.2 External Standards

- Health and Disability Services Standards 2008

7. Associated Documents

7.1 Associated Waikato DHB Documents

Restraint specific

- Waikato DHB Restraint Self Directed Learning Package, and Moodle Certification
- Waikato DHB Restraint Elimination Safe Practice and Effective Communication, Mental Health and Addictions Services, current training package (MHAS only)
- Waikato DHB Restraint Use form (up to three months), (109592)
- 2156 Waikato DHB Restraint - Lap Belts procedure,
- 2154 Waikato DHB Restraint Paediatrics Limb, ICU specific procedure,
- 2153 Waikato DHB restraint Mittens/ Boxing Glove Bandaging procedure,
- 2157 Waikato DHB Restraint - Specialist Chairs procedure,
- 2158 Waikato DHB Restraint- Wrist/ Ankle Restraints procedure
- 2891 Waikato DHB Restraint – Chair Support Brief
- 0538 High Care Secure Lounge Puna Maatai and Puna Awhi rua
- 1860 Waikato DHB Use of Seclusion in Mental Health and Addictions inpatient setting
- 1865 Waikato DHB Use of Personal Restraint in Mental Health and Addictions inpatient setting
- 3727 Waikato DHB Use of Physical Restraint in Mental Health and Addictions inpatient setting
- Waikato DHB Restraint Event Notification (REN) form ((T1738HWF))
- Waikato DHB ICU Monitoring sticker
- Waikato DHB e-Seclusion Authority form (and monitoring & review MHAS only)
- Waikato DHB Seclusion Record / Monitoring (A1029MHF)

Mental Health and Addictions specific

- 5241 Risk: The Assessment and Management of Consumers/Tāngata Whaiora at Risk of Harm to Self or Others procedure
- 5238 Levels of Observation Inpatient Services
- 0896 Family – Whānau Participation Policy

Waikato DHB

- 1969 Waikato DHB Informed Consent policy
- 0138 Waikato DHB Medicine Management policy
- 0104 Waikato DHB Incident Management policy
- 0108 Waikato DHB Māori Health policy
- 0182 Waikato DHB Clinical Records Management policy
- 0001 Waikato DHB Orientation policy

7.2 References

- Ministry of Health (July 2008), Seclusion under the Mental Health (Compulsory Assessment and Treatment) Act 1992. Wellington: MoH

Procedure

Restraint – Wrist and/or Ankle

Procedure Responsibilities and Authorisation

Department Responsible for Procedure	Restraint Committee
Document Owner Name	Colleen Hartley
Document Owner Title	Chair, Restraint Committee
Sponsor Title	Director of Nursing and Midwifery
Sponsor Name	Sue Hayward

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Procedure Review History

Version	Updated by	Date Updated	Description of Changes
6	Colleen Hartley	June 2016	Updating the form name as commensurate with the new process Restraint device changed and procedure updated to reflect this.
6.1	Areann Libline	November 2017	Addition of mental health specific detail for the use of physical restraint in the inpatient setting

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1. Overview

1.1 Purpose

- This procedure specifies the conditions under which wrist and/or ankle restraints may be used, to ensure compliance with the Waikato DHB Restraint Policy.
- This procedure is primarily used in the Critical Care Department, Neurosurgery Inpatient Ward and the Emergency Department but may be used in the ward setting when necessary.

Note: *Restraints applied by Police and / or Prison Officers are not the responsibility of Waikato DHB therefore not subjected to the monitoring requirements as per the restraint policy. The patient still requires appropriate nursing care monitoring by Waikato DHB staff.*

1.2 Scope

Clinical staff at Waikato District Health Board

2. Clinical Management

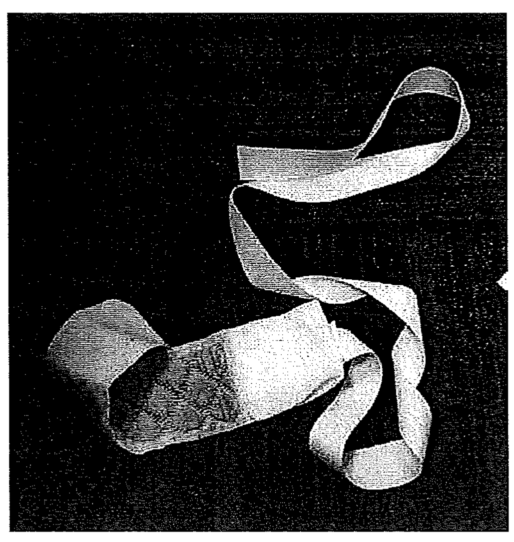
2.1 Competency required

- This form of restraint shall only be applied under the direction of a Registered Health Professional.
- The person applying this restraint shall have completed specific training in its use.
- Completion of this training must be recorded (as from the date of authorisation of this procedure), on the staff member's personal file held in payroll and / or in the department training record.

2.2 Equipment

Universal wrist and/or Ankle Restraint –oracle code 180583 from Propharma

Note: These are the only items authorised for use for wrist and/or ankle restraints.

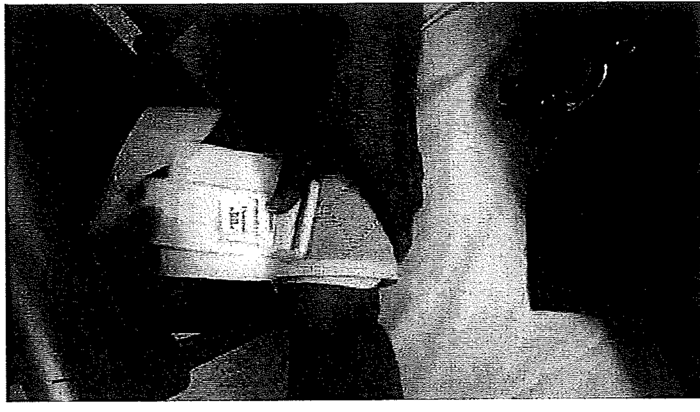
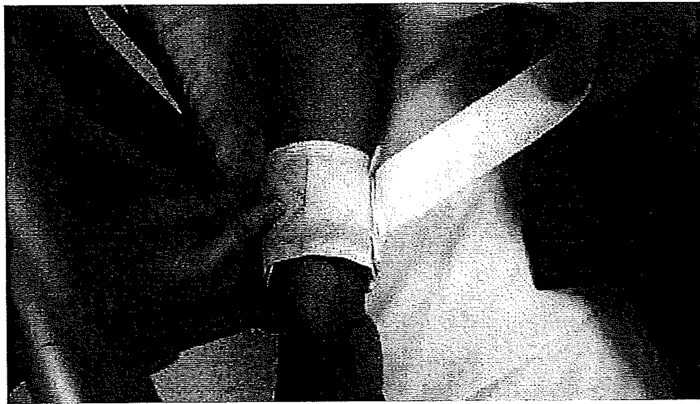
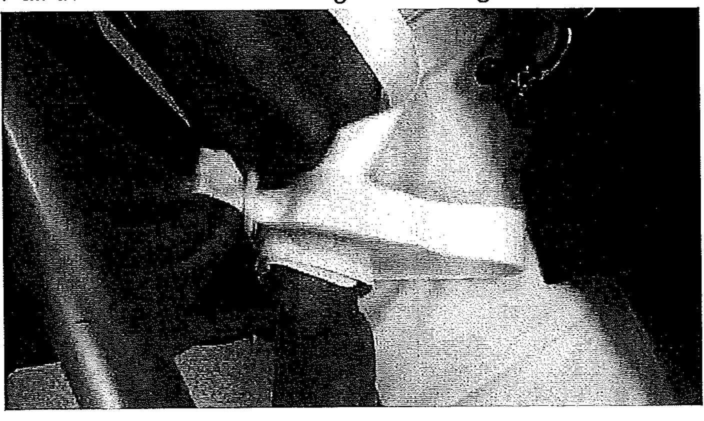


