Restraint Minimisation and Safe Practice Policy for Patients

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• Organisation(s)	Auckland District Health Board
• Directorate(s)	All directorates
• Department(s)	All departments
• Used for which patients?	All patients
• Used by which staff?	All clinicians and security staff
• Excluded	Mental Health
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Contents

Back to Contents

1. Purpose of policy

This document explains what is meant by restraint and enablers, the importance of minimising the use of restraints and enablers, why restraint and enablers are used and how restraint and enablers are managed. This Policy describes Auckland DHB's expectations for the use of restraint and enablers and outlines the approved steps, documentation and follow up. Auckland DHB 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 abuse or acts of aggression.

2. Scope of policy

This policy applies to all employees, contracted security staff, students on placement and visiting health professionals to Auckland DHB 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. Patients in mental health facilities and patient visitors are not covered by this policy, they are covered by the Restraint Minimisation and Safe Practice in Mental Health Policy.

Where the Auckland DHB Restraint Minimisation and Safe Practice Steering Committee agrees that a clinical area has a particular need for a more detailed description of the restraint process, (which reflects the particular circumstances and requirements of those services) a local policy may be developed for use in that area (subject to Restraint Steering Committee approval). Local policies (see associated documents) must be consistent with the Auckland DHB Restraint Minimisation & Safe Practice policy.

3. Policy statements

Restraint is a serious intervention. Any unauthorised restriction of a patient's freedom of movement could be viewed as a false imprisonment and could result in an allegation of assault. Restraint accordingly requires clinical rationale and oversight. It is not a treatment in itself but is one of a number of strategies used by service providers to limit or eliminate a clinical risk. Restraint must only be used in the context of ensuring, maintaining or enhancing the safety of the patient, service providers or others. Use of restraint must be clearly justified and based on sound clinical judgement. It must be assessed as reasonable each time it is applied. Restraint should only be used as a last resort after alternative, less restrictive interventions have been attempted (such as de-escalation, interpreters, cultural support). It must be used for the shortest time possible. Equipment and techniques used must be of the approved type and cause the least injury to the patient. The decision to restrain must be documented and the rationale explained.

Restraint as compulsion is not acceptable. Health Professionals may not compel a competent patient to receive treatment and a patient may not be unlawfully detained except where there is a legal right to restrain (such as under the Crimes Act 1961, the Health Act 1956, the Intellectual

Disability (Compulsory Care and Rehabilitation) Act 2003 and the Mental Health (Compulsory Assessment and Treatment) Act 1992 (see legislation), and/or the patient is at risk of harm to themselves or others or is likely to cause damage to property.

All restraint related policies must be reviewed by the Auckland DHB Restraint Minimisation and Safe Practice Steering Committee every three years (or more frequently if the need arises).

4. Definitions

The following terms are used within this policy:

De-escalation	This is an interactive 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. This usually occurs through timely, appropriate, and effective interventions and is achieved by service providers using skills and practical alternatives*." 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. An enabler can become a restraint if it is not removed when the patient requests. Examples of enablers are : • *Example: A patient voluntarily uses a fixed tray in front of their chair to assist them to independently have a meal.* • *Example: Equipment devices or furniture is used, following appropriate assessment, to assist in the physical positioning of a consumer without limiting their normal freedom of movement. These interventions are not considered a form of restraint, but rather are a normal component of the consumer's day-to-day life."* NZS 8134.0:2008 Specific considerations for children: "*Where children and young people receive care and treatment, there is an ethos of caring and respect for the child's rights where the use of restrictive physical interventions or therapeutic holding without the child/young person's consent are used as a last resort and are not the first line of intervention…Therapeutic holding for a particular clinical procedure also requires nurses to: comfort the child or young person where it hasn't been possible to obtain their consent, and explain clearly to*

Back to Contents

	them why immobilisation is necessary." (Royal College of Nursing, 2010 - see supporting evidence)
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 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 eg wrist restraints, lap belts or specialised seating. • **Environmental restraint:** "*Where a service provider intentionally restricts a consumer's normal access to their environment. For example, where a consumer's normal access to their environment is intentionally restricted by locking devices ….*" NZS 8134.0:2008, or by positioning a security guard outside their room.
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.
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.
Patient	The term 'patient' is used in the Health and Disability Services Restraint Minimisation and Safe Practice Standard when referring to individuals who receive health or disability services. Services in Auckland DHB usually refer to patients, clients or service users according to the type of service. For consistency, the term 'patient' has been used in this policy.

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 Restraint Monitoring Form (see - clinical forms).
Restraint Approval Register	Each restraint type is reviewed annually and documented in a Restraint Register.

5. Principles

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.
- 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 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 whanau in a meaningful, empowering and therapeutic manner.

'Tikanga Best Practice' is a policy founded on Maori concepts, views of health, tikanga (Maori 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 Maori patients. Tikanga Best Practice Policy outlines "*a holistic approach encompassing the elements of wairua (spiritual), hinengaro (psychological), tinana (physical) and whanau (extended family).*"

Back to Contents

Relevant cultural advice and/or guidance is sought wherever possible in order to maintain and practise cultural safety.

