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## 1. Policy Statement

The West Coast District Health Board (WCDHB) is committed to minimisation of the use of restraint. Restraint will be used only when all other interventions have been tried and proven unsuccessful to ensure the physical safety of the Patient concerned, and/or other Patients, staff and visitors.

The use of restraint forms only one component of clinical management as a short-term strategy and is only used in the context of good clinical practice. The dignity, privacy and all other rights as specified in the Code of Health & Disability Consumers' Services Rights 1996 will be upheld at all times, taking into consideration individual cultural values and beliefs.

## 2. Purpose

This Policy establishes standards in relation to the use of restraint. The intent of this Policy is to cover all acts of restraint where it is required to keep the Consumer/Patient safe, or in situations where restraint is used against the Consumer/Patients will.

## 3. Application

This Policy applies to all WCDHB clinical staff members.

## 4. Responsibilities

For the purpose of this Policy:

**Staff Members** are required to:

- Ensure they abide by the requirements of this Policy
- Abide by all other relevant WCDHB Policy and Procedures;
- Abide by all WCDHB Health and Safety Policy and Procedure;
- Be aware of their own physical limitations prior to initiating an approved restraint technique.

## 5. Definitions


**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, except where a patient is isolated for infection control purposes.

Restraint is only used as a last resort for the least amount of time necessary to protect the patient, others or property from harm. All restraint must have a clinical rationale.

**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. Types of voluntary enablers may 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).

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- Splints and over-bandaging (only for the maintenance of IV treatment and therapy)
- Physical touch-support during procedures (e.g. during epidural insertion and limb support during cannulation)
- 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 on chairs that are used for safety reasons (e.g. to prevent falling) – the use of lap belts on chairs to restrict patient movement such as where staff wish to prevent a patient from wandering off are considered to be restraint.

**Note: Enablers** are to be used in a **voluntary manner only**, and should involve the least restrictive option so that the needs of the consumer are met along with promoting their independence and safety.

**Standard** is taken to mean the NZS 8134.2:2008 “Restraint Minimisation and Safe Practice”

**Restraint Committee** is taken to mean a group of staff members who have the appropriate expertise and experience to make decisions relating to the approval of restraint techniques. It may also have Consumer/Patient and family/whanau/caregiver input.

**Restraint Co-Ordinator** is taken to mean an appropriately skilled and experienced staff member (in relation to restraint use).


## 6. Process

### **1.00 Introduction**

- 1.01 The WCDHB is committed to only using forms of restraint that are approved and appropriate for the individual Patients safe care and welfare. Episodes of restraint will be kept to a minimum. The requirements of legislation, external standards and relevant professional codes of practice will be met throughout each episode of restraint to ensure Consumer/Patient rights are protected.
- 1.02 CQIT is responsible for the approval and to ensure that WCDHB Restraint Use Policy is adhered to at all times. This group is responsible for ensuring that the use of restraint approval throughout the WCDHB is fully reviewed at least 6 monthly or if an adverse event occurs during the use of restraint.

### **2.00 Approval Process**

- 2.01 The relevant Clinical Nurse Managers are responsible for ensuring that the requirements of the Restraint Safe Practice and Minimisation Standard are met. This includes ensuring that a restraint register is maintained accurately at all times (See WCDHB Restraint Register).
- 2.02 Restraint will only be initiated after the implementation of the WCDHB Management of Challenging Behaviours Procedure, which includes the use of de-escalation techniques.

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- 2.03 Approved restraints in WCDHB facilities include:
- i) Tray chairs
  - ii) Beanbag
  - iii) Bed Loop
  - iv) Lap belts (where staff wish to prevent a patient from wandering off)
  - v) Environmental
  - vi) Personal – Individual requirements

NOTE: these can be either used as enablers or restraints depending on the situation and patient's clinical condition

### **3.00 Cultural Recognition:**

- 3.01 The holistic framework of Te Whare Tapa Wha is central to the recovery of Maori people. The four dimensions of Te Ware Tapa Wha are:

Te taha hinengaro	-	mental wellbeing
Te taha tinana	-	physical wellbeing
Te taha wairua-		spiritual wellbeing
Te taha whanau	-	family/whanau wellbeing.

