Policy Applies to

All Mercy Hospital clinical staff.
Compliance will be facilitated for Credentialed Specialists

Exclusions:

This policy does not apply to:

- Safe handling/technical positioning
- Safe holding which may be part of usual clinical procedures or to briefly manage clinical symptoms
- Recognised/approved use of enablers

Related Standards:

- Nga Paerewa Health and Disability Services Standard NZS 8134: 2021
  Part 6: Restraint and Seclusion

Rationale

Mercy Hospital is restraint free. Staff in Mercy hospital are committed to optimising patient safety, in a restraint free environment as far as is reasonable practicable. This document explains what is meant by restraint and enablers

Cultural Considerations:

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

Definition:

Restraint is the implementation of any forcible control by a health service provider that limits the actions of a patient in circumstances where the patient is at risk of injury or of injuring another person.

Personal restraint
Where a service provider uses their own body to intentionally limit the movement of a patient.

Physical restraint
Where a service provider uses equipment that limits the normal freedom of movement, e.g. belts.

De escalation
A complex interactive process in which the highly roused consumer 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.

Enablers
Enablers limit the normal freedom of movement of the consumer. It is not the properties of the equipment, device or furniture that determines whether or not it is an enabler or restraint, but rather the intent of the intervention. For instance, the use of bedsides in an awake patient who voluntarily requests them for comfort and safety, constitutes an enabler.

At Mercy Hospital the following enablers are in use and are not considered to be restraint:

- Use of bedside rails when transporting patients around the facility
- 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.

Safe holding/technical positioning
Safe holding which may be part of usual clinical procedures or possible clinical interventions, e.g. positioning and support during procedures, or to briefly manage clinical symptoms.

Safe holding, supporting and the positioning of a patient so that a procedure can be carried out in a safe and controlled manner with their consent, is not considered a form of restraint.

Safe holding may be required when the patient is not competent or fully conscious. Examples include a patient who is emerging from a GA, where used for immediate patient safety and therapeutic purposes, within accepted clinical practice. This is not restraint, but an expected PACU nursing intervention.

Objectives:

- To support Mercy's commitment to being a restraint-free' facility.
- To ensure staff have access to learning resources relating to Restraint Minimisation and Safe Practice and have an understanding of the Nga Paerewa health and disability services standard 2021.
- To ensure staff know where to access and complete the appropriate documentation

Implementation:

See Holistic assessment and Risk mitigation sections below

Staff awareness involves, knowledge of Nga Paerewa Health and Disability Services Standard through LearnOnline eLearning module. Ongoing Learning opportutnities exist in the Clinical Services Work Manual – details below.

Staff will understand the cultural and legal aspects of restraint through the healthLearn modules, and further reading within Mercy Hospital Policy.

Education: All clinical staff complete learning items 1-3, and all hospital staff have access to items 4 -5

1. HealthLearn module Communication and De-Escalation 2 yearly certification
2. HealthLearn module Restraint Minimisation and Safe Practice
3. HealthLearn module Falls Prevention and associated Policy
4. LearnOnline module, 'Nga Paerewa Health and Disability Services Standard', which provides staff with real life examples of what successful Te Tiriti partnerships can look like.
Through engaging with and understanding the real-life examples provided in the Nga Paerewa eLearning package, staff will have an understanding of what successful Te Tiriti partnerships can look like.

Staff are encouraged to seek further learning and reflect on daily practice, as suggested within Nga Paerewa eLearning package

5. How we engage with and include patients and whānau is a key part of the success we have in our ability to avoid the need for restraint.
To enable patient and whānau involvement in all steps of their care episode, staff awareness is needed and will be continually improved through reflection – formally during PDRP and appraisal, as well as during daily work, as opportutnies to involve patients in planning are realised and actioned.
The evolving model of care supports how we learn from and with one another in this space.

Related Organisational Plans & Committees

All Mercy Hospital plans give consideration to the cultural and specifically Te Tiriti o Waitangi requirements of patients and families.

- Maori Organisational Plan
- Pacifica Organisational Plan
- Infection Prevention and Control Plan
- Quality Plan
- Clinical Learning and Development Plan

- Recognition and Response Committee

Records - Training records are maintained by the Professional Development Committee, in Tautoko and healthLearn.