2.3 Criteria for use

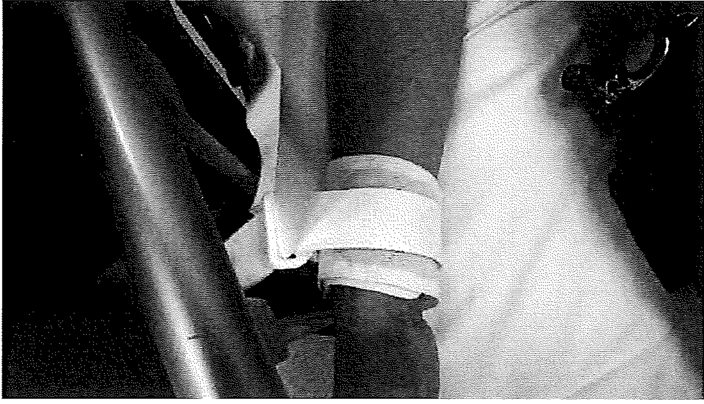
- Wrist restraints should only be used when all other options have been considered.
- Ankle restraints should only be used when all other options have been considered
- When it is necessary to give essential care or clinical treatment to an individual.
- Where an individual is refusing treatment that is deemed clinically appropriate
- At risk of harming self or others

2.4 Procedure

ACTION	RATIONALE
• Assess each patient individually to ensure restraint is appropriate. • Assessment should be completed with thought given to cultural considerations, respect for dignity, patients privacy. • Ensure patients are repeatedly reminded of the reason for restraint.	To ensure options other than restraint have been considered. To identify risk factors associated with the use of restraint and to develop a plan to minimise that risk to the patient. Reduction of patient anxiety with implementation of procedure.
• Request for patient restraint is made by a Registered Health Professional.	Identification of a need to control an unsafe situation.
• Gather equipment required – Universal restraint,	Patient, staff and environment safety.

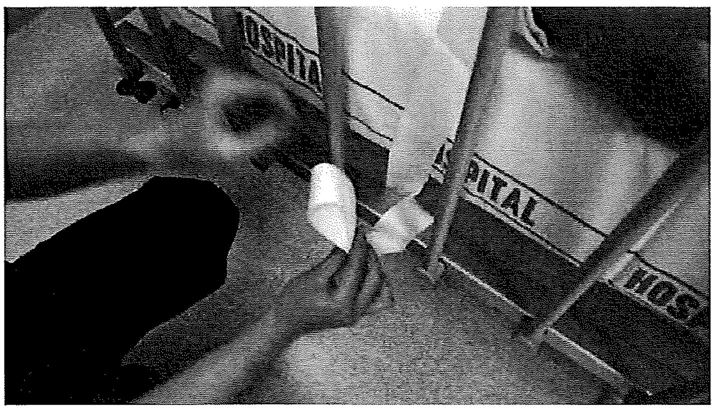
• Ensure area is clear of excess equipment and safe for the patient. Securely wrap the blue band around the patient's wrist or leg.  Ensure the Velcro is securely fastened  Pull the end of the tie through the D ring 	To achieve a safe environment.

And Repeat. The D is the place that takes the pressure from the pulling, not the patient limb.

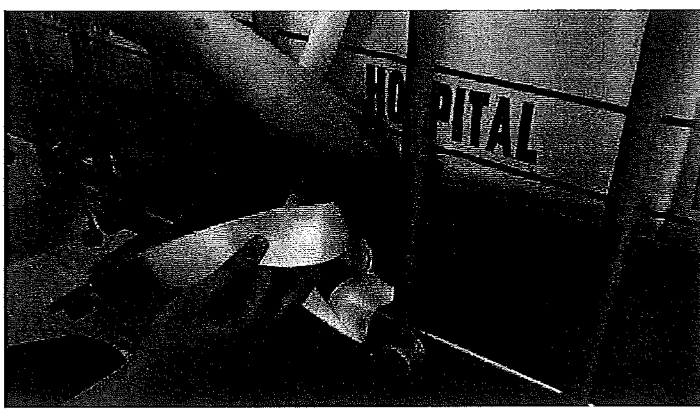


Loop the tie around the bed rail to assist in fastening the restraint

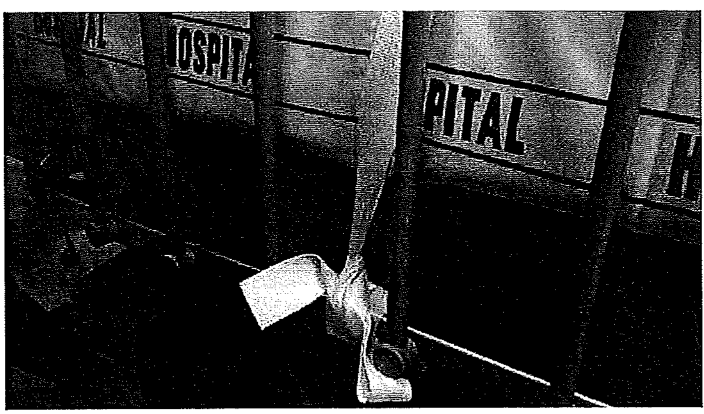
Make a bow loop

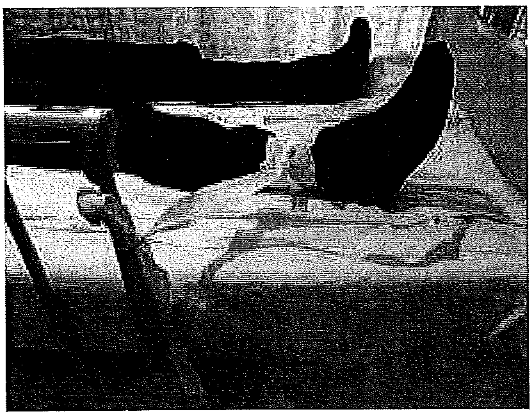


Tie the bow as if you were tying your shoe laces



The final restraint securely tied to the bed will look like this. A quick release knot that enables the nurse to remove the restraint quickly and easily.





• Apply wrist and /or ankle restraints firmly enough to hold the patient, but not so to interfer with circulation distal to the restraint. • Ensure the limb is restrained in a functional position allowing as much movement as safely possible.	Prevent nerve and circulatory injury.
• Inform patient family/whanau as soon as possible to ensure there is full understanding as to why restraint has been applied and document this in the clinical notes. • Ensure appropriate documentation is completed on the Restraint Event Notification, (REN) form #: T1738HWF from print shop • Scan to comments@waikatodhb.health.nz having completed sections 1 - 4.1b • Initiate monitoring as per back of REN	To ensure family/ Whanau understand the need for restraint to achieve patient care requirements in a timely manner.

