NORTHLAND DISTRICT HEALTH BOARD
Te Poari Hauora Ā Rohe O Te Tai Tokerau

22 January 2018

E-MAILED

Health Sector Workers Network
Fyi-request-7088-fec9028c@requests.fyi.org.nz

Dear Health Sector Workers Network

Official Information Act Request

You have asked for information about restraint policies and use in all Northland DHB services.

> *Can you please provide all policy documents relating to restraint practices at Northland DHB?*

Northland DHB's policies are attached:

- Procedure: Personal/Physical Restraint Mental Health and Addiction Services
- Restraint Minimisation and Safe Practice Policy
- Soft Limb Restraint Policy
- Post Anaesthetic Care Unit: Soft Restraint Guideline

> *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 (eg older adult physical health, emergency department, mental health adult/older persons) associated with this data?*

The data is attached.

If you have any queries regarding Northland DHB's response to your information request please contact me.

Yours sincerely

Dr Nick Chamberlain
Chief Executive

34287

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Procedure: Personal/Physical Restraint Mental Health and Addiction Services

Note: This procedure must be read in conjunction with NDHB Restraint Minimisation Policy

SCOPE: Mental Health and Addiction Service staff

RATIONALE:

Northland District Health Board (NDHB) Mental Health and Addiction Services (MHAS) is committed to the reduction of the use of restraint. Staff recognise the restrictive and potentially traumatising effects on patients who experience restraint and that thorough exploration of alternatives is expected at all times.

This procedure is to:

- Clarify the process for personal restraint whilst adhering to the expected standard of least restrictive practice.
- Clarify the roles and responsibilities of staff involved in restraint.
- Ensure accountability for restraint events at all levels.

Personal Restraint:
Where a staff member uses their own body to intentionally limit the movement of an individual. Its purpose is to safely immobilise or restrict movement of part/s of the body of the individual concerned.

Physical (Mechanical) 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: design of the chair, the use of a belt, or the position of a table or fixed tray.

NB: Mechanical restraints are not approved for use in NDHB. Police should be called in the first instance.

This applies to ongoing use of handcuffs without police presence.
Any indications that mechanical restraint may be considered MUST be immediately directed to the CHoD for discussion and involvement of Clinical Director and DAMHS at their discretion.Full consultation planning will occur at senior level.

Standards to be followed:

All restraint techniques used must have service approval for use. Any variation on approved techniques must be reported in an incident form

- Practice is guided by ethical principles that include acting for the patients' good, avoiding harm to the patient, avoiding harm to self or others and respecting the dignity of the patient
- Any use of personal restraint must be in accordance with relevant legislative framework
- Any unauthorised restriction on a patient's freedom of movement could be seen as unlawful
- Personal restraint should only be applied for the minimum time to establish safety or self control or to deliver essential treatment
- All personal restraint will be reviewed against the Health and Disability standards through a robust review process
- Best practice is maintained through mandatory annual education updates
- All Registered Nurses must be competent in the prevention, recognition and management of the risk of positional asphyxia

Restraint can only be used:

- With a patient who is in the process of being placed under the MHA or subject to the MHA
  - With a patient whose behaviour indicates that he /she is seriously at risk to self or others.
  - Where it is necessary to give a planned treatment to a patient who is refusing and there is therapeutic justification for immediate provision of this treatment.

People involved and responsibilities

This procedure may be carried out by any inpatient or community staff. Staff involved in restraint must have attended Safe Practice and Effective Communication (SPEC)Training, and subsequent annual updates.

> Staff working in the community should only undertake physical restraint to assist police (in emergency situations) or assist Tumanako staff (e.g. on an admission to an inpatient setting.)
>
> Staff need to be aware of the legal framework supporting restraint in a community setting.

A Registered Nurse is responsible for overseeing the process of restraint. Registered Nurses take clinical responsibility for all restraint procedures.

Full restraints must ONLY be undertaken with a minimum of THREE STAFF

- 'LEAD NURSE' is responsible for Communication, Co-ordination, monitoring patients airway and ensuring physical wellbeing of the patient and staff.
- 'Staff Two and Three: Follow Instructions from Lead Nurse, are committed to the task, assist to immobilise the limbs, observe and communicate to Lead Nurse.

Extra Staff: Follow instructions from Lead Nurse (ie. Assist in moving patient to seclusion area, prepare medication, communicate with security or medical staff, isolate other patients, assist with Restraint Process)

PROCEDURE / METHOD:

Assessment	On admission a risk assessment will be undertaken for all patients to establish whether they are at risk of perpetrating or being vulnerable to acts of violence or aggression and/or self harm. This assessment will include a review of history to inform planning: Restraint and seclusion history ? Trauma history ? Advance Directive exists ? Cautions to consider before restraint ? If identified at high risk, an immediate 24 hr plan to maintain safety is developed. Discussion should occur with client and family/whanau.	Assesment and Treatment Plan OR Comprehensive Risk Assessment and Treatment plan. Initial 24 hr Plan
Prevention	When high risk of need for restraint or seclusion is identified a comprehensive Risk Management plan will be developed in consultation with the patient, multi-disciplinary team , and discussed when appropriate with the family/whaanau. Planning for minimising these risks should be robust and clearly located in documention. Discussion with patient should occur on admission or as soon as reasonable. Environmental and staffing factors should be considered. Utilise Occupational Therapy and Cultural Advisor expertise in planning.	Comprehensive Risk Assessment and Management Plan Advance Directive located

	Advance directives must be searched for and if in place fully considered by team. The plan will detail strategies for managing distress, de-escalation techniques and prevention measures and should be supplemented by the patient's self- identified strategies in a Personal Safety or Sensory Preferences form. These plans can include: • sensory modulation • CBT or DBT strategies • distraction techniques • calming or self soothing activity • relaxation • other identified coping strategies • Staffing and environmental factors/Room selection The assessment findings and plan should be discussed with all staff at handovers and clinical meetings to ensure wide familiarity with the plan is established.	Personal Safety Plan/Sensory Preferences Form Plans discussed at handovers and MDT Meetings.
Situations of Extreme Caution	Personal restraint should be used with extreme caution in the following circumstances and all efforts made to maintain the person in an upright position. • Where the patient is elderly (over 65) or young (under 18, but especially under 14) • Where the patient is physically compromised (known physical disabilities, medical issues including infectious disease, cardiovascular disease, dehydration, physically frail, excessive weight, intoxication from alcohol or drugs, pregnancy, etc). • When the patient is in possession of a weapon. (Section 41 Crimes Act 1961). Additional support/emergency responses	

	must be considered. • Where it compromises the psychological wellbeing of patients with particular attention to vulnerable and previously traumatised indivuals	