6. Ethical and legal considerations

Services are required to ensure adequate and appropriate observation, care, dignity, respect and on-going assessment occurs to minimise the risk of harm to consumers during restraint. The frequency and level of observation and assessment should be appropriate to the level of risk associated with the restraint procedure, and the setting in which it is occurring. All service provision should reflect current accepted good practice.

7. Restraint minimisation and safe practice policy and process within Auckland DHB

Auckland DHB is committed to the minimisation of restraint of patients. The Auckland DHB Restraint Minimisation and Safe Practice Steering Group and the restraint coordinators are responsible for ensuring that the organisation has policies and guidelines in place to ensure that this occurs and that compliance occurs with this policy.

7.1 Auckland DHB Restraint Minimisation and Safe Practice Steering group

The Auckland DHB Restraint Minimisation Steering Group has the responsibility for:

- Ensuring all policies and guidelines related to restraint comply with the Restraint Minimisation and Safe Practice - Restraint Minimisation 2008 standard (see legislation).
- Approving and documenting annually all forms of restraint to be used within Auckland DHB
- Ensuring the approval for each restraint type is reviewed regularly on a six (monthly basis) and documented.
- Ensuring restraint training meets the assessed needs of the organisation.
- Undertaking a monitoring function of restraint use, trends and adverse outcomes, with the aim of achieving a reduction in overall usage.
- Assessing compliance with restraint policies and the need for updates or changes to the policies.

Restraint processes must not be implemented until the Restraint Minimisation and Safe Practice Steering Group has endorsed them, and the requirements of the Restraint Minimisation Standard 2008 have been met.

7.2 Restraint coordinators

Restraint coordinators include the Lead Restraint Coordinator and service level representatives whose key accountabilities include:

- Providing leadership and guidance in Restraint Minimisation and Safe Practice within designated service area.

- Maintaining appropriate training resource for staff members involved with direct patient care.
- Ensuring a training record is maintained.
- Participating in relevant restraint related policy review.
- Monitoring restraint usage to ensure all restraints are carried out as required by the Policy.
- Post evaluation of a restraint episode.
- Facilitating audits against policy and providing feedback to quality groups on restraint use.

8. 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 on the Auckland DHB section of the Ko Awatea LEARN website must be completed by all clinical staff members and security staff. Modules include:
    - Restraint Minimisation and Safe Practice;
    - 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 restraint may co-ordinate and manage a personal restraint event.
- Where physical/mechanical restraints are applied as part of a clinical procedure, staff members must have been trained in and competent with their safe application.

9. Safety

9.1 Patient safety

Patients should be informed, wherever possible, in emergency or life threatening situations, that the staff members have a duty of care to ensure the patient receives medical and/or psychiatric assessment (see legislation).

In emergency situations where the patient has not responded to de-escalation or other techniques and where the safety of other patients and/or staff members is threatened:

- Clinical Services on the Grafton and GCC sites - Code Orange (ext 777) must be called, or in AED, the AED Response team will be called.

Extreme caution must be taken if the psychological wellbeing of the patient is compromised with particular attention paid to vulnerable individuals.

If the environment becomes unsafe, for patient, staff or visitors emergency assistance must be activated as soon as possible.

9.2 Staff safety

Extreme caution must be taken when the individual is in possession of a weapon and additional support/emergency responses must be considered (Section 41 Crimes Act 1961 - see legislation).

If at any time during the intervention a staff member feels at risk of personal harm they must report this to their manager by completing an incident form in in the online Auckland DHB safety management system - Datix.

Auckland DHB is committed to taking all practicable steps to eliminate or reduce threats to personal safety of its employees caused by aggressive behaviour or overt actions of a patient, a visitor and other employees. Staff members' safety must be managed according to the Workplace Violence and Aggression Management guideline (see associated documents).

10. De-escalation and safe use of restraints

10.1 De-escalation principles

The implementation of a cascade of escalating interventions is ideal. It is acknowledged that in order to fulfil the duty of care to render a situation safe, a clinical decision must be required as to which point the cascade is entered. This decision must be dependent on history and current presentation.

The cascade is likely to begin with:

- Verbal de-escalation (which may involve family/whānau presence or phone contact).
- Environmental de-escalation - moving the patient to a quieter area such as a single room or bed space.
- Personal restraint.
- Physical/mechanical restraint - use of equipment (in extreme situations only).

10.2 Situations where restraint may be appropriate

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];

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.

Back to Contents

d. When a patient seriously compromises the therapeutic environment eg 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[5].
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[6].
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.

10.3 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[7]. 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.

10.4 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.

10.5 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.

[4] Crimes Act 1961, sections 42, 52 and 56.
[5] Crimes Act 1961, section 35.
[6] Policing Act 2008, section 51.
[7] Crimes Act 1961, section 62

Back to Contents

- Desired outcome of using restraints and the detailed criteria for ending restraint.
- Possible alternative interventions/strategies.

Patients with a history of aggression or self-harm must have their history documented in their assessment documentation. Assessment of risk associated with behaviour disturbance is undertaken by nursing or medical staff members and documented. A plan of care is to be developed. Staff members should refer to the Restraint Management Tool in Section 11, to ensure the appropriate assessment has been completed.