2.5 Education

- All staff shall have knowledge of "The Health and Disability Service standard 2008"
- All staff shall have knowledge of "The Health and Disability Service Consumer rights" 1996 (Code of Rights)
- All staff shall receive education about the use of Wrist and/or Ankle restraints and alternatives.
- All staff shall have knowledge of Treaty of Waitangi and other cultural considerations regarding use of Restraint

2.6 Monitoring and reviewing

Emergency Department

The Emergency Department will have a dispensation from using the restraint as photographed in this guideline due to their specific clinical needs. They can continue to use the device that suits their clinical needs

The current restraint device can continue to be used for a period of one year, in order for us to evaluate their data. Following this a review will take place in 2017
Monitoring requirements for ED:

- 30-minute observation of limbs restrained - check limb for colour, warmth, movement, sensation and distal pulses and document on REN.
- Check invasive lines underneath restraints for patency, inflammation or bleeding. Keep restrained sites clean and dry.
- Care for patient in a single safe room with limited access if possible
- The restrained patient will be observed through high vigilance of staff in the department.
- Release restraints 2 hourly for inspection and 4 hourly to perform limb range of movement.
- Any adverse reactions i.e. pain, swelling or impaired circulation must be reported immediately to medical staff and must be documented on a Waikato DHB Datix Incident database.
- Ensure patients fluid / nutrition and hygiene needs are met.
- Complete the REN at initiation of restraint episode. Document in the care plan and in the clinical notes, the effectiveness of restraint episode.
- Inform patient family/whanau as early as possible, regarding the patients situation and need for restraint.
- Review and document the need for ongoing restraint every shift.

Critical Care Department

- Critical Care patients are nursed as 1:1 or 1:2 ratios and there is a nurse at the bedside ensuring constant observation.
- Check invasive lines underneath restraints for patency, inflammation or bleeding 2 hourly. Keep restrained sites clean and dry.
- Observe fingers and toes for Neurovascular / circulatory impairment two hourly and PRN and document on 24-hour chart
- Inspect area under restraint for pressure area / trauma 2 hourly and PRN
- Keep restrained sites clean and dry
- Release restraints 2 hourly for inspection and 4 hourly for range of motion.
- Complete the REN at initiation of restraint episode. Document in the care plan and in the clinical notes the effectiveness of restraint episode.
- Inform patient family/whanau as early as possible, regarding the patients situation and need for restraint.
- Review and document the need for ongoing restraint every shift.

Ward Environment

- 30-minute observation of restrained limbs, - check limb for colour, warmth, movement, sensation and distal pulses and document on patient assessment sheet.
- Check invasive lines underneath restraints for patency, inflammation or bleeding. Keep restrained sites clean and dry.
- Release restraints 2 hourly for inspection and for range of motion. (This time frame may be changed to a maximum of 4 hourly from 2300hrs to 0600hrs following clear documented RN assessment.)
- Record in clinical notes and on the Restraint Event Notification form why patient was restrained. The date and time they were applied and the date and time removed.
- Inform patient family/whanau as early as possible, regarding the patients situation and need for restraint.

Mental Health and Addictions Inpatient Services

- The service user / tangata whaiora will be under the appropriate legislation that allows for the provision of the application of physical restraints as a last resort to maintain safety.
- The responsible clinician, senior medical officer or delegate, must support the registered nurses decision to apply wrist and ankle restraints and document the rationale for use in the service users / tangata whaiora clinical notes.
- The appropriate level of observations will be assigned whilst any service user / tangata whaiora is in wrist and ankle restraint, the minimum being high risk observations.
- 30-minute observation of restrained limbs, - check limb for colour, warmth, movement, sensation and distal pulses and document on patient assessment sheet.
- Release restraints 2 hourly for inspection and for range of motion. (This time frame may be changed to a maximum of 4 hourly from 2300hrs to 0600hrs following clear documented RN assessment.)
- The restraint must be reviewed at least once per shift by the responsible clinician, senior medical officer or delegate and written in the clinical notes as to why the restraint continues or ends.
- Record in clinical notes and on the Restraint Event Notification form why patient was restrained. The date and time they were applied and the date and time removed.
- Inform patient family/whanau as early as possible, regarding the patients situation and need for restraint.
- The registered nurse must notify the District Inspector as soon as possible, once the situation is safe.
- The registered nurse must email the Director of Area Mental Health Services as soon as possible, informing them of the physical restraint event.

2.7 Documentation

Documentation requirements are specified in the Waikato DHB Restraint policy.

- Complete the Waikato DHB Restraint Event Notification (REN) Form sections 1-4b.

- This must be scanned to comments@waikatodhb.health.nz Quality and Patient Safety (QPS) after completion of above sections.
- Initiate monitoring as per the restrain monitoring form on the back of the REN
- Ensure the patient care plan is updated appropriately
- Ensure there is an entry into the clinical notes each shift the patient is restrained
- Complete a Waikato DHB Datix Incident database for any adverse events as a result of the wrist and ankle restraints.
- Involvement of the patient and family / whānau in the evaluation of the restraint is documented in the clinical records and on the "Restraint Use Form" as is appropriate

3. References

- Restraint Minimisation and Safe Practice (NZS 8141:2001)
- HAPNZ Long Term Care Accreditation Standards
- Waikato DHB Restraint policy (Ref. 2162)

Restraint – Lap Belts

Procedure Responsibilities and Authorisation

Department Responsible for Procedure	Restraint Committee
Document Owner Name	Colleen Hartley
Document Owner Title	Chair, Restraint Committee
Sponsor Title	Director of Nursing and Midwifery
Sponsor Name	Sue Hayward
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5	Colleen Hartley	June 2016	

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1. Overview

1.1 Purpose

This procedure specifies the conditions under which lap belts may be used and ensures compliance with the Waikato DHB Restraint Policy.

Where lap belts are used as an enabler at the request patient's request to assist them maintain independence, and where patients can operate the restraint independently, is not included in the procedure.

1.2 Scope

Clinical staff at Waikato District Health Board

2. Clinical Management

2.1 Competency required

- This form of restraint shall only be applied under the direction of a Registered Health Professional.
- The person applying this restraint shall have completed specific training in its use. Completion of this training must be recorded (as from the date of authorisation of this procedure), on the staff member's orientation record and / or in the department training record.

2.2 Equipment

Lap belts / safety belts for wheelchair or specialist chair

2.3 Criteria for use of Lap Belts

- Lap belts for safety or restraint should only be considered when all other options have failed.
- Lap belts are to be used only as a safety precaution which will promote the patients wellbeing, and when the patient is restless or would be unsafe without a lap belt.