INITIATION, THROUGH TO FOLLOW-UP OF RESTRAINT

Step	Action
1. **Initiating Restraint**	When de-escalation and use of alternative strategies has been unsuccessful, or restraint is planned to deliver essential treatment, and restraint is assessed as the only safe mechanism to prevent harm: • Adequate staffing must be assembled to initiate restraint. Even in an emergency, restraint should have an approach plan and the team should be ready. • The least restrictive intervention should be chosen to match the level of risk. • A Registered Nurse must take lead responsibility for the restraint process including delegating roles to safely manage the incident and the other patients in the unit. • A Registered Nurse must take responsibility for the restraint process including the monitoring of both patients and staff involved, and for documentation of the incident. Shift coordinator to check documents before end of shift. • Nurse In Charge on the shift should be informed immediately and attend the incident. • The cultural advisor should be involved when appropriate for advice and support for patient/whanau. • The Responsible Clinician or On Call Psychiatrist must be informed as soon as possible. • Discussion with patient should include explanation about restraint and under what conditions it will be ceased.
2. **Application**	The shift coordinator or other senior nurse present will identify and designate a restraint team. The team will be directed by who is responsible for Communication, Co-ordination, airway / physical management and the wellbeing of the

Step	Action
	patient. 'Numbers Two' and 'Three': must follow instructions from'Lead Nurse', be committed to the task, immobilise the limbs, observing and communicating with'Lead Nurse' . Extra Staff: Must follow instructions from 'Lead Nurse' (ie. moving patient to seclusion area, administering medications, communicating with medical staff, assisting with the Restraint Process). Continuous assessment must be carried out by the Lead Registered Nurse to establish the level of intervention required and direct any rotation of staff
3. Monitoring of Restraint	When the patient is restrained, checks must be made to ensure the patient has a clear airway and that no significant pressure is applied to the neck, chest, lower back or abdomen. Throughout the procedure 'Lead Nurse" or other delegated staff member,will lead the communication with the patient. This should include, where appropriate an explanation for the intervention. During this process, acknowledgement and management of any patient distress should be addressed.
4. Ending Restraint	This should be managed in a gradual manner under the direction of a Registered Nurse. This will follow an ongoing assessment and evaluation of risk and outcomes to ensure the patient is reintegrated into the least restrictive environment. The patient must be monitored and supported post-restraint including integration back into the ward environment. Staffing and environment will be reviewed with the nurse in charge
5. Documentation	Every situation where personal restraint occurs must be recorded in: The JADE restraint form AND An Incident form, including, type of restraint, timeframe and outcome. Full documentation of the incident including the restraint process and follow up must be recorded in the patient's clinical notes. Risk Assessment and Care Plans are to be updated following incidents

Step	Action
	Shift coordinator must ensure all processes and documentation is completed by end of shift.
6. Defusing/ Initial review	Following a Restraint Incident, all staff involved should attend a defuse and initial review This must occur as soon as possible after the event.This will be led by the Shift coordinator/Manager or delegated other, prior to the end of their shift. Discussion will include: • Review of the environmental factors / internal patient factors that may have triggered the need for restraint. • Alternatives that were attempted, including de-escalation techniques. • The availability of cultural support. • Effectiveness of restraint process and techniques • Any injury occurred to staff or the patient involved in the restraint. • Patient, family / whanau and staff requirements or needs following the restraint • Plan for de-briefing patient and any others
7.Debriefing	Staff formal debriefs will be conducted when arranged by Manager (See Critical Incidents: Support for Employees) Patients involved and/or witnesses to a Restraint Incident must be offered the opportunity to debrief following the incident. Debrief should be offered at an appropriate time by the allocated nurse or on a subsequent shift, as soon as possible after the event. Debrief should cover : The need for restraint / what alternatives could have prevented the restraint / how the patient feels about the process / and what supports are required A record of the patient debriefing should be made within clinical notes and details in the client debrief template (scanned to JADE documents) Any identified strategies to prevent future restraint should also be documented in • a personal safety form • the risk management plan • within the clinical notes

Step	Action
8.Evaluation of Restraint	Information from the staff post event defusing meeting should documented in the client records. Additionally the weekly MDT will fully review and finalise the JADE restraint Event (MDT forms need to record the review ?) Agreement of whether any formal investigation and/or process review is required will involve the Clinical Haed of Department and Unit manager.

Education

Ongoing education is provided to all identified NDHB Mental Health staff. This includes, trauma informed care and sensory modulation principles communication, de-escalation, break away techniques. Personal restraint techniques are taught to those working in Inpatient units and crisis roles

Specific Training Objectives

Registered Nurses and Doctors will be able to :

- Use the required skill and expertise to assess/anticipate 'at risk' patient behaviour, monitor behaviour and initiate activities to minimise the need for intervention.

All clinical staff will be able to :

- Be able to take appropriate action to control the situation to minimise the possibility of injury.
- Maintain, as far as possible, a safe environment for all patients, family whaanau and staff which avoids traumatisation.
- Ensure that the specific needs of patients during each stage of de-escalation and restraint are recognised.
- Ensure relevant cultural advice and/or guidance is sought in order to maintain and practice cultural safety.

Definitions

Term/Abbreviation	Description
Restraint	The use of any intervention by a service provider that limits a patient's normal freedom of movement.
Personal Restraint	Where a staff member uses their own body to intentionally limit the movement of a patient e.g. holding a patient
De-escalation	The act of reducing intensity of (arousal)

Defusing	Defusing is a group meeting of those involved in or affected by a critical incident. It is often the first formal intervention shortly after an incident where staff can discuss the incident in a personal way in a safe, supportive environment. Information is provided to those involved. It is usually held at the work site, but away from the scene of the incident. It may be followed up by a debriefing session, the defusing process may eliminate the need to provide a formal debriefing, or may enhance the effectiveness of the debriefing.
Debriefing	Debriefing is a structured discussion following a critical incident.
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 patient to achieve and maintain an optimal range of performance and adapt to challenges in daily life.
CBT	Cognitive behavioural therapy
DBT	Dialectical behavioural therapy

Associated Documents

Other documents relevant to this procedure are listed below:

NZ Legislation	Crimes Act 1961 section 41 Mental Health (Compulsory Assessment & Treatment) Act 1992 Human Rights Act 1993 NZ Bill of Right Act , 1990 Health and Disability Act 2001 Code of Health and Disability Services Rights 1996 Protection of Personal and Property Right Act 1988 Health and Safety in Employment Act 1992
NZ Standards	Restraint Minimisation and Safe Practice Standard NZS 8134.2:2008 Health and Disability Services (general) Standard NZS 8134.0: 2008. Health and Disability Services (core) standards NZS 8134.1: 2008
NDHB Policies / Procedures	Restraint Minimisation and Safe Practice Policy

References

Health and disabilities services Restraint Standard NXS 8134:2008

Seclusion under the Mental Health Act – Ministry of Health Clinical Guidelines

Huckshorn, K, A. (Draft, 2005). *Six core strategies to reduce the use of seclusion and restraint planning tool.* Alexandria, USA: National Technical Assistance Centre.