Early warning alerts for security, behavioural or management plans should be actioned by staff on patient arrival thus providing continuity of care by all services for patients and or minimising risk to the staff and to the patient themselves and others. Staff should also contact external or other DHB organisations early for behavioural or management plans where they believe the patient is exhibiting behavioural concerns and organisations who have been involved in their care may have information pertinent to their current management and care. If the plan states security staff or a patient attender is required this should then be arranged.
If an infant or young child requires holding, the parents must be involved in the decision and verbal consent obtained. Discuss with the parents if they wish to be present and involved. If the parents do not wish to be present, they must be supported in their decision.

10.6 Application of restraint

Only Auckland DHB approved restraint techniques will be utilised. The principle of least restrictive practice will apply. There are potential risks associated with the use of physical 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.

10.7 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 restraint.

Back to Contents

- During this process, acknowledgment and management of any patient distress should be addressed.
- The above monitoring must be recorded in the individual's Restraint Monitoring Form (CR8803 - see clinical forms), and in their clinical record.

10.8 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.

10.9 Documentation and plan of care for restraint use

Plan of care

A plan of care relating to the potential need to calm and restrain is to be developed in at risk patients, or in patients who require restraint. The plan of care should be updated in accordance with the patient's assessed and changing needs.

The plan of care must include:

- Details of the assessment and actions as a result of the assessment
- Behaviour of Concern Pathway or assessment of challenging behaviours
- The identified restraint, interventions to minimise risk, and monitoring requirements.
- Challenging behaviours assessments where applicable.
- Methods of managing disruptive behaviour or identify interventions to manage relevant risk behaviour or triggers.
- Timelines and frequencies of monitoring and reviews.

This may be a standardised plan of care with the ability to individualise. Any plan of care or management plan should outline the intervention to be implemented. This should be done in consultation with patient/family/whānau.

A multidisciplinary team review (which may include behavioural experts such as the Liaison Psychiatry team, Clinical Nurse Managers and security managers), should occur if a patient is requiring code orange calls or restraint on multiple occasions during a single admission.

CR8803: Restraint Monitoring (see clinical forms) is to be used to monitor the ongoing use of restraint.

Clinical record

The clinical record or plan of care must contain evidence of:

- Details of the reasons for initiating the restraint, including the desired outcome.

- Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint.
- The nurse allocated to the patient must ensure completion of the incident in the patient's Progress Notes.
- Advocacy/support offered, provided or facilitated.
- The outcome of the restraint.
- Observations and monitoring of the patient during the restraint if it was continuous.
- Any injury to any person as a result of the use of restraint.

Restraint monitoring form

- The CR8803: Restraint Monitoring Form (see clinical forms) is to be used to monitor ongoing restraint for both restraint used to enable treatment and safety, and restraint used to prevent harm to self or others when applicable.
- This form only requires completion when physical/mechanical restraints are used.

Incident Management System (online)

- An on-line incident report needs to be completed for any type of restraint used.
- The nurse allocated to the patient must ensure completion of the incident in the online incident management system (with the support of the Team Leader of the Code Orange team).

10.10 Communication with patient and family/whānau

Communication with the patient/family/whānau must occur in all circumstances where the use of restraint is anticipated. In emergency situations staff members must endeavour to communicate with the patient at the earliest opportunity. Evidence of communication must be documented in the clinical record including the patient's response where appropriate.

Debrief

If staff members are unable to offer the patient an opportunity to debrief as it is not clinically appropriate to do so after an episode of restraint, or the patient has been removed by either the police or psych services staff members must document it in the clinical record.

The patient must be offered the opportunity (where clinically appropriate) to discuss/debrief after an episode of restraint. This can be arranged with the appropriate health personnel eg the nurse in charge, social worker, psych liaison, cultural liaison teams etc. and must be arranged as soon after the event as possible. If discussion/debrief occurs this must be documented in the clinical record.

Children

Staff members must ensure that families are aware of the need to hold or secure children for specific procedures. Verbal consent is obtained from the child where appropriate or parent prior to commencement of hold or application of device. This is in line with the *Informed Consent* policy (see associated documents).

10.11 Evaluation of the restraint

Whenever possible, staff members must evaluate the restraint after each restraint episode. Unless otherwise approved by the Restraint Minimisation and Safe Practice Committee, DD3097 Restraint Post Evaluation (see clinical forms) is to be used for evaluation of restraint.

Evaluation should include:

- Whether a patient's plan of care/care plan/management plan were in place and followed.
- Any review or modification required to the patient's plan of care (or management plan).
- Whether alternatives or de-escalation techniques were attempted and whether there was identification of future options to avoid the use of restraint.
- Whether the restraint was the least restrictive/intrusive intervention option to achieve the desired outcome.
- Whether the duration of the restraint episode was documented and whether this was for the least amount of time required.
- Whether it was the correct decision to initiate restraint and whether it was effective?
- Whether there is evidence that attempts to release personal restraint every 10 minutes during the episode were made.
- Whether the responsible clinician remained throughout the restraint (personal restraint only).
- Whether the observations and monitoring were adequate and maintained the safety of the patient.
- Where an episode of restraint is ongoing the time intervals between evaluation processes should be determined by the nature and risk of the restraint being used and the needs of the patients and/or family/whānau.
- Whether policies/procedures were followed.
- Whether the impact of restraint on the patient, staff and others was assessed and documented.
- Whether adequate advocacy and a support person of the patients choice was provided to those affected, including whether the patient was provided with an opportunity to discuss their views on the restraint episode at defined and regular intervals.
- Whether there are any identified changes or suggested additions required to the restraint; then education is provided to the patient and staff.

