Restraint Minimisation and Safe Practice in Mental Health

Document Type	Policy
Function	Clinical Practice
Directorate(s)	Mental Health & Addictions (MH&A)
Department(s) affected	All services within MH&A
Applicable for which patients, clients or residents?	All tangata whai i te ora / service users within MH&A Directorate
Applicable for which staff members?	All clinicians within MH&A Directorate
Key words (not part of title)	Use of Force, Personal Restraint
Author – role only	Specialist Allied Health Professional, Seclusion and Restraint Reduction
Owner (see ownership structure)	Director of Mental Health and Addictions Directorate
Edited by	• Clinical Policy Advisor • Copy edit by Document Controller • Formatting by Document Controller • Proofreading by Document Controller
Date first published	October 2008
Date this version published	January 2016
Review frequency	3 yearly
Unique Identifier	PP40/RBP/030

Contents

Back to Contents

1. Purpose of policy

This policy outlines the commitment to:

- Reducing the use of force/restraint within MH&A Directorate
- Encouraging restraint free processes as far as possible
- Ensuring that when personal restraint is clinically indicated it is undertaken in a safe and respectful manner by appropriately trained staff member

This policy ensures compliance with the legal requirements and standards set out in:

- Section 122B of the Mental Health (Compulsory Assessment and Treatment)Act 1992; and
- The Health and Disability Services (Restraint Minimisation and Safe Practice) Standards (NZS 8134.2:2008)

2. Policy statements

Restraint is a serious intervention requiring clear clinical rationale, close monitoring and oversight. Restraint is viewed in the wider context of risk management and is one of a number of strategies that can be used to manage instances of high-risk behaviour.
There are a number of different interventions, which may constitute 'restraint' – see section 3 Definitions

Personal restraint must only be used as a last resort after alternative, less restrictive interventions have been exhausted (examples include but are not limited to appropriate cultural and whānau/family support, sensory modulation, access to activity, enhanced engagement and de-escalation).

All staff members working in Auckland DHB MH&A Directorate must be aware of the potentially harmful physical and psychological effects of restraint, particularly for individuals with a known trauma history.

All forms of restraint used within Auckland DHB MH&A Directorate require approval through the Less Restrictive Practices Governance Group.

Back to Contents

3. Definitions

The following terms are used within this document:

Service User:
Used to refer to tangata whai ite ora, service users, consumers, patients and users of all Auckland DHB Mental Health and Addictions services

Use of Force / Restraint:
Use of force / restraint is the implementation of any forcible control by a service provider that:

- Limits the actions of a service user in circumstances in which the individual is at risk of injury or of injuring another person
- The intentional removal of the individual's normal right to freedom.

As per the Restraint Minimisation and Safe Practice Standard NZS8134.2:2008) restraint can be divided up into distinct categories outlined below:

Personal Restraint:
When a staff member/members use their own bodies to intentionally limit the movement of a service user eg to physically hold the individual.

Physical Restraint:
When a staff member or members of the treating team use equipment, devices or furniture that limit an individual's normal freedom of movement eg where a service user is unable to independently get out of a chair due to the design of the chair, the use of a belt which they cannot undo themselves or the positioning of a table or fixed tray preventing them from getting up.

The use of fixed belts, equipment or furniture specifically to physical restrain service users in Auckland DHB MH&A Directorate is not supported.

Note: Use of mechanical restraint in Auckland DHB MH&A Directorate is subject to a separate policy (Restraint –Mechanical)

Environmental Restraint
This form of restraint can range from a contained environment ie utilising doors and fencing to plan interventions that reduce the level of social contact and/or environmental stimulation. It can also refer to restricting liberty by having an individual's normal means of mobility denied (eg removing someone's wheelchair)

Note: Within MH&A Directorate, some of our wards / units are approved as locked environments and this is as a permanent aspect of service delivery.

The practice of locking open wards in mental health units is at times necessary for clinical reasons – please refer to local guidelines for each service

Back to Contents

Enablers
These are equipment, devices or furniture voluntarily used by an individual following appropriate assessment that limit the normal freedom of movement with the intent of promoting independence, comfort or safety eg a voluntary use of raised bedsides to assist mobility in bed and aid positioning.

Both enablers and restraint limit the normal freedom of movement of the consumer. It is not the properties of the equipment, device or furniture that determines whether it is an enabler or restraint but rather the intent of the intervention. Where the intervention is to promote independence, comfort and safety, and the intervention is voluntary, this constitutes an enabler rather than a restraint.

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.

4. Use of personal restraint

It is recognised that there will be times when the use of personal restraint becomes necessary. In such situations, it must be utilised for as short a period of time as possible and with the least possible force, it must be used as a last option, where other, less restrictive options have been exhausted.

Personal restraint must be initiated only after assessment of the individual's clinical presentation (including any identified physical health conditions), and discussion with clinical team (to include medical practitioner if available).