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Te Pou o te Wakaaro Nui. (2011). *De-escalation training for clinicians: a literature review and recommendations*. Auckland, N.Z: Te Pou o te Whakaaro nui.

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National Institute for Clinical Excellence. (2005). Clinical Guideline 25. Violence- the short term management of disturbed/violent behaviour in inpatient psychiatric settings and emergency departments. London. National Institute for Clinical Excellence.

Mason. T & Alty A. (1994). Seclusion and Mental Health: A break with the past. London. Chapman & Hall.

Acknowledgements: Counties Manukau District Health Board

RESTRAINT MINIMISATION AND SAFE PRACTICE POLICY

Purpose:

Restraint is a serious clinical intervention used only as a last resort to protect patients/consumers, others, or property, from harm.

Northland DHB (NDHB) will meet the Restraint Minimisation and Safe Practice Standard NZS8134.2:2008 and all other relevant legislation.

Policy Statement

- All forms of restraint will be reduced
- All restraint use is clinically justified
- Any restraint occurs in a safe and respectful manner under the direction and supervision of the most appropriate health professional
- Any restraint occurs for the least amount of time possible

For Mental Health & Addiction Services, this policy must be read in conjunction with the Mental Health & Addiction Services Seclusion Policy and Procedure for Physical & Personal Restraint.

NB. In the course of assessing and treating patients, occasions arise in which staff take actions to limit the movement of patients through the use of various types of restraints. Broad categories of the actions taken by staff that can be termed restraint are:

Any hold or action that although part of routine clinical practice within a service setting is of a duration that **exceeds normally accepted** time frames
&/or
Any **forcible hold or action,** which is outside the bounds of routine clinical practice in a area, but which is deemed necessary to avoid of minimise harm to the patient or others.

It is important that the rights of a patient are balanced with the right of a patient to be safe whilst receiving treatment. Restraining a patient without satisfactory justification would amount to false imprisonment, and could lead to litigation.

Definitions:

Restraint:
The use of any intervention by a staff member that limits a consumer's normal freedom of movement.

Personal Restraint:
Where a staff member uses their own body to intentionally limit the movement of an individual. Its purpose is to safely immobilise or restrict movement of part/s of the body of the individual concerned.

Physical (Mechanical) restraint
Where a service provider uses equipment, devices or furniture that limits the consumer's normal freedom of movement, For example: 1. where a consumer is unable to independently get out of a chair due to: design of the chair, the use of a belt, or the position of a table or fixed tray. 2. when a confused patient (or their family) is unable to consent to bedrails.

Environmental restraint:
Environmental restraint is when access is intentionally restricted by a locking device or door or by having their normal means of independent mobility denied (such as wheelchair).

Medication (Chemical) restraint:
The term chemical restraint is often used to mean that rather than using physical methods to restrain a consumer at risk of harm to themselves or other, various medications are used to ensure compliance and to render the person incapable of resistance. NDHB does not support the use of medication as a form of "chemical restraint".

De-escalation:
Is 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 utilising skills and practical alternatives.

Enabler:
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.

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

An enabler can become a restraint if it is not removed when the patient/consumer requests i.e. the enabler ceases to be voluntarily used.
Refer to – Safe use of enablers guideline

Exclusions to this policy:
- Environmental isolation of patients for infection prevention and control purposes.
- The restraint of patients who are prisoners for security purposes
- The restraint of patients being transported and subject to specific provision under the Mental Health Act.

STANDARD:
Northland District Health Board is committed to minimising the use of restraint, and ensuring that those legal and professional restraint standards are met whenever restraint is applied. It is expected that:

- Staff will act lawfully and with due care when applying any form of restraint to maintain the rights and safety of both patients and staff.
- Whenever possible restraint will be avoided and verbal consent obtained from the patient or guardian prior to a restraint event.
- All types of restraint used with a patient will be recorded in the patient's notes and a clinical review will be undertaken following each event.
- Any restraint will be documented and reported in DATIX which serves as the NDHB restraint register.
- The safe use of enablers guidelines will be followed.

Refer to – Safe use of enablers guideline

GUIDELINE:

1: The Indications for use of different types of restraint:

The procedures to be followed when restraint occurs are dependent on the rationale for the use of restraint, the force required to administer the restraint procedure and the ability and willingness of the patient to provide consent prior to the administration of the restraint procedure.

NB: ***Staff must determine the 'intent of the intervention' for the use of restraint***

1.1 Mechanical restraint for non compliance with treatment

- Mechanical restraint may be appropriate for the provision of a particular treatment.
- The decision to initiate mechanical restraint should be made by either the clinician with the patient at the time of the incident, or the Consultant, RMO or Nurse in charge at the time.
- Types of mechanical restraint used in each service must have had prior approval. A Restraint adverse event form should also be completed.

1.2 Environmental restraint:

- On occasions, patients are placed alone in areas for their safety or the safety of others. Where they cannot leave of their own free will.
- A Restraint adverse event form needs to be completed.

1.3 Locked Units

In a "Locked Unit" the locked exit is a permanent aspect of the service to meet the safety needs of consumers who have been assessed as requiring that level of containment. Although by standard definition locking exits constitutes environmental restraint it does not apply where the exits of the unit:

- Clearly designated a "locked unit".
- Has admission criteria that the consumer is assessed against.
- Where the consumer who does not, or no longer meets the criteria can independently exit at any time.

Refer Seclusion policy: *Mental Health & Addiction Services for environmental restraint for the management of problem behaviour without approval of patient.*

2. Roles and responsibilities in relation to Restraint Minimisation and safe practice

2.1 Organisational Responsibilities.

Northland District Health Board has a Restraint Minimisation Group that will meet at least once a year (or more frequently if required). The terms of reference for this group are as follows:

- Endorses restraint techniques.
- Reviews restraint trends, adverse outcomes and restraint usage at least yearly in order to validate the appropriateness of techniques, ensure safety and identify alternative interventions. A consumer representative will be present when these reviews happen.
- Collates the Restraint incidents to maintain an organisational Restraint Register via quarterly reports from Datix.

