PROCEDURAL GUIDELINES FOR PHYSICAL RESTRAINT

MENTAL HEALTH POLICY SECTION
DEPARTMENT OF HEALTH

June 1993

Department of Health
TE TARI ORA

These procedural guidelines for the use of restraint have been developed by the Mental Health Policy Section of the Department of Health following widespread consultation. They have been developed to provide a national model for a safe, effective and appropriate use of physical restraint.

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FOREWORD

These guidelines for Physical Restraints have been facilitated by the Department of Health, and developed by the Physical Restraints Working Party.

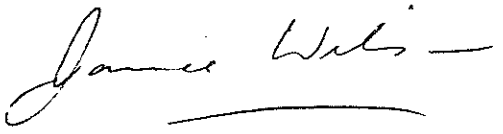
The Working Party undertook wide consultation and received a large number of useful submissions to the draft document. Amendments were made in the light of feedback received.

The guidelines are seen as the beginning of an on-going process of development, monitoring and maintenance of good standards of practice for the use of physical restraints.

The use of physical restraints should be recorded under the guidelines for Incident Reporting; guidelines for this are also available and a reporting format is included in the Incidents Guidelines.

I would like to thank the members of the Working Group for the development of these guidelines.

Any feedback on the use of these guidelines would be appreciated and should be sent to Bridget Taumoepeau, Deputy Director Mental Health, Department of Health Wellington.



Janice Wilson
Director Mental Health

WORKING GROUP MEMBERS

The following people were on the working party to address issues associated with the practice and management of physical restraints and to prepare the guidelines.

Keith Roffe, Manager, Forensic Psychiatric Services, Lake Alice Hospital, Manawatu-Wanganui Area Health Board; (Chair)

Ray Watson, Manager Service Development, Mental Health Services Otago Area Health Board;

Pauline Hinds, Chairperson ANOPS (Consumer Representative and Consumer Advocate Otago

Colleen Ellison-Toomer, Unit Manager, Purehurehu, Forensic Services, Porirua Hospital, Wellington;

Bruce Talbot, Unit Manager, Totara Unit, Mason Clinic, Regional Forensic Services, Auckland;

Bridget Taumoepeau, Psychiatrist, Department of Health

Mary Ann van Helden Stevens and Jan Emson, Project Officers, Department of Health

Numerous comments were submitted to the working group from consumer, service provision and educational groups (see Appendix 1).

CONTENTS

PROCEDURAL GUIDE-LINES FOR PHYSICAL RESTRAINT

1. BACKGROUND

This document is written with the understanding that physical restraint should be used only after techniques for calming the individual have been attempted (including diversion, changing the environment, providing structure through an activity, directing the patient, utilising specific resources for support of the patient [advocacy, family, cultural], time out in a quiet area).

2. SCOPE

The brief of this working group was to provide guide-lines for Mental Health Services for the appropriate application of personal restraint including the technique itself.

Although the guide-lines have been designed specifically for Mental Health Services, they may be useful for other health agencies.

3. DEFINITIONS

Physical Restraint is an approved, skilled intervention by staff to prevent individuals from harming themselves, endangering others or seriously compromising the therapeutic environment. It includes personal restraint and mechanical restraint.

Personal Restraint A hands on method of physical restraint involving one or preferably more designated health professionals. Its purpose is to safely immobilise the individual concerned.

Mechanical Restraint A method of physical restraint involving the use of authorised equipment applied in an approved manner by designated health professionals. Its purpose is to safely immobilise or restrict movement of part/s of the body of the individual concerned.

4. GUIDING PRINCIPLES

The practice of physical restraint should always incorporate:

- Safe practice.
- Use of an approved technique or equipment by suitably trained designated health professional(s).
- A system of review.
- Active and on-going empowerment of the individual of concern in decisions related to their care.

- Individual cultural appropriateness
- Consideration of any special need, (including gender or age), that the individual may have.
- Maintaining respect for a person's dignity, by minimising the intrusion on a individual's privacy and/or threats to their self respect.
- Thoughtful and considerate treatment of the person as an individual.
- Consideration of the legal rights and responsibilities of both patients and staff, including advocacy.

It is the responsibility of each service to have policy guide-lines on providing culturally responsive services. Cultural issues should always be addressed. Relevant advisers should be consulted. Physical Restraint is no exception.