- 3.02 Consultation will take place with family/whanau (with the permission of the Patient) through all phases of service provision to ensure the Patient's cultural values and beliefs are known and complied with.
- 3.03 Interpreter services will be arranged where necessary to ensure the Patient's needs are recognised and met.
- 3.04 Patients will be assisted in accessing spiritual care/support where this is identified as being important to the individual Patient. Where it becomes necessary to remove personal objects of significance, e.g.; taonga, spiritual/cultural symbols, to maintain Patient safety, this will be respectfully achieved with assistance from family/whanau.

### **4.00 Guidelines for Use of Approved Restraints**


#### **4.01 Tray Chairs**

Ensure that the tabletop is tightened sufficiently as not to be pushed back out and therefore may cause an injury to the Patient. Use only those chairs that are in a good state of repair. Ensure the table is not pushed so tightly that it presses on the Patient. Approval for use of a tray chair is given only as required to ensure nutritional requirements are met.

Monitoring whilst using a tray chair must be constant unless otherwise approved as per the restraint record form. Monitoring is documented in the Clinical Notes, or in Kahurangi, the Restraint Monitoring Form.

#### **4.02 Bean Bag**

A large beanbag may be used for a Patient to sit in where a Patient may attempt to move from a chair without assistance of staff or mobility aids, and the potential for

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injury is high. While in this form of restraint the Patient will be given reading material or an activity which will be detailed in the individual Patient's long term care plan.

Monitoring whilst in restraint must take place according to the restraint record form. The minimum requirement is every 30 minutes. Monitoring is documented in the Clinical Notes, or in Kahurangi, the Restraint Monitoring Form.

#### 4.03 **Lap Belts**

The use of lap belts on chairs to restrict patient movement such as where staff wish to prevent a patient from wandering off are considered to be restraint. The chair must have been specifically approved by an Occupational Therapist for the individual Patient prior to the restraint approval process being completed.

Monitoring whilst in restraint must take place according to the restraint record form. The minimum requirement is every 2 hours. Monitoring is documented in the Clinical Notes, or in Kahurangi, the Restraint Monitoring Form.

#### 4.04 **Environmental**

The WCDHB operates a secure Dementia Unit (Kahurangi). As a requirement of this level of care, all staff only areas and external gates and doors must be locked at all times. Only Patients who have the necessary diagnosis and specialist recommendation will be admitted to the Dementia Unit and therefore individual approval and monitoring is not required. Areas that a Patient can usually access but for some reason are considered unsafe may be sectioned off to restrict access on a temporary basis while necessary repairs etc are carried out.

Monitoring of environmental restraint, that is, that the unit remains secure, is completed via the maintenance schedule. Any breaches of the secure unit will be documented through the incident reporting process. From time to time monitoring of individuals may be required as per individual Patient care plans.

#### 4.05 **Individual Patient Requirements**


All forms of restraint not outlined above being considered for an individual Patient must be presented to the Restraint Committee for approval.

### **5.00 Training**

5.01 All clinical staff are to complete restraint minimisation and safe practice training as part of their orientation to their area of work within the first 6 weeks of commencing work.

5.02 All staff will receive training in restraint minimisation and safe practice at a frequency determined by the WCDHB Restraint Committee. Staff will address any queries they have relating to restraint to the relevant Clinical Nurse Manager or Restraint Co-ordinator. Training will also include education on:

- Focus on de-escalation techniques;
- The principles of Informed Consent;
- Recognising the importance and rights of family/whanau;

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- Risk assessment and decision-making in relation to restraint use;
- Recognising the impact of restraint on the individual and on others;
- Documentation and consultation.
- Frequency of training will be in accordance with meeting Patient's needs in conjunction with recommendations from the Restraint Committee.