2.4 Procedure – Use Of Lap Belts

ACTION	RATIONALE
Assessment • Assess each patient individually. • Assessment should be completed in partnership with patient, family / whānau. This will ensure cultural considerations, respect for dignity, patients privacy and choices are met. This will also assist to identify triggers and alternatives. • Obtain other relevant assessments from multidisciplinary team e.g. Physiotherapist, Occupational Therapist, Medical Officer. Specific assessments such as pain, pressure area, mental state and continence shall be considered. • Ensure there is a comprehensive plan of care that includes the reason for use of lap belts, time and duration of use, limits and risk of use. • Seat patient comfortably in chair ensuring an optimal seating position. • Fasten lap belt firmly but not tightly, check for comfort, ensure that there is no undue pressure occurring.	To ensure options other than restraint have been considered and to identify the risk factors associated with the use of restraint and develop a plan to minimise the risk to the patient. Ensure patient is seated in a way that promotes functional independence. Ensure risk of developing pressure areas is minimal
Education • All staff shall have knowledge of "The Code of Health and Disability Service's Consumers Rights 1996." This includes being able to assist consumers to access the information. • All staff shall receive education about the use of lap belts and alternatives, which is relevant to their level of practice. This shall be documented in their education records. • All staff shall have knowledge of Human Rights, scopes of practice, relevant legislation and Waikato DHB relevant policies and procedures. • Knowledge of Treaty of Waitangi and cultural considerations regarding use of chair restraint **Partnership** is between the caregiver and the patient. Nursing staff will ensure a holistic view of the needs of the Māori consumer in order to achieve the best possible outcome under the circumstances. **Participation** is having access to culturally appropriate services to Māori and **Active protection** relates to equity and privileges of citizenship. Māori shall receive health and disability services commensurate with their health needs.	To ensure that restraint is used appropriately and legislative requirements are met.

2.5 Process for monitoring /reviewing the use of lap belts

ACTION	RATIONALE
Monitoring • All patients using lap belts for safety or restraint must be monitored in accordance with the individual care plan. • The Restraint Monitoring Form must be completed at least 8 hourly or less as is identified in individual care plans • Observe for physical discomfort and offer assistance with personal requirements. • Ensure adequate food and fluids • Psychological, cultural and spiritual factors need to be considered. • Any signs of stress or discomfort must be reported to the Nurse in charge immediately. • Ensure compliance with comprehensive individual plan of care in relationship to the use of lap belts. This must include reason for their use, the time and duration they are to be used, limits of use, possible risks, monitoring and review required.	Maintain patient safety and wellbeing
Evaluation • An evaluation for the use of individual plans for lap belts is carried out on an ongoing basis and any exceptions documented in the clinical record. (Review date, termination date nominated on assessment) • Reassess need for lap belts. Check patient for negative effects such as increased incontinence, pressure areas, muscle atrophy, decreased muscle tone and strength, contractures, loss of ability to walk, loss of autonomy and psychological, spiritual and cultural wellbeing. Revisit other options.	To evaluate effectiveness of the use of a lap belt and review the requirement for restraint.

2.6 Quality Review of Use of Lap Belts

The need to use lap belts for patients in long term care shall be reviewed three monthly and a new Restraint Use Form shall be completed.

Involvement of the consumer and family / whānau in the evaluation of the restraint is documented in the clinical records and on the Restraint Use Form as is appropriate.

2.7 Documentation

Documentation requirements are specified in the Waikato DHB Restraint policy.

- Complete the Waikato DHB Restraint Event Notification form.
- A copy must be scanned to comments@waikatodhb.health.nz when questions 1 – 4.1b are completed
- Upon termination, questions 5 – 7 must be completed.
- After completion of form, copy and place one copy in clinical notes and one into the restraint folder on the ward for audit purposes.
- Complete a Waikato DHB Incident / Accident / Near Miss Notification Form (HP410) for any adverse skin conditions as a result of the restraint.
- Involvement of the patient and family / whānau in the evaluation of the restraint is documented in the clinical records and on the Restraint Use Form as is appropriate

3. Associated Documents

- Waikato DHB Clinical Records Management policy (Ref 0182)
- Waikato DHB Incident Management policy (Ref. 0104)
- Waikato DHB Restraint policy (Ref. 2162)
- Waikato DHB Restraint Use form

4. References

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

Restraint – Specialist Chairs

Procedure Responsibilities and Authorisation

Department Responsible for Procedure	Restraint Committee
Document Owner Name	Colleen Hartley
Document Owner Title	Chair, Restraint Committee
Sponsor Title	Director of Nursing and Midwifery
Sponsor Name	Sue Hayward
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1. Overview

1.1 Purpose

This procedure specifies the conditions under which specialist chairs may be used, and ensures compliance with the Waikato DHB Restraint policy.

1.2 Scope

Clinical staff at Waikato District Health Board

1.3 Definitions

Specialist Chairs

- Chairs specifically designed to prevent people from getting out of

This procedure **does not** include:

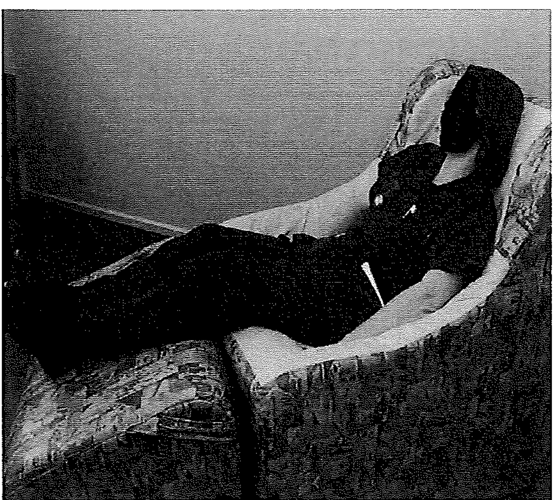
- specialist chairs that are requested by the patient to assist them maintain independence and where the patients can operate them independently
- wheelchairs specifically designed for use by an individual
- lazy-boy chairs
- chairs pushed under tables or old geriatric chairs with a fixed table. These aids are for use at meal times or for activities and should not be used as a form of restraint.

2. Clinical Management

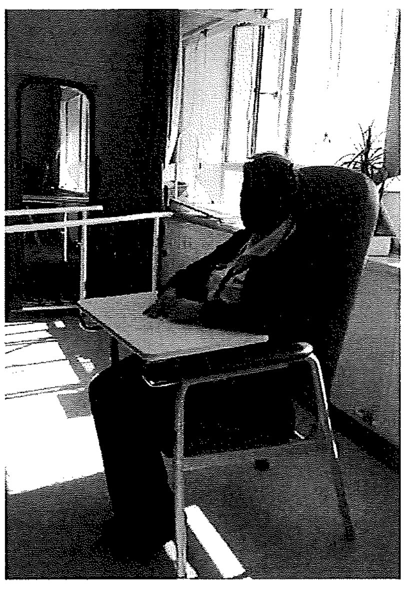
2.1 Competency required

- This form of restraint shall only be applied under the direction of a Registered Health Professional.
- The person applying this restraint shall have completed specific training in its use.
- Completion of this training must be recorded (as from the date of authorisation of this procedure), on the staff member's orientation record and / or in the department training record.

2.2 Equipment



Fall out Chair



Stroke Chair

2.3 Criteria for use of Specialist Chair

- When it is necessary to give essential care or clinical treatment to an individual.
- Should only be considered when all other options have failed.
- At risk of harming self.

