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Policy

Restraint is a serious clinical intervention used only as a last resort to protect patients/consumers, others, or property, from harm.

The Canterbury DHB (CDHB) will meet the Restraint Minimisation and Safe Practice Standard NZS 8134.2:2008 and all other relevant legislation.

- The CDHB is committed to:
- Reducing the use of all forms of restraint
- Ensuring that all restraint use is clinically justified
- Ensuring restraint occurs for the least amount of time possible
• Ensuring restraint only occurs in a safe and respectful manner under the direction and supervision of the most appropriate Health Professionals

Purpose

To determine CDHB responsibilities and overarching processes in relation to restraint.

Scope/Audience

The restraint of patients/consumers within CDHB Hospital and Specialist Services under the direction and supervision of a CDHB staff member who is registered with an authorising body.

Staff other than health professionals defined above may participate in restraint episodes but only under the direction and supervision of the most appropriate Health Professional.

Associated documents

• CDHB Restraint Minimisation and Safe Practice SharePoint site
  ➢ CDHB Restraint Minimisation and Safe Practice Self Directed Learning Package
  ➢ CDHB Restraint Minimisation and Safe Practice Resource/Guidance
  ➢ CDHB Restraint Minimisation and Safe Practice Responsibilities
  ➢ Older Person’s Health and Rehabilitation Restraint Minimisation and Safe Practice Resource
  ➢ Child Health Restraint Minimisation and Safe Practice Self Directed Learning Package
  ➢ NZS 8143.2:2008 Restraint Minimisation and Safe Practice standard
  ➢ Specialist Mental Health Services Restraint and Seclusion policy and procedure
  ➢ Personal Limb Holder or Soft Limb Restraint Policy – Medical Surgical volume A
• Psychiatric Services for Elderly and Specialist Mental Health Services Seclusion Observation forms
• Physical Restraint Monitoring forms
Definitions

Restraint

The use of any intervention, by a service provider, that limits a patient's/consumer's normal freedom of movement.

Episode of Restraint

For the purposes of restraint documentation and evaluation, a restraint episode refers to a single restraint event, or, where restraint is used as a planned regular intervention and is identified in the consumer's service delivery plan, a restraint episode may refer to a grouping of restraint events.

Chemical Restraint – PLEASE NOTE Chemical restraint is not condoned by the CDHB and is considered abuse.

The use of medication solely for the purpose of limiting a patient's/consumer's freedom of movement or to render them incapable of resistance is considered chemical restraint.

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.

Physical Restraint

Where a service provider uses equipment, devices or furniture that limits the patient's/consumer's normal freedom of movement. For example, where a patient/consumer is unable to independently get out of a chair due to: the design of the chair; the use of a belt; or the position of a table or fixed tray.

Environmental Restraint

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 or by having their normal means of independent mobility (such as a wheelchair) denied.

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.

**Exclusions to this Policy**

1. The use of Enablers which are equipment, devices or furniture, voluntarily used by a patient/consumer following appropriate assessment, that limits normal freedom of movement, with the intent of promoting independence, comfort and/or safety. **Please note:** Both enablers and restraint limit a patient’s/consumer’s normal freedom of movement; 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 and more importantly whether it is voluntarily used by the consumer/patient.

   An enabler can become a restraint if it is not removed when the consumer/patient requests i.e. the enabler ceases to be voluntarily used.

2. Environmental isolation and/or detainment of patients/consumers for infection prevention and control purposes. Refer to the Canterbury DHB intranet for Volume 10, Infection Prevention and Control manual.

3. The restraint of patients/consumers who are prisoners for security purposes. Refer to the Canterbury DHB intranet Volume 11, Patients who are Prisoners policy.

4. The restraint of patients/consumers being transported and subject to specific provisions under The Mental Health (Compulsory Assessment and Treatment) Act 1992 or The Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003.

**Clinical Responsibilities**

The following are clinical activities and decisions which are to be undertaken by the most appropriate Health Professional/s:

- Undertaking a Restraint Minimisation and Safe Practice Assessment
- Making the decision to use restraint
- Monitoring and documenting the consumer’s/patient’s health and wellbeing during the restraint episode

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• Monitoring the consumer's/patient's ongoing need for restraint and ensuring restraint is used for the least amount of time
• Making the decision to cease using restraint
• Undertaking an evaluation of the restraint episode in collaboration with the patient/consumer, including future options to avoid restraint
• Reporting the restraint episode on the CDHB Incident Management System ‘Safety 1st’ (in services where ‘Safety 1st’ is yet to be deployed staff are to report restraint on their divisional restraint reporting form until such time as Safety 1st is deployed).
• Documenting the restraint episode in Safety 1st and in patient’s/consumer’s clinical record

Divisional Responsibilities

The following responsibilities are largely undertaken by the divisional Restraint Monitoring Committees:

• Maintaining approved Restraint Minimisation and Safe Practice procedures - approval is through the CDHB Restraint Approval and Monitoring Group
• Promoting the intent of the Restraint Minimisation and Safe Practice Standards and CDHB policy
• Monitoring compliance with the Restraint Minimisation and Safe Practice Standard and CDHB policy
• Providing or facilitating approved education appropriate to clinical settings - approval is through the CDHB Restraint Approval and Monitoring Group
• Providing representation on the CDHB Restraint Approval and Monitoring Group
• Monitoring the use of restraint in the division
• Providing bi-annual reports on the use of restraint to the CDHB Restraint Approval and Monitoring Group

Corporate Responsibilities

The following responsibilities are largely undertaken by the CDHB Restraint Approval Monitoring Group and the CDHB Nurse Coordinator Restraint Minimisation and Safe Practice

• Organisational-wide restraint Minimisation and Safe Practice policy
- The approval and review of all forms of restraint, restraint education, restraint policy and restraint procedures across the CDHB.
- Maintaining an approved restraints database and 2 yearly review
- Providing Restraint Minimisation and Safe Practice advice and leadership
- Assisting in the review of restraint issues/adverse events
- Ensuring appropriate Restraint Minimisation and Safe Practice guidance is readily available
- Monitoring and Quality review of restraint use

**Measurement/Evaluation**

- Evaluation of every episode of restraint
- Monitoring of restraint data by the divisional Restraint Monitoring Committees
- Biannual Divisional Restraint Monitoring Committee reports to RAMG
- Biannual reports to the Clinical Board supplied by the Nurse Coordinator Restraint Minimisation and Safe Practice on behalf of the Restraint Approval and Monitoring Group
- Safety 1st reports

**References**

- NZS 8143.2:2008 Restraint Minimisation and Safe Practice standard
- The Mental Health (Compulsory Assessment and Treatment) Act 1992
- The Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003
- Memorandum of Understanding between the Ministry of Justice and the Ministry of Health

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<td>Policy Authoriser</td>
<td>Chief Medical Officer or Executive Director of Nursing on behalf of Clinical Board</td>
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