Waitemata
District Health Board

Best Care for Everyone

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1 Febraury 2018

Health Sector Workers Network
Via email: fyi-request-7087-a0da0e70@requests.fyi.org.nz

Dear Sir/Madam

Re: OIA Request – Restraints in all Services

Thank you for your Official Information Act request received 9 January 2017 seeking the following of Waitemata District Health Board (DHB):

> *"Can you please provide all policy documents relating to restraint practices at WDHB?*
>
> *Are there instances in the last year (June 2016 to June 2017) of the use of mechanical restraints? (i.e. strapping arms to bed) this is also referred to as physical restraint.*
> *Can you please provide this data for both physical and mental health services and identify the service (e.g. older adult physical health, emergency department, mental health adult/child, mental health forensic) associated with this data?"*

In response to your request we are able to provide the following information.

Waitemata DHB has a policy of not using restraint [personal or mechanical] unless communication and defusing strategies have not worked and where there is a threat to the individual or others. The DHB complies with the standard "Restraint Minimisation & Safe Practice" (NZS 8134.2:2008) and practice is reviewed as part of regular certification processes by the approved Designated Auditing Agency.

The policy principles state:

> Restraint should be applied only to enhance or maintain the safety of consumers, service providers, or others. **All efforts must be made to prevent the need for restraint using assessment, anticipation, defusing /de-escalate and management using the prescribed treatment plan.**
>
> **Restraint is used as a last option only;** restraint to be used only after all less restrictive interventions have been attempted and found to be inadequate.
>
> **Use of restraint is actively minimised.** The use of restraint is a clinical decision. It is not a treatment in itself but is one of a number of strategies used at a particular time with a particular goal in mind. **Restraint should be used only in the context of good clinical practice.** Practices and training in restraint should ensure that any techniques are firmly grounded in this context. NZS 8134.2

Data as requested

Waitemata DHB: 1 July 2016 to 30 June 2017 of the use of mechanical restraints/physical restraint

Total by Service	Number
Acute Medical Services	0
Mental Health for Older People	0
Emergency Department, ADU	10
Mental Health	0
Regional Forensic Psychiatric Service (RFPS)	2

Totals by Month	
Jul-16	
Aug-16	2
Sep-16	2
Oct-16	
Nov-16	
Dec-16	2
Jan-17	
Feb-17	1
Mar-17	4
Apr-17	
May-17	
Jun-17	1
Total:	12

Breakdown Summary

Date	Start	End	Service	Restraint type		Duration
08/08/2016	09:00:00 pm	09:45:00 pm	RFPS	mechanical restraint	Belt	0.45hrs
09/08/2016	10:20:00 am	01:20:00 am	RFPS	mechanical restraint	Belt	15hrs
01/09/2016	04:08:00 am	08:00:00 am	ED/ADU	mechanical restraint	ankle & wrist	4hrs
01/09/2016	13:00:00 pm	05:20:00 pm	ED/ADU	mechanical restraint	wrist	4:20hrs
24/12/2016	02:12:00 am	08:00:00 am	ED/ADU	mechanical restraint	Wrist & ankle	5.45 hrs
31/12/2016	07:46:00 pm	09:38:00 pm	ED/ADU	mechanical restraint	Wrist & ankle	1.53hrs
10/02/2017	11:10:00 pm	02:00:00 am	ED/ADU	mechanical restraint	Wrist & ankle	3:10hrs
07/03/2017	02:07:00 am	08:00:00 am	ED/ADU	mechanical restraint	Wrist & ankle	6hrs
19/03/2017	10:24:00 pm	08:00:00 am	ED/ADU	mechanical restraint	Wrist & ankle	3 hrs
20/03/2017	10:30:00 pm	2:20:00 am	ED/ADU	mechanical restraint	Wrist & ankle	3.50 hrs
20/03/2017	11:30:00 pm	02:20:00 am	ED/ADU	mechanical restraint	Wrist & ankle	3 hrs
03/06/2017	12:17:00 am	12:25:00 am	ED/ADU	mechanical restraint	wrist & ankle	8 mins

Many of the patients placed on mechanical restraint in ED/ADU are experiencing withdrawal from drugs and are unable to be reasoned with. A number have been brought into the ED by the Police from the community in cuffs. The ED staff will try without the restraint and then place them in the soft leather restraint until they are able to be calmed. An ankle restraint is used if a person kicks and harms our staff, using their legs to lever up. Most become calm and sleep once the restraints are applied. At times wrist restraint is used where a patient is receiving an infusion after an overdose and tries to remove the cannula administering critical medication to reverse the impact of the overdose.

We have attached Waitemata DHB policies as requested.

We trust this information will be sufficient in answering your request.

Yours sincerely

Cath Cronin
Director Hospital Services
Waitemata District Health Board

Dr Susanna Galea-Singer
Director Specialist Mental Health & Addiction
Waitemata District Health Board

Restraint Minimisation – Adult and Auckland Regional Forensic Mental Health Services

Contents

1. Overview

Purpose

This document outlines the approach to restraint minimisation and safe practice in Adult and Forensic Mental Health Services Inpatient Units.