2.4 Procedure

ACTION	RATIONALE
• Assess each patient individually to ensure restraint is appropriate. • Assessment should be completed with thought given to cultural considerations, respect for dignity, patients privacy. • Ensure patients are repeatedly reminded of the reason for restraint. • Seat patient comfortably in chair ensuring an optimal seating position. •	To ensure options other than restraint have been considered. Ensure patient is seated in a way that promotes functional independence. Ensure risk of developing pressure areas is minimal

2.5 Education

- All staff shall have knowledge of "The Health and Disability Services Consumers' Rights 1996" This includes being able to assist consumers to access the information.
- All staff shall receive education about the use of Specialist Chair restraints and alternatives.
- All staff have knowledge of Human Rights, scopes of practice, relevant legislation and Waikato DHB relevant policies and procedures.
- Knowledge of Treaty of Waitangi and cultural considerations regarding use of Specialist Chair Restraint

2.6 Monitoring and reviewing

- All patients restrained by a Specialist Chair must have an individualised plan of care.
- Patients must have a position change at least 2 hourly during the day for pressure area management, and to provide hygiene and toileting requirements.
- If an RN assessment has been documented and the patient is asleep they can remain in place for a maximum of 4 hours before a position change is required.
- Record in the clinical notes why the patient was restrained, date and time restraints were applied and date and time they were removed.
- Ensure adequate food and fluids
- Review and document the need for ongoing restraint every shift
- Ensure patients are repeatedly reminded of the reason for restraint.

2.7 Documentation

Documentation requirements are specified in the Waikato DHB Restraint policy.

- Complete the Waikato DHB Restraint Event Notification (REN) Form sections 1-4b.
- This must be scanned to comments@waikatodhb.health.nz Quality and Patient Safety (QPS) after completion of above sections.
- Initiate monitoring as per the restrain monitoring form on the back of the REN
- Ensure the patient care plan is updated appropriately
- Ensure there is an entry into the clinical notes each shift the patient is restrained
- Complete a Waikato DHB Incident / Accident / Near Miss Notification Form (HP410) for any adverse events as a result of the wrist and ankle restraints.
- Involvement of the patient and family / whānau in the evaluation of the restraint is documented in the clinical records and on the "Restraint Use Form" as is appropriate

3. References

- Restraint Minimisation and Safe Practice (NZS 8141:2001)
- HAPNZ Long Term Care Accreditation Standards
- Waikato DHB Restraint policy (Ref. 2162)

Restraint – Paediatric Limb (ICU specific)

Procedure Responsibilities and Authorisation

Department Responsible for Procedure	Restraint Committee
Document Owner Name	Colleen Hartley
Document Owner Title	Chair, Restraint Committee
Sponsor Title	Director of Nursing and Midwifery
Sponsor Name	Sue Hayward

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6	Colleen Hartley	June 2016	

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Restraint – Paediatric Limb (ICU specific)

1. Overview

1.1 Purpose

This procedure specifies the conditions under which Limb Restraint may be used to restrain paediatric patients in the Waikato Hospital and ensures compliance with the Waikato DHB Restraint policy.

1.2 Scope

Clinical staff at Waikato Hospital

1.3 Patient / client group

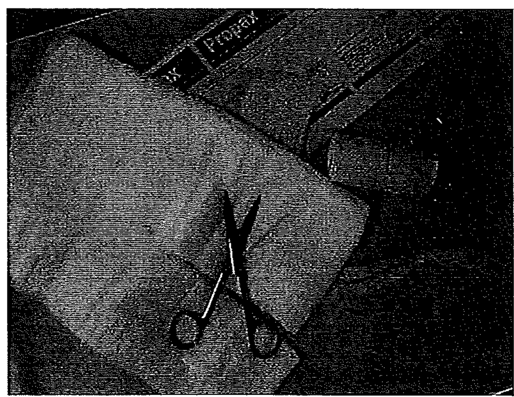
Paediatric patients in Waikato Hospital

2. Clinical Management

2.1 Competency required

- This form of restraint shall only be applied under the direction of a Registered Health Professional.
- The person applying this restraint shall have completed specific training in its use.
- Completion of this training must be recorded (as from the date of authorisation of this procedure), on the staff member's orientation record and / or in the department training record.

2.2 Equipment



- Surgifix, Safety pins, Elastoplast, Gamgee or cotton gauze.

Note: These are the only items authorised for use when applying Limb restraint.

2.3 Criteria for Using Limb Restraint

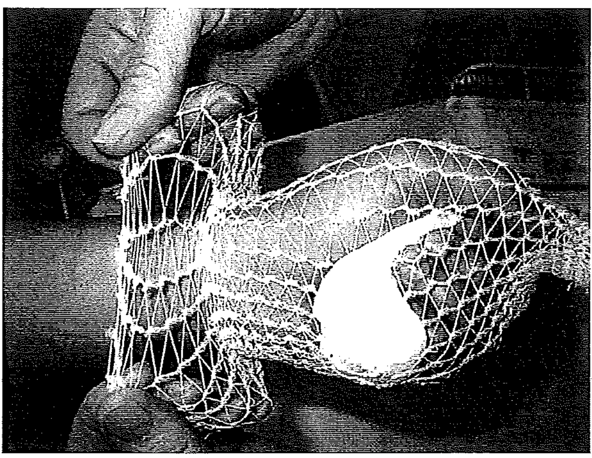
- Paediatric patients who are at high risk of pulling out invasive lines, artificial airways.
- Restraint will be discontinued following assessment by the registered nurse or medical officer that the patient is no longer at risk of pulling out invasive lines or artificial airways.

2.4 Procedure

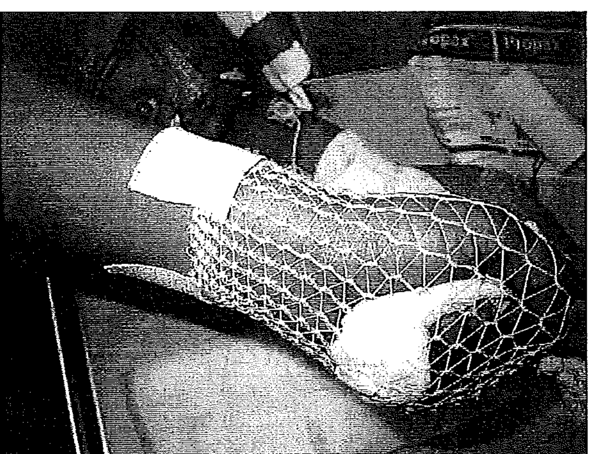
ACTION	RATIONALE
• Assess each patient individually.	To ensure options other than restraint have been considered. To identify the risk factors associated with the use of restraint. Develop a plan to minimize the risk to the patient.
• Inform child family/whanau as soon as possible to ensure there is full understanding as to why restraint has been applied.	To ensure family/whanau understand the need for restraint.
• Document on the ICU 24-hour chart/or standard restraint monitoring form.	Ensure patient care requirements are achieved in a timely manner
• Inspect wrist prior to restraint application.	To ensure the patients skin is free from injury. To ensure lines are secure.
• Document the time and date that restraint was applied and what lines were present.	To ensure documentation is complete
• Make a fist around the gamgee	To prevent potential skin excoriation. To protect invasive lines.

