DCCM - Restraint use

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Contents

Back to Contents

1. Purpose of policy

This policy guides the safe use of restraint with critically ill patients to ensure that staff within the Department of Critical Care Medicine practice within the legislative framework of NZS 8134.2:2008 Health and Disability Services (Restraint Minimisation and Safe Practice) Standards.

2. Scope

This policy applies to all staff, contracted security staff, students on placement and visiting health professionals caring for patients who may require restraint while receiving intensive therapies within DCCM, at Auckland DHB.

This policy is subject to the approval of the Auckland DHB Restraint Minimisation and Safe Practice Steering Group and is consistent with the 'Auckland DHB Restraint Minimisation and Safe Practice Policy' and NZS 8134.2:2008.

3. Policy statements

Please refer to the 'Auckland DHB Restraint Minimisation and Safe Practice Policy'. The Auckland DHB Restraint Minimisation and Safe Practice Steering Group review all restraint related policies every three years (or more frequently if the need arises).

4. Definitions

Term	Definition
De-escalation	This is an interactive person-centred process using specific verbal and non-verbal strategies aimed at defusing potential conflict; in which an agitated or anxious patient "*is re-directed from an unsafe course of action towards a supported and calmer emotional state*." NZS 8134.0:2008.
Enablers	The use of Enablers at Auckland DHB is a voluntary option, which requires consent, and must be the least restrictive option to meet the needs of the consumer. "*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*." NZS 8134.0:2008.
Restraint	Restraint is the use of any intervention by a service provider that limits a patient's normal freedom of movement. Restraints may be categorised as : • **Personal restraint**: This is where a service provider uses their own body to intentionally limit the movement of a patient such as holding a patient. Personal restraint may only be used in emergency situations such as when a patient is a danger to him or herself or

Back to Contents

Term	Definition
	others. This type of restraint can only be applied by staff members trained in the Auckland DHB approved technique. • **Physical or mechanical restraint**: This is where a service provider uses "equipment, devices or furniture that limits the consumer's normal freedom of movement." NZS 8134.0:2008 e.g. wrist restraints. • **Environmental restraint**: "Where a service provider intentionally restricts a consumer's normal access to their environment." NZS 8134.0:2008, or by positioning a security guard outside their room.
Medication and restraint	Auckland DHB does not support the use of chemical restraint. "*Use of medication as a form of chemical restraint is in breach of standard NZS8134.2: 2008. 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*." NZS 8134.0:2008. **In DCCM Sedation** is prescribed by the Intensivist to allow intensive therapies to be administered safely. Medical staff will assess and review sedation regularly (8 hourly) or more frequently.
Restraint episode	"*For the purposes of restraint documentation and evaluation, a restraint episode refers to a single restraint event, or where restraint is used as a planned regular intervention and is identified in the consumer's service delivery plan, a restraint episode may refer to a grouping of restraint events*." NZS 8134.0:2008.
Restraint initiator	The restraint initiator is the registered health professional who is trained in de-escalation and restraint, and decides that the patient requires restraining. The name and designation of the Restraint Lead needs to be documented on the CR8803 Restraint Monitoring Form.
Restraint approval register	Each restraint type is reviewed annually and documented in a Restraint Register.

5. Principles

Please refer to the 'Auckland DHB Restraint Minimisation and Safe Practice Policy' for clinical practice excluding Mental Health.

Key principles that underpin interactions with patients and restraint episodes or consideration of restraint:

- Respect: All actions should demonstrate respect for the person and others.
- Dignity: All actions should maintain the dignity of the person where possible.
- De-escalation: Emphasis should be on de-escalation to minimise the need for restraint wherever possible.
- Engagement: Where possible, engage the patient and the family/whānau and obtain cultural advice so that the situation can be calmed and de-escalated.

Back to Contents

- Safety: Restraint is only used where there is a safety risk to the patient or others, or compromises the therapeutic environment. Restraint should never be used to inflict pain or to deprive the patient's rights as a means of diversion, distraction or punishment.
- Last resort: Restraint is only to be used when necessary and after all less restrictive interventions have been considered or trialled and found to be inadequate.

Cultural aspects

All staff need to communicate with tangata whai i te ora and their whānau regarding cultural safety requirements, when managing challenging behaviours and situations and during each stage of de-escalation and restraint or when using enablers.

All staff need to understand Tikanga Best Practice and be culturally competent when working with Tangata whai i te ora and their whānau in a meaningful, empowering and therapeutic manner.

