

Policy Applies to

All Mercy Hospital staff including Credentialed Specialists and students.

NOTE: This policy is made available to patients or support people.

The Health and Disability Advocacy Service may be contacted at <https://advocacy.org.nz/>

Related Standards:

Nga Paerewa Health and Disability Services Standard NZS 8134: 2021

Part 6: Restraint and Seclusion

Objectives

Mercy Hospital aims to be a restraint free facility and is committed to the preservation of dignity and mana for patients.

To ensure Mercy Hospital has a clear process and clinical governance if an episode of restraint occurred.

Rationale

Everyone who is legally competent has the right to refuse to undergo or continue medical treatment.

Any application of force to a person, without their consent, is an assault unless permitted by law. (Refer to *The Health and Disability Commissioner's Services Consumers' Rights Regulation 1996* to clarify issues relating to consent).

Staff will provide care in the least restrictive way possible, while ensuring a safe environment free from threats to the physical or psychological well-being of patients and staff.

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

Use of restraint must be clearly justified, consider the persons previous history, and be based on sound clinical judgement.

The decision to restrain and the rationale for its use must be documented in the clinical record.

Cultural Consideration and Patients' Rights:

Essential to the ongoing ability to be a restraint free hospital, is a workforce that is knowledgeable and sensitive to Te Ao Māori, which enables us to work in the spirit of the principles of Te Tiriti. Tikaka best practice guidelines form the basis for all patient journeys.

Patients and where appropriate, whānau are informed of their rights during the admission process.

Definitions

The following definitions apply, as per NZS 8134:2021

Term	Description
De-escalation	A set of complex interactive processes in which a highly aroused person is redirected from an unsafe course of action towards a supported and calmer emotional state. This usually occurs through timely appropriate and effective interventions and is achieved by service providers using communication and non-verbal skills along with practical alternatives
Safe use of equipment	A person can make their own decision about equipment use and can free themselves from the equipment if required.
Restrictive Equipment	Use of restrictive equipment items limits a person's normal freedom of movement and can only be used after appropriate clinical assessment and requires voluntary agreement with the user. Items that constitute restrictive equipment include, but are not limited to, bedrails, tray tables, chair that patients cannot move out of independently. Use of restrictive equipment is to be considered a physical restraint if the patient/service user requires the assistance of a 3rd party to release them from its use (i.e. move it so they can move) and be recorded as such on the restraint register. The use of restrictive equipment is to be monitored and recorded in the clinical record.
Restraint	The use of any intervention by a service provider that limits a person's normal freedom of movement. Where restraint is consented to by a third party it is always restraint.
Restraint episode	A single restraint event, or where restraint is used as a planned regular intervention and is identified in the person's service delivery plan. The term may also refer to a grouping of restraint events.
Restraint initiator	The restraint initiator is the registered health professional who is trained in de-escalation and least restrictive practice and decides that the patient requires restraining. Restraint Approval and Register Restraint type are reviewed annually (or as necessary) and documented in the restraint register.
Restraint elimination	Evidence of good assessment and planning processes, that provide early identification of a possible need for restraint and therefore assist in planning interventions that best reduce the likelihood of restraint being required.
TPSC	Any restraint event must be documented on the Patient Safety Company (TPSC) incident reporting system.
Restraint register	A Restraint Register is held and will record this information so that the organisation has an auditable record of restraint use. This is stored electronically in the Chief Operating Officer's files.

Categories of Restraint

Personal Restraint

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

Physical Restraint

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

Locked Doors

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

Seclusion

Where a patient/consumer is placed alone in a room or area, at any time and for any duration, from which they cannot freely exit. Seclusion is a specific type of environmental restraint and can only be legally implemented for patients/consumers who are under the Mental Health (Compulsory Assessment and Treatment) Act 1992 or the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003. Seclusion only occurs in approved and designated seclusion rooms.

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

For the purposes of this process and all associated procedures and requirements our organisation recognizes the following as 'restraint'.

Any type of restraint which is outside the bounds of accepted normal clinical practice in an area as described in the policy definition, but which is necessary to avoid or minimize harm to the patient or others. Examples may include (but are not limited to):

- When a patient becomes confused due to sleep deprivation
- When a patient suffers untoward effects of confusion or aggression through withdrawal from alcohol or recreational drugs

Exclusions:

If the patient or caregiver is competent and has given consent to the following activities, this is **not** considered to be restraint.

- Paediatric Therapeutic Holding (supportive holding or clinical holding). The immobilisation of an infant or young child to help them manage a painful procedure quickly and effectively or to enable the procedure to be carried out in a safe and controlled manner. Wherever possible the consent of the parent/s and assent of the child after the rationale and technique has been clearly described, should be obtained. The technique used is built around soothing/self-soothing strategies which the child has historically initiated or demonstrated that they respond positively to and makes skilled use of age-appropriate techniques such as wrapping and splinting.
- Use of bedside rails when transporting patients around the facility.
- If a patient requests a bed rail to be placed up for comfort, this is not considered restraint, so long as the patient can freely exit from one side.
- Use of cot sides when transporting all children.
- Voluntary use of over bed tables in front of chairs and over beds.
- Using relatives to sit with patients during the day or night if there is a concern for patient safety.
- Patients who are prisoners under the Department of Corrections who are admitted with any requirements that could be considered related to restraint e.g. patient watch, handcuffs, will remain the responsibility of the Department of Corrections throughout the hospital stay. Mercy Hospital staff are responsible for the assessment, planning, implementation and evaluation of care required relating to the episode of clinical care required.
- Environmental isolation and/or detainment of patients for Infection Prevention and control purposes.
- The restraint of patients being transported and subject to specific provisions under the Mental Health Act 10=992 (compulsory assessment and treatment) or the Intellectual Disability (compulsory care and rehabilitation) Act 2003.