#### 6.00 **Use of Restraint**

- 6.01 Restraint of a Patient will only occur after a comprehensive assessment has occurred that identifies the risks involved.
- 6.02 Restraint must only be used when all other options as documented in the Patient's Individual Care Plan have been attempted and were unsuccessful.
- 6.02 Restraint must never be used to inflict pain, deprive a Patient of their rights or as a means of diversion, distraction or punishment.
- 6.04 The use of restraint is a clinical decision only.
- 6.05 Restraint is only to be used where indicated and prescribed.
- 6.06 Restraint is not a treatment in itself but is one of a number of strategies used at a particular point in time with a particular goal in mind.
- 6.07 Restraint should only be used in the context of good practice.
- 6.08 The use of chemical restraint to ensure compliance and render the Patient incapable of resistance is a hallmark of abuse and is not supported. All medications should be prescribed and used for valid reasons only.
- 6.09 Before restraint is used, the following factors must be considered:
- i) Any risks associated with the intended type of restraint;
  - ii) Any underlying causes for the patient's behaviour;
  - iii) Any advanced directive that the patient has made concerning restraint;
  - iv) Evaluation outcomes of previous use of restraint;
  - v) Any history of abuse/trauma previously suffered by the patient;
  - vi) Desired outcome for using restraint.

#### 7.00 **Indications for use**

- 7.01 The use of restraint could be considered where:
- A Patient's behaviour indicates they are a significant risk to themselves (e.g. falls) or others.
  - A Patient makes a serious attempt or act of self-harm.
  - A Patient makes a sustained or serious attack on another person.
  - A Patient seriously compromises the facility's environment, e.g. by damaging property.

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### **8.00   Consent**

8.01 The intended restraint process must be explained to the Patient and/or their family/legal representative by the Registered Nurse or Clinical Nurse Manager and approval to apply restraint obtained. A signed consent section on the WCDHB Restraint Record Form (or Restraint Prescription in Kahurangi) indicates approval.

### **9.00   Application of Restraint**

9.01 The safety of all people involved in the restraint process must be maintained at all times.

9.02 The restraint process will follow current, accepted best practice and the Standard.

9.03 Any decision to initiate restraint must be made by the most appropriate/designated health Professional.

9.04 Prior to the use of restraint the following must be considered:

- The Patient's physical and psychological health,
- The Patient's gender and culture,
- The degree of risk to the Patient, others and the environment,
- The Patient's Individual Care Plan,
- Use of alternative interventions/strategies,
- Possible compromise to the future relationship with the Patient,
- Desired outcome and criteria for ending restraint,
- Legal status and implications.

### **10.00   Initiating and Ending Restraint**

10.01 The decision to initiate and end restraint must be made:

- By the most appropriate designated health professional.
- When the environment is appropriate for successful initiation and discontinuation.
- When adequate resources are available to ensure safe initiation and discontinuation.
- When appropriate planning and preparation has occurred.


### **11.00   Emergency Restraint Process**

11.01 Restraint may be initiated without prior consultation in instances when the Patients' behaviour is so dangerous that:

- i) The potential for self harm is extreme and, or
- ii) There is a risk of harm to others.

11.02 In these circumstances the:

- i) Least restrictive/intrusive method of restraint will be implemented,
- ii) The Clinical Nurse Manager, Registered Nurse or other Senior Clinical Staff member on duty will be notified as soon as practicable.
- iii) Continued use of restraint will be reviewed as soon as practicable.

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- 11.03 The Clinical Nurse Manager, Registered Nurse or other Senior Clinical Staff member on duty will notify the patient's Doctor and family/legal representative as soon as practicable.
- 11.04 In instances where a signed consent is absent, verbal approval from family/legal representative will be obtained and documented as soon as practicable.
- 11.05 The documented consent approval process will be completed as soon as practicable.

## **12.00 Monitoring Procedure**

### **12.01 Observation**


- To minimise the risk of harm to the Patient during any period of restraint the patient's physical safety, comfort, provision of all care/support and treatment needs must be met at all times.
- This includes but is not limited to the provision of foods and fluids, personal hygiene and toileting, suitable clothing, medications, exercise and activity as appropriate.
- The patient's right to dignity, privacy and self-respect will be maintained at all times during any periods of restraint.
- Visual and auditory privacy will be promoted at all times.
- During the period of restraint regular observations will be completed according to the consent form and care plans requirements.
- Release from restraint for mobilisation, a position change, and toileting will take place at least two hourly.

### **12.02 Documentation**

- i) The restraint will be fully documented in the Patient's Individual Care Plan.
- ii) Every episode of restraint will be documented:
  - on a restraint record form
  - In the Patient's Progress/Clinical Notes
  - On the Patient Restraint Monitoring Form (Kahurangi only)
- iii) Documentation will be sufficient to enable a review of the restraint episode to be undertaken and includes:
  - An evaluation of the effect/impact and the Patient's response to the restraint
  - Cares provided
  - The outcome of the restraint process.
- iv) All restraint reviews:
  - Will be documented in the Patient's Progress Notes,
  - Amendments to the Individual Care Plan and Individual Restraint Record made as required.