'Tikanga Best Practice' is a policy founded on Māori concepts, views of health, tikanga (Māori values/practices) and Te Tiriti o Waitangi. Modules are available on Ko Awatea LEARN and may assist staff more effectively with De-Escalation and Restraint Management for Māori patients. Tikanga Best Practice Policy outlines "*a holistic approach encompassing the elements of wairua (spiritual), hinengaro (psychological), tinana (physical) and whānau (extended family)*."

Relevant cultural advice and/or guidance is sought wherever possible in order to maintain and practise cultural safety. Please make use of translation services where English is a patient's second language.

6. Staff training

To ensure all staff members understand the requirements of the Restraint Minimisation and Safe Practice Standard 8134.2.1:2008, 8134.2.2:2008, 8134.2.3:2008, mandatory training is found on the Auckland DHB section of the Ko Awatea LEARN website and must be completed by all clinical staff members and security staff. Modules include:

- Restraint Minimisation and Safe Practice in DCCM
- Restraint Minimisation and Safe Practice, Nursing staff in Adult Services
- CALM Communications for Auckland DHB
- 'Understanding Tikanga Recommended Best Practice'.

Any staff member involved in personal restraint must have undertaken the approved Auckland DHB de-escalation and personal safety courses. These courses will assist in raising awareness of how challenging behaviours may be triggered; how to de-escalate a situation; and how to prevent and manage challenging behaviours in safety.

Only staff members trained in de-escalation and restraints may co-ordinate and manage a personal restraint event.

Where physical restraints are applied as part of a clinical procedure, staff members must have been trained in and competent with their safe application.

7. De-escalation, legislative guidelines and safe use of restraints

7.1 De-escalation

This is a person-centred process. De-escalation includes the use of specific verbal strategies, including volume, tone, and cadence; and non-verbal strategies including body position, posture, and proximity. These strategies are aimed at defusing potential conflict; in which an agitated or anxious patient "*is re-directed from an unsafe course of action towards a supported and calmer emotional state*."

7.2 Indications for use of restraint

- The decision to restrain a patient in DCCM is the responsibility of the Nurse assigned to the patient and/or Intensivist on duty.
- Restraint in DCCM is for patients with behaviour that is combative, confused, disorientated or violent. This behaviour is a result of physiological dysfunction of a range of systems, or from pharmacological therapies.
- Restraint is required to keep the patient safe while intensive therapies are administered.

7.3 Legislative guidelines for use of restraint

a. Where behaviour indicates that the patient is seriously at risk to him or herself or others[1];
b. When the patient makes a serious attempt or act of self-harm[2];
c. When a patient makes a sustained or serious attack on another person[3];
d. When a patient seriously compromises the therapeutic environment e.g. by damage to property, social milieu or relationship with other consumers or service providers[4].
e. When a patient is found to be committing an offence against the Crimes Act 1961 for which the maximum punishment is not less than three years imprisonment, or when a patient is found committing a Crimes Act offence at night.
f. Where an on duty Police Officer asks a person to assist in apprehending or securing a person or transporting the person to another location[5].
g. Additionally restraint could be appropriate when it is necessary to give a planned prescribed essential treatment to an individual who is resisting and there is a legal justification.

7.4 Restraints - reasonable force

Importantly, while restraint may be used in the above circumstances, the level of force used must always be reasonable in the circumstances with regard to age and clinical condition. Criminal liability can result from an excessive use of force[6]. This concept of 'reasonable force' prevents the use of any greater force than is necessary in the circumstances to prevent the harm that would otherwise come from not using restraint. If there are other options available, these should be used.

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[1] Crimes Act 1961, sections 41 and 48 and section 61(1)(a) Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003
[2] Crimes Act 1961, section 41
[3] Crimes Act 1961, section 48
[4] Crimes Act 1961, sections 42, 52 and 56
[5] Policing Act 2008, section 51
[6] Crimes Act 1961, section 62

Back to Contents

7.5 Considerations before restraint is applied

Approved restraint is only applied as a last resort, with the least amount of force, after alternative interventions have been considered or attempted and determined inadequate. Where there is a legal duty of care justification (see Legislation), and all other clinical interventions or calming and defusing strategies have failed the decision to approve restraint for a patient should be made:

- Only as a last resort to maintain the safety of patients, service providers or others;
- Following appropriate planning and preparation;
- By the most appropriate health professional;
- When the environment is appropriate and safe for successful initiation;
- When adequate resources are assembled to ensure safe initiation;
- Only under the direction of the responsible clinician.

7.6 Assessments for restraint use

In assessing whether restraint will be used consideration of the following factors should occur:

- Any risks related to the use of restraint including patient response to previous restraint events.
- Any underlying causes for the relevant behaviour or condition if known.
- Existing advance directives the patient may have made in relation to restraint.
- Any gender and cultural considerations.
- Desired outcome of using restraints and the detailed criteria for ending restraint.
- Possible alternative interventions/strategies.