- Reviews the Restraint, Minimisation and Safe Practice policy and any compliance changes.
- Reviews the types of restraint training and implementation.
- Considers monitors and approves methods of restraints commonly used in each service (both personal and mechanical).
- Monitors the safe use of enablers.
- Reviews staff training - determining educational needs.
- Monitoring by Mental Health Restraint Approval Committee and DHB Clinical Governance Board.
- A Restraint coordinator will be identified to oversee/ensure organisational requirements are met - this may be one or more people.

3. Procedure for Personal and Mechanical Restraint

3.1 Restraint guiding principles

All use of restraint shall:

- Focus on de-escalation and the minimisation or elimination of restraint.
- Promote the safety of all involved.
- Be based on effective risk assessment and decision making.
- Reflect best practice health care to the consumer, including keeping the patient informed of the reasons for the application of restraint and the process of restraint.
- Respect the specific cultural considerations of the consumer.
- Promote and maintain the consumers dignity, privacy and respect.

3.2 Assessments prior to considering using personal, environmental and mechanical restraint.

In order to reduce the likelihood of restraint taking place assessment, planning and risk management should reflect careful consideration of the risks that could lead to a restraint event and the risks of using a restraint should be identified, and minimised in consultation with the patient and their family.

Prior to the initiation of a restraint procedure, there should be evidence that there has been careful consideration of the compromise between the following factors:

- Personal safety or safety of others.
- Cultural safety.
- Spiritual safety.
- Short –term benefits versus long-term effects(including impact on the service provider/ consumer relationship).
- Emotional safety versus physical safety.
- Previous life experience and/ or trauma.

Consideration to the patient must be given should the likelihood of cultural or spiritual risk occur. Taonga should not be removed, except in an emergency situation, without advice from whanau or a cultural advisor.

3.3 Monitoring and care whilst a restraint is in place.

Each service should have procedures that are easily available to staff, that outline the monitoring requirements for any approved restraint that is used in the service.

Each service should have systems in place that clearly demonstrate that the monitoring took place as per recommended procedure:

Personal Restraint

- Patient's airway, pulse, skin colour (presence of cyanosis).
- Bleeding.
- Other physical injuries or discomfort.
- Appropriate neurological observations.

Mechanical restraint

When a patient is immobilised, the following must be assessed:

- The extremities of any limbs mechanically restrained must be regularly assessed for signs of restricted blood flow (ask the patient about his/her comfort).
- Pressure area assessment and care should be taken with those body areas most at risk (eg. sacrum, heels, elbows).
- Great care must also be taken when mechanical restraints are used to restrict the torso (such restraint should pass across the ischial tuberosities and not allowed to move up to the abdomen and chest).
- Mechanically restrained limbs must be exercised at least two-hourly.
- Special attention must be paid to providing opportunities for the patient to take food and drink and to void bladder and bowels.

A range of motions should be carried out on restrained limbs to prevent cramp or loss of circulation (skin care to restrained limbs).

Psychological care

- **Assess and document:**
  - General mental state, including general assessment of alertness
  - Response to the physical/mechanical restraint event.

3.4 Communication.

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

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

- What is happening throughout the procedure.
- Why the physical/mechanical restraint is required.
- The range of options available for the patient in the circumstances.
- The right that the patient has to access the services of an advocate throughout the restraint process.

3.4.2 Communication with the physical/mechanical restraint team members includes:

- Checking the wellbeing of members, and
- Checking with each member that their holds/mechanical restraint is applied safely.

3.4.3 Communication with other staff and significant individuals, eg. Patients, visitors directly affected include:

- Advising them of the chosen course of action

- The need for that action
- How they might assist.

3.5 Review of restraint procedure.

- As with any patient intervention, restraint must be evaluated for its effectiveness following each event.

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

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

3.5.1 The review should include:

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

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

3.5.2 Each time restraint is used; it must be documented in clinical record, and should include:

- The assessment of the patient.
- Justification for use.
- The time the consumer was restrained.
- The method used and effectiveness of same.
- Consent/ discussion with family/ whanau.

3.5.3 If approval has been obtained for the restraint procedure, this needs to be clearly documented in the clinical file, and a consent form signed if practical.

3.5.4 If approval has not been obtained, and the restraint has been used to control problem behaviour, a restraint incident should be entered into Datix.

Associated Legislation:

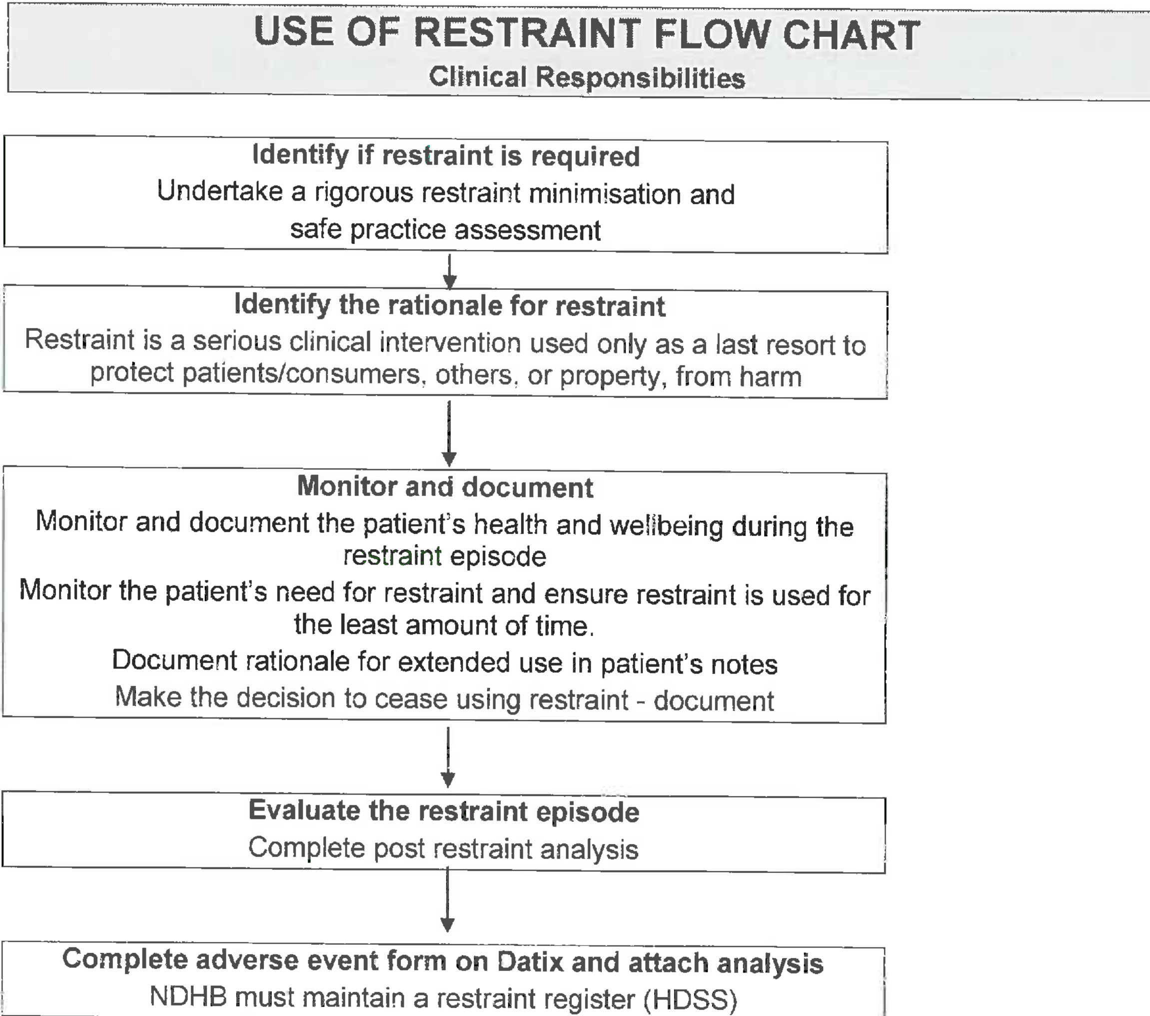
- Code of Health and Disabilities Services Consumers Code of Rights 1996

- Privacy Act 1993
- Health Information Privacy Code 1994
- Human Rights Act 1993
- Protection of Personal and Property Rights Act 1988
- Crimes Act 1961
- Mental Health (Compulsory Assessment and Treatment) Act 1992
- NZ Bill of Rights Act 1990

Associated Documents:

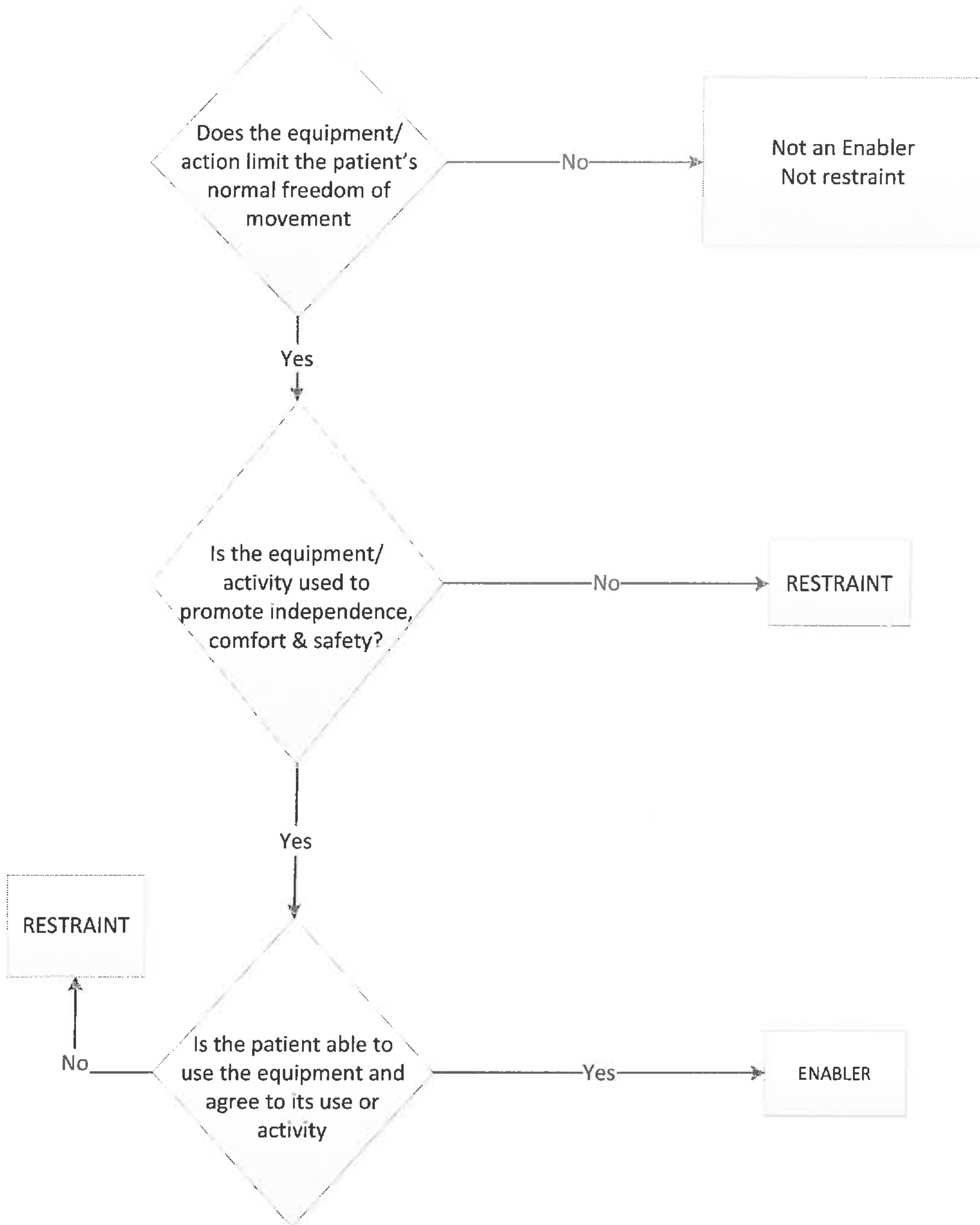
- NZ Standard Restraint Minimisation and Safe Practice NZS 8134.2:2008
- NH Mental Health Policy - Seclusion
- ICU Applying Soft Limb Restraint Guideline
- PACU: Procedure for Soft Limb Restraint
- Safe use of enablers guideline

Appendix 1



Appendix 2

Enabler vs Restraint decision making tool



SOFT LIMB RESTRAINT POLICY (excl Mental Health)
Wrist restraints to maintain life preserving interventions - adults

Rationale / Purpose:
The purpose of this policy is to provide guidance to staff that will be using soft limb restraints on a patient. This policy is to be used in conjunction with the NDHB Restraint Minimisation Guidelines.

