

18 December 2017

Health Sector Workers Network  
Email: <mailto:fyi-request-7001-f70d3592@requests.fyi.org.nz>

To Whom It May Concern

**Re: Official Information Act**

I am responding on behalf of Taranaki District Health Board (DHB) to your OIA request of 13 December 2017, requesting the following information:

- *Can you please provide all policy documents relating to restraint practices at Taranaki DHB?*

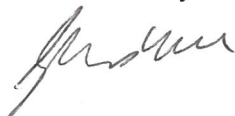
Enclosed please find Taranaki DHB's "Use of Personal Restraint in the Mental Health and Addiction Inpatient Setting Protocol".

- *Are there instances in the last year (June 2016 to June 2017) of the use of mechanical restraints? (i.e. strapping arms to bed) this is also referred to as physical restraint.*
- *Can you please provide this data for both physical and mental health services and identify the service associated with this data?*
- *This data should be recorded in a Restraint Register and specify the type of restraint used (ie wrist strap) and the start and finish times of each individual mechanical/physical restraint. Obviously the presentation of this data should be anonymised for the protection of privacy.*

Please see *Appendix 1*.

I trust the above information answers your OIA request.

Yours sincerely



**Gillian Campbell**  
Chief Operating Officer

Enc.



**Appendix 1****Physical Health**

<b>Datix Incident number</b>	<b>Date</b>	<b>Area</b>	<b>Type of restraint</b>	<b>Reason</b>	<b>Date &amp; Time initiated</b>	<b>Date &amp; Time terminated</b>
9725	18/07/2016	Ward 2A (Older Peoples Health and Rehabilitation Ward)	Mittens	Pt Removing NG tube	18/07/2016 1135	21/07/2016
22098	23/03/2017	Emergency Department	Handcuffs and Lap belt (Restrained by police)	Aggression, agitation after using methamphetamine and other recreational drugs. Safety of patient and staff at risk.	23/03/2017 0745	23/03/2017 0945

**Mental Health**

There were no mechanical restraint incidents in Mental Health between the dates of June 2016 and June 2017.



# Use of Personal Restraint in the Mental Health and Addiction Inpatient Setting: Protocol

## Potentially Significant Risk Procedure

### Purpose

The Mental Health and Addiction Service supports the reduction in the use of restraint in all its forms and encourages the use of least restrictive practices. Restraint minimisation and safe practice is underpinned by 'Recovery' orientated service delivery.

This protocol specifies the clinical practice requirements for the correct and safe use of personal restraint as an intervention used by staff for service users/tangata whaiora.

The protocol also ensures compliance with the Restraint Minimisation and Safe Practice Standards, NZS 8134.2:2008 and Taranaki District Health Board (DHB) Restraint Policy.

### Definitions

#### *Restraint:*

The use of any intervention by a service provider that limits a consumer's normal freedom of movement (NZS 8134.0:2008, Health and Disability Services (General) Standards, p.30).

#### *Personal restraint:*

Where a service provider uses their own body to intentionally limit the movement of a consumer. For example, where a consumer is held by a service provider (NZS 8134.0: 2008, Health and Disability Services (General) Standards, p. 30).

Service users/ tangata whaiora can only be subject to the use of personal restraint when there is an assessed risk to the safety of the service user, to other service users, service providers or others.

*SPEC – Safe Practice and Effective Communication* previously known as de-escalation and calming and restraint.

### Competency required

The use of personal restraint shall only be applied under the direction of a registered nurse.

All persons applying personal restraint MUST have completed Safe Practice and Effective Communication (SPEC) training and this is recorded on individual staff record and SPEC training register.

### Resources

A restraint team who are trained in Safe Practice and Effective Communication ( SPEC) ; and undertake annual SPEC update training. It is preferable that a 4 person team is available, however the minimum is 3, one of whom must be a Registered nurse.

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Te Puna Waioira is to have a minimum of 6 Safe Practice and Effective Communication (SPEC) restraint capable staff, 2 of which must be Registered Nurses for both morning and afternoon shifts and 5 restraint capable staff, 2 of which must be Registered Nurses on Night shift. This is a rostering minimum to maintain the safety of Service Users/Tangata Whaiora, visitors and staff within the TPW environment

## **Procedure**

### **Pre-Restraint**

#### ***Rationale***

Personal restraint is a serious intervention that requires clinical rationale and oversight. It should not be taken lightly, should be considered as one of a range of possible interventions in the care setting and always in the context of the requirements of the Standard and current good practice.

Services shall ensure thorough assessment of service users is undertaken, where indicated, in relation to the use of restraint.

Any use of personal restraint must be based on the Taranaki DHB Restraint Policy and current accepted best practise.

