Restraint Elimination and Safe Practice Policy

Purpose

Te Whatu Ora Health New Zealand Waitaha Canterbury and Te Tai o Poutini West Coast aims for a restraint free environment to preserve the dignity and mana for people we provide health services to. This policy is underpinned by the criteria provided in Ngā paerewa Health and disability services standard NZS 8134:2021; Section 6 – Here taratahi Restraint and Seclusion.

Policy

Te Whatu Ora Waitaha and Te Tai o Poutini takes the health, safety and welfare of its patients and staff seriously.

Staff will ensure that patients receive services in the least restrictive form appropriate; whilst recognising that all staff have the right to perform their duties without being subject to such behaviours that is threatening the physical/psychological safety of others.

A restraint minimisation and safe practice education programme is in place to minimise/eliminate restraint use through communication and de-escalation and promote correct use of restraint practices throughout the organisation. The overarching aim of the education programme is to ensure appropriate clinical staff are competent to meet both the individual needs of the consumer and staff.

Restraint is a serious clinical intervention that requires clinical rationale and oversight.

Restraint should only be used as a last resort after alternative, less restrictive interventions have been attempted (such as communication and de-escalation, cultural support, interpreters) acknowledging the potential for physical and psychological impact restraint has on the individual consumer, their whānau-family and others.

Use of restraint must be clearly justified and takes into account the persons previous history and based on sound clinical judgement. The decision to restrain and the rationale for its use must be documented in the clinical record.

All restraints and techniques used must be approved for use. All restraint events are continually monitored and reviewed and applied for the minimum amount of time necessary.

Each episode of restraint must be recorded in the clinical notes and in the restraint register inclusive of indication of use, intervention, duration and outcome and what de-escalation strategies were tried prior to the restraint being implemented.

Services are required to record and ensure that specified observation and on-going assessments are carried out throughout the restraint event. The consumer's dignity is maintained to minimise the risk of physical and psychological harm to consumers during the restraint event.

The frequency and level of observation and assessment should be appropriate to the level of risk associated with the organisation and service specific restraint procedures reflecting current accepted best evidence-based practice.

A timely debriefing for all parties involved in a personal restraint is considered for people who are restrained and their whanau and staff who were involved in the restraint episode.

The multidisciplinary Restraint Elimination Safe Practice Governance Group (RESPGG) governs and approves all forms of restraints permitted for use as submitted by the divisional Restraint Elimination and Safe Practice Committees (RESPC).

Note: The use of medication as a form of chemical restraint is in breach of standard NZS 8134:2021. All medicine must be prescribed and used for valid therapeutic indications. Appropriate health professional advice is important to ensure that the relevant intervention is appropriately used for therapeutic purposes only. The use of medication solely for the purpose of limiting a consumer's freedom of movement or to render them incapable of resistance is considered 'chemical restraint' and is a breach of the standard.

Applicability

Applies to all employees, security staff, students on placement and visiting health professionals across all services, who have direct patient contact as part of their work requirements and who might at some stage be required to manage challenging behaviours and assist in communication and de-escalation or apply restraint (only if trained).

The restraint of patients/consumers is always under the direction and supervision of a staff member who is a registered health professional. Security staff may participate in restraint episodes but only under the direction and supervision of a registered health professional.

Exclusions to the policy include

- The restraint of patients who are **prisoners** for security purposes i.e. under corrections or police supervision.
- Environmental isolation and/or detainment of patients/consumers for **infection prevention and control** purposes.
- The restraint of patients/consumers being transported and subject to specific provisions under the **Mental Health Act 1992** (Compulsory Assessment and Treatment) or the **Intellectual Disability** (Compulsory Care and Rehabilitation) Act 2003.
- **Paediatric Therapeutic holding** (supportive holding or clinical holding) The immobilisation of an infant or young child to help them manage a painful procedure quickly and effectively or to enable the procedure to be carried out in a safe and controlled manner. Wherever possible the consent of the parent/s and assent of the child after the rationale and technique has been clearly described, should be obtained. The technique used is built around soothing/self-soothing strategies which the child has historically initiated or demonstrated that they respond positively to and makes skilled use of age appropriate techniques such as wrapping and splinting.