Evaluation

- Annual review and audit of restraint episodes if appropriate, by the Clinical Learning and Development Coordinator
- Incident forms, patient complaints, patient feedback pertaining to patient restraint.
- Training records audited in healthLearn 3 monthly as part of Clinical Orientation follow up, by the Clinical Learning and Development Coordinator, communicated to Clinical Nurse Managers.

Review

The review must consider:

- Type, frequency, duration and appropriateness of restraints used
- Compliance with Nga Paerewa Health and Disability Services Standard (NZS 8134:2021)

Document Reviewed By:

- Cultural Advisor – Hine Forsyth
- Advocacy Services.

Associated Documentation:

- Restraint Register – located in Chief Operating Officers office.
- Record of Restraint Care Plan – refer Appendix 1
- Record of Restraint Care Plan Guidelines – refer Appendix 2
- Cultural Policy
- Alcohol withdrawal guidelines.
- Hypoglycaemia Guideline
- New Zealand Formulary
- Intravenous Manual
- Maori health model – Te Whare Tapa Wha
- The Patient Safety Incident System Mercy Hospital (TPSI)
- online learning modules
    1. healthLearn Communication and De-escalation
    2. healthLearn Restraint Minimisation and Safe Practice
    3. healthLearn Falls Prevention and Falls prevention Policy
    4. LearnOnline Nga Paerewa Health and Disability Services Standard – Compliance with Te Tiriti o Waitangi requirements in Nga Paerewa

This policy is made available to patients or support people.
In addition the Advocacy Service may be contacted at 479 0265 or 0800 377766.

References

- Nga Paerewa Health and Disability Services Standard NZS 8134:2021
- Code of Health and Disability Services Consumers' Rights 1996
- Human Rights Act 1993
- Health and Disability Commissioner Act 1994
- Mental Health (Compulsory Assessment and Treatment) Act 1992
- Health and Disability Services Act 1993
- Health and Safety at Work Act 2015
- New Zealand Bill of Rights Act 1990
- Waikato District Health Board Restraint Policy May 2009
- Lippincott Procedures 'Delirium, care of patient'.

Patient Rights

Everyone who is legally competent has the right to refuse to undergo or continue medical treatment. Any application of force (including use of restraint techniques) 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).

Best Practice

All patients have a right to be free from restraint except in an emergency, when other methods to maintain patient safety have been attempted and failed or when the risk of not using the restraint is extreme.

Use of restraint in clinical areas will reflect a robust clinical decision and will meet cultural requirements in order to maintain the philosophy of Te Whare Tapa Wha (four Cornerstones).

a) Te Taha hinengaro – mental wellbeing
b) Te Taha Tinana -physical well being
c) Te Taha wairua- spiritual well being
d) Te Taha whānau - whānau wellbeing

Categories of Restraint

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) :
    1. When a patient becomes confused due to sleep deprivation

2. When a patient suffers untoward effects of confusion or aggression through withdrawal from alcohol or recreational drugs

Any restraint event must be documented on the The Patient Safety Company (TPSC) incident reporting system.
A Restraint Register held and will record this information so that the organisation has an auditable record of restraint use.
Any restraint event will also be reported quarterly to the Quality and Risk Committee.

Restraint Process

1) Assessment – see criterion 6.1.4, 6.1.5, 6.2.1
2) Consent
3) Reporting and documentation
4) Monitoring/Observation Guidelines – see criterion 6.2.2
5) Ongoing management
6) Emergency management
7) Debrief Process- see criterion 6.2.5, 6.2.8

1) Assessment of the patient

Prior to or on admission, a documented assessment of the patient is completed to identify any risks including history of confusion, adverse effect of drug administration, recreational drug usage, relevant changes in social circumstances, trauma history, known strategies

Holistic Assessment is undertaken by preadmissions. Where a risk is identified, special cares put in place as agreed with patient and whānau. Communication systems are in place to manage this between pre-admissions and Associate Charge Nurse (or shift coordinator).

