PURPOSE

This protocol specifies the conditions under which personal restraint minimisation is used for patients causing safety concern and ensures compliance with the Bay of Plenty District Health Board (BOPDHB) policy 1.2.4 Restraint Minimisation and Safe Practice.

Security should always be called to any situation of safety concern. Refer to:

- Patient Causing Safety Concern Flowchart (Appendix 1)
- AGGRESSION Emergency Action Card (coloured yellow) for the BOPDHB procedure in this situation.
- In a situation where the individual is in possession of a weapon and expresses the intention to use this, staff safety is paramount and Security / the Police should be called. Restraint must not be attempted.

Personal hold may be used as an enabler, the details of which are covered in Clinical Practice Manual protocol CPM.E1.1 Enablers. Enablers are only used when communication, comforting and distraction techniques have all failed. They should be the least restrictive option, consent should be obtained and the risks discussed with the patient and / or family if possible or appropriate.

STANDARDS TO BE MET

1. Criteria For Using Personal Hold Restraints

a) Personal hold as restraint when a person is causing safety concern is used only after de-escalation has been attempted and found to be inadequate to prevent harm to patients, staff or members of the public.

b) The decision to restrain must be made by a registered health professional on the basis of clinical best practice and must be utilised within the limits of the legislation.

c) The following are situations where restraint may be indicated, when an individual:
   - i. Behaves in a manner which indicates potential risk to self or others
   - ii. Attempts self-harm
   - iii. Attempts to attack another person
   - iv. Compromises the environment e.g. wilful damage
   - v. Or when it is necessary to give prescribed essential medical treatment to an individual who is resisting, and this is deemed absolutely essential by the medical officer in charge of the individual's care

d) Medication used as a form of chemical restraint is considered to be abuse and is not supported by BOPDHB.

e) All staff need to be familiar with BOPDHB policy 1.1.1 Informed Consent.

2. Level Of Competency Of Staff Involved In The Use Of Personal Hold As Restraint

a) The person applying personal hold as restraint must be trained and assessed as competent in the use of personal hold techniques, e.g. Mental Health personal hold restraint training, or equivalent as approved by Practice of Restraint Advisory Group (PRAG).

3. Risk Assessment And Management

	Potential Risks	Risk Management
1	• Potential for physical and psychological harm or injury to patient / client requiring restraint	• Staff trained in use of personal hold techniques • Documented process for the initiation of personal hold restraint
2	• Positional Asphyxia	• See Appendix 1
3	• Restraint used when not indicated or justified	• Ongoing assessment and review of personal hold restraint use
4	• Restraint continued longer than necessary	• Assessment and evaluation of use of personal hold restraint and risks
5	• Potential infection risk to staff	• Standard precautions used by staff

4. Procedure For Using Personal Restraint

Patient requirements for the use of Personal Hold as restraint is assessed according to the BOPDHB policy 1.2.4 Restraint Minimisation and Safe Practice Standards

STEP	ACTION	RATIONALE
1	**Assessment and documentation of the use of Personal Hold as restraint** • Assess patient needs for personal hold restraint using the Patient Causing Safety Concern Needing Intervention Flow Chart Appendix 1: All possible alternatives to the application of personal hold restraint must be considered prior to proceeding to personal hold restraint • Assessment of requirement for personal restraint will include: – Safety considerations for patient and staff involved in restraint – Degree of urgency and danger – Available resources to manage the situation safely • Seek advice from Mental Health & Addiction Services (MH&AS) staff in event of known client or presumed mental health issue • Assessment is ideally completed in partnership with family / whānau and significant others • If the use of personal hold as restraint is indicated on completion of assessment commence documentation of the restraint use on the Incident Management form and in the patient care plan. Refer to Flowchart (Appendix 1)	• To ensure that a restraint is initiated in a timely manner, is used appropriately, results in a desired outcome and maintains safety for patients and staff • To maintain safety for individual and staff • To ensure informed consent is obtained and cultural needs are met.