#### ***Action***

Collaborative assessment should help identify key factors which contribute to the possibility that restraint might be considered. The service provider must consider the following factors that may influence the decision to use restraint or not:

1. The degree of risk to the individual and others
2. others, and the environment and any underlying causes of the risk behaviour.
3. Any signs and symptoms that may indicate a risk related behaviour or condition is present.
4. The service user's physical and psychological health including adverse health effects that may result due to the restraint.
5. The past history of restraint and evaluation of episodes; any history of trauma or abuse which may have involved the service user being held against their will.
6. The service user's age, gender and culture.
7. Does the service user's multidisciplinary team treatment plan that includes triggers that may increase the likelihood of risk related behaviour and how to manage or avoid risk related behaviour and strategies to manage or avoid behaviours..
8. Possible alternative interventions/strategies and those that have worked in the past.
9. The use of advance directives and recovery action plans.
10. In assessing the use of restraint the service user and/ or family/whanau are informed and their input sought when practical.
11. The experience of the individual and possible compromise to the future therapeutic relationship.
12. Legal and ethical considerations for the use of restraint.

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## Indications for the Use of Personal Restraint

- Personal restraint should be applied only to enhance or maintain the safety of service users/tangata whaiora, service providers or others. (There must be an assessed safety risk).
- When there is legal support to carry out prescribed treatment against the service user's will.

## The Decision to Initiate Personal Restraint

### *Rationale*

Approved personal restraint is only applied as a last resort with the least amount of force, after alternative interventions have been considered or attempted and determined ineffective.

Service providers recognise and facilitate the right of service user's to advocacy/support persons of their choice.

Service provider training, competency and adequate staffing levels are critical both in the appropriate and safe use of restraint, and minimising the use of restraint.

Psychiatric assistants work under the direct supervision of a registered nurse.

### *Actions*

- The decision to initiate personal restraint is made by an experienced registered nurse that has current competency in Safe Practice and Effective Communication (SPEC).
- Restraint is initiated only when adequate resources are assembled to ensure safe initiation and use.
- Family/whanau and or consumer adviser may be consulted to advocate for consumer as appropriate.
- Except in an emergency, the decision to use personal restraint is only made after consideration of the factors noted above in pre-restraint episode.

## Implementation of Personal Restraint

### *Rationale*

Service users receive services of an appropriate standard, performed in a safe and timely manner.

The use of personal restraint is conducted in the safest, least restrictive and most appropriate manner, by trained staff.

### *Action*

- Only staff with current competency in SPEC will be involved in the restraint process.
- Only approved SPEC techniques will be utilised during restraint.
- A restraint team consists of preferably four trained staff however the minimum of three trained staff must be present at the time of implementation except under exceptional circumstances where serious harm is imminent.
- At least one registered nurse must be present throughout the restraint.

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- Dignity, privacy, self-respect and safety for the service user are paramount throughout restraint. Interventions must be delivered in a manner that respects and acknowledges the individual cultural values and beliefs.
- Any removal of objects / items of cultural significance will be respectfully undertaken and involve consultation with the family/whanau and or significant others as possible.
- At least one person of the same gender as the service user must be present throughout the restraint wherever possible.
- The service user's physical and psychological well being is monitored throughout the restraint process.
- Use of personal restraint is continually monitored and regularly reviewed to ensure it is applied appropriately and, for the minimum amount of time necessary, bearing in mind the clinical indicators and safety of all involved.

#### **Role of non-TPW staff in personal restraint situations**

- Acute Intervention Staff (AIS) or other hospital staff providing assistance will in the first instance cover the Open and Quiet Areas in TPW to enable TPW restraint capable staff to participate in restraint situations.
- Should it be necessary for non TPW staff to be used in a restraint situation these staff are to undertake supportive roles. TPW staff will be used to compose the main restraint team responsible for the head and arms. The Registered Nurse caring for the Service User/Tangata Whaiora is to plan and lead the intervention at all times with assistance from the TPW ACNM or Shift Coordinator (unless the RN is not restraint capable, the assigned nurse is an Enrolled Nurse or the service user is targeting that particular staff member).

### **Communication**

#### ***Rationale***

Service providers communicate effectively with service users/tangata whaiora and provide an environment conducive to effective communication.

Service users are able to maintain links with their family/whanau and their community.

The right of service users to make a complaint is understood, respected and upheld.

#### ***Action***

- Service users are informed of the reasons why they are being placed in personal restraint and what needs to occur for the personal restraint to end.
- Effective communication with the service user is ongoing throughout the restraint process, including what is required of the service user to enable restraint to be discontinued.
- Service users (and where appropriate their family/whanau) must be informed of their rights and encouraged to make informed choices.

### **Ending personal restraint**

#### ***Rationale***

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Services will ensure thorough assessment and care of service users is undertaken in relation to the use of personal restraint.

Ending personal restraint is to be undertaken as soon as possible, with due consideration of the clinical indicators and safety for all.