This Policy should be read in conjunction with the Health and Disability Services (Restraint Minimisation and Safe Practice) Standards. (NZS 8134.2:2008).

Scope

Applies to Specialist Mental Health and Addiction Adult and Forensic Inpatient Units

1.1 Definitions

Advance Directive	An advance directive is the giving or refusing of consent to treatment in the future. It is a statement to others, usually in writing, setting out your treatment preferences if you experience another episode of mental illness that leaves you unable to decide or communicate your preferences at the time. (HDC)
Collaborative Recovery Plan/Unified Care Plan	An individualised plan which is consistent with the values of 'Recovery' and written in partnership with the service user and the clinician.

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De-briefing	Purposeful conversations with Service Users and staff involved in an incident in order to review the event and establish strategies to avoid it reoccurring and providing an acknowledgement of the distress and trauma which may have been associated with the event.
De-escalation	A complex interaction between the clinician and the service user during which the sometimes highly aroused service user is redirected from an unsafe course of action to a supported and calmer emotional state. (NZS 8134,2:2008) .
Early Warning Signs (EWS)	Behaviours or thoughts, which an individual identifies that are recognised as indicating a return in signs or symptoms of mental illness.
Restraint	Restraint is any intervention by a service provider that limits the freedom of movement of a service user

Environmental restraint	This is where a service intentionally restricts a service user's normal access to their environment, (NZS 8134.2:2008) i.e. locking of doors and fencing.
Mechanical restraint (Regional Forensic Psychiatry Service only)	Any restrictive device (e.g., mechanical restraint, plastic/cloth tie, vest, or physical confinement) used to restrict a person's free movement.
Personal restraint	Where a service provider uses their own body to intentionally limit the movement of a service user (NZS 8134.2:2008).

Safe Practice and Effective Communication (SPEC)	Training for all mental health clinicians involved in Restraint practices will be in accordance with the National Guidelines developed by the SPEC Governance Group, endorsed by the Director and Chief Advisor of Mental Health
Sensory Modulation	The capacity to regulate and organise the degree, intensity, and nature of responses to sensory input in a graded and adaptive manner. This allows the person to achieve and maintain an optimal range of performance and to adapt to challenges in everyday life
Trauma	Trauma may be defined as the experience of violence and victimisation including sexual abuse, emotional abuse, physical abuse, severe neglect, loss, domestic violence and/or the witnessing of violence, terrorism or disasters
Trauma informed care	Trauma informed care is care which recognises the neurological, biological, psychological, and social effects of trauma and violence on an individual, and uses a collaborative and supportive approach, and recognises that restraint can intensify trauma.
Trigger	Stimulus events, situations, or circumstances that precede a response.

2. Aims and Principles

2.1 Aim

Service users will be supported to manage their distress in a proactive manner without the use of restraint. Staff will apply restraint ONLY when all other interventions have been unsuccessful & for the shortest time possible.

2.2 Principles

- All staff will treat service users with respect, by;

- informing people of their rights
- listening to their perspectives
- validating concerns
- using polite, thoughtful and valuing language
- offering choice where possible

- Restraint has the potential to cause loss of dignity, and mana.
- Trauma informed care principles will be applied at all times with the understanding that many service users have a history of trauma and this will impact on their experiences of restraint.
- Tools which are shown to reduce the likelihood of restraint will be used.
- Distress and tensions are identified and minimised or removed.
- Service users will be involved in the development of their own recovery and/or collaborative recovery plans and sensory preferences and this information will be used to minimise distress.
- All restraint events are evaluated (NZS 8134.2:2008) by the local Restraint Minimisation Committee.
- Restraint may only be applied in an inpatient unit.

The decision to use restraint will:

- Only be made as a last resort to maintain safety for service users, staff or others (Workplace Violence Prevention, 2006).
- Follow appropriate planning, using WDHB approved team approach

3. Activities Supporting Restraint Minimisation

3.1 Advance Directives

Advanced Directives will be known, will inform decisions and will be adhered to whenever possible.

3.2 Assessment

Assessments which will inform restraint minimisation practices will be undertaken and documented in the clinical file at the point of admission and updated regularly and whenever new information becomes available.
The assessment will include:

- Medical conditions
- Psychiatric conditions
- Substance use / history
- Previous history of trauma
- Triggers and early warning signs
- History of violence
- History of vulnerability
- History of restraint and/or seclusion
- Cultural needs

- Sensory preferences

3.3 Monitoring & Safety Plans

- Monitoring of Service Users mental state occurs at each clinical contact.
- Instances of agitation, aggression or conflict will be discussed with the Service User and documented in the clinical file.
- All service users will have an Inpatient Care Plan or a safety plan within the Unified Care Plan.

3.4 Early Warning Signs and Triggers

Service Users early warning signs and triggers are known and documented in the Inpatient Care Plan/Unified Care Plan.
Documentation will include strategies to respond to early warning signs and minimise the likelihood of exposure to known triggers.

Strategies will include:

- **Engagement in meaningful activities**

  Service Users will be provided with opportunities to engage in in rewarding activities can help to reduce experiences of frustration/or aggression and enhance recovery (e.g. exercise, creative expression, sensory exploration, therapeutic discussions).