For the post evaluation the DD3097: Restraint Post Evaluation (see clinical forms) must be used.

11. Restraint classification tool

Restraints					
Category	**Descriptor**	**Usage**	**Application**	**Assessment and Monitoring**	**Documentation**
Environmental Restraint	Security guard stationed directly outside the patient's room.	For patients accompanied by a Patient Attender or clinical person (with the exception of AED and Short Stay Inpatient Unit).	Where patient presents a risk to staff/visitors or themselves.	• If patient is on a Behaviour of Concern pathway, complete this hourly. • Intentional rounding on an hourly basis by the RN or EN or more often if clinically indicated (adult - ward use).	• Security support record to be completed (see clinical forms). • Clinical record to be completed by the nurse allocated to the patient. • Intentional rounding form (For adult - ward use) and and in Starship Clinical Care Reviews are undertaken every two hours. • Behaviour of concern hourly documentation if required. • Incident reporting form (online)
Physical/ Mechanical restraint	Wrist restraint (2 point restraint)	For an extremely restless patient who requires essential treatment.	The patient at risk of pulling out tubes/lines which are essential for treatment.	• Ensure correct application. • Check for skin integrity. • Ongoing communication with the patient, family/whānau. • Complete Behaviour of Concern Pathway (BOCP) if required.	• Patient may be on a Behaviour of Concern Pathway (BOCP) if required. • CR8803: Restraint Monitoring form. • Clinical record. • **Neuroservices**: Restraint monitoring care plan for

Back to Contents

Restraints					
Category	**Descriptor**	**Usage**	**Application**	**Assessment and Monitoring**	**Documentation**
					(CR4514) and Wrist Restraint Assessment & Monitoring stamp. • **DCCM:** Care plan and initial assessment on form CR4771 with constant 1:1 observation. • CR5710 24 hour chart, clinical record and CR3605 Nursing History form. • Evaluation may be used DD3097 (see clinical forms).
Physical /Mechanical restraint	Three or four point restraint – used in DCCM, the use of wrist and ankle Velcro ties Responsibility of bed side nurse.	For a patient who is demonstrating violent behaviours towards others (kicking). To prevent staff members' injury.	By staff members trained in the use of four point restraints.	• Observe and document behaviour. • Record physiological changes. • In DCCM the patient is electronically monitored.	• Shift assessment form • Clinical record completed by the nurse allocated to the patient. • In DCCM document in initial shift assessment/Nursing Care Plan CR4771 • CR8803: Restraint Monitoring form. • In DCCM: Care plan and initial assessment Form CR4771 with constant 1:1 observation. • CR5710 24 hour chart, clinical record and CR3605 Nursing

Back to Contents

Restraints					
Category	**Descriptor**	**Usage**	**Application**	**Assessment and Monitoring**	**Documentation**
					History form • Incident Monitoring form (online) known as Datix.
Personal restraint	This may range from low to high level holding, a full restraint to five point restraint	A last resort physical emergency response to an individual in crisis displaying risk behaviour posing an imminent or immediate risk of harm to self or others demonstrating violent behaviours towards others (kicking).	By staff members trained in the use of de-escalation, restraint and five point restraints.	• Observe and document behaviour. • Physiological changes. • Sedation. • Clinical staff must be present throughout the restraint. • A clinical re-assessment must be undertaken every 10 minutes. • 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.	• Document in clinical record • Behaviours of Concern Pathway (BOCP) (CR4778) may be used. • Incident Monitoring form (online) known as Datix. • In DCCM: Care plan and initial assessment on form CR4771 and • In DCCM on CR5710 24 hour chart, clinical record and CR3605 Nursing History form. • Evaluation Form DD3097 (see clinical forms).

Back to Contents

Restraints					
Category	**Descriptor**	**Usage**	**Application**	**Assessment and Monitoring**	**Documentation**
Personal Restraint	Personal restraint by Code Orange team.	For the patient at risk of self-harm or harm to others. Staff members unable to manage the patient behaviour/actions.	Carried out by trained 'Code Orange' team or AED Response team - may or may not lead to personal restraint.	• Skin integrity. • Breathing - asphyxiation. • 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.	• Behaviours of Concern Pathway (BOCP) (CR4778) may be used. • Clinical record. • Record event via Incident Monitoring Form (online) type: 'Restraint'. • CR8803: 'Restraint Monitoring' form if mechanical restraint is continued after Code Orange deemed complete. • Evaluation Form DD3097 (see clinical forms).

Back to Contents

12. Enablers

12.1 Indications for use of enablers

The use of an enabler is indicated where consent is obtained from the patient and a device or equipment is required to promote independence, comfort and safety and the least restrictive option to meet the needs of the patient with the intention of promoting or maintaining patient independence and safety.

12.2 Assessments for use of enablers

Assessments must be developed in partnership with the patient/family/whānau and documented in the clinical record.