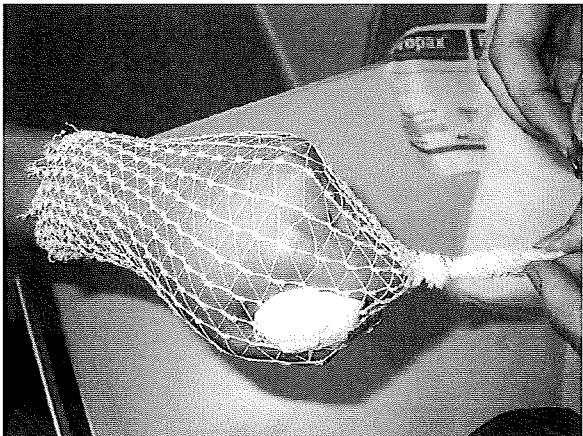
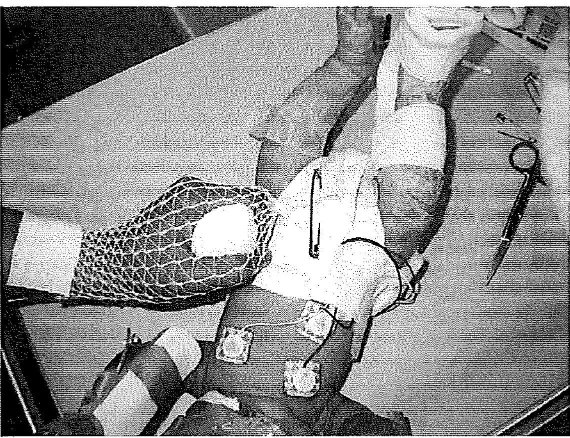
<table>
<tr><td>

- **Apply surgfix over a closed fist up to the wirst**


</td><td>To keep the hand in closed position</td></tr>
<tr><td>

- If necessary secure the surgifix with elastoplast tape partially around the wrist as below.
- Often the surgifix will stay in place without the need to use tape. Do not wind tape around the entire wrist


</td><td>To ensure circulation to the hand is not compromised</td></tr>
</table>

• **Tie a knot in the end of the tubigrip** 	To prevent the hand coming out the other end of the surgifix
• **Use a hooded safety pin to secure the restraint to the child's nappy** 	To prevent the child moving arms together and accidentally removing line or tubes

2.5 Education

- All staff shall receive education about the use of Limb restraint for paediatrics in Waikato Hospital and alternatives which is relevant to their level of practice and this is documented in their education records.
- All staff shall have knowledge of "The Health and Disability Service's Consumers Rights 1996" This includes being able to assist consumers to access the information.
- All staff shall have knowledge of Human Rights, scopes of practice, relevant legislation and Waikato DHB relevant policies and procedures.
- Cultural considerations regarding the use of paediatric Limb restraint in ICU.

2.6 Monitoring and reviewing

- Most patients in ICU are nursed with a 1:1 or 1:2 ratio. There is usually a nurse at the bedside ensuring constant observation.
- Observe fingers for circulatory impairment half hourly and release restraints 2hrly for inspection and range of motion. Document on 24 hr Chart or standard restraint monitoring form.
- Check invasive lines underneath restraints for patency, inflammation or bleeding.
- Keep restrained sites clean and dry
- Document in clinical record why patient was restrained, the date and time they were applied and date and time when they were removed. Include informing the patients family/Whanau.
- Review and document the need for continuation of restraints every shift. Document under patient assessment on the 24-hour chart and in nursing care plan.

2.7 Documentation

Documentation requirements are specified in the Waikato DHB Restraint policy.

- Complete the Waikato DHB Restraint Event Notification form.
- A copy must be scanned to comments@waikatodhb.health.nz when questions 1 – 4.1b are completed
- Upon termination, questions 5 – 7 must be completed.
- After completion of form, copy and place one copy in clinical notes and one into the restraint folder on the unit for audit purposes.
- Complete a Waikato DHB Incident / Accident / Near Miss Notification Form (HP410) for any adverse skin conditions as a result of the restraint.
- Involvement of the patient and family / whānau in the evaluation of the restraint is documented in the clinical records and on the Restraint Use Form as is appropriate.

3. References

- NZS 8134.2:2008 Health and Disability Services (Restraint Minimisation and Safe Practice) Standards
- Waikato DHB Restraint policy (Ref. 2162)

Restraint – Mittens / Boxing Glove Bandaging

Procedure Responsibilities and Authorisation

Department Responsible for Procedure	Restraint Committee
Document Owner Name	Colleen Hartley
Document Owner Title	Chair, Restraint Committee
Sponsor Title	Director of Nursing and Midwifery
Sponsor Name	Sue Hayward

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Procedure Review History

Version	Updated by	Date Updated	Description of Changes
5	Colleen Hartley	June 2016	

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1. Overview

1.1 Purpose

This procedure specifies the conditions under which mittens / boxing glove bandaging may be used for restraint, and ensures compliance with the Waikato DHB Restraint Policy and Health and Disability Services Standards.

1.2 Scope

Clinical staff at Waikato District Health Board

2. Clinical Management

2.1 Competency required

- This form of restraint shall only be applied under the direction of a Registered Health Professional.
- The person applying this restraint shall have completed specific training in its use.
- Completion of this training must be recorded (as from the date of authorisation of this procedure), on the staff member's orientation record and / or in the department training record.

2.2 Equipment

- Gamgee or gauze padding
- Bandages
- Micropore tape or standard medical tapes.

Note: These are the only items authorised for use when applying mittens/ boxing glove bandaging.

2.3 Criteria for Using Limb Restraint

Mittens and boxing glove bandaging should only be used when all other alternative options have been considered. Mittens and boxing glove bandaging may be used when the following criteria apply:

- When it is necessary to give essential care or clinical treatment to an individual who is:
  - refusing treatment that is deemed clinically appropriate
  - at risk of harming self or others
- When it is necessary to protect a treatment that has been given e.g. patients that are likely to pick at a wound or dressing
- Where it is necessary to prevent worsening of a condition e.g. scratching of skin conditions.

Note: For ICU the use of mittens and boxing gloves are considered to be a restraint only when these are pinned to the nappy. (See Restraint procedure: restraint – Paediatric Limb).

2.4 Procedure

ACTION	RATIONALE
• Assess each patient individually to ensure restraint is appropriate. • Assessment should be completed with thought given to cultural considerations, respect for dignity, patients privacy. • Ensure patients are repeatedly reminded of the reason for restraint.	To ensure options other than restraint have been considered. To identify risk factors associated with the use of restraint and to develop a plan to minimise that risk to the patient. **Reduction of patient anxiety with implementation of procedure**
• Hands are padded with bulky gauze in “resting” position. • Firmly but not tightly using crepe bandaging form a boxing glove. • Ensure bandaging and taping is not too tight.	To maintain a comfortable hand position To maintain patient safety.

2.5 Education

- All staff shall have knowledge of "The Health and Disability Services Consumers' Rights 1996" This includes being able to assist consumers to access the information.
- All staff shall receive education about the use of mitten and boxing glove bandaging or alternatives.
- All staff have knowledge of Human Rights, scopes of practice, relevant legislation and Waikato DHB relevant policies and procedures.
- Knowledge of Treaty of Waitangi and cultural considerations regarding use of mitten and boxing glove bandaging.