Roles and Responsibilities

Clinical

- Consider least restrictive practice to achieve desired outcome with emphasis on communication and de-escalation and demonstrate respect for the person and others and maintaining the dignity of the person in partnership with patient and the whānau-family.
- Staff communicate with tangata whai i te ora and their whānau regarding cultural safety requirements, when managing challenging behaviours and situations in a meaningful, empowering and therapeutic manner.
- Cultural advice is sought where indicated
- Where the communication, de-escalation and all alternative strategies are unsuccessful, restraint can only be applied with clinical assessment and oversight by trained staff.
- Restraint episode is documented, monitored and evaluated in the clinical record and the restraint register
- Decision to cease restraint and ensuring restraint is used for the least amount of time is continually monitored and reviewed

- Episode of restraint is recorded inclusive or communication and de-escalation strategies tried in Incident Management System
- Opportunity to debrief a restraint event is offered with cultural support to consumer and or their whānau-family

Clinical Leaders/Managers

With the guidance of the divisional Restraint Elimination and Safe Practice Committees

- Promote restraint minimisations practices
- Monitor and evaluate use of restraint
- Advance least restrictive practice including the reduction of all forms of restraint
- Initiate, review, implement and evaluate tools, initiatives and approaches that are evidence based best practice for restraint minimisation
- Identify and evaluate concerns regarding compliance related to restraint and least restrictive practice and elevate to divisional leadership teams and local Restraint Elimination and Safe Practice Committees ESPC

Divisional Restraint Elimination Safe Practice Committees

- Have improvement programmes in place to minimise/eliminate restraint
- Monitor education as planned
- Monitor restraint events and evaluate (clinical record audit)
- Ensure environmental scan audits of restrictive equipment audits are completed
- Provide regular reports to RESPGG of activity

Restraint Elimination and Safe Practice Governance Group (RESPGG)

- Actively monitor, evaluate and promote a consistent, standardised approach to meeting the Ngā paerewa Health and disability services standard NZS 8134:2021 Section 6 standard across Te Whatu Ora Waitaha and Te Tai o Poutini responsibility and regionally and nationally.
- To ensure monitoring and improvement systems and process are in place supporting Restraint Elimination and Safe Practice
- Approves all associated policy collateral
- Approves all restraints interventions and techniques for use at least annually
- Oversees the supporting education and training programme
- Assists in the review of restraint issues/adverse events
- Provides expertise and oversee best practice

Clinical Governance Committees

Assists with the function of overseeing quality systems in all areas of Te Whatu Ora Waitaha and Te Tai o Poutini responsibility by

- Overseeing minimisation/elimination of restraint with supported improvement programmes
- Ensures restraint use is monitored and organisation processes are adhered to
- Service specific training programmes are in place

Categories of Restraint

Personal Restraint

Where a service provider uses their own body to intentionally limit the movement of a patient/consumer. For example, where a consumer is held by a service provider. This is either a partial personal hold or full personal hold.

Physical Restraint

Use of restrictive equipment is to be considered a physical restraint if the patient/consumer requires the assistance of a 3rd party to release them from its use (i.e. move it so they can move). Items that constitute restrictive equipment include, but are not limited to, bedrails, tray tables, chair that patients cannot move out of independently.

Locked Doors

Where a service provider intentionally restricts a patient's/consumer's normal access to their environment. For example, where a patient's/consumer's normal access to their environment is intentionally restricted by locking devices on doors.

Seclusion

Where a patient/consumer is placed alone in a room or area, at any time and for any duration, from which they cannot freely exit.

Seclusion is a specific type of Environmental Restraint and can only be legally implemented for patients/consumers who are under the Mental Health (Compulsory Assessment and Treatment) Act 1992 or the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003. Seclusion only occurs in approved and designated seclusion rooms.