5. APPROVAL OF A PHYSICAL RESTRAINT TECHNIQUE

Each service must approve defined techniques and equipment and any changes made to the aforesaid. A personal restraint technique or item of mechanical restraint equipment would be considered approved after gaining endorsement from a committee encompassing the following perspectives:

- consumer
- physiotherapy
- nursing
- medical
- psychiatric
- cultural
- legal

An approved technique would not include methods which deliberately compromise dignity of the individual or safety of the head (neck, airway, mouth, nose), genitalia, breasts, abdominal areas, lower back or circulation.

6. INDICATIONS FOR PHYSICAL RESTRAINT

Physical Restraint is a serious intervention which requires clinical rationale. It must not be undertaken lightly and should be considered as one of a range of possible interventions in the clinical setting.

The following are situations where Physical Restraint may be appropriate:

Personal Restraint

- When an individual's behaviour indicates that s/he is a danger to self or others.
- When an individual makes a serious attempt or act of self harm.
- When an individual makes a sustained or serious attack on another person
- When an individual seriously compromises the therapeutic environment.
- When it is necessary to give a planned prescribed ***essential*** treatment to an individual who is resisting, and is being treated compulsorily.

Mechanical Restraint

- When an individual exhibits serious and on-going self-mutilatory behaviour

The following legislation relates to compulsory and emergency treatment:

Criminal Justice Act 1985, sections: 115(1)a; 115 (1)b; 121(2) (b) 2; 120; 115 (2); 118; 116; 117;

Mental Health (Compulsory Assessment & Treatment) Act 1992, sections 11, 13, 30, 45, 55, 62;

Crimes Act 1979, sections 41, 48, 62.

7. SITUATIONS OF EXTREME CAUTION

Physical Restraint should be used with extreme caution in the following circumstances:

- When the use of Physical Restraint would threaten to compromise the physical well-being of the individual or others. Consideration must be given to the comparative risks of using physical restraint or <u>not</u>.
- When the individual is in possession of a weapon. Consideration must be given to the intent and capability of the individual to use the weapon.

8. MANAGEMENT PLAN

On admission patients **identified/assessed as having "indications for physical restraint"** (sec 6 above Indications for Physical Restraint)) should have a management plan developed which will include the possibility of physical restraint. Management plans must be developed with the patient, and discussed with the family, whanau and patient advocates. The management plan should be developed in consultation with a multidisciplinary team. During the process of admission all such identified patients should be made aware that restraint procedures may be used and under what circumstances this could occur.

9. DECISION TO INITIATE PHYSICAL RESTRAINT

The following points must be considered in initiating physical restraint

- Degree of urgency and danger.
- Patient's management/ care plan
- Possible alternative interventions (psychological, intensive nursing) (refer to flow chart, appendix A)
- Indications for physical restraint
- Factors suggesting extreme caution
- Desired outcome and criteria for ending restraint.

A decision to initiate Personal Restraint should be made by the most appropriate designated health professional (i.e. an approved person trained in the skilled application of the restraint technique).

A decision to initiate Mechanical Restraint should be made by the patient's responsible clinician in consultation with the multidisciplinary team.

10. AN APPROVED PHYSICAL RESTRAINT TECHNIQUE

Personal Restraint

A specific method or technique should be adopted. The numbers of staff involved in Physical Restraint should not be so many as to make the process chaotic but enough to make it safe for all involved. An approved method which has been examined and endorsed by the "Approval Committee" (sec 5 above Approval of a Restraint Technique) would include the following:

1 One designated staff member enters into dialogue with the individual while the other staff members assume part of the restraint team positions appropriate to the initiation of the restraint technique.

2. The restraint team would assume a stance which allows them to move swiftly and directly toward the individual should s/he become assaultative.

3. Should the staff member talking to the individual decide that restraint be initiated, s/he will give a verbal or physical signal to that effect.

4. When the signal is given the restraint team will initiate the approved restraint technique.

5. Restraint will be effected by immobilising the upper and/or lower limbs of the individual. Staff members should always endeavour to minimise the pain or discomfort associated with resisted personal restraint. It should never be the deliberate aim of staff members to inflict pain.

6. One team member should be assigned the responsibility for the safety (including cultural safety) of the individual's head.

7. Should restraint prove difficult to effect, the patient may be put to the floor in as controlled a way as circumstances allow. The restraint could be applied with the individual lying on her/his back or abdomen, but ideally the individual should be placed in the prone position with their head to one side.

