PURPOSE

It is the Bay of Plenty District Health Board (BOPDHB) Mental Health & Addiction Services (MH&AS) protocol intent that services shall aim for a restraint and seclusion free environment, in which people's dignity and mana are maintained.

the use of restraint for tāngata whai ora / service users in all forms is used as a last resort, after all other interventions or de-escaltion strategeries have been tried or implemented and that when practiced, it occurs in a safe, respectful and culturally appropriate manner.

OBJECTIVE

To ensure that the MH&AS staff have knowledge of restraint, with regards to the requirements of legislation, consumer rights, current standards and relevant professional codes of conduct.

STANDARDS TO BE MET

1. Indications for Restraint

1.1 The following are situations where restraint MAY be indicated:

a) When an individual's behaviour indicates that he / she is seriously at risk to self or others.
b) When an individual makes a serious attempt or act of self-harm.
c) When an individual makes a sustained or serious attack on another person.
d) When an individual seriously compromises the safety of the environment, e.g. by damage to property.
e) When it is necessary to give a planned prescribed essential treatment to an individual who is resisting and is being treated compulsorily.

2. Situations of Extreme Caution

2.1 When the use of restraint would threaten or compromise the physical well-being of the individual or others. Consideration must be given to the comparative risks of using restraint or not.

3. Assessment

3.1 All tāngata whai ora / service users will have an assessment carried out to include risk, triggers and early warning signs and identification of de-escalation interventions / strategies to ensure that restraint is used only where it is clinically indicated and justified.

3.2 Assessment information will form the basis of an individualised nursing care plan and risk management treatment plan which will be formulated and documented in the tāngata whai ora / service user's health record.

3.3 Assessments will be carried out by the allocated Registered Nurse (RN) and / or the Responsible Clinician / On call medical practitioner in consultation with the tāngata whai ora / service user and whānau / family, if nominated by the client, and other members of the multidisciplinary (MDT) team.

4. Legal / Ethical

4.1 The requirements of legislation, consumer rights, current standards and relevant professional codes of practice will be met.

4.2 Practice will be guided by ethical principles including acting for the good of the tāngata whai ora / service user, avoiding harm to the client, self and others and respecting the dignity of the client and their human rights.

4.3 Requirements of the Mental Health Act 1992 (MHA) and its amendments will be met.

5. Education / Training

5.1 Staff employed in the adult and older adult acute mental health units (full-time, part-time and casual/on-call staff excluding administrative staff) and DAO's / Acute Care Team staff are required to undertake the National "Safe Practice & Effective Communication" (SPEC) training and will attend a 2 day revalidation training annually.

5.2 This training is carried out by approved Mental Health Service SPEC trainers and Clinical Co-ordinator/Team leaders have the responsibility of ensuring that staff are included in planned revalidation training days in a timely manner.

5.3 All training programmes will be approved by the Clinical Governance Commitee (CGC), be evidenced based and consumer focused and shall include reference to and detail related to:

a) Adequate and appropriate individual planning of care and/or support in order that alternatives to restraint can be identified in conjunction with the client.
b) The requirements of the Health & Disability Services (Restraint Minimization and Safe Practice) Standards, 2008.
c) Current accepted good practice.
d) Assessment, Risk assessment and management, de-escalation training.
e) Trauma Informed Care
f) Decision making skills required in relation to the use/non-use of restraint.
g) Technical skills related to the safe use of restraint techniques.
h) Demonstration of a wide range of de-escalation skills.
i) Participants demonstrating an ability to function effectively as a member of a team in a potentially threatening situation.
j) Participants demonstrating knowledge in the process of debriefing.
k) Participants demonstrating knowledge regarding the Mental Health (Compulsory Assessment and Treatment) Act 1992 and the legal implications of the management of violent and aggressive clients.

5.4 Individualized records of the education and competency of MH&AS staff in relation to SPEC training will be kept in a central mental health service staff training register.