NOTE:

Bed Rails **will not prevent** patients from falling and can pose a higher risk to the patient and therefore, are **contraindicated when the patient is confused**.

Risk Mitigation in Mercy Hospital

Holistic Preadmission and ongoing assessment

Considerations to avoid the use of restraint, include preventative measures that work for the patient and the use of alternatives.

The persons care plan may include:

- Cultural support or interventions including contacting experts. Consideration of Māori specific needs or interventions, including waiata (songs), pūrākau (legends), karakia (ritual chant or prayer) and what has worked previously for the patient and their whānau.
- Positive behaviour support strategies and support of social needs that are important to the patient and whānau.
- A flag from preadmissions relating to risk mitigation, on Personify.
- Person and whānau centred approaches, such as sensory modulation and use of whānau and other support people. Support of an overnight border (where fee may be waived if appropriate).
- Lessons from previous restraint, including environmental triggers and where appropriate, awareness of known strategies to support the person when they are experiencing distress.
- Mindfulness & other therapeutic approaches.
- Specialling, use of diversion or low beds where appropriate, Specialling the person in the absence of a known person or family member (if foreseen, this is set up during pre-admissions).
- The use of early intervention with alcohol (drug) withdrawal plan. (Mercy Hospital Clinical Services Work Manual Alcohol Withdrawal Guideline).
- Allocation of resource to minimise restrictive practices including access to cultural support for patients and whānau.

Ongoing assessment & support

- Relevant information about the patients' preferences will be shared via verbal handover, written documentation, theatre briefing. That is during all transitions in care, to ensure a smooth patient journey.
- Skilled use of de-escalation to reduce the emotional response in stressful situations e.g. use of sensory modulation resources, diversional therapy, mindfulness, peer support, occupational therapy, low beds, specialling, other therapeutic approaches. Document in patient's notes any significant change in mental or physical state, e.g. increasing restlessness or confusion.
- Consultation by staff with the patient and whānau (or significant other) to indicate any change in mental status.
- The relative danger of the patient's behaviour versus the potential danger of using a restraint is considered and documented.

Roles and Responsibilities throughout the patient's journey

Clinical Staff

Completes the Patient Restraint course NAHS100 on Health Learn.

Maintain the dignity of the person in partnership, considering Māori or culturally specific needs with patient and whānau during all care and communication.

Communicate with patients and their whānau regarding cultural safety requirements, when managing challenging behaviours and situations in a meaningful, empowering and therapeutic manner.

Seek cultural advice where indicated and patients are given opportunity to express their wishes for cultural advice at all opportunities specifically during transitions in care.

Document all planning and interactions making patients and whānau involvement clear in the notes.

Clinical Leaders/Managers

Promote restraint minimisation with the least restrictive practices.

Monitor and evaluate use of restraint through any incidents occurring and debrief accordingly.

Initiate, review, implement and evaluate initiatives and approaches that are evidence based best practice for restraint minimisation in consultation with wider leadership and management teams.

Ensures Clinical Risk Mitigation Committee has area representation.

Clinical Risk Mitigation Committee

Communicate and educate to eliminate restraint. Support the Professional Development Committee (PDC).

Assists the clinical area and Quality Manager to monitor and evaluate restraint events or near miss.

Works with PDC to ensure key messaging from education is clear to area staff.

Clinical Learning and Development Coordinator

Works with relevant committees to promote consistency in meeting the Ngā paerewa Health and Disability Services Standard (NZS 8134:2021 Section 6) across Mercy Hospital Dunedin, including planning and evaluation of the education plan and updating policy.

Staff Education

All staff complete Ngā Paerewa – Health and Disability Services Standard (Introduction) on Tautoko. Additionally, the Restraint Elimination course on Health Learn (NAHS100) is to be completed.

All patient facing clinical staff including health care, and allied health assistants, complete Communication and De-escalation, Restraint Elimination, Falls Prevention, Code of Health & Disability Services Consumers Rights training modules.

Key Performance Indicators

- Education is completed as per service requirements.

- Incident forms, patient complaints, patient feedback pertinent to restraint will be reviewed annually by Quality Manager and restraint related incidents reported to Quality and Risk Committee.
- If a restraint episode occurs, there will be annual review and audit of any restraint episodes initiated by Quality Manager working with Clinical Managers and Clinical Learning & Development Coordinator. Audit reports demonstrate evaluation for any episode of restraint.

If restraint is required, please utilise appendices to this policy for appropriate process

Internal Documents

- Record of Restraint Care Plan – refer Appendix 1
- Record of Restraint Care Plan Guidelines – refer Appendix 2
- Statement on the management of restraint – Appendix 3
- Mercy Hospital Process – refer Appendix 4
- Restraint Register
- New Zealand Formulary & notes on injectable drugs
- Cultural Information SharePoint
- Clinical Services Work Manual (Alcohol withdrawal guidelines, Hypoglycaemia Guideline)
- Intravenous Manual
- Māori health model – Te Whare Tapa Wha
- Health & Safety Plan Mercy Hospital

External Documents

- Nga Paerewa Health and Disability Services Standard NZS 8134:2021; Section 6.
- HQSC Code of Expectations for health entities engagement with consumers and whanau (2024)
- Human Rights Act (1993)
- Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003
- Mental Health (Compulsory Assessment and Treatment) Act 1992
- Privacy Act (1993)
- New Zealand Bill of Rights Act 1990
- Code of Health and Disability Services Consumers' Rights 1996
- Health and Disability Commissioner Act 1994
- Restraint Elimination and Safe Practice Policy. Health NZ I Te Whatu Ora May 2023
- Crimes Act 1961
- Health and Safety at Work Act 2015