The underlying cause of current crisis, personal history including known or assumed trauma history, previous experience of restraint and any advance directives / preferences of the individual must be considered at this point.

Exceptional crisis situations where immediate high risk is posed to the individual or others may require emergency use of personal restraint; however, wherever possible discussion and consent processes must occur with the individual and their whānau / family prior to restraint and alternatives to personal restraint will be explored.

The decision making process re initiating use of force / personal restraint must be clearly documented in HCC. If it becomes clear that due to clinical presentation an individual may be at risk and need more than one episode of personal restraint a care plan must be established documenting the rationale including decision making process re-use of force / personal restraint.

Back to Contents

5. Monitoring of service user

During episodes of personal restraint, a registered nurse must closely monitor the service user. It is essential that the service user's airway is not obstructed at any time, that only authorised holds and positioning are used so as to minimise the potential for physical harm / injury.

Adequate physical observations post-personal restraint must be undertaken and staff member must maintain high awareness of this as a time when risk of physical collapse may be increased.

Any injuries incurred during episode of personal restraint need to be assessed / reviewed as soon as possible and relevant treatment / care provided.

The above monitoring must be recorded in the individual's HCC clinical record.

6. Discontinuation of personal restraint

The desired outcome of the use of personal restraint and criteria for ending restraint must be clear to staff members and explained to the service user.

The decision to discontinue restraint must be undertaken by a registered nurse after careful assessment that immediate risk issue leading to use of personal restraint have lessened / receded.

Personal restraint must be used for the shortest period of time possible and with the least force possible.

7. Documentation

All episodes of personal restraint require clear documentation using the 'Use of Force' form in HCC, including alternatives to restraint considered, rationale for initiation of restraint, monitoring, timeframe, who was involved, alternatives / additional support, evaluation and whether family members / next of kin have been advised.

Within the general clinical notes / record a more indepth rationale for the decision to use personal restraint and details of precursors / any identified prompting events or contributing factors. Evidence of monitoring of both physical condition and mental state must also be entered.

The paper restraint / use of force register must be completed.

Any injuries which incurred during personal restraint, either to service user or staff member, must be logged via the Risk Monitor Pro system and appropriate first aid / medical attention given.

All legally required documentation – use of force form, paper register and HCC clinical note must be completed by the service user's allocated nurse prior to the end of their shift.

Back to Contents

8. Evaluation and review

An evaluation of the effectiveness of any episode of personal restraint must be undertaken and documented in HCC by registered nurse and/or clinical team. Ideally the evaluation must include feedback from the service user on their experience of the situation, what they feel was useful or not and what might be effective if a similar situation arises again – it is recognised that the service user may not want to give feedback or that their feedback may come at a later time.

All episodes of use of force / personal restraint must be reviewed by Charge Nurses / Service Leaders including Consumer Representatives separate to this initial evaluation.

9. Education and training

All staff members working in MH&A Directorate must have access to information and training that reflects the organisation's commitment to reducing the use of coercive practice and restraint. The suite of trainings to support restraint minimisation is focussed on building skill and resource and includes sensory modulation training, communication and de-escalation training, and Safe Practice for Inpatient Settings / Safe Practice for Community Settings.

The training provided must be at a level that supports safe practice for staff members in their role, professional discipline and service.

Staff members employed in Auckland DHB Community based MH&A Directorate are trained in de-escalation and the use of breakaway techniques rather than in personal restraint. As a safety precaution for all involved it is expected that the police will attend any situation in the community that may require personal restraint and take the lead in managing physical containment.

10. Legislation

- NZS8134.2:2008 Health and Disability Services (Restraint Minimisation (MH&A) Standards
- Crimes Act, 1961
- Health and Disability Commissioners Act 1994 (and Code of Rights)
- Health Practitioners Competence Assurance Act 2003
- Mental Health (Responsible Clinician Assignment for Patients under the Mental Health (Compulsory Assessment & Treatment) Act) 1992, and Amendment Act 1999
- Privacy Act 1993
- The Health & Disability Commissioner (Code of Health & Disability Consumer Rights) Regulations 1996

Back to Contents

11. Associated Auckland DHB documents

- Detention of Voluntary Service Users
- District Inspectors
- Informed Consent
- Observation - Increased - in Mental Health & Addictions
- Police & MoH Memorandum of Understanding (National)
- Psychiatrist Availability
- Seclusion in Mental Health

12. Disclaimer

No guideline can cover all variations required for specific circumstances. It is the responsibility of the health care practitioners using this ADHB guideline to adapt it for safe use within their own institution, recognise the need for specialist help, and call for it without delay, when an individual patient falls outside of the boundaries of this guideline.

13. Corrections and amendments

The next scheduled review of this document is as per the document classification table (page 1). However, if the reader notices any errors or believes that the document should be reviewed ***before*** the scheduled date, they should contact the owner or the Clinical Policy Advisor without delay.