

The WCDHB has a policy of restraint minimisation. (See WCDHB Restraint Use Policy – available on the Intranet)

However, there may be instances where the use of restraint is necessary for a Patient's safety or wellbeing, i.e. the use of a tray chair if a Patient with dementia is unable to remain seated at a table long enough for adequate nutrition and/or hydration.

Restraint is defined as “to hold back or hinder movement” and limits the normal functioning ability of a patient. Restraint can be divided up into distinct categories. These are:

- **Personal:** For example, service providers physically holding a Patient;
- **Physical:** For example, the use of equipment and furniture;
- **Environmental:** For example, this form of restraint can range from a contained environment to planned interventions that reduce the level of social contacts and/or environmental stimulation.

Enablers are not classified as a type of restraint. Enablers are used for short-term use only, and are a normal part of a patient's planned care or a procedure. Enablers are used voluntarily by the patient. Types of enablers can include:

- Bedrails and cot sides (only when being used for patient transportation between departments/wards, for post-anaesthetic or post-operative reasons, and during the normal care pathway for a patient.
- Splints and over-banding (only for the maintenance of IV treatment and therapy)
- Physical touch-support during procedures (e.g. during epidural insertion and limb support during canulation)
- Use of cots to maintain patient safety in paediatric care
- Use of high chairs and pushchairs with harnesses to maintain safety and activities of daily living in paediatric care
- Lap belts

There are 2 types of restraint:

1. **Emergency Restraint** - this is used only when there is extreme potential for self harm or a risk of harm to others. This must be reported to the RN/Manager, and a WCDHB Restraint Record Form completed.
2. **Authorised Restraint** - in all other cases, authorisation must be gained from the Patient/Patients family, their Doctor, Nurse Manager or other Senior Clinical staff member. The authorisation will only apply to the particular type of restraint, and the situations, outlined in the Patient's restraint care plan, and must be re-approved 6 monthly. Details of monitoring required will be documented in the Patients care plan (between 15 min and 2 hourly). At which times the Patient must be checked for: hydration, nutrition, comfort, hygiene, suitable clothing, medications, exercise and activity. This is recorded on the restraint monitoring form, and documented in the progress notes. The Patient's dignity, privacy and self-respect must be maintained at all times. A WCDHB Restraint Record Form is also to be completed.

In all cases, the risk of the unsafe behaviour must be weighed up against the risks of restraint. These include:

- Infection
- Asphyxiation due to strangulation
- Aspiration

- Suffocation
- Cardiac episodes due to fighting against restraint for several hours
- Burns
- Broken bones
- Contractures
- Nerve damage
- Ischaemic injury pressure areas
- Incontinence
- Loss of muscle tone/mobility issues - falls
- Increase agitation
- Antisocial behaviour
- Increased cognitive decline
- Dehydration/weight loss
- Inappropriate or excessive sedation
- Emotional and cultural distress

DE-ESCALATION

De-escalation techniques can be used to reduce a person's agitation (which may present as changes in behaviour, refusal to co-operate, loud speech or unreasonable requests); and return them to a calmer state of mind.

An individual may have particular warning signs and/or stressors, which will be outlined in their care plan.

Techniques for de-escalation may include:

- Use of a clam, modulating voice, medium tone, volume and speed
- Establish eye contact but do not stare
- Stand side on to the person, at least arms length away, with relaxed stance (do not fold arms, hands on hips etc).
- Keep movement minimal/no sudden movement
- Listen attentively to what the person is saying / acknowledge what they are saying
- Engage in conversation
- Invite them to move to a quieter area
- Keep other Patients away
- Diversion - ask them to help do something - offer food, cup of tea
- Ask another staff member to take over

Although you may use many of these techniques constantly throughout your workday, de-escalation must be recorded in progress notes and on a WCDHB Accident/Incident Form when -

- a) This behaviour is unusual for the Patient
- b) You must consciously put these skills in to place to prevent a likely incident

By reporting de-escalation, this allows for assessment of the situation and guidance in the long-term management of the Patient.