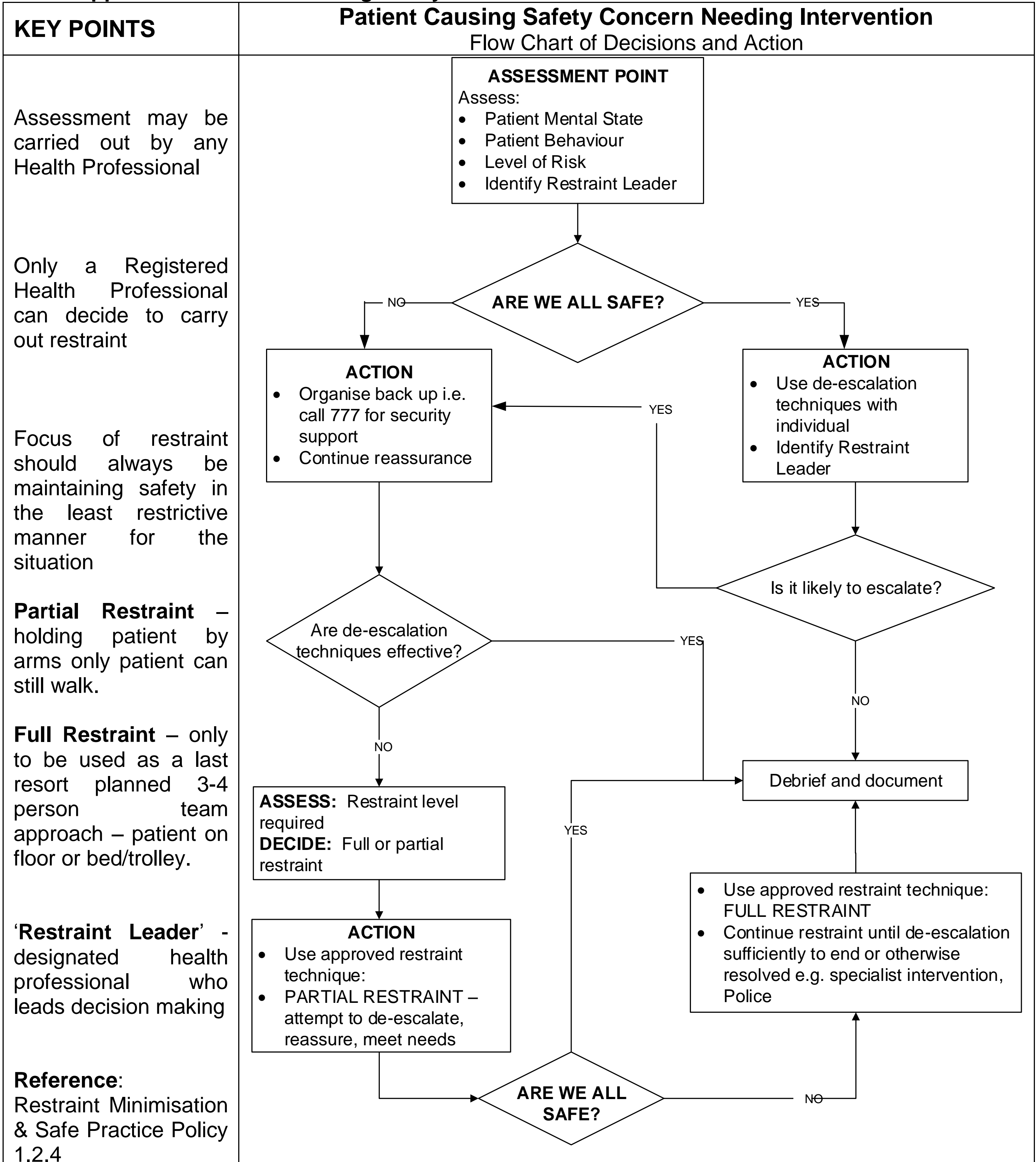
STEP	ACTION	RATIONALE
2	**Application and use of personal hold restraint** • Personnel who are formally trained in personal hold techniques may only apply this form of restraint. • A restraint leader is identified for all instances of personal hold restraint	• To reduce risks to patient / client and staff • To ensure ongoing effective communication with the patient / client, staff member and others including family / whānau during the procedure
3	**Process and frequency for monitoring / reviewing the use of personal hold restraint** Monitoring of patient • Continual assessment including observation and care of the individual's airway, breathing, circulation, level of consciousness, discomfort, skin colour, limb and body positioning • Continual assessment of the level of risk that the individual poses and the response of the individual to the restraint Formal review of the use of personal hold restraint • This will be ongoing as well as at the end of the restraint use and will focus on: – Response of the individual to the restraint – The level of risk the individual poses to self, others and environment	• To ensure patient / client physical safety is maintained throughout the procedure • To ensure patient safety and evaluate the effectiveness of the use of personal hold restraint
4	**If injury or adverse effect occurs:** • An Incident Management Form is completed with full details of incident	• To maintain patient and staff safety
5	**Discontinuation of the use of personal hold restraint** • The decision to end restraint is communicated to the personnel holding the patient / client by the Restraint Leader • Ongoing planning for patient management as clinically indicated • Complete an Incident Management form.	• To evaluate the effectiveness of the use of personal hold restraint