A plan of care is to be developed outlining the use of an enabler. This must be done in consultation with patient/family/whānau.

12.3 Monitoring when enablers are used

The frequency and extent of monitoring of the patient during the use of an enabler must be determined by the risks associated with the patient's needs and the type of enabler being used (see Restraint classification tool).

12.4 Documentation when using enablers

The clinical record or plan of care must contain evidence of:

- Details of the reasons for the use of an enabler, including the desired outcome.
- That consent has been obtained by the patient/family/whānau for the use of the enabler.
- Details of support offered.
- The outcome of the use of an enabler, if applicable.
- Any injury to any person as a result of use of an enabler.

12.5 Communication when enablers are used

Consent for an enabler must occur. Communication with the patient/family/whānau must occur in all circumstances where the use of an enabler is anticipated.

Evidence of communication must be documented in the clinical record including the patient's response where appropriate.

12.6 Evaluation when using enablers

After the use of enablers staff members must determine:

- Whether the desired outcome was achieved.
- The impact the enabler had on the patient.
- Whether the observations and monitoring were adequate and maintained the safety of the patient.

12.7 Bedrails when used as enablers

Bedrails when used as an enabler eg when a patient has requested their use, can be helpful and would not constitute a restraint or deprivation of liberty.

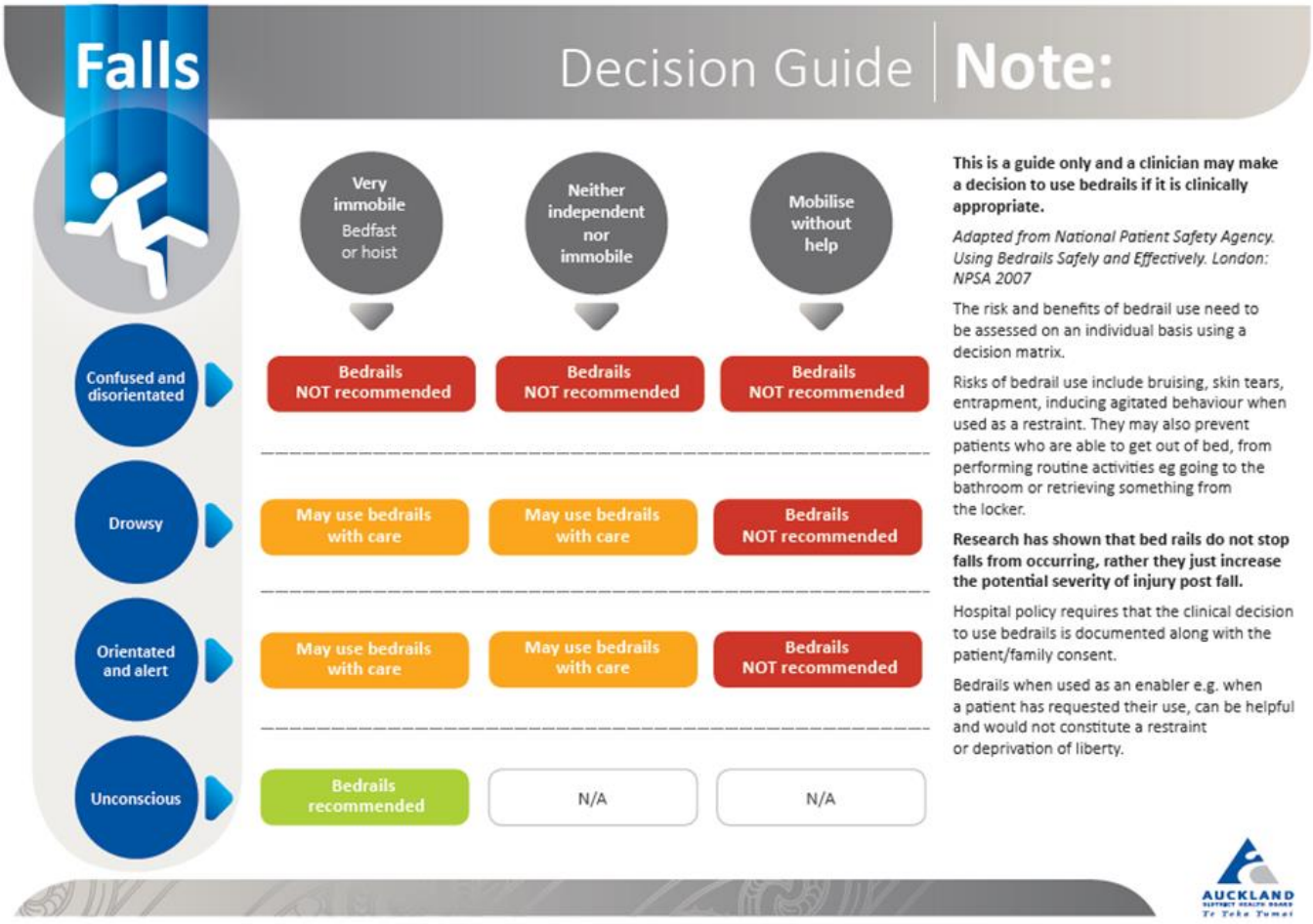
Risks of bedrail use include bruising, skin tears, entrapment, inducing agitated behaviour when used as a restraint and prevent patients, who are able to get out of bed, from performing routine activities such as going to the bathroom or retrieving something from the closet. Research has shown that bedrails do not stop falls from occurring; rather they just increase the potential severity of injury post fall.