2.6 Monitoring and reviewing

- Mittens / boxing gloves are to be taken off at least 4 hourly during the day or when awake for inspection of warmth, colour movement and sensation of hands, for the provision of hygiene requirements and hand and finger movements. While the patient is asleep the mittens / boxing glove bandaging can remain in place.
- Bandages must be reapplied or secured as necessary.
- Any adverse reactions i.e. pain, swelling or impaired circulation must be reported immediately to medical staff and must be documented on a Waikato DHB Incident/Accident/Near Miss Form (HP 410).
- Ensure patients fluid / nutrition and toiletry needs are met.
- Record in the clinical notes why the patient was restrained, date and time restraints were applied and date and time they were removed.
- Review and document the need for ongoing restraint every shift.

2.7 Documentation

Documentation requirements are specified in the Waikato DHB Restraint policy.

- Complete the Waikato DHB Restraint Event Notification form.
- A copy must be scanned to comments@waikatodhb.health.nz when questions 1 – 4.1b are completed
- Upon termination, questions 5 – 7 must be completed.
- After completion of form, copy and place one copy in clinical notes and one into the restraint folder on the unit for audit purposes.
- Complete a Waikato DHB Incident / Accident / Near Miss Notification Form (HP410) for any adverse skin conditions as a result of the restraint.
- Involvement of the patient and family / whānau in the evaluation of the restraint is documented in the clinical records and on the Restraint Use Form as is appropriate.

3. References

- Restraint Minimisation and Safe Practice (NZS 8141:2001)
- HAPNZ Long Term Care Accreditation Standards
- Waikato DHB Restraint policy (Ref. 2162)

Procedure

Use of Personal Restraint in Mental Health and Addictions Inpatient Setting

Procedure Responsibilities and Authorisation

Department Responsible for Procedure	Mental Health and Addictions
Document Owner Name	Carole Kennedy
Document Owner Title	Nurse Director Mental Health
Sponsor Title	Clinical Services Director
Sponsor Name	Rees Tapsell
Disclaimer: This document has been developed by Waikato District Health Board specifically for its own use. Use of this document and any reliance on the information contained therein by any third part is at their own risk and Waikato District Health Board assumes no responsibility whatsoever.	

Procedure Review History

Version	Updated by	Date Updated	Description of Changes
05	Kylie Balzer	October 2015	Updated into new procedure template. Inclusion of non-use of restraint in Puna Whiti (previously procedure 1549)
	Areann Libline and Nicky Barlow	November 2015	Inclusion of panic button for Puna Whiti. Updating of monitoring information, terminology e.g. treatment changed to recovery, and documentation requirements

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1. Overview

1.1 Purpose

This procedure specifies the clinical practice requirements for the correct and safe use of personal restraint as an intervention used by inpatient staff for tāngata whaiora / service user / care recipients under either the Mental Health (Compulsory Assessment & Treatment) Act 1992 [MH (CAT) Act] or those care recipients under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 [ID(CC&R) Act] Section 60 (2), within an inpatient Mental Health & Addictions Service setting.

The procedure also ensures compliance with the Restraint Minimisation and Safe Practice Standards, NZS 8134.2:2008 and Waikato District Health Board (DHB) Restraint Policy (2162).

1.2 Scope

Applicable to Mental Health inpatient wards with the exception of Puna Whiti.

1.3 Patient / client group

Mental Health and Addictions service users / tāngata whaiora

1.4 Exceptions / contraindications

Personal restraint is not to be used in Puna Whiti; alternative interventions are to be used in situations that result in damage to persons or property. In some situations it may be necessary to use a radio transmitter or press one of the two panic buttons located in Puna Whiti to request support from staff throughout the Henry Rongomau Bennett Centre to assist or aid transfer of a client to another unit.

The police may be called when a resident of Puna Whiti:
- Seriously compromises the therapeutic environment (e.g. by damage to property) or assaults any other persons

Rationale:
The aim is to deal with challenging situations in the same way that would occur within a flatting situation in the community
To ensure the safety of all

1.5 Definitions

Good Practice:
The current accepted range of safe and reasonable actions that result in efficient and effective use of available resources to achieve quality outcomes and minimise risk for the consumer. Current accepted good practice should also reflect standards for service delivery this may include but is not limited to:
- Codes of practice;
- Research / evidence / experience based practice;
- Professional standards;
- Good practice guidelines;
- Recognised / approved guidelines; and
- Benchmarking.

NZS 8134.0:2008 Health and Disability Services (General) Standards, p.24)

Personal restraint
"Where a service provider uses their own body to intentionally limit the movement of a consumer" tāngata whaiora / service user. For example, where a tāngata whaiora / service user / is held by a service provider (NZS 8134.0: 2008, Health and Disability Services (General) Standards, p.30). Tāngata whaiora / service users / can only be subject to the use of personal restraint when there is an assessed risk to the safety of the tāngata whaiora / service user, to other tāngata whaiora / service users, service providers, or others.
Restraint:
The use of any intervention by a service provider that limits a tāngata whaiora / service user's normal freedom of movement. (NZS 8134.0:2008, Health and Disability Services (General) Standards, p.30).

Tāngata whaiora / service user / care recipient:
Tāngata whaiora / Service user / in this document is a term inclusive of tāngata whaiora i.e. tāngata whaiora / service users who identify as Māori; and care recipients.

2. Clinical Management

2.1 Competency required

All persons applying personal restraint MUST have completed Restraint Elimination Safe Practice and Effective Communication (RESPECT) training and this is recorded on individual staff record and RESPECT training database.

The use of personal restraint shall only be applied under the direction of a RESPECT trained registered health professional.

2.2 Equipment and personnel

A minimum of a three person restraint team who are trained in RESPECT; and undertake two yearly RESPECT update training

Duress alarm

2.3 Procedure

1. Action: Pre-restraint episode

Collaborative assessment(s) will help identify key factors which contribute to the possible use of restraint.

Rationale: Services shall ensure rigorous assessment of tāngata whaiora / service users is undertaken.

Kaitakawaenga and if appropriate, whānau involvement from the outset supports efforts to reduce Māori over-representation in personal restraint and seclusion.

2. Action: Indications for the use of personal restraint

Tāngata whaiora / service users can only be subject to the use of personal restraint when there is an assessed risk to the safety of the tāngata whaiora / service user, to other tāngata whaiora / service users, service providers, or others.

Personal restraint is only applied as a last resort with the least amount of force, after alternative interventions have been considered or attempted and determined ineffective.

Rationale: Personal restraint should be applied only to enhance or maintain the safety of tāngata whaiora / service users, service providers or others.

3. Action: The decision to initiate personal restraint

Restraint is initiated only when adequate personnel are assembled to ensure safe initiation, use and termination.

The tāngata whaiora / service user / responsible clinician (or delegate) must be contacted immediately of the clinical emergency and decision to use personal restraint.
The tāngata whaiora / service user / care manager (or delegate), if under the ID (CC&R) Act must be notified immediately of the clinical emergency and decision to use personal restraint.

The charge nurse manager, associate charge nurse manager or after hours nurse co-ordinator must be notified immediately.

The dignity of the restrained tāngata whaiora is maintained at all times by ensuring privacy and respect in their time of distress.

In an emergency, psychiatric assistants who have current competency in RESPECT may apply personal restraint and this must be reported to the registered health professional at the earliest opportunity.