ASSOCIATED DOCUMENTS

- Bay of Plenty District Health Board Restraint Minimisation & Safe Practice controlled documents
- Bay of Plenty District Health Board policy 0.0 Glossary of Terms / Definitions
- Bay of Plenty District Health Board policy 1.1.1 Informed Consent
- Bay of Plenty District Health Board policy 2.1.1 Risk Management
- Bay of Plenty District Health Board policy 2.1.2 protocol 2 Controlled Document Development Standards
- Bay of Plenty District Health Board policy 2.1.2 protocol 6 Controlled Document Review Standards
- Bay of Plenty District Health Board policy 2.1.3 Hazard Management

- Bay of Plenty District Health Board policy 2.1.4 Incident Management
- Bay of Plenty District Health Board policy 5.4.7 Threatening Behaviour, Bullying, Harassment and Violence in the Workplace - Management
- Bay of Plenty District Health Board policy 7.104.1 protocol 3 Care Delivery – Observing Patients
- Bay of Plenty District Health Board Practice of Restraint Advisory Group (PRAG) Terms of Reference
- Bay of Plenty District Health Board Incident Management Form

Appendix 1: Patient Causing Safety Concern Flowchart



Appendix 2: Positional Asphyxia

(Reference: UK Ministry of Justice. Prison Service Order 1600. Use of Force. *Positional Asphyxia*)

Physical restraint can lead to harm and even death. The person being restrained must have close observation by a member of medical or nursing staff including A B C at all times.

There are a number of potential adverse effects of the application of restraints. These include; being unable to breathe, feeling sick or vomiting, developing swelling to the face and neck, and the developments of petechiae (small blood-spots associated with asphyxiation) to the head, neck and chest.

Restraining an individual in a position that compromises the airway or expansion of the lungs (i.e. in the prone position) may seriously impair an individual's ability to breathe and can lead to asphyxiation. This includes pressure to the neck region, restriction of the chest wall and impairments of the diaphragm. When the head is forced below the level of the heart, drainage of the blood from the head is reduced and brain swelling can result. Swelling of the head and neck and bloodspots (petechiae) are signs of reduced drainage of blood from the head and neck. They are warning signs of actual or impending brain injury.

Pressure should not be placed on the neck, especially around the angle of the jaw or the windpipe. Pressure on the neck, particularly in the region below the angle of the jaw (carotid sinus) can disturb the nervous controls to the heart and lead to a sudden slowing or even stoppage of the heart.

A degree of positional asphyxia can result from any restraint position in which there is restriction of the neck, chest wall or diaphragm.

This risk is increased where:

- The head is forced downwards towards the knees
- The subject is immobilised seated (the angle between the chest wall and the lower limbs is already decreased).
- The torso is compressed against or towards the thighs (restricts the diaphragm and compromises lung inflation).
- In prone restraints the body weight of the restrained person acts to restrict movement of the chest wall and the abdomen (restricting diaphragm movement).

Factors that predispose a person to positional asphyxia and sudden death under restraint include:

- Drug/alcohol intoxication (because sedative drugs and alcohol act to depress breathing so reducing oxygen taken into the body)
- Physical exhaustion (or any factors that increase the body's oxygen requirements, for example a physical struggle or anxiety)
- Obesity

Warning signs related to positional asphyxia:

- An individual struggling to breathe
- Complaining of being unable to breathe
- Evidence or report of an individual feeling sick or vomiting
- Swelling, redness or bloodspots to the face or neck
- Marked expansion of the veins in the neck
- Individual becoming limp or unresponsive
- Sudden changes in behaviour (both escalated and deescalated)
- Loss of, or reduced levels of, consciousness

- Respiratory or cardiac arrest.

Where warning signs are present the restraint must immediately be released or modify the restraint as far as practicable to reduce body wall restriction, and call 777.

No person should be restrained face down (or in the case of a pregnant person, on her side) for longer than is absolutely necessary to gain control. There must be continuous observation of a person following relocation in the prone position until such time as the person is no longer lying face down (or in the case of a pregnant person, on her side).

There is a common misconception that if an individual can talk then they are able to breathe, this is NOT the case. An individual dying from positional asphyxia may well be able to speak or shout prior to collapse.