Documentation should reflect the regular assessment and monitoring for the safe use of bedrails eg hourly with intentional rounding in adult services and in Starship Clinical Care Reviews are undertaken every two hours.

The risk and benefits of bedrail use need to be assessed on an individual basis using a decision matrix.

Decision matrix

This is a guide only and a clinician may make a decision to use bedrails if it is clinically appropriate.



Back to Contents

13. Quality review/audits

A six monthly restraint and enabler audit must be completed for each service by the restraint coordinator. This is sent to the Auckland DHB restraint coordinator (Clinical Quality and Safety Service).

Quality reviews of restraint use are undertaken at service level Quality Groups, and these are used to improve service delivery and safety.

These reviews incorporate:

- Type, volume, frequency and duration of restraint use.
- A review of restraint type must occur at least every two years or more frequently depending on the level of risk (HDANZ, 2015).
- Compliance with the Auckland DHB approval process, policies and guidelines.

Audit of records to establish:

- Whether individual plans of care include alternative techniques.
- Whether the approved restraint is necessary, safe, of an appropriate duration and appropriate in light of consumer and service provider feedback, and current accepted practice.
- Whether there were any adverse outcomes.
- Effectiveness of communication with patient and (as appropriate), family/whānau throughout the restraint episode.
- Support provided to the patient and staff members involved in restraint.
- Effectiveness of individual restraint evaluation and review.
- Monitoring and observation documentation.
- The competency of staff members in relation to all stages of restraint use.
- Evaluation of the appropriateness and effectiveness of restraint related education.
- Identification of opportunities for improving practice.
- Progress towards a restraint free environment.
- Whether any changes to policy, guidelines or training are required as a result of the restraint issues identified.

Reports collated by the Auckland DHB restraint coordinator (Clinical Quality and Safety Service) enable the Auckland DHB Restraint Minimisation Steering Group to undertake Board-wide monitoring at regular 3 monthly intervals.

14. Low stimulus areas

A number of areas have low stimulus environments. The requirements relating to the assessment, planning, monitoring, documentation, evaluation and review apply to all instances where the low stimulus area is used.

Policy statement: Low stimulus areas are not to be used as seclusion rooms.

Adult Neuroservices - low stimulus area (ward 81 HDU ward 83 HDU, ward 81 & 83 single room

Indications for use:

- Close observation to monitor behaviour.
- A patient who needs the HDU environment.
- A patient who requires a quiet, low stimulus environment or is at risk of harm with equipment and a patient requiring HDU nursing care.
- The low stimulus room is dual purpose for patient assessment and ongoing treatment. In the event of a patient requiring low stimuli and/or a room free of harmful objects, this room can be used to ensure a safe environment is maintained.
- Patient who presents with extremely threatening/violent behaviour, who is at risk of harming themselves or others.
- Cognitively impaired patient where decreased external stimulation is appropriate.
- Assess need for a patient attender.

Adult Enhanced Support Rooms (ESR) - 4 bedded low stimulus rooms

These are located in Reablement and some General Medical Wards.

Indications for use:

- Patients at risk of injury to themselves or others due to altered cognition and therefore require enhanced support, assistance or interventions to ensure their safety is maintained.

Adult Emergency Department - low stimulus rooms

These are located in Adult Emergency Department.

Indications for use:

- Patients at risk of injury to themselves or others due to altered cognition and therefore require enhanced support, assistance or interventions to ensure their safety is maintained

15. Enabler classification tool

Enablers used with Auckland DHB include but are not limited to:

ENABLERS					
Category	**Descriptor**	**Usage**	**Application**	**Assessment and Monitoring**	**Documentation**
Enabler	Splinting neonates and paediatrics.	Peripheral IV and IA lines. Percutaneously inserted lines. Care of intravenous sites is documented under IV care and is not a restraint.	Limb immobilised: held by medical/nursing staff members during insertion. Splint applied to limb across joint.	• Hourly site checks	• Clinical record
Enabler	Therapeutic Holding for infants or young children	To prevent harm to an infant or young child by inadvertent patient movement during a procedure.	To keep the infant/young child still during procedure. In perioperative services this may be both pre and post procedure	• Anticipate and prevent the need for holding, by giving the child information, encouragement, distraction and, if necessary, using sedation. • Make skilled use of minimum pressure and other age-appropriate techniques, such as wrapping and splinting, explaining and preparing the child. • If wrapping an infant/young child who has a tracheostomy tube in situ, ensure the wrap is kept well clear of the tracheostomy tube to minimise risk of accidental dislodgement. • Comfort the child where it hasn't been	• Clinical record. • The relevant service to document if more than one person is required to hold, or if the procedure is traumatic for the child.

