

### Policy Applies to

All Mercy Hospital clinical staff.

Compliance will be facilitated for Credentialed Specialists and Allied Health personnel involved in patient care.

### **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:**

- NZS 8134.2.1 Restraint Minimisation
- NZS8134.2.2 Safe Practice

### Rationale

**Mercy Hospital staff are committed to ensuring safety in a restraint free environment**

#### **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 educate staff and to minimise the use of restraint in all forms at Mercy Hospital
- To support Mercy's commitment to being a restraint-free' facility.

### **Implementation:**

Education for clinical staff is provided through a blended approach of e-learning, face-to-face opportunities, mandatory requirement during clinical orientation. Staff access this via SharePoint directly or from their training record

Education covers -

- Communication & De-escalation skills
- Documentation skills and familiarisation with the standardised forms
- Cultural/legal aspects of restraint
- Staff will have knowledge of 'The Code of Health & Disability Service's Consumers Rights 1996' including assisting patients to access the information
- This occurs on the mandatory training cycle as an annual update

- Staff will have knowledge of the terms PJP paralysis and deconditioning in relation to restraint minimisation and safe practice.

**Records** - The Clinical Educator will ensure that Training records are maintained.

### **Evaluation**

- Annual review and audit of restraint episodes and training records by the Clinical Educator
- Patient Restraint Minimisation face to face session will be evaluated as part of an annual evaluation of Clinical Orientation content
- Incident forms, patient complaints, patient feedback pertaining to patient restraint.

### **Review**

*The review must consider:*

- Type, frequency, duration and appropriateness of restraints used
- Compliance with the Restraint Minimization and Safe Practice
- NZS81342.1 & NZS81342.2 2008.

### **Document Reviewed By:**

- Cultural Advisor – Hine Forsyth
- Advocacy Services.

### **Associated Documentation:**

- Restraint Register – located in Director of Clinical Services' Office
- Record of Restraint Care Plan – refer Appendix 1
- Record of Restraint Care Plan Guidelines – refer Appendix 2
- Restraint Minimisation and De-escalation Quiz accessed through SharePoint
- Cultural Policy
- Alcohol withdrawal guidelines.
- Hypoglycaemia Guideline
- New Zealand Formulary
- IV Manual
- Maori health models – Te Whare Tapa Wha
- Training Requirements Clinical Staff
- Incident System
- PJ paralysis
- Communication and De-escalation

**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

- Code of Disability Services Consumers' Rights 1996
- NZ Standard 8134.2.2.2008 - Restraint Minimization and Safe Practice
- Mental Health (Compulsory Assessment and Treatment) Act 1992
- Human Rights Act 1993
- Health and Disability Services Act 1993
- Health and Safety at Work Act 2015
- Health and Disability Commissioner Act 1994
- 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).

### Recommended 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 whanau- whanau 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 an incident form. A restraint register held by the Director of Clinical Services 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
- 2) Consent
- 3) Reporting and documentation
- 4) Monitoring/Observation Guidelines
- 5) Ongoing management
- 6) Emergency management
- 7) Debrief Process

#### 1) Assessment of the patient

Prior to or on admission, a documented assessment of the patient is completed to identify any risks, e.g. history of confusion, previous history of adverse effect of drug administration, high risk medications, recreational drug usage or changes in social circumstances that impact on their mental status.

Where a risk is identified prior to admission, the pre-admission nurses will notify the patient's surgeon, anaesthetist and relevant clinical staff. Nursing staff must discuss with whanau/family/significant other a plan of care to minimize the use of restraint and identify acceptable forms of treatment to the patient and their whanau/family, should the need arise. It is also important to ensure that individual cultural needs are met and that the patient and relatives are aware of *The Code of Health and Disability Services Consumers' Rights Regulation 1996*.

- 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 whanau/family/significant other to indicate any change in mental status;
- Skilled use of de-escalation to reduce the emotional response in stressful situations and to minimise the need for intervention, e.g. dim the lighting, reduce the noise, place patient closer to nurses' station, place mattress on floor; whanau/family member encouraged to sit with patient whenever possible; familiar articles, e.g. a photograph, music to help settle the patient;
- 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, whanau /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 whanau/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
- whanau 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, whanau/family/significant other.

### 7) Debrief Process

The nursing staff in consultation with medical staff, the patient and their whanau/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 whanau/family
- The adequacy of the support that was provided to both patient and whanau 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 Director of Clinical Services and forwarded to the Quality and Risk Advisory Committee.