Service users/tangata whaiora rights and access to support and advocacy is adhered to.

Appropriate standards of care are provided.

**Action**

- The decision to end personal restraint is made by the registered nurse leading the restraint in consultation with members of the restraint team, service user and any others involved.
- This will occur when there is no longer any clinical justification to continue using personal restraint or when the risks to the service user or others outweigh the benefit of its use.
- Following ending of personal restraint, the service user is to be reintegrated into the appropriate environment and given the opportunity and access to support/advocacy, to discuss the events if desired and appropriate.

**Follow-up procedures to investigate any physical harm or treatments required by the service user and / or staff are conducted on a case by case basis and recorded on an Incident/ Accident/ Near Miss Notification Form.**

**Documentation**

Documentation is completed in a clear, concise and timely manner and adheres to relevant policy and sector standards.

**Action**

The registered nurse is responsible for the documentation of the personal restraint episode. This should include input from the restraint team members and others present.

Documentation of each personal restraint episode will include:

- Details of reasons for initiating personal restraint including the desired outcome.
- Any identified triggers and the strategies to minimise / eliminate them are included in the service user’s multidisciplinary team treatment plan.
- Details of the alternative interventions including de-escalation techniques attempted prior to the use of personal restraint.
- Details of advocacy / support offered and provided.
- The outcome of the personal restraint episode.
- Observations and monitoring of the service user/tangata Whaiora during the personal restraint episode.
- The personnel involved in the restraint and their role. Brief description of holds used.
- Any comments resulting from the evaluation of restraint.

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- Any injury to any person as a result of the use of personal restraint.
- Completion of TDHB electronic restraint record
- Completion of an Adverse event form; and staff injury form if required.

*NB: Documentation may be in various forms; clinical notes, electronic record, incident report forms.*

## Evaluation

Services evaluate all episodes of personal restraint with a view to reducing use of personal restraint. Any new learning will support service improvement including changes in staff training and or procedures.

Each episode of personal restraint is evaluated by the personal restraint team any other staff involved via the electronic record.

The following areas will be evaluated;

- Whether the personal restraint episode was the least restrictive option to achieve the desired outcome.
- The duration of the personal restraint episode and whether this was for the least amount of time required.
- The impact the personal restraint had on the service user.
- Whether the appropriate advocacy/support was provided or facilitated.
- Whether the observations and monitoring were adequate and maintained the safety of the service user
- Whether the service user's multidisciplinary treatment plan was followed.
- Any review or modification required to the service user's multidisciplinary treatment plan.
- Whether the desired outcome was achieved.
- Future options to avoid the use of personal restraint.
- Following each episode of personal restraint the service user, and where appropriate their family/whanau, receives support to discuss their views on the personal restraint episode. This may be done in conjunction / facilitated by the Consumer Advisor.
- Monitoring of personal restraint is recorded as per appropriate procedure, and associated forms as approved by the Taranaki DHB Restraint Minimisation Committee.
- Whether the services policies and procedures were followed.
- Any suggested changes or additions required to SPEC training for service providers.

## Education

Services use personal restraint safely.

All staff will have access to education and ongoing training on use of personal restraint, including relevant legislation and regulation governing the use of personal restraint.

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- All staff will have knowledge of “The Code of Health and Disability Service’s Consumers Rights 1996”. This includes being able to assist service users to access the information.
- All staff have knowledge of human rights, scopes of practice, relevant legislation and relevant Taranaki DHB policies and procedures.
- All staff have knowledge of Tikanga Best Practice Guidelines and cultural considerations regarding use of personal restraint.
- All inpatient nursing staff, psychiatric assistants and crisis team will receive full SPEC training and annual updates.
- A register of all SPEC trained staff is kept by the Inpatient Clinical Nurse Manager.
- Staff education records are maintained by the organisation.

**Evidence**

- Use of personal restraint is audited at 6 monthly intervals to monitor compliance with Taranaki DHB Restraint Policy.
- Monitoring of restraint is completed monthly via the Inpatient Service Quality-risk group.

**References**

- Health and Disability Services (Restraint Minimisation and Safe Practice) Standards – Restraint Minimisation NZS 8134.2:2008

**Hazard ID and Control for Staff**

Hazard		Rating Significance	Action to be taken by Staff to Control Hazard		Review Date	Last Review Date of Action
Type of Hazard and/or harm	Where or what task involves the hazard	Significant hazard- Yes or No	Does the action eliminate, isolate or minimise the risk of the hazard?	Action to be taken	How often action is monitored?	
<i>Aggressive or non-co-operative client</i>	<i>Potential risk to performing client care</i>	<i>Yes</i>	<i>Minimise</i>	<i>Use of appropriately trained restraint team</i>	<i>6 monthly audit and episodic review</i>	<i>Dec 2009</i>

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