Back to Contents

ENABLERS					
Category	**Descriptor**	**Usage**	**Application**	**Assessment and Monitoring**	**Documentation**
				possible to obtain their consent, and explain clearly to them why immobilisation is necessary. • Ensure no excess pressure on the infant/child, especially in cases where there is a high risk of bruising eg if the child is receiving anti-coagulant therapy or chemotherapy. • Monitor for bruising. • Ensure growth plates not taking excess pressure. • The holder must be aware of the potential for soft tissue trauma, especially if their hold has a tourniquet effect on the immobilised. • This procedure would be for a defined time with continual monitoring and then not required after completion of the procedure.	

Back to Contents

ENABLERS					
Category	**Descriptor**	**Usage**	**Application**	**Assessment and Monitoring**	**Documentation**
Enabler	Gaiters and arm splints (eg for cleft lip/palate repair). Splinting of elbow after consent from the parent. Including Post Anaesthetic Care Unit patients	To promote safety and reduce harm for extremely restless patients who require essential treatment. To prevent interference with recent surgical procedures, or drains.	For a patient at risk of pulling out tubes/lines essential for treatment.	• Correct application. • Restraint remains intact. • Skin integrity. • Ongoing communication with patient, family/whānau. • Check bony prominences. • Check pressure to top and bottom of splints. Implement range of movement exercises as per care plan when whole arm in splint.	• Clinical record. • CR8803: Restraint Monitoring form.
Enabler	Wheelchair / buggy harness Mostly used in paediatrics.	To provide additional postural stability when an individual has poor trunk control. This then allows the individual more opportunity to participate in daily occupations.		• Correct application. • Communication with patient, family/whānau.	• Clinical record
Enabler	Radiology - Holds for skeletal survey and other radiological procedures. Cradles in x-ray.	Used to immobilise young children during radiological procedures and catheterisation, barium and fluoroscopy procedures.		• Ensure staff members are trained in holds. • Ensure adequate padding along cradle. • Ensure ties are not secured too tightly. • Ensure safe arm and leg positioning. • Check for bruising etc. after procedure. • Explanation to family.	• Clinical record. • Radiology Information system.

Back to Contents

ENABLERS					
Category	**Descriptor**	**Usage**	**Application**	**Assessment and Monitoring**	**Documentation**
Enabler	Radiology - Foam wedges.	Variety of X-rays.	Assist with positioning for x-ray.	• Constant monitoring; applied for short period - duration of x-ray eg seconds.	• Radiology procedures.
Enabler	Radiology - Perspex cradles and foam pads and Velcro straps.	Paediatric fluoroscopy studies and some CT/MRI studies.	Most babies under two years - it reduces the radiation dose to the baby and holders. Reduces movement artefact/repeat x-ray.	• Constant monitoring. • Duration of fluoro study but someone (nurse/MRT/Parent) checking child at all times.	• Use of cradle documented in Radiology Information system.
Enabler	Radiology- High chair and Velcro straps.	Fluoroscopy Swallow studies (SLT).	Sitting swallow assessment for infants.	• Constant monitoring.	• Radiology procedures.
Enabler	Velcro straps on CT scanning tables, Interventional Radiology tables and operating tables. This includes forehead straps used in ophthalmology.	Adult Radiology patients	Prevent the patient from moving during CT scan, interventional radiology or surgical procedure. Not used with all patients, only those at risk of moving.	• Patient informed of reason for use of straps and verbal consent gained • Duration of CT scan /interventional procedure • Nurse/MRT monitoring regularly.	• Radiology documentation

Back to Contents

ENABLERS					
Category	**Descriptor**	**Usage**	**Application**	**Assessment and Monitoring**	**Documentation**
Enabler	Enabler Bed rails/padded bed rails.	Prevent the patient from falling from bed during transportation. Patient requesting bedrails for safety, e.g. during breastfeeding. For use to mobilise in bed or for safety, e.g. fear of falling. In areas where patients are recovering from anaesthetic or sedation and are under constant observation until deemed as fully alert and safe by the medical nursing team.	Transportation of patients. It is inappropriate to use as the means to prevent the patient from climbing out of bed. Please refer to Decision matrix for bedrails. For mobilising in bed or for safety. Either 1 or 2 sides may be used, dependent on need.	• Bed in low position. • Do not use bedrails when a patient is confused. • Ensure rails are secure. • Intentional rounding hourly - or more often if clinically indicated (for adult ward use).	• Falls assessment if indicated CR4562 - see clinical forms. • Consent in A - D planner if applicable. • Clinical record. • Plan of care. • Intentional rounding form (for adult ward use) in Neuroservices a stamp for patients using bed rails is used and in Starship Clinical Care Reviews are undertaken every two hours.