Policy statements

1. The wrist restraint is only applied as a **last resort**, with the least amount of force.
2. The reason for the restraint must be discussed with the patient and family / whanau **before** the restraint is applied, during the time of restraint and upon removal of the restraints.
3. Agreement must be obtained from family / whanau and documented in the patient progress notes – refer to NDHB informed consent policy
4. This policy applies to **adult** patients who are confused, disoriented or aggressive who **will** remove essential life supportive interventions, e.g arterial lines, IV lines, catheters, drains, nasogastric feeding and central lines- causing potential harm to themselves.
5. The service General Manager must be notified at time of decision to restrain patient.
6. All use of restraint **must** be added to the restraint register by completing an incident form in Datix by RN initiating restraint.
7. All events of wrist restraints will be audited and evaluated by the Restraint Minimisation Group and reviewed by the Reportable Events Committee (REC) and Clinical Governance Board (CGB).

Scope: All Nursing, Medical and Health Care Assistants.

Procedure:

- Soft limb wrist restraints are to be prescribed by the consultant (SMO) responsible for the patient in collaboration with the family/whanau. This is to be documented in the progress notes and signed by the prescriber, including date and time applied on the shift initiated. Phone order from SMO acceptable but must be documented and signed by a registrar. An expiry time of approval must be stated.
- If the patient is under the Mental Health Service including Psychiatry for Older People (PoPS) then ensure that prior consultation occurs with the Psychiatry SMO or the on call SMO for Mental Health Services
- The reason for the restraint must be explained to the patient before the restraint is applied, during the time of restraint and upon removal of the restraints.
- The restraint equipment used should be only as authorised by Restraint Minimisation Group.
- The patients joints are to be restrained in a neutral position and the limbs are to be fully supported.
- The restraints must be removed each shift for a thorough check of the limb. This needs to be documented on the wrist restraint assessment & monitoring sticker (see CNM) placed in the progress notes.
- When wrist restraints are used the following assessment and monitoring documentation (on sticker) must occur each shift :
  - Limbs restrained (L& R wrist)
  - Decision to continue with restraint (Y/N)
  - Communication to update family

- The restraint will be checked **1hrly minimum** and the limb assessed for signs of pressure areas, skin integrity, colour and warmth. If the skin appears blue or feels cold or if the patient complains of a tingling sensation or numbness, loosen the restraint. This needs to be documented on the Neurovascular Observations form available on CKC.

- All other patient care will be provided e.g hygiene cares, pressure area care, and range of motion exercises.
- Patients will remain closely monitored – hourly rounding, given regular opportunity for fluid, food and toileting.
- The restraint is to be discontinued as early as possible when the nurse has assessed that the patient's behaviour no longer necessitates the application
- An appropriate monitoring plan is developed for the immediate post restraint period.

CULTURAL AND LEGAL CONSIDERATIONS:

- The patient's dignity must be protected and respected at all times.
- The patient has a right to question the need for restraint and ask that it be removed.

References:

Ministry of Health (2008) Health and Disability Services (restraint minimisation and safe practice) Standards NZS 8134.2:2008

NDHB Restraint Minimisation and Safe Practice Policy

NORTHLAND DISTRICT HEALTH BOARD
Te Poari Hauora Ā Rohe O Te Tai Tokerau

POST ANAESTHETIC CARE UNIT: SOFT RESTRAINT GUIDELINE

INTRODUCTION:

- To provide guidance to staff in PACU who will be using soft limb restraints
- To prevent the adult patient who is waking up from an Anaesthetic and is confused, disoriented or aggressive, from injuring themselves or others, while maintaining the patients' rights, dignity and safety.
- To be used in conjunction with the NDHB Restraint Guidelines

MANAGEMENT:

- Adult patients waking up from an Anaesthetic who are confused, disoriented or aggressive, could remove essential supportive equipment, e.g arterial lines, IV lines, catheters, drains and central lines- causing potential harm to themselves.
- To ensure the safety of Staff from aggressive patients
- This guideline applies to all staff working in PACU - Nursing, Medical and Health Care Assistants.
- All use of restraint must be added to the restraint register by completing an incident form in Datix.

GUIDELINES:

- Soft limb restraints are to be prescribed by the Anaesthetist involved or the Supervising Anaesthetist, on a sticker placed on the back of the Anaesthetic chart.
- Patient to be nursed by a recovery nurse one on one only.
- The reason for the restraint must be explained to the patient before the restraint is applied, during the time of restraint and upon removal of the restraints. Then again once the patient is fully awake and coherent.
- Any knots which are required should be tied in a manner which permits their quick release (slip knot or bow)
- The patients joints are to be restrained in a neutral position and the limbs are to be fully supported.
- The restraint will be checked 15 minutely and the limb assessed for signs of pressure areas, skin integrity, colour and warmth. If the skin appears blue or feels cold or if the patient complains of a tingling sensation or numbness, loosen the restraint. This needs to be documented.
- The restraints must be removed hourly for a thorough check of the limb. This needs to be documented.
- All other patient cares will be provided e.g hygiene cares, pressure area care, range of motion exercises.
- Patients will remain closely monitored.
- The Anaesthetist needs to review the patient hourly when they have ongoing confusion, disorientation or aggression.
- Prior to discharging the patient to the ward, notify the ward of any special requirements the patient may need on the ward e.g. a HCA Special

CULTURAL AND LEGAL CONSIDERATIONS:

- The patient's dignity must be protected and respected at all times.
- The patient has a right to question the need for restraint and ask that it be removed.
- The restraint is to be discontinued as early as possible when the PACU nurse has assessed that the patient's behaviour no longer necessitates the application (as per Management)

Acknowledgements/References:

NDHB Restraint Minimisation and Safe Practice

Applying soft limb restraint guideline by Alesha Long. ICU

Northland District Health Board Restraint use June 2016-June 2017

Event date	Ward/Department	Event type tier two	Event type tier three	Time Band	Type of mechanical restraint	Type of personal restraint	Length of time in restraint (minutes)
16/07/2016	MH / Mental Health Unit Inpatients (Tumanako) (Whangarei)	Inpatient	Personal restraint	15:00 - 15:59		Pistol grip	1
26/05/2017	MH / Mental Health Unit Inpatients (Tumanako) (Whangarei)	Inpatient	Personal restraint	20:00 - 20:59		Figure of 4 hold, Taken to floor-front	5
08/02/2017	MH / Community MH & Addiction SOUTH (Whangarei)	Outpatient	Mechanical restraint	23:00 - 23:59	Handcuffs		180
30/11/2016	Ward 14 Medical (Whangarei)	Inpatient	Personal restraint	03:00 - 03:59		Painfree hold	5
18/02/2017	MH / Mental Health Unit Inpatients (Tumanako) (Whangarei)	Inpatient	Personal restraint	02:00 - 02:59		Painfree hold	2
12/12/2016	MH / Mental Health Unit Inpatients (Tumanako) (Whangarei)	Inpatient	Personal restraint	08:00 - 08:59		Painfree hold	2
30/10/2016	MH / Mental Health Unit Inpatients (Tumanako) (Whangarei)	Inpatient	Procedural restraint	11:00 - 11:59		Painfree hold at patients request	0.3
21/11/2016	MH / Mental Health Unit Inpatients (Tumanako) (Whangarei)	Inpatient	Personal restraint	15:00 - 15:59		Painfree hold	2
26/09/2016	MH / Mental Health Unit Inpatients (Tumanako) (Whangarei)	Inpatient	Personal restraint	21:00 - 21:59		Painfree hold	1
27/09/2016	MH / Mental Health Unit Inpatients (Tumanako) (Whangarei)	Inpatient	Personal restraint	13:00 - 13:59		Painfree hold, Taken to floor-front	0.02

27/09/2016	MH / Mental Health Unit Inpatients (Tumanako) (Whangarei)	Inpatient	Procedural restraint	21:00 - 21:59			4
15/10/2016	MH / Mental Health Unit Inpatients (Tumanako) (Whangarei)	Inpatient	Procedural restraint	21:00 - 21:59			0.3
10/03/2017	MH / Mental Health Unit Inpatients (Tumanako) (Whangarei)	Inpatient	Personal restraint	18:00 - 18:59		Painfree hold	3
15/02/2017	MH / Mental Health Unit Inpatients (Tumanako) (Whangarei)	Inpatient	Personal restraint	22:00 - 22:59		Painfree hold	2
29/10/2016	MH / Mental Health Unit Inpatients (Tumanako) (Whangarei)	Inpatient	Personal restraint	10:00 - 10:59		Painfree hold	0.1
29/10/2016	MH / Mental Health Unit Inpatients (Tumanako) (Whangarei)	Inpatient	Environmental	10:00 - 10:59			2
07/03/2017	Ward 1 Orthopaedic (Whangarei)	Inpatient	Personal restraint	12:00 - 12:59		Figure of 4 hold	1.35
12/06/2016	MH / Mental Health Unit Inpatients (Tumanako) (Whangarei)	Inpatient	Personal restraint	18:00 - 18:59		Pistol grip, Taken to floor-front	3
17/06/2016	MH / Mental Health Unit Inpatients (Tumanako) (Whangarei)	Inpatient	Personal restraint	04:00 - 04:59		Figure of 4 hold	1
30/06/2016	Emergency Department (Whangarei)	Inpatient	Environmental	08:00 - 08:59			4
04/12/2016	MH / Mental Health Unit Inpatients (Tumanako) (Whangarei)	Inpatient	Personal restraint	19:00 - 19:59		Taken to floor-front	15
13/09/2016	MH / Mental Health Unit Inpatients (Tumanako) (Whangarei)	Inpatient	Personal restraint	22:00 - 22:59		Taken to floor-front	27
30/10/2016	MH / Mental Health Unit Inpatients (Tumanako) (Whangarei)	Inpatient	Personal restraint	17:00 - 17:59		Figure of 4 hold, Painfree hold	4
18/10/2016	Ward 2 Childrens (Whangarei)	Inpatient	Personal restraint	11:00 - 11:59		Painfree hold	1
06/01/2017	MH / Mental Health Unit Inpatients (Tumanako) (Whangarei)	Inpatient	Personal restraint	16:00 - 16:59		Painfree hold, Taken to floor-front	2
12/06/2016	MH / Mental Health Unit Inpatients (Tumanako) (Whangarei)	Inpatient	Personal restraint	13:00 - 13:59		Painfree hold	3
07/06/2016	MH / Mental Health Unit Inpatients (Tumanako) (Whangarei)	Inpatient	Personal restraint	15:00 - 15:59		Painfree hold	10
07/06/2016	MH / Mental Health Unit Inpatients (Tumanako) (Whangarei)	Inpatient	Personal restraint	16:00 - 16:59		Painfree hold	5
01/06/2016	MH / Mental Health Unit Inpatients (Tumanako) (Whangarei)	Inpatient	Personal restraint	09:00 - 09:59		Painfree hold	3

02/06/2016	MH / Mental Health Unit Inpatients (Tumanako) (Whangarei)	Inpatient	Personal restraint	14:00 - 14:59		Painfree hold	5
07/03/2017	MH / Mental Health Unit Inpatients (Tumanako) (Whangarei)	Inpatient	Personal restraint	20:00 - 20:59		Taken to floor-back	10
10/03/2017	MH / Mental Health Unit Inpatients (Tumanako) (Whangarei)	Inpatient	Personal restraint	17:00 - 17:59		Painfree hold, Taken to floor-back, Taken to floor-front	5
12/03/2017	MH / Mental Health Unit Inpatients (Tumanako) (Whangarei)	Inpatient	Personal restraint	14:00 - 14:59		Painfree hold	2
17/03/2017	MH / Mental Health Unit Inpatients (Tumanako) (Whangarei)	Inpatient	Personal restraint	09:00 - 09:59		Painfree hold	30
27/03/2017	MH / Mental Health Unit Inpatients (Tumanako) (Whangarei)	Inpatient	Personal restraint	15:00 - 15:59		Taken to floor-back	2
09/07/2016	MH / Mental Health Unit Inpatients (Tumanako) (Whangarei)	Inpatient	Personal restraint	19:00 - 19:59		Painfree hold	2
14/04/2017	MH / Mental Health Unit Inpatients (Tumanako) (Whangarei)	Inpatient	Personal restraint	20:00 - 20:59		Painfree hold	3
15/04/2017	MH / Mental Health Unit Inpatients (Tumanako) (Whangarei)	Inpatient	Personal restraint	14:00 - 14:59		Figure of 4 hold, Painfree hold, Taken to floor-back, Taken to floor-front	0
17/04/2017	MH / Mental Health Unit Inpatients (Tumanako) (Whangarei)	Inpatient	Personal restraint	10:00 - 10:59		Painfree hold, Taken to floor-front	0
18/04/2017	MH / Mental Health Unit Inpatients (Tumanako) (Whangarei)	Inpatient	Personal restraint	08:00 - 08:59		Painfree hold	0.3
19/04/2017	MH / Mental Health Unit Inpatients (Tumanako) (Whangarei)	Inpatient	Personal restraint	09:00 - 09:59		Taken to floor-front	1
19/04/2017	MH / Mental Health Unit Inpatients (Tumanako) (Whangarei)	Inpatient	Personal restraint	15:00 - 15:59		Painfree hold, Taken to floor-front	2
20/04/2017	MH / Mental Health Unit Inpatients (Tumanako) (Whangarei)	Inpatient	Personal restraint	08:00 - 08:59		Figure of 4 hold, Painfree hold, Taken to floor-back, Taken to floor-front	8
20/04/2017	MH / Mental Health Unit Inpatients (Tumanako) (Whangarei)	Inpatient	Personal restraint	09:00 - 09:59		Painfree hold, Taken to floor-back, Taken to floor-front	8