Definitions

The following definitions shall apply as per NZS 8134:2021

Term	Description
De-escalation	A set of complex interactive processes in which a highly aroused person is redirected from an unsafe course of action towards a supported and calmer emotional state. This usually occurs through timely appropriate and effective interventions and is achieved by service providers using communication and nob-verbal skills along with practical alternatives
Safe use of equipment	A person is able to make their own decision about equipment use and can free themselves from the equipment if required.
Restrictive Equipment	Use of restrictive equipment items limits a person's normal freedom of movement and can only be used after appropriate clinical assessment and requires voluntary agreement with the user. Items that constitute restrictive equipment include, but are not limited to, bedrails, tray tables, chair that patients cannot move out of independently. Use of restrictive equipment is to be considered a physical restraint if the patient/service user requires the assistance of a 3rd party to release them from its use (i.e. move it so they can move) and be recorded as such on the restraint register. The use of restrictive equipment is to be monitored and recorded in the clinical record.

Restraint	The use of any intervention by a service provider that limits a person's normal freedom of movement. Where restraint is consented to by a third party it is always restraint.
Restraint episode	A single restraint event, or where restraint is used as a planned regular intervention and is identified in the person's service delivery plan. The term may also refer to a grouping of restraint events.
Restraint initiator	The restraint initiator is the registered health professional who is trained in de-escalation and least restrictive practice and decides that the patient requires restraining.
Restraint Approval Register	Restraint type is reviewed annually (or as necessary) and documented in the restraint register.
Restraint elimination	Evidence of good assessment and planning processes, that provide early identification of a possible need for restraint and therefore assist in planning interventions that best reduce the likelihood of restraint being required.

Key Performance Indicators

- Audit reports demonstrate evaluation for each episode of restraint
- Restraint monitoring of divisional and Te Whatu Ora Waitaha and Te Tai o Poutini
- Environmental audit providing confidence that restrictive equipment is not used as a restraint
- Education programme attendance is monitored as per service requirements

Associated material

Controlled documents

- *Informed-Consent Ref: 2400626*
- *Privacy Policy Ref: 2400038*
- *Patients who are Prisoners Ref: 2400619*
- *Transmission Based Precautions (Isolation) Ref: 2400389*
- *Section 111 Mental Health Act* Ref: 2401704
- *Soft Limb Restraint Procedure –Medical Surgical Ref: 2402726*
- *Restraint-use Ref: 2400366*

Supporting research

- *Memorandum of Understanding between the Ministry of Justice and the Ministry of Health*
- *Mental Health (Compulsory Assessment & Treatment) Act 1992, and Amendment 1999*
- *Health and Disability Commissioner (Code of Health & Disability Services Consumers' Rights) Regulations 1996*
- *The Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003*
- *CDHB RESPGG Approved Restraint Minimisation Education Programme overview*
- Health and Disability Commissioner (HDC) Act 1994
- *Human Rights Act 1993*
- *New Zealand Bill of Rights Act 1990*
- *Privacy Act 1993*
- *Mental Health (Compulsory Assessment & Treatment) Act 1999 and 1 April 2000 Amendments:*
- *Section 111 Mental Health Act 1999 & amendments (SMHS/OPMH)*
  - *Section 111(1): No person shall be detained under this section for more than 6 hours from the time when the nurse first calls for a mental health practitioner to examine the person. amended, on 1 April 2000, by section 61(b) of the Mental Health (Compulsory Assessment and Treatment) Amendment Act 1999 (1999 No 140)*
    - *Section 111 -Powers of nurse where urgent assessment required*
    - *Section 2 - Interpretation*
    - *Section 7A - Medical practitioner or responsible clinician to consult*
    - *Section 8A - Application for assessment*
    - *Section 8B - Medical practitioner's certificate to accompany application for assessment*
    - *Section 9 - Assessment examination to be arranged and conducted*
    - *Section 10 - Certificate of preliminary assessment*
    - *Section 11 - Further assessment and treatment for five days*
- *Health Information Privacy Code 2020*
- *Health & Disability Services Standards 8134:2021*
- *Health & Disability Services Standards (Restraint & Seclusion) 8134:2021*
- *Health (Retention of Health Information) Regulations 1996*
- *Restraint Event Monitoring forms*
- *CDHB Restraint and Seclusion Minimisation Documentation Audit*