Back to Contents

ENABLERS					
Category	**Descriptor**	**Usage**	**Application**	**Assessment and Monitoring**	**Documentation**
Enabler	Patient Attender.	To prevent the patient self-harm and/or harming of others and/or leaving the environment.	As per restraint cascade guidelines. The Registered Nurse will identify behaviours of concern to the Patient Attender.	• The Registered Nurse or Enrolled Nurse is responsible for overseeing this. • Communication of patient condition with RN/EN. • The patient may be on a Behaviours of Concern Pathway. • The Patient Attender will monitor the patient at all times and notify the RN accountable for the patient of any changes of condition or concerns. • Intentional rounding on an hourly basis by the RN or EN or more often if clinically indicated (adult ward use). • Patient may be on Behaviour of Concern Pathway.	• Consent in A - D planner if applicable. • Patient may be on Behaviour of concern hourly documentation. BOCP CR 4778 (see clinical forms). • Intentional rounding form. (For adult ward use). • Clinical record. • Plan of care.
Enabler	Bed lever is a piece of equipment with a metal loop that extends up the side of the mattress, often referred to as bedside handles bed grab rails or bed loops.	To enable independent mobility in the bed.	To enhance bed mobility where required.	• Assessed by Occupational Therapist where clinically indicated. • Ongoing monitoring and evaluation by nurses. • Intentional rounding on an hourly basis by RNs and ENs or more often as clinically indicated for adult ward use.	• Consent in A - D planner if applicable. • Plan of care. • Clinical record. • Intentional rounding form for adult ward use.

Back to Contents

ENABLERS					
Category	**Descriptor**	**Usage**	**Application**	**Assessment and Monitoring**	**Documentation**
Enabler	High back chair with table in front of patient - outside of meal times.	Used in a patient with reduced postural stability.	As part of falls prevention. To prevent the patient from slipping down/out of chair.	• Ensure no excess pressure on patient causing injury. • Ongoing communication with the patient. • Regular walks and toileting. • Intentional rounding on an hourly basis by RNs and ENs or more often as clinically indicated for adult ward use.	• Consent in A - D planner if applicable. • Plan of care. • Clinical record. • Intentional rounding form (for adult ward use). • In Neuroservices a stamp for patients using High back chairs is used.
Enabler	Safety belt/lap belt in chair	To prevent a patient from slipping down out of chair.	As part of fall prevention program.	• Ensure no excess pressure on patient causing injury. • Ongoing communication with the patient. • Intentional rounding on an hourly basis by RNs and ENs or more often as clinically indicated for adult ward –use. • In Neuroservices if the patient is not under the direct supervision whilst in the chair, then the patient must be observed at least every 20 minutes.	• Consent in A - D planner if applicable. • Plan of care • Clinical record • Intentional rounding form for adult ward use. • In Neuroservices the form 'Use of a Lap Belt to Promote Safety and Treatment' is to be completed, Form CR4514.
Enabler	Wheelchair/	To assist with safe	For positioning the	• Appropriate fitting i.e. not too tight or	• Consent in A - D

Back to Contents

ENABLERS					
Category	**Descriptor**	**Usage**	**Application**	**Assessment and Monitoring**	**Documentation**
	commode harness	positioning.	patient with reduced trunk control.	loose. • Check for skin integrity. • As clinically indicated by RN or EN.	planner if applicable. • Plan of care. • Clinical record.
Enabler	Specialist chair - eg Regency chair.	For comfort and change of positioning.	For comfort and change of positioning.	• Ongoing communication with the patient/family/whānau. • Hourly intentional rounding and reviewing of positioning, and more frequently if clinically indicated (For adult ward use).	• Consent in A - D planner if applicable. • Include in clinical record. • Plan of care. • Intentional rounding form (For adult ward use).
Enabler	Adults holding for clinical procedures eg phlebotomy procedures.	To prevent injury by inadvertent patient movement.	To keep an adult still during procedure.	• Ensure/attempt to ensure the adult understands the need to remain still. • Ensure an assessment has been completed for the necessity of the intervention, eg is the blood really required. • Ongoing communication with the adult as appropriate and family/whānau. • Best practice is used.	• Clinical record to document the rational for the requirement to hold an adult for the clinical procedure.

Back to Contents

16. 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
- Royal College of Nursing. (2010). *Restrictive physical intervention and therapeutic holding for children and young people Guidance for nursing staff*. London.

17. Legislation

- 8134.0:2008 Health and Disability Services General Standard
- 8134.2.1:2008 Restraint Minimisation and Safe Practice - Restraint Minimisation
- 8134.2.2:2008 Restraint Minimisation and Safe Practice - Safe Restraint Practice
- 8134.2.3:2008 Restraint Minimisation and Safe Practice - Seclusion
- 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, and requires a focus on restraint reduction.
- Direct quotes from Standard 8134.2: 2008 are reproduced in italics

18. Associated documents

- Behaviours of Concern (BoC) - Patient Observation
- Bicultural Policy
- Code Orange Calls
- Health & Safety

- Informed Consent
- Medications - Prescribing
- Restraint use in DCCM
- Restraint Minimisation and Safe Practice in Mental Health
- Seclusion in Mental Health
- Tikanga Best Practice
- Restraint Minimisation Steering Group (TOR)
- Workplace Violence and Aggression Management
-

Clinical Forms

- CR3605: DCCM Patient History and Nursing Documentation
- CR4514: Nursing Care Plan
- CR4562 Falls Needs Assessment and Care Plan
- CR4771: DCCM Initial Assessment and Care Plan
- CR4778: Behaviour of Concern Pathway (BOCP)
- CR5710: Department of Critical Care Medicine 24 Hour Chart
- CR8803: Restraint Monitoring
- DD3097: Restraint Post Evaluation
- DD3136: Security Briefing Form

Other links

- KIOSK

19. Disclaimer

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

20. 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 Document Control without delay.