- **Cultural considerations**

  A cultural assessment or consultation will be offered to all Service Users

3.5 Restraint

If a Restraint occurs the following activities must be undertaken:

- **Effective Communication**

  Service Users will be informed of the reasons why restraint is indicated, and strategies available to end the restraint episode as quickly as possible.
  Service users must be informed of their rights as early as possible.

- **Monitoring during restraint**
  - Staff must ensure the service user's airway is clear and unobstructed at all times
  - One staff member should be identified (Number One) to ensure there is constant communication with the service user, informing them of what is happening
  - If there are physical concerns then physical observations (BP, P, O2) should be taken
  - Holds should be released at the earliest opportunity

Mechanical Restraint:

- is restricted to the Regional Forensic Psychiatry Service
- may only be initiated by the Service User's Responsible Clinician (or On-Call Consultant, if after-hours), in consultation with the multi-disciplinary team

- must be discussed with the Clinical Director RFPS (DAMHS) prior to initiation
- Refer to Appendix 1 for procedures

3.6 Post restraint de-briefing/notifications

De-briefing includes:

- **Service User de-brief:** This should occur when the service user has had time to recover from the physical and emotional impact of the restraint. The Consumer Advisor for the service must be consulted and may be the appropriate person to lead the de-brief. (Appendix 2)
- **Service User Witness de-brief**: This should be offered to any service users who have witnessed a restraint event, at the earliest opportunity.
- **Staff de-brief:** This should be led by the senior nurse on the unit and occur as soon as practicable after termination of the restraint. (Appendix 3)
- **Family/Whanau notification:** The identified contact person (family/whanau/caregiver/friend) must be notified of any restraint episode and this contact documented in the clinical file.
- **Service User medical review:** Medical staff should be requested to provide a physical examination if there are indications that injury may have occurred, or if the restraint has been unusually long.

4. Structures and Processes Supporting Restraint Minimisation

4.1 Behaviours of Concern Committee

A WDHB Organisational Committee which maintains oversight of compliance with the current Restraint Minimisation Standard. This committee receives an annual report from the MHSG Restraint Minimisation and Safe Practice Committee.

4.2 MHSG Restraint Minimisation and Safe Practice Steering Committee

The Restraint Minimisation and Safe Practice Steering Committee provides leadership and support for all restraint minimisation activities within MHS divisions. This committee receives and considers restraint review reports, training reports and reviews trends provided by the Restraint Coordination Committees.

4.3 Restraint Coordination Committees (Adult Mental Health Services/Regional Forensic Psychiatric Services)

These committees promote the reduction of restraint and progress toward restraint-free mental health services by engaging with the Six Core Strategies. They are tasked with identifying any issues arising for service users, staff or the service and provide recommendations to the Service Improvement Team and reports to the Restraint Minimisation and Safe Practice Steering Committee.

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4.4 Restraint Review

All restraints are review by the Clinical Charge Nurse (CCN), Clinical Nurse Specialist (CNS) or Unit Manager (UM) to ensure that documentation is accurately completed. This includes:

- Clinical practice is in accordance with Restraint Minimisation principles.
- Trends and patterns are identified, analysed and reported to the local Restraint Coordination Committee and Service Clinical Governance.
- Trends and patterns are fed back to staff in approved forums i.e. staff meetings, quality meetings.
- Documentation is completed via the following:

Place for Documentation	Description of Documentation
Clinical notes The template is accessed by typing **restraint** in the HCC clinical notes	• Reasons for initiation of restraint • The availability of gender matched staff • The impact restraint had on the service user • Details of alternative interventions attempted prior to the use of restraint • Details of advocacy/support offered/provided • Observations and monitoring of the service user during the restraint episode
Restraint & Seclusion form	Electronic form available in the HCC system is completed by allocated Registered Nurse
Incident Reporting	Electronic RiskPro form available via the intranet is completed by individual staff member and/or Registered Nurse/Shift Co-ordinator for: • any injury to any person as a result of the use of restraint. • any damage to the building / facility
Restraint register	RFPS only - All restraints must be recorded in the RiskPro reporting system
Service user debrief form (Appendix 2)	Electronic form available in the HCC system is completed by the person who conducted the debrief (enter service user debrief\ to bring up the form template)
Operational Debriefing Form (Appendix 3)	Paper form available in the filing cabinet is completed by the Clinical Charge Nurse, Unit Manager or delegate on the shift the event occurred. Form is given to the CNS on completion.

4.5 Staff Training in Safe Practice and Effective Communication (SPEC)

- SPEC trainers are sourced from within the clinical setting and approved by the Restraint Minimisation and Safe Practice Steering Committee
- Regional Forensic Psychiatric Services require all clinical staff working in the Mason Clinic units to be trained in Calming and Restraint (C&R) practice.
- Adult Mental Health Services require all clinical staff working in the acute adult and older adult inpatient units to be trained in Complete Intervention Training (CIT) practice.
- Attendance at annual updates is required to support ongoing currency and competency of practice.