5.5 All training will be carried out by appropriately trained staff. Appropriately trained staff can be identified as having completed the Mental Health Service Train the Trainer course and have a minimum of at least 3 years practice experience, some of which has been within an acute inpatient mental health facility.

5.6 The SPEC training course will be reviewed and updated on an ongoing basis (minimum 3 yearly).

5.7 In mental health clinical areas restraint use is moderated at a national level with SPEC (safe practice and effective communication). Te Pou o Te Whakaaro nui.

6. Initiating / Ending Restraint

6.1 Restraint shall only be initiated when attempts at de-escalation have been found to be inadequate to prevent the use of restraint or where a the tāngata whai ora / service user's behaviour immediately threatens serious harm to themselves or others.

6.2 The decision to initiate or discontinue restraint will be made when:

a) The environment is appropriate and safe for successful initiation or discontinuation.
b) When adequate resources are assembled to ensure it is safe to do so.
c) When appropriate planning and preparation has occurred.

6.3 Any decision to initiate restraint will be made by the RN allocated to that the tāngata whai ora / service user on that shift (may not always be possible if open ward scenario), in consultation with the Shift Co-ordinator (may not always be possible if IPC scenario). Staff who initiate and participate in restraint procedures must at all times be competent in personal restraint.

6.4 Discontinuation of restraint will occur following on-going assessment and evaluation of outcomes. The decision will be made by the Co-ordinator of the restraint, in consultation with the restraint team and will be a planned process.

6.5 The Responsible Clinician / On-call Doctor will be notified as soon as is practicable of restraint and outcomes.

7. Communication / Support

7.1 Staff must maintain clear, effective and appropriate communication with each other, ensuring they understand what is happening and that the procedure is carried out safely.

7.2 Prior to and throughout restraint staff must maintain clear, effective and appropriate communication with the client, ensuring they understand what is happening and that their communication needs are met.

7.3 Wherever possible and practical the the tāngata whai ora / service user and their whanau / family, as nominated, will be consulted about the use or potential use of restraint.

7.4 Wherever possible the tāngata whai ora / service user may have access to whānau / family providing the safety of the environment, individual and others will not be compromised.

8. Observation and Care

8.1 Physical well-being will be promoted throughout the procedure including ongoing assessment of:

a) Airway
b) Breathing } to avoid positional asphyxia.
c) Circulation
d) Level of Consciousness/vital signs
e) Circulation and range of motion extremities
f) Signs of injury / discomfort

8.2 Once confirmed, ongoing assessment of mental status, level of risk and response to restraint can be carried out.

8.3 All tāngata whai ora / service user's requiring full restraint must be assessed by the duty Psychiatrist as soon as is practicable.

9. Prolonged Restraint

9.1 If the individual requires restraint for a prolonged period of time (over 60 minutes) safe removal to a suitable designated area may be appropriate using an approved technique. This should be attempted as soon as it is safe to do so.

9.2 During the period of restraint the the tāngata whai ora / service user may be offered fluid and nourishment, the opportunity to attend to personal hygiene needs and toileting, suitable clothing, medications, exercise and activity (active or passive) as appropriate.

10. Restraint Use during Transportation / Transfer

10.1 The transportation / transfer of tāngata whai ora / service users requiring to be restrained will only be undertaken in an emergency / crisis.

10.2 The transfer of the tāngata whai ora / service user between in-patient units requires the approval of the person's Responsible Clinician and / or DAMHS.

10.3 For individual's requiring restraint for transportation / transfer.

a) The transfer team will identify a restraint leader.
b) If physical restraint is indicated, physical restraint should be applied in a manner that enables the tāngata whai ora / service user to be seated with dignity, comfortably and without undue distress in the transfer vehicle.
c) A Restraint kit bag including First Aid Kit will be carried by the transfer team
d) The transfer team will carry a means of communication (Mobile phone, Blackberry, 2-way radio etc) during transport / transfer.