Rationale: Service providers recognise and facilitate good practice and legal notification process.

To ensure adequate resource and environmental needs are available.

Psychiatric assistants work under the direct supervision of a registered health professional.

4. Action: Implementation of personal restraint

Only staff with current competency in RESPECT will be involved in the restraint process.

At least one RESPECT trained registered health professional must be present throughout the restraint.

At least one person of the same gender as the tāngata whaiora / service user must be present throughout the restraint.

The tāngata whaiora / service user physical and psychological well-being is monitored throughout the restraint process by direct monitoring of the airway, breathing and circulation. The person's dignity and privacy is maintained and the process of de-escalation and active listening continues.

Rationale: The use of personal restraint is conducted in the safest, least restrictive and most appropriate manner, by trained staff, and this includes monitoring and evaluating the process.

5. Action: Communication

Tāngata whaiora / service users are informed of the reasons why they are being placed in personal restraint and what needs to occur for the personal restraint to end.

Tāngata whaiora / service users (and where appropriate their family / whānau) must be informed of their rights and advocacy services in a timely way.

Rationale: Service providers communicate effectively with tāngata whaiora / service users.

Service providers recognise and facilitate the right of tāngata whaiora / service users to advocacy support persons of their choice.

The right of tāngata whaiora / service users to make a complaint is understood, respected and upheld.

6. Action: Ending personal restraint

The decision to end personal restraint is made by the registered health professional following rigorous risk assessment and care / re-integration planning and feedback from the restraint team as to whether there are any concerns relating to the release of the holds. Following ending of personal restraint, the tāngata whaiora / service user / is to be given the opportunity and access to support / advocacy, to discuss the events if desired and appropriate.
Following ending of personal restraint the personal restraint team must review the restraint episode. A senior nurse is appropriate to lead this activity (diffusion).

Formal debrief to be arranged by charge nurse manager if required.

Rationale: All clinical factors and safety issues are well considered.

Tāngata whaiora / service user rights and access to support and advocacy is adhered to.

To identify any learnings to promote best practice.

7. Action: Post-implementation of personal restraint

Once restraint is ended the registered nurse will:

- Check if the tāngata whaiora / service user has incurred any injuries and arrange medical treatment and this is noted in the clinical record.
- Check if any staff member has incurred any injuries and arrange medical treatment
- Ensure that an opportunity for staff to discuss the incident is initiated (diffusion). Formal debrief may be considered and arranged

Rationale: Safety needs and wellbeing of tāngata whaiora / service user and staff are met.

8. Action: Documentation

The registered health professional is responsible for the documentation of the personal restraint episode. This should include input from the restraint team members.

Documentation of each personal restraint episode will include:

- Details of reasons for initiating personal restraint including the desired outcome
- Details of the alternative interventions including de-escalation techniques attempted prior to the use of personal restraint
- Details of advocacy / support offered and provided
- The outcome of the personal restraint episode
- Observations and monitoring of the tāngata whaiora / service user during the personal restraint episode
- Completion of Waikato DHB restraint event notification form (T1738HWF)
- Completion of incident form (109481 and from February 2016 DATIX) detailing the incident that lead to personal restraint use
- Completion of incident form (109481 and from February 2016 DATIX) for any injury to any person as a result of the use of personal restraint
- Complete Risk Assessment and formulation for the event
- Amend Recovery Plan to include early warning signs of escalation and interventions for de-escalation

Rationale: Each episode of restraint is documented in sufficient detail to provide an accurate account of the use of personal restraint AND inform recovery planning by ensuring early warning signs and methods of de-escalation are clearly documented.

Services evaluate all episodes of personal restraint with a view to reducing use of personal restraint.

9. Action: Evaluation

Each episode of personal restraint is evaluated by the personal restraint team, and any other staff involved: additionally evaluated in collaboration with the tāngata whaiora / service user, and their family / whānau (as appropriate).

Evaluation shall include:

- Whether the personal restraint episode was the least restrictive option to achieve the desired outcome
- The duration of the personal restraint episode and whether this was for the least amount of time required
- The impact the personal restraint had on the tāngata whaiora / service user
- Any identified triggers and the strategies to minimise / eliminate them are included in the tāngata whaiora /service user / multidisciplinary team treatment plan
- Whether the appropriate advocacy / support was provided or facilitated
- Whether the observations and monitoring were adequate and maintained the safety for the tāngata whaiora / service user
- Whether the tāngata whaiora / service users / multidisciplinary treatment plan was followed
- Whether the services policies and procedures were followed
- Any suggested changes or additions required to RESPECT training for service providers

Rationale: Any new learning will support service improvement including changes in staff training, nursing practice and processes and procedures.

Recovery plans and risk tools are updated in response to the evaluation.

10. Action: Education

All inpatient nursing, occupational therapists, social workers and psychiatric assistant staff will receive full RESPECT training and 2 yearly updates.

The Waikato DHB electronic Restraint Self Directed Learning, Restraint Minimisation and Safe Practice questionnaire is completed 3 yearly.

All inpatient registered health professional staff must have completed mandatory training related to legal frameworks and risk assessment.

All staff will have knowledge of "The Code of Health and Disability Service's users / tāngata whaiora Rights 1996", AND be able to assist tāngata whaiora / service users to access the information.

All staff have knowledge of human rights, scopes of practice, relevant legislation and relevant Waikato DHB policies and procedures including MH (CAT) Act 1992, IDDCR Act, CIP Act 2003.

All staff have knowledge of Tikanga Best Practice Guidelines.

Staff education records are maintained by the organisation.

Rationale: All inpatient registered health professionals and psychiatric assistant staff will have access to education and ongoing training on use of personal restraint, including relevant legislation and regulation, and cultural considerations related to the use of personal restraint.

3. Patient Information

Restraint pamphlet

4. Audit Indicators

4.1 Indicators

Use of personal restraint is audited at 6 monthly intervals to monitor compliance with Waikato DHB Restraint policy as per the restraint committee requirements

4.2 Tools

Waikato DHB Restraint Committee audit tool

5. Evidence Base

5.1 References

Health and Disability Services (Restraint Minimisation and Safe Practice) Standards – Restraint Minimisation NZS 8134.2:2008

Nursing Council of New Zealand (June 2008) Guideline: direction and delegation. Wellington: Author

Te Pou o Te Whakaaro Nui (May 2015) Towards restraint free mental health practice. Supporting the reduction and prevention of personal restraint in mental health inpatient settings.

5.2 Associated Documents

- Waikato DHB Restraint Policy (2162)
- Waikato DHB Restraint Event Notification form T1738HWF
- Waikato DHB Incident notification (109481 and from February 2016 DATIX)
- Electronic clinical workstation record
- Tāngata whaiora / service user's multidisciplinary team recovery plan
- Tāngata whaiora / service user's / relapse and recovery plan
- Waikato DHB electronic Restraint Self Directed Learning, Restraint Minimisation and Safe Practice questionnaire
- Restraint Elimination Safe Practice and Effective Communication Training (RESPECT) Trainers manual 2013
- Restraint Elinimination Safe Practice and Effective Communication Training Participants Manual 2013
- Waikato DHB Tikanga Recommended Best Practice Guidelines (2118)
- Waikato DHB Health and Rehabilitation Policy