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- Training records are kept for all staff
- Training in the use of prone (floor) and the wrist lock restraint types will be phased out eliminated over the next two years. This will result in the elimination of prone and wrist locks by 2020.

5. References & Associated Documents

WDHB Policy/ Procedure	• Seclusion Procedure – Adult MHS • Seclusion Review Panel – ToR – AMHS • Restraint & Safe Practice Steering Committee – TOR - AMHS • Incident Reporting • Defusing and Debriefing • Restraint – Mechanical (2005) • Sensory Modulation Guidelines
Legislation	• Mental Health (CAT) Act, 1992 • Health & Disability Services (Safety) Act, 2001 • IDCCR Act, 2003 • CP(MIP) Act, 2003
Codes	• Code of Health and Disability Services Service users' Rights, 1996 (The Code)
Standards	• Restraint Minimisation and Safe Practice Standard: NZS8134:2008
References	• Huckshorn, K. (2005). Monitoring Injury Rates in S/R Reduction Projects, National Executive Training Institute Presentation. • Mason approach - e-learning tool. WDHB • National Association of State Mental Health Program Directors (NASMHPD) (2001). Reducing the Use of Seclusion and Restraint Part II: Findings, Principles, and Recommendations for Special Needs Populations. • NASMHPD (2006). Training Curriculum for the Reduction of Seclusion and Restraint. • National Technical Assistance Centre (NTAC) (2007). Improving Safety and Reducing Violence: Implementing Trauma Informed Care Training Curriculum. • Te Pou (2007). Best Practice in the Reduction and Elimination of Seclusion and Restraint. Seclusion: Time for Change. Auckland, Te Pou o Te Whakaaro Nui • Te Pou (2014). Debriefing following seclusion and restraint; A summary of relevant literature. Auckland, Te Pou o Te Whakaaro Nui • NZMA and HDC definition at: http://www.hdc.org.nz/publications/resources-to-order/leaflets-and-posters-for-download/advance-directives-in-mental-health-care-and-treatment-%28leaflet%29

Restraint Minimisation – Adult and Auckland Regional Forensic Mental Health Services

Appendix 1 - Guideline for use of Mechanical Restraint

1) A decision to initiate mechanical restraint should be made:
   - If urgent: by the RN overseeing the Service User's care and in consultation with the Senior Nurse on Duty. The responsible clinician or on-call registrar/consultant is then notified a.s.a.p.
   - If time permits: in consultation with the Service User's responsible clinician (or on-call registrar or consultant, if after-hours).
   - If in the community, only with the explicit approval from the DAMHS and Director of Mental Health

2) When not in use, the authorised equipment is to be stored in a designated area. For Kauri, this is the High Care Area; in Rata the Unit Managers office.

3) Once the decision is made to apply mechanical restraints, the Service User is to be placed on Constant Observations by a *minimum* of 2 staff members, of which one is a Registered nurse, in the High Care area.

4) The senior nurse/nurse-in-charge on duty is to arrange staffing resources. Staffing should be gender appropriate where possible and there will always be at least one female nurse present to provide care for a female service- user.

5) Nursing staff will continuously assess the comfort and safety of the service-user by observing colour and temperature of hands and/or feet in restraint. Every hour that the service-user is awake each limb will be released in turn from mechanical restraint. Staff will restrain the limb whilst applying passive exercise.

6) The responsible clinician, on-call psychiatric registrar, or on-call psychiatrist is required to attend and complete an examination of the Service User within two hours of the initiation of mechanical restraint.

7) If the decision to continue with mechanical restraints is made, the assessing doctor must prescribe this for the Service User in the appropriate authorised form with a corresponding written entry in the clinical notes, and notify the Clinical Director, RFPS.

8) If there are concerns for the physical condition of the Service User a medical officer (or on-call medical officer after hours) is to attend the unit as soon as possible and conduct a physical examination of the Service User.

9) The key to the mechanical restraint lock is to remain with the equipment during storage, and on the staff assigned for constant observation when in use constant observation staff when in use.

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Appendix 2 Service User debriefing form following Seclusion/Restraint

Service User Debrief following a Seclusion or Restraint Incident

Name of Person Conducting the Debrief: _____

Name of Person who was restrained or secluded: _____

Service User name:	Incident Date: Time: Debrief Date: Time:
Service User's view of the incident – what happened for you?	
Leading up to the incident – what was going on for you? E.g. anything that caused distress or frustration for you, from today or even past few days, any worries that stand out for you?	
What was the risk to others, from your point of view? Do you see why people felt unsafe?	
What could we do for you to ensure we can avoid incidents in future? e.g. sensory modulation preferences, preferred staff, communication style, distractions, family involvement, spiritual support, peer support , cultural support	
Do you feel valued and safe in our environment?	