## **13.00 Support of Patient, Family/Whanau and Staff**

- 13.01 The impact and stress associated with the utilisation of restraint will be minimised by:
- i) The Patient and their family/whanau participating in all decisions regarding restraint whenever practicable,
  - ii) Ensuring the facilitation of timely and effective communication,
  - iii) The provision of support/advocacy to the Patient as appropriate,
  - iv) The provision of information and support to the Patient's family/whanau,
  - v) The provision of staff training and support (including debriefing) as appropriate.

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#### **14.00 Review and Evaluation**

- 14.01 The relevant Clinical Nurse Manager and Doctor will hold a formal evaluation at least six monthly of each Patient who has restraint in place. All evaluations will:
- i) Be discussed with the Patient and their Patient's next-of-kin/advocate;
  - ii) Consider any future options available to avoid use of restraint;
  - iii) Whether Patient's care plan was followed and are there any modifications required;
  - iv) Whether the desired outcome was achieved;
  - v) The period of restraint and whether this was appropriate;
  - vi) The impact of the use of restraint on the Patient;
  - vii) Whether there was appropriate monitoring/observation during the period of restraint;
  - viii) Whether this Policy was followed.
- 14.02 The Doctor will re-sign and date the extended authorisation when it is decided that the period of restraint is to be extended.
- 14.03 The Restraint Committee will conduct 6 monthly audits of all restraint processes which evaluates:
- The assessment phase;
  - The need for the restraint;
  - The appropriateness of the restraint
  - The usage of restraint interventions taken prior to restraint authorisation,
  - The impact and response of restraint,
  - Level of consultation with family/whanau and advocacy support;
  - The effectiveness of the restraint,
  - How periods of restraint were monitored,
  - The competency and training needs of staff,
  - And progress towards a restraint free environment.

The Restraint Register, Restraint Records, Restraint Monitoring Charts (Kahurangi only) and clinical record will be utilised during the audits, with results discussed in the Restraint Committee, and reported through the relevant Clinical Governance group. The Restraint Committee will be responsible for monitoring implementation of recommendations.

## **7. Legislative Requirements**

- Code of Health and Disability Services Clients' Rights 1996
- Crimes Act 1961
- Health and Disability Services (Safety) Act 2001
- Health and Safety in Employment Act 1992
- Health Information Privacy Code 1994
- Human Rights Act 1993
- Mental Health (Compulsory Assessment and Treatment) Act 1992

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- Mental Health Risk Assessment and Management Policy
- New Zealand Bill of Rights Act 1990
- Privacy Act 1993
- Protection of Personal and Property Rights Act 1988

## 8. Related Documents

WCDHB Restraint Register  
WCDHB Restraint Record Form  
WCDHB Restraint Monitoring Chart (Kahurangi)  
Restraint Prescription (Kahurangi)  
WCDHB Restraint Internal Audit Tool  
WCDHB Incident Reporting Form

## 9. Reference

NZS 8134.2:2008 “Restraint Minimisation And Safe Practice”

<b>Revision History</b>	Version:	11
	Developed By:	Calming and Restraint Working Party
	Authorised By:	Chief Executive Officer
	Date Authorised:	August 2003
	Date Last Reviewed:	March 2012 by Restraint Committee
	Date Of Next Review:	March 2014

## 10. Guidelines

### Enablers Process

- The use of enablers shall be the **least restrictive option** to meet the needs of the patient
- Both enablers and restraint limit the patient’s normal freedom of movement. It is not the properties of the equipment that determines whether or not it is an enabler or restraint – the distinction is that an enabler is **voluntarily used** to promote independence, comfort and/or safety.
- The same equipment can shift from being used as an enabler (voluntarily used) to a restraint if the equipment is not removed when the patient indicates that they want it removed.
- Voluntarily used – where doubt exists, for example where a patient has diminished competence, consider whether the patient is capable of indicating if and when they want the equipment removed. (See also *WCDHB Informed Consent Procedure*)