7.7 Procedure

- Patients are assessed **three times a day by an Intensivist** on the ward rounds.
- Registrar cover is rostered over a 24 hour period within the department.
- Medical staff document key treatment concepts on the 'Plan of the day'.
- At the commencement of each shift nursing staff assess and document the patient's risk of falling, violent behaviour, disorientation and/or self-harm.
- This assessment is undertaken in relation to the disease process and physiological abnormalities.

8. Restraint considerations

- At all times the **safety, dignity and autonomy** of the patient should be prioritised. However, at no time should staff and other patients have their safety compromised.
- If the situation/environment becomes **unsafe, emergency assistance** (i.e. "Now Call" must be activated as soon as possible however if the patient is too aggressive for intervention a Code Orange must be called.)
- Appropriate and timely communication with the patient, family/whānau must occur.
- Documentation requirements are outlined in the Restraint classification tool.

Back to Contents

- Communication with the family must ensure that they understand the need for intervention and have received all the information they require.
- If valuables/taonga/items of cultural, religious significance are removed during restraint for the safety of the patient, this must be done as per Auckland DHB valuables policy.

8.1 Application of restraint

Only approved restraint techniques will be utilised. The principle of least restrictive practice will apply. There are potential risks associated with the use of physical/mechanical restraint. These include: psychosocial injury; soft tissue injury; articular or bony injury; respiratory compromise; and cardiovascular compromise. Prolonged physical restraint increases the risk of restraint-related death.

8.2 Monitoring of personal restraint

- The restraint initiator is responsible for monitoring the patient during the time of restraint in order to ensure the safety of the patient. The restraint initiator must be a health professional who is trained in de-escalation and restraint.
- It is essential that the patient's airway is not obstructed at any time, and that only authorised holds and positioning are used to minimise the potential for physical and psychological harm/injury.
- When the patient is restrained, checks must be made to ensure that no pressure is applied to the head, neck, chest, lower back or abdomen.
- The restraint initiator can delegate another health professional to continually monitor the patient for: level of consciousness, clear airway, breathing, skin colour and limb positioning.
- Verbal de-escalation should continue throughout restraint.
- Wherever a personal restraint exceeds 10 minutes all reasonable actions to end the restraint and seek an alternative non-physical intervention must be considered.
- A clinician (nursing or medical) must remain throughout the full length of a personal restraint.
- During this process, acknowledgment and management of any patient distress should be addressed.

8.3 Discontinuation of restraint

- The desired outcome of the use of personal, environmental and physical/mechanical restraint and criteria for ending restraint must be clear to staff members and explained to the patient.
- The decision to discontinue restraint must be undertaken by a responsible health professional after careful assessment that the immediate risk or issue leading to the use of restraint has lessened/receded.

Back to Contents

9. Evaluation and review

- The Restraint Minimisation and Safe Practice Steering Group and DCCM evaluates restraint event for audit purposes.
- Restraint use is reviewed at the monthly DCCM Quality Committee.
- The Restraint Coordinator must send six monthly audits of restraint usage to the Restraint Minimisation and Safe Practice Steering Group, c/o Quality Department. (See the Restraint page on the Auckland DHB Intranet site: 'Restraint Auditing: A how to guide.)
- DCCM documentation audits are completed three monthly capturing restraint documentation on the Initial Shift Assessment Form, Nursing Care Plan, Patient History and Nursing Documentation Form, 24 hour chart and Clinical notes.

10. Restraint classification tool

Type of restraint used	Usage	Application	Monitoring	Documentation
Padded bedrails	Bedrails may be padded to prevent the patient from injuring themselves Bedrails are applied to the bed of any restless patients who are at risk of hurting themselves through restless behaviour.	Ensure a safe environment for the patient and prevent injury. Bedrails may be used in conjunction with other measures.	• Monitor level of restlessness and physiological changes • Check appropriateness if the patient is confused and at risk of climbing out of bed, safety needs to be considered • Ensure the rails are secure • Continual electronic monitoring of patients vital signs; and Nursing observations occurs in DCCM	• DCCM Initial Shift Assessment form/care plan CR4771 (include restraint interventions and communication with family) • Nursing History Form CR3605 • 24 hour chart for ongoing half hourly monitoring CR5710 • Clinical notes
Four point restraint	Responsibility of bedside nurse to prevent staff/patient injury	For patients with pathophysiology demonstrating violent behaviour towards others (kicking)	• Observe and document behaviour • Physiological changes • Sedation • Continual electronic monitoring of patient's vital signs; and Nursing observations occurs in DCCM	• DCCM Initial Shift Assessment form/care plan CR4771 (restraint interventions, the clinical risk; date, time; when the restraint was withdrawn and communication with family) • Restraint Monitoring initiating and record of monitoring CR8803 • Nursing History Form CR3605 • 24 hour chart for ongoing half hourly monitoring CR5710 (e.g. skin integrity of limbs where restraints are applied)