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Appendix 3: Seclusion/Restraint Operational Debriefing Form (Staff)

Seclusion / Restraint Operational Debriefing Form (Version Two)

Date: Time:	Service User:
Staff: Staff Injuries (if so, what): Documentation Required: Risk Pro, HCC Clinical notes, Restraint/Seclusion Register, Update Care Plan Service User Debrief: (circle option) Done (Form and Note template) Added to plan/handover for next shift	
CLIENT: What was happening for the client e.g. Triggers &/or EWS :	
STAFF: What interventions were attempted with the client e.g. Sensory modulation?	
RISK: (A) Seclusion: What was the imminent risk to others? (B) Restraint: Reasons for restraint	
What needs to happen to prevent this occurring again e.g. Sensory Preference Forms?	
Any follow up required: By Whom:	

Name of Person Conducting the Debrief: _____
PLEASE GIVE TO CNS or CCN once completed (or place under door of CCN office)

Restraint - Mechanical

Contents

1. Overview

Purpose

Use of mechanical restraints is used in exceptional circumstances only. Mechanical restraints may only be applied by Security after appropriate authorisation by the WDHB Restraint Coordinator and supervision by the Duty Nurse Manager. Only approved mechanical restraints may be used in specified circumstances.

Scope

Only where situations require use of mechanical restraint and all alternatives have been tried.

2. Mechanical Restraint - Indications & Authorisation

2.1 Indications

Mechanical restraint use must be reasonably justified e.g. in specific circumstances, such as assaultive behaviour, where personal restraint has been prolonged and is causing harm or the client continues active self-harming behaviours and where all other treatment options have been tried, with little or no success.

Examples may include:

- Ongoing serious self-mutilation behaviours
- Safe air travel
- General transport
- Ongoing serious assaultive behaviours

2.2 Authorisation

The decision to initiate mechanical restraint must be a multidisciplinary decision, i.e. responsible clinician (or on-call medical staff if after-hours), most senior nurse involved in the patient's care and Duty Nurse Manager at NSH and WTH.

Restraint - Mechanical

- Prior to mechanical restraint being applied there must be a **documented order** – use approved form
- **The Restraint Coordinator (Director of Nursing & Midwifery) must be informed each time mechanical restraint is used.** *This call must be made any time in the 24 hours.* The caller must provide rationale and receive verbal approval. This must be documented in the clinical record.

3. Constant Observation

Any patient undergoing personal or mechanical restraint must receive constant observation i.e. constant observer, maybe security staff. The observation must be recorded using the approved form.

4. Medical Assessment

The responsible clinician is required to complete an examination of the patient within **two hours** of the initiation of mechanical restraint and at least **8 hourly** thereafter.

A medical officer must attend the unit as soon as possible and conduct a physical examination of the patient if there are concerns for the physical condition of the patient.

The decision to use mechanical restraint must be documented in the patient's records as part of a clinical management plan.

5. Observations & Care

The registered nurse undertaking close monitoring of the patient should observe the following:

- Airway clearance and respiration rate
- Skin colour, circulation
- Range of movement
- Level of comfort/discomfort, i.e. muscular cramps
- Pressure areas
- Hydration
- Neuro-observation
- Other delegated medical care
- Changes in mental state that could indicate a review of restraint status.

Special attention must be given to providing opportunities for the patient to take food and fluid and opportunity to void their bladder and bowels.

Communication with the patient and their family/whanau must continue and include:

- Explanations for what is happening, and why
- Reassurances of their safety

5.1 Extremities monitored and exercised

- Extremities of limbs mechanically restrained must be regularly assessed for signs of restricted blood flow (ask the individual about their comfort). Document assessment using approved form.

Restraint - Mechanical

- Mechanically restrained limbs must be exercised one at a time at regular intervals. This may be restricted where a client is very disturbed and at high risk. Document assessment and rationale where exercise is not possible.

6. Termination of restraint

Mechanical restraint should be terminated by the senior nurse on duty or responsible clinician after appropriate evaluation. This should be as soon as reasonably possible.

7. Evaluation & Documentation of Restraint

7.1 Evaluation

Once restraint has been instituted, there should be planned regular review of the need for restraint and when it can be discontinued i.e. a minimal therapeutic time.

- **Personal** restraint where staff are holding a client - review every 30 minutes
- **Mechanical** restraints - review at least every two hours or as per local policy.

The multi-disciplinary team should always consider the decision to continue or end the restraint. *Wherever possible the evaluation should be done in partnership with the client and whoever the client requests to have present.*

For each situation where restraint has been used, its use shall be evaluated by the manager, Charge Nurse Manager and medical team at least daily and by the shift coordinator with the Duty Nurse Manager every 8 hours to determine

a. the appropriateness of the need for restraint
b. the restraint used
c. outcome achieved.

There should be regular communication with the patient and their family so that they understand the need for the mechanical restraint and the plan of care, including regular evaluation.

7.2 Documentation

The nurse responsible for the care of the patient must document each shift the details of the care of the patient against the care plan including the patients cognitive state, taking care to be clear, thorough and aware of medico-legal requirements in the documentation. The nurse must sign the Constant Observation sheet completed by the security watch and constant observer assistant.

8. Equipment

Types

Only approved equipment/ belts/cuffs may be used and must be approved by the WDHB Behaviours of Concern and Occupational Violence Committee.

Storage

- Mechanical restraint cuffs or belts must be stored in a locked cupboard and only accessed after approval for has been given on a case by case basis.
- Equipment must be check regularly for safety and maintenance.