Risk mitigation considerations include the use of alternatives, in the first instance to avoid the need for restraint

- What has worked previously for the patient and whānau.
- Cultural support or interventions including contacting experts (waita, puakau and karakia)
- Positive behaviour support strategies & support of social needs that are important to the patient and whānau
- Use of whānau and relevant support people
- Support of overnight border (where fee may be waived if appropriate).
- Use of low beds
- Use of diversion
- Specialling where appropriate
- Allocation of resource to minimise restrictive practices including access to cultural support for patients and whānau

Patients (and where appropriate) relatives are informed of their rights *Code of Health and Disability Services Consumers' Rights Regulation 1996*.

Ongoing assessment

- Document in patient's notes significant change in mental or physical state, e.g. increasing restlessness or confusion;
- Consultation by staff with the patient and whānau/family/significant other to indicate any change in mental status;
- 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.
- The relative danger of the patient's behaviour versus the potential danger of using a restraint is considered and documented.

2) Verbal consent

It is important to attempt to gain verbal consent prior to initiating restraint. Consent is obtained from the patient or family. Initiate ongoing dialogue regarding the restraint. In addition ensure the patient, whānau/family/ significant others know the reason for the restraint, have access to support or advocacy, are involved in decisions relating to care and ensure staff facilitate appropriate access to visitors.

Document in the patient's notes, any information and consultation with the patient. Where possible, this should involve the patient and whānau/family/significant other. If consent is not able to be obtained, document this also in the clinical record.

3) Reporting and Documentation

The patient's Credentialed Specialist must be notified when a physical restraint is necessary or has been necessary.

If sedation is required the Doctor must assess the patient before charting any sedation to ensure that there is no alternative to maintaining the patient's safety or the safety of others. All medications should be prescribed and used for valid indications.

For documentation requirements please refer to;

- Incident form
- Restraint register
- Record of Restraint Care Plan
- Record of Restraint Care Plan Guidelines

4) Monitoring/Observation Guidelines

The frequency and level of observation and assessment must be appropriate to the level of risk associated with the restraint procedure and may include:

- airway clearance, respiration rate
- skin colour, circulation
- neurological assessment
- level of comfort/discomfort

- hydration needs
- pressure area needs
- privacy
- whānau may assist with observation

5) Ongoing Management

Patient care must ensure that the patient's physical safety, maximum comfort and all other care and treatment needs are met. (Patients should be included in decision making regarding cares as able).

Nursing staff must reassess the patient regularly to determine whether the restraint is effective and or required.

A documented assessment of the patient response to the intervention is to be completed by nursing staff at least 2- hourly or more frequently if the patient's condition requires.
The restraint process should be reduced or discontinued as soon as it is safe to do so.

6) Emergency Management

In the event of a patient becoming a physical threat to either staff or other patients the following actions should be taken;

- employ de-escalation skills
- remove any unnecessary furniture or equipment that could harm the patient
- if possible, remove all invasive lines or tubes
- call the patient's surgeon and or anaesthetist for advice on treatment. Any medication must be prescribed for valid reasons, i.e. for therapeutic interventions only
- if out of hours, phone the on call nurse for additional support
- if the patient requires personal restraint and staff are unable to do this safely, call the police for assistance or access Emergency Psychiatric Services at Dunedin hospital (0800 44 33 66).

Nursing staff must keep the medical staff fully informed of the patient's condition and response to treatment so that further interventions may be initiated, e.g. psychiatric referral.

Transfer to an appropriate psychiatric service may be initiated following a team meeting including the surgeon, psychiatric consultant, nursing staff, whānau/family/significant other.

7) Debrief Process

The nursing staff in consultation with medical staff, the patient and their whānau/family/significant others will evaluate the restraint event identifying;

- Presence of any early warning signs that could have been identified at patient admission and assessment
- The timeliness and appropriateness of communication with whānau/family

- The adequacy of the support that was provided to both patient and whānau throughout the restraint episode
- Appropriateness of de-escalation methods attempted
- Whether the least restrictive intervention was used
- Whether policies and procedures were followed adequately
- The appropriateness and effectiveness of the individual care plan
- The effectiveness and impact of the intervention.

After reviewing a restraint event, any changes in practice, policies/procedures or training that are identified during the debrief will be communicated to the Policy committee, the appropriate Manager and to clinical staff communication.

Restraint incidents are to be discussed at ward/unit team meetings, reviewed by the Chief Operating Officer and forwarded to the Quality and Risk Advisory Committee.