20/04/2017	MH / Mental Health Unit Inpatients (Tumanako) (Whangarei)	Inpatient	Personal restraint	15:00 - 15:59		Painfree hold, Taken to floor-front	2
25/07/2016	Ward 14 Medical (Whangarei)	Inpatient	Mechanical restraint	21:00 - 21:59	Limb restraint		0
21/12/2016	MH / Mental Health Unit Inpatients (Tumanako) (Whangarei)	Inpatient	Personal restraint	23:00 - 23:59		Painfree hold	2
01/06/2016	MH / Mental Health Unit Inpatients (Tumanako) (Whangarei)	Inpatient	Personal restraint	01:00 - 01:59		Taken to floor-front	0.01
23/02/2017	MH / Mental Health Unit Inpatients (Tumanako) (Whangarei)	Inpatient	Personal restraint	20:00 - 20:59		Painfree hold	5
30/01/2017	MH / Mental Health Unit Inpatients (Tumanako) (Whangarei)	Inpatient	Personal restraint	22:00 - 22:59		Figure of 4 hold, Painfree hold, Taken to floor-front	5
04/04/2017	MH / Mental Health Unit Inpatients (Tumanako) (Whangarei)	Inpatient	Personal restraint	15:00 - 15:59		Painfree hold	0.5
05/04/2017	MH / Mental Health Unit Inpatients (Tumanako) (Whangarei)	Inpatient	Personal restraint	12:00 - 12:59		Painfree hold	6
09/08/2016	Ward 4 Surgical (Whangarei)	Inpatient	Personal restraint	08:00 - 08:59		Painfree hold	5
02/06/2016	MH / Mental Health Unit Inpatients (Tumanako) (Whangarei)	Inpatient	Personal restraint	16:00 - 16:59		Painfree hold	15
25/07/2016	MH / Mental Health Unit Inpatients (Tumanako) (Whangarei)	Inpatient	Personal restraint	10:00 - 10:59		Pistol grip	2
27/08/2016	MH / Mental Health Unit Inpatients (Tumanako) (Whangarei)	Inpatient	Personal restraint	13:00 - 13:59		Figure of 4 hold, Pistol grip, Taken to floor-front	5
07/03/2017	MH / Mental Health Unit Inpatients (Tumanako) (Whangarei)	Inpatient	Personal restraint	23:00 - 23:59		Painfree hold	1
14/10/2016	General Ward (Dargaville/Kaipara)	Inpatient	Positioning/supportive device	22:00 - 22:59			1.5
09/11/2016	MH / Mental Health Unit Inpatients (Tumanako) (Whangarei)	Inpatient	Personal restraint	09:00 - 09:59		Painfree hold	4
05/11/2016	MH / Mental Health Unit Inpatients (Tumanako) (Whangarei)	Inpatient	Personal restraint	08:00 - 08:59		Painfree hold, Taken to floor-front	10
22/10/2016	MH / Mental Health Unit Inpatients (Tumanako) (Whangarei)	Inpatient	Personal restraint	13:00 - 13:59		Figure of 4 hold	0.3
02/07/2016	MH / Mental Health Unit Inpatients (Tumanako) (Whangarei)	Inpatient	Personal restraint	13:00 - 13:59		Figure of 4 hold, Taken to floor-front	20
04/05/2017	MH / Mental Health Unit Inpatients (Tumanako) (Whangarei)	Inpatient	Personal restraint	00:00 - 00:59		Painfree hold	2

26/03/2017	MH / Mental Health Unit Inpatients (Tumanako) (Whangarei)	Inpatient	Personal restraint	13:00 - 13:59		Painfree hold	1
01/04/2017	MH / Mental Health Unit Inpatients (Tumanako) (Whangarei)	Inpatient	Personal restraint	22:00 - 22:59		Painfree hold	2
19/08/2016	MH / Mental Health Unit Inpatients (Tumanako) (Whangarei)	Inpatient	Personal restraint	16:00 - 16:59		Painfree hold, Pistol grip, Taken to floor-front	7
27/07/2016	MH / Mental Health Unit Inpatients (Tumanako) (Whangarei)	Inpatient	Personal restraint	03:00 - 03:59		Painfree hold	2
02/06/2016	MH / Mental Health Unit Inpatients (Tumanako) (Whangarei)	Inpatient	Personal restraint	14:00 - 14:59		Painfree hold	5
16/10/2016	MH / Mental Health Unit Inpatients (Tumanako) (Whangarei)	Inpatient	Personal restraint	15:00 - 15:59		Painfree hold	1

Date started	Date stopped	Type	Reason for restraint
5/11/16	6/11/16	Wrist x2	To keep patient's oxygen tubing on and stop Femoral CV Line being pulled out
5/11/16	8/11/16	Wrist x2	To keep patient from pulling Endotracheal tube and lines out
8/11/16	11/11/16	Wrist x2	To prevent patient from pulling lines out
5/1/17	7/1/17	Wrist x1	To prevent tracheostomy tube being inadvertently knocked out
8/03/17	15/3/17	Wrist x2	To prevent essential lines and endotracheal tube from being pulled out
27/03/17	29/03/17	Wrist x2	To prevent Naso-gastric tube being pulled out by patient
11/4/17	13/4/17	Wrist x2	To prevent patient removing intravenous lines