Restraint - Mechanical

9. Associated Documents

Type	Title/Description
Legislation	• Mental Health (Compulsory Assessment and Treatment) Act 1992 • Criminal Justice Act 1985 • Intellectual Disabilities Act 2001 • Crimes Act 1961 • Health Act
Code	• Code of Health and Disability Services Consumers' Rights 1996 (The Code)
Standard	• **Restraint Minimization and Safe Practice Standard, NZS 8141:2008** • National Mental Health Sector Standard 2001
WDHB Policy	• Incident Reporting • Challenging Behaviour: Calming & Restraint • Seclusion

Forms for use

1. Apply Restraint Approval Request
2. Approval Request for Constant Observation
3. Mechanical Restraints Time Record
4. DMH Authorisation Apply Mechanical Restraint

Restraint Minimisation

Contents

1. Overview

Purpose

This document explains what is meant by restraint, why it is used, when it may be used, how it is managed (assessed as necessary, authorised, applied, monitored, documented and stopped). This detail is based on compliance with the standard "Restraint Minimisation & Safe Practice" (NZS 8134.2:2008). This document describes expectations for use of restraint in Waitemata DHB and outlines the approved steps, documentation and follow-up.

Note: Seclusion is covered in other specific documents

Restraint Minimisation

Scope

The principles of this document applies to all staff across all services who have direct patient contact as part of their work requirements and who might at some time be required to manage challenging behaviours

All forms of restraint, that is personal, physical, environmental and enablers.

2. Definitions

Terms used	The standard - Restraint Minimization & Safe Practice NZS 8134.2:2008 Shall - mandatory, must Should - recommended Client - patient / consumer / service user
Restraint	The use of any intervention by a service provider that limits a consumer's normal freedom of movement.
Enablers	Equipment, devices or furniture that limits normal freedom of movement, with the intent of promoting independence, comfort and/or safety. Enablers may only be used **where client consent is obtained,** agrees / voluntary and must follow appropriate assessment. If the client is not competent to make decision, family/whanau must be consulted
De-escalation/ non-violent crisis intervention	De-escalation/non-violent crisis intervention is an interactive process (using specific strategies) in which an agitated or upset service user is re-directed form an unsafe course of action towards a supported and calmer emotional state.
Seclusion	Where a service user is placed alone in a room or area, at any time and for any duration, from which they cannot freely exit. Seclusion can only be used if there is a legal basis for this intervention.

3. General

3.1 Restraint Category Descriptions

Restraint	NZS 8134.2:2008 describes the following restraint categories and effectively supersedes the Ministry of Health's previous guidelines on restraint and seclusion. (Reference: page 18) Restraint is part of a comprehensive risk management intervention. It can only be applied if there is a clinical rationale and oversight. Restraint can only be used in the context of ensuring, maintaining, or enhancing the safety of the patient / service users, staff or others.
Personal restraint	Where a service provider uses their own body to intentionally limit the movement of a consumer. For example, where a client is held by a service provider.
Physical restraint	Where a service provider uses equipment, devices or furniture that limits the consumers normal freedom of movement. *For example, where a client is unable to independently get out of a chair due to the design of the chair, the use of a belt, or the position of a table or fixed tray.*
Environmental restraint(e.g. locked wards)	Where a service provider intentionally restricts a client's normal access to their environment. For example, locking devices on doors or by having their normal means of independent mobility (such as a wheelchair) denied.
Chemical restraint	The inappropriate use of medication to render the service user incapacitated (refer also to PRN medication management). This is not allowed under the Standard: NZS8134.2.2008.

3.2 Principles

Key Principles that underpin interactions with clients and restraint"

Respect	All actions should demonstrate respect for the person and others.
Dignity	All actions should maintain the dignity of the person where at all possible.
De-escalation	Emphasis should be on de-escalation to minimise the need for restraint where at all possible.
Communication	Where restraint is a possibility, communication with the client must occur in advance of applying restraint. The client should know what may happen and be able to take appropriate action to minimise the need for restraint. Where possible involve others who can de-escalate and calm the situation.
Engagement of the client/ service user and/or family/ whanau	Where possible, engage the client / service user and/or the family/whanau / cultural advise so they can de-escalate and calm the situation.
Safety	Restraint is only used where there is safety risk to the person and others. Restraint should not be used to inflict pain or deprive an individual's right as a means of diversion, distraction or punishment.
Cultural safety	Contact cultural advisors where possible to de-escalate and calm the situation, acknowledging the different cultural interpretations.

3.3 Ethical and legal considerations

Any unauthorised restriction of a consumer's freedom of movement could be seen as false imprisonment and could result in an action for assault. Organisations should develop clear policies and procedures to guide service providers and seek legal advice to ensure the practice they are specifying is legal.

Services are required to ensure adequate and appropriate observation, care, dignity, respect, and on-going assessment occurs to minimise the risk of 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 the setting in which it is occurring. They should reflect current accepted good practice.

4. Key Practices

Restraint should be applied only to enhance or maintain the safety of consumers, service providers, or others. **All efforts must be made to prevent the need for restraint using assessment, anticipation, defusing /de-escalate and management using the prescribed treatment plan.**

Restraint is used as a last option only; restraint to be used only after all less restrictive interventions have been attempted and found to be inadequate.