Back to Contents

Type of restraint used	Usage	Application	Monitoring	Documentation
				• Clinical notes • Incident reporting form (online) known as Datix. Completion of Datix should be documented in the patient's clinical notes. • Audit: **Post incident Review Form/DD3097 following restraint**. (This form is on the Intranet). Include any other factors associated with the decision making or any negative outcomes from the use of restraint e.g. skin tear.
Wrist restraint	Physical restraints used to retain invasive therapies. The decision to apply restraint is the responsibility of the RN caring for the patient. Approved wrist restraints are applied to patients at risk of pulling out vital invasive lines and airway related tubes.	Used for patients who have the potential to remove invasive intensive therapies. Only approved wrist restraints are to be applied to patients. These must be applied and tied in the correct way without impeding circulation to the hand along with correct and comfortable limb alignment.	• Ensure correct application • Monitor skin integrity • Undertake continual electronic monitoring of patients vital signs; and Nursing observations	• DCCM Initial Shift Assessment form/care plan CR4771 (restraint interventions and communication with family are to be included here) • Nursing History Form CR3605 • 2-hourly releases of wrist restraint documented on 24 hour chart with ongoing monitoring CR5710 (e.g. skin integrity of limbs where restraints are applied) • Clinical notes
Personal restraint	Personal restraint by Code Orange team.	For the patient at risk of self-harm or harm to others.	• Carried out by trained 'Code Orange' team or AED Response	• Skin integrity • Breathing - asphyxiation

Back to Contents

Type of restraint used	Usage	Application	Monitoring	Documentation
		Staff members unable to manage the patient behaviour/actions.	team - may or may not lead to personal restraint	• Cardiovascular risk • Physical pressure points (limbs) • Assessment for release • A clinical re-assessment must be undertaken every 10 minutes • Wherever a physical restraint exceeds 10 minutes all reasonable actions to end the restraint and seek an alternative non-physical intervention must be considered • The desired outcome and criteria for ending restraint must be clear to staff and explained to the patient • Personal restraint must be used for the shortest period of time possible and with the least force possible

11. Supporting evidence

- Counties Manukau DHB. 2.3.13. *Restraint Minimisation and Safe Practice*.
- Guidelines to the Mental Health Act (Compulsory Assessment & Treatment) Act 1992 (2012)
- Guidelines for Clinical Risk Assessment and Management in Mental Health Services (1998)
- Hauora Tairāwhiti. (January 2015). *Restraint Minimisation and Safe Practice*.
- HDANZ. (2015). HDANZ *Health and Disability Auditing tool*. Retrieved from http://hdanz.co.nz/wp-content/uploads/2015/09/HDSS-RestraintMinimisationSafePractice_Aug19_151.docx

12. Legislation

- 8134.0:2008 Health and Disability Services General Standard and 8134.2 Restraint Minimisation and Safe Practice
- Code of Health and Disability Services Consumers' Rights (1996)
- Crimes Act 1961 (Section 41, 48, 52 and 56)
- Health Act 1956
- Health and Safety at Work Act 2015
- Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003
- Mental Health (Compulsory Assessment & Treatment) Act 1992 and Amendment Act 1999
- NZ Bill of Rights 1990 (Section 11 & 22)
- Protection of Personal and Property Rights Act 1988
- The publication of NZS8134.2: 2008 (Health and Disability Services Restraint Minimisation and Safe Practice Standard) is a gazetted (mandatory) standard for health services require a focus on restraint reduction.

13. Associated documents

- Behaviours of Concern (BoC) - Patient Observation
- Bicultural Policy
- Code Orange
- Health & Safety
- Informed Consent
- Medications - Prescribing
- Restraint Minimisation and Safe Practice in Mental Health
- Tikanga Best Practice
- Restraint Minimisation Steering Group
- Valuables, Property and Taonga
- Workplace Violence and Aggression Management

Clinical Forms

- CR4771 DCCM Initial Assessment and Care Plan
- CR8803 Restraint Monitoring
- CR3605 DCCM Patient History and Nursing Documentation
- CR5710 DCCM 24 Hour Chart
- DD3097 Restraint Post Evaluation

14. Disclaimer

No guideline can cover all variations required for specific circumstances. It is the responsibility of the health care practitioners using this Auckland DHB 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.

15. 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 Document Control without delay.