10.4 **Please Note:**

a) Procedures regarding the **transfer of consumers between inpatient Psychiatric Units** are detailed in Bay of Plenty District Health Board Clinical Practice Manual protocol CPM.M6.4 Inpatient Psychiatric Unit Transfers: Te Toki Maurere and Te Whare Maiangiangi
b) Procedures regarding the **general requirements for the transportation of consumers** are detailed in Bay of Plenty District Health Board policy 6.4.1 protocol 19 Transportation of Tangata Whaiora / Consumers

11. Defusing

11.1 Appropriate support and defusing will be offered to the tāngata whai ora / service user, their nominated whānau / family as soon as possible after the process as is safe and practical. It is critical that the tāngata whai ora / service user and whānau have an opportunity to express their feelings and to discuss events leading up to and during the restraint. And ideas for how the tāngata whai ora / service user may be de-escalated and restraint avoided in future. Other witnesses, allied staff or other tāngata whai ora / service users should also have an opportunity to express their feelings and to discuss events leading up to and during restraint.

11.2 All staff will be encouraged to defuse after all restraint situations and access to appropriate support will be provided as per BOPDHB policy 3.50.02 protocol 7 Supporting Staff. The personal restraint leader for any given incident will be responsible for facilitating a defusing session for involved staff.

12. Documentation

12.1 The following documentation will be completed after all restraint procedures:

a) An Incident Report (Datix) using the event category: Restraint that meets the criteria specified in NZS 8134: 2021 (standard 6.2.1)
b) Seclusion Incident Recording form (if relevant)
c) A detailed entry in the clinical file
d) Risk Review Updated (if relevant)
e) A thorough update in the clients treatment plan

12.2 Copies of all forms will go to the Team Leader of the staff member(s) undertaking the restraint.

12.3 A summary of personal restraint incidents will be formulated by the MH&AS Quality & Patient Safety Co-ordinator on a monthly basis.

13. Evaluation and Review

13.1 Evaluation shall determine if the intended outcome was achieved or not for each individual tāngata whai ora / service user and consideration shall include the decision to continue or end the restraint.

13.2 Evaluation of restraint shall occur to validate the appropriateness of restraint, ensure safety and identify alternative interventions including the ending of restraint. Wherever possible this shall occur in partnership with the tāngata whai ora / service user, and whomsoever the tāngata whai ora / service user wishes to have present.

13.3 The frequency and content of on-going education in relation to restraint minimization and safe practice shall be determined by the findings / outcomes of the Quality Improvement Group and the CGC.

REFERENCES

- Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992 | Ministry of Health NZ 2020
- NZS 8134.2:2008 Restraint Minimization and Safe Practice Standards
- NZS 8134:2021 Nga paerewa Health and Disbility Service Standards
- Safe Practice & Effective Communication (SPEC) Adult: Participant Manual
- Safe Practice & Effective Communication (SPEC) Adult: Trainers Manual
- Safe Practice & Effective Communication (SPEC) OLDER: Participant Manual

ASSOCIATED DOCUMENTS

- Bay of Plenty District Health Board policy 1.2.4 Restraint Minimisation & Safe Practice
- Bay of Plenty District Health Board policy 1.1.1 Informed Consent
- Bay of Plenty District Health Board policy 5.3.1 P6 OSH Accident Claims & Return to Work
- Bay of Plenty District Health Board Clinical Practice Manual protocol CPM.M6.4 Inpatient Psychiatric Unit Transfers: Te Toki Maurere and Te Whare Maiangiangi
- Bay of Plenty District Health Board Multidisciplinary Admission to Discharge Planner Form (7760)
- Bay of Plenty District Health Board Seclusion Event Form
- Bay of Plenty District Health Board Treatment Plan Acute In-Patient Units
- Bay of Plenty District Health Board Clinical Governance Committee (CGC) Terms of Reference
- Bay of Plenty District Health Board Incident Management Form