Use of restraint is actively minimised. The use of restraint is a clinical decision. It is not a treatment in itself but is one of a number of strategies used at a particular time with a particular goal in mind. **Restraint should be used only in the context of good clinical practice.** Practices and training in restraint should ensure that any techniques are firmly grounded in this context. NZS 8134.2

Proactive approaches should be used at all times. Where reactive strategies become necessary, de-escalation should be used before restraint. More intrusive interventions such as restraint should only be used where they are indicated. However, the reduction of restraint will rely on good assessment and planning processes, which provide early identification of a possible need for restraint and therefore assist in planning interventions that best reduce the likelihood of restraint being required.

Restraint Minimisation

Restraint is a serious intervention that requires clinical rationale. It should not be undertaken lightly and should be considered as one of a range of possible interventions in the care setting, and always in the context of the requirements of the Standard, and current accepted good practice.

Service provider training and competency is critical, both to the appropriate and safe use of restraint, and to minimising the use of restraint.

4.1 Reduce Need for Restraint

Restraint should not be used unless absolutely necessary and all alternative approaches have been tried.

- Focus primarily is on communication, prevention, defusing and skilfully managing the situation, prevention/de-escalation and early therapeutic interventions.
- Includes appropriate cultural support people to maximise de-escalation success.

4.2 Restraint Justified and Reasonable

In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. Restraint must be justified and assessed as reasonable each time the restraint is applied.

Any restraint should be *the least restrictive measure possible in the circumstance*, to protect the patient. The aim should be to stop the harm, not the patient.

- Equipment and techniques used must of the approved type and cause the least injury to the patient.
- The decision to restrain must be documented and the rationale explained.

4.3 Restraint Not Justified

Restraint must not be attempted outside of the inpatient setting. Where appropriate staff must stand back for their own safety and call for Police back-up.

4.4 Situations where Restraint Might be Appropriate

1. Where behaviour indicates that the person is seriously at risk to self or others
2. When an individual makes a serious attempt or act of self-harm
3. When an individual makes a sustained or serious attack on another person
4. When an individual seriously compromises the therapeutic environment, e.g. by damage to property, social milieu or relationship with other consumers or service providers

4.5 Authorisation

- Restraint may only occur on the authorisation of a person with appropriate authority. This includes: the most senior Registered Nurse present using S111 (MHA); responsible clinician or DAO, medical staff under whose care the patient is admitted, the leader of the 3 person team/Code Orange Team.
- Decision must be documented and part of an agreed clinical management plan.

4.6 Accepted Restraint Technique

Restraint technique may only be according to:

- **The approved restraint methods.** Use of unapproved techniques will be formally reviewed with the practitioner and disciplinary action may be taken.
- Those taught by WDHB credentialed instructors.

Environmental restraint: Lock-down and appropriate environmental restraint processes relevant to the safe management of a client group will be approved by the clinical team i.e. charge nurse manager and medical team in discussion with Security.

4.7 Restraint as Compulsion Not Acceptable

Health professionals may not compel competent clients to receive treatment and may not unlawfully detain a person, except where:

- There is a legal right to restrain, e.g. Mental Health Act, infectious diseases, crimes legislation
- The person is at risk of harm to themselves or someone else or is likely to cause damage to property.

Where a patient refuses to remain in the general health inpatient setting and there is no reason to legally detain the person, then they should receive an explanation of the need to remain for treatment and the risks associated with leaving – but they may not be involuntarily detained.

4.8 Management Plan

All consumers should have a management plan. This is especially important where the possible need for physical restraint is identified.

- Restraint in the plan must be developed in consultation with the multi-disciplinary team and the client; and discussed (if possible) with the family/ whanau and significant others (if appropriate)
- The plan should identify proactive interventions (e.g. behavioural support and de-escalation techniques).
- Utilisation of seclusion in Mental Health settings must be discussed with the client, their family/ whanau or advocate(s).

4.9 Documentation and Reporting

In all events where restraint is applied, the most senior clinical person leading the restraint must complete the plan in the clinical record and fill out an incident form using RiskPRO.

Documentation should include:

- A description of the type of restraint used
- The names of staff, patients and/ or others involved.
- Circumstances of the restraint must also be recorded in the patient's clinical file.

If the non-approved restraint techniques is used then a report must be written to explain the situation.

5. Managing Restraint

5.1 Assessment

Issues to Consider *Before* Applying Restraint

Risk assessment should occur for all consumers on admission and each shift. Where there is identified risk the potential need for restraint should be included in care planning.

The following points shall be considered **prior to** the use of restraint and where at all possible, alternative approaches to managing the situation considered:

a. Assessment and care planning must be documented from consumer physical and psychological health
b. Legal status and implications.
c. Any risks related to the use of restraint;

d. Any underlying causes for the relevant behaviour or condition if known;
e. Existing advance directives the consumer may have made;
f. Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;
g. Any history of trauma or abuse, which may have involved the consumer being held against their will;
h. Maintaining culturally safe practice;
i. Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable , made clear to the consumer);
j. Possible alternative intervention/strategies.

5.2 Initiating Restraint

Restraint may only occur:

- **With a nurse present** – to observe the clients behaviour and clinical condition; and issues affecting environment and safety/risk issues
- **Where adequate resources are assembled** i.e. enough and appropriately trained staff to apply restraint, equipment present. If necessary people should withdraw until resources are available unless there is undue risk.
- Once **the lead person decides that restraint is safe** to be initiated, (s)he will give a verbal or recognised signal to that effect.
- If restraint is thought to be essential. Only approved techniques may be used.

5.3 Monitoring of the Patient While Restraint is Applied

All trained staff must be competent in the recognition, prevention and management of the risk of restraint asphyxia.

When the patient is personally restrained, continuous checks must be made to ensure the patient has a clear airway and that no pressure is applied to the neck, chest, lower back or abdomen.

Throughout the procedure, the lead person will be the only one who continues to communicate with the patient. All communication must be calm, respectful, direct, uncomplicated and clear, with the aim of gaining the patient's co-operation.

5.4 Moving to a Low Stimulus Environment

If the client is moved to a low-stimulus environment, the lead team member must continue to communicate with the patient during the moving procedure, explaining clearly the need for the low stimulus environment and that this level of containment is necessary for safety of the patient and others.

During and on ceasing physical restraint, nursing staff must ascertain that the client is experiencing no physical distress.

5.5 Ending Restraint

Ending restraint should be managed in a gradual manner under the direction of a person trained in restraint and following on-going assessment and evaluation of outcomes to ensure the patient is reintegrated into the least restrictive environment. At the conclusion of the restraint the clinical leader should complete the Waitemata DHB Restraint Safe Practice Review form.

6. Debriefing - Patient and Staff

6.1 Staff Debriefing

Staff should have access to structured defusing and case review to ensure maximum learning by the clinical team.

Team debriefing facilitation is available in discussion with the manager of the team. Discussion should occur about what occurred and what has been documented on the Restraint reporting form.

Personal debriefing is available through Occupational Health.

6.2 Patient / Client Debriefing

As soon as practicable, clients should also be offered a debriefing session.

Wherever possible, the client's family and or advocate should be present.

The feedback is to be considered when reviewing

a) Restraint practices
b) The client's management plan

7. Quality Review

7.1 Service-Based Monitoring

- Each restraint is logged into the Reportable Events database (RiskPro).
- Each service should review reported incidents where restraint is required.

7.2 Evaluation and Review of Restraint Use by the Behaviours of Concern Group

The Behaviours of Concern Group maintains oversight of compliance with the standard NZS 8134.2:2008.

- Data from the Reportable Events database (RiskPro) forms the Restraint register.
- The register contains sufficient information to provide an auditable record of restraint use.
- Restraint trends will be reviewed by the Behaviours of Concern Group.

7.3 Formal Review of Documented Restraint Reports

The DHB Restraint Coordinator will review

a) Trends
b) Formal review / evaluation of restraint investigations reports: including
    i. whether the individual management plan was followed;
    ii. whether alternatives or de-escalation techniques were attempted;
    iii. whether the least restrictive/intrusive intervention was used;
    iv. achievement of outcomes, including from the patient's or advocate perspective and staff;
    v. whether advocacy support and support for staff was sought;
    vi. any injury to any party as result of the restraint;
    vii. whether it was the correct decision to initiate restraint and it was effective, i.e. to prevent the need to use restraint again;
    viii. the associated policies/procedures were followed;
    ix. that impact the restraint episode had on the patient, staff and others

Restraint Minimisation

8. Staff Training

8.1 Staff Preparation

Managers are responsible to ensure that their staff receive appropriate training to minimise harm to them or their clients. The bureau and reception staff also requires training.

Staff involved in restraint events must:

- Have received training to use the approved techniques: assessment, de-escalation, distraction/defusing, clinical intervention
- Be deemed competent to take appropriate action
- Maintain a safe environment for all the clients and staff
- Ensure that the specific needs are recognized, involving relevant cultural advice and/or guidance is sought
- Undertake at least hourly assessment of the consumer and review the reason for restraint.

8.2 Frontline Staff

The type of training for each group of staff is appropriate to their role

General	Non-violent crisis intervention (CPI) • Includes de-escalation and defusing
Mental Health	Calming & Restraint • Includes de-escalation and defusing
Duty Nurse Manager, Security, Orderly	Code Orange training • Includes personal restraint techniques

8.3 Course Content

The Behaviours of Concern & Occupational Violence (BOCOV) group will maintain overview of the training options and ensure trainers are approved and up to date.

8.4 Records

Training records will be maintained by Learning and Development.

9. Associated Documents

The table below identifies associated documents.

Type	Title/Description
Legislation	• Mental Health (Compulsory Assessment and Treatment) Act 1992 • Criminal Justice Act 1985 • Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 • Crimes Act 1961 • Health Act 1956
Code	Code of Health and Disability Services Consumers' Rights 1996 (The Code)
Standard	Restraint Minimization and Safe Practice Standard, NZS 8134.2:2008
WDHB Policy	• Incident Management • Seclusion • Defusing and Debriefing