8. When the individual is restrained, checks must be made to ensure that they have a clear airway and that no direct pressure is applied to the head, neck, face, airway, genitalia, breasts, chest, lower back , abdomen or major blood vessels.

9. Throughout the procedure one identified team member would continue to communicate with the individual. All communication should be direct, uncomplicated and clear.

Mechanical Restraint
Mechanical restraint should be applied as instructed by the multidisciplinary team.

11. OBSERVATION AND CARE DURING PHYSICAL RESTRAINT

Any patient undergoing personal or mechanical restraint requires intensive and continuous observation.

Personal Restraint

(A) Physical Care

When the individual is immobilised the following must be assessed:

1. Patent airway, pulse, skin colour (i.e. for presence of cyanosis)
2. Bleeding

3. Other physical injuries or discomfort
4. Appropriate neurological observations

and appropriate action taken before considering movement of the patient.

(B) Psychological Care

When physical well-being is confirmed the following must be assessed:

1. General mental state, including general assessment of alertness.
2. Response to Physical Restraint event

(C) Communication

Ensure that the following communications are made during the use of physical restraint:

Communication with the restrained individual:

One team member should be responsible for communicating with the individual.

Explain to the individual what is happening throughout the procedure.

Explain what has happened, why it has happened and the range of options for the individual. The option chosen should be explicitly communicated and repeated if necessary.

Communication with Physical Restraint team members:

Check the well-being of members.

Check with each member that their holds are applied safely.

Communication with other staff and significant individuals: (e.g. patients, staff, visitors directly affected)

Advise them of the chosen course of action and how they might assist.

Mechanical Restraint

(A) Physical Care

1. Extremities of limbs mechanically restrained must be regularly assessed for signs of restricted blood flow (ask the individual about their comfort).

2. Pressure area assessment and care should be taken with those body areas most at risk, (e.g. sacrum, heels, elbows)

3. Great care must be taken when mechanical restraints are used to restrict the torso; such restraints should pass across the ischial tuberosities and not be allowed to move up to the abdomen and chest.

4. Mechanically restrained limbs must be exercised at frequent intervals.

5. Special attention must be paid to providing opportunities for the patient to take food and drink and to void bladder and bowels.

(B) Psychological Care

1. Mental status must be assessed at frequent intervals.

2. The response to the mechanical restraint event must be assessed at frequent intervals.

(C) Communication

As for Personal Restraint above.

12. PROLONGED RESTRAINT

Personal Restraint

Prolonged physical restraint may be considered as an alternative to other interventions e.g., seclusion and time out or heavily sedating drugs. Its form is more "holding" than restraint and enables a therapeutic dialogue to be maintained in safe circumstances for those involved.

If personal restraint needs to be maintained over a prolonged period of time (longer than sixty minutes), safe removal to a suitable designated area using an approved technique may be required. Consideration must be given to involving family, whanau or advocates in the management of the patient.

In addition to following guide-lines for Observation and Care outlined in the previous section, the following should be completed:

- Range of motion should be carried out on restrained limbs to prevent cramp or loss of circulation.
- Check for muscle or ligament damage.
- Complete physical examination within each 24 hour period
- Rotate designated staff to alleviate fatigue.

Mechanical Restraint

As per personal restraint with one addition:

- Skin care to restrained limbs.

13. ENDING RESTRAINT

This must be done in a planned, controlled manner.

Personal Restraint

- Reduction in physical resistance and content of discussion with the individual of concern by the restraint team leader will indicate whether the individual is regaining control.
- Clear limits should be set regarding expected behaviour once the restraint is withdrawn.
- Holds are loosened then released.
- Staff involved move out of individual's personal space though remain ready to instigate restraint again if needed.
- Restraint team leader would remain with the individual for a time to provide support and reinforce positive behaviour.
- Reassure other observers and inform them that the situation has been resolved.

Mechanical Restraint

- Decision to end mechanical restraint must be justified subsequently to the patient's multidisciplinary team.
- Prior to the removal of mechanical restraint a management/care plan must be developed which details procedures (which may include repeat use of mechanical restraint should they again exhibit the behaviour previously requiring mechanical restraint.)

14. EVALUATION OF USE OF RESTRAINT

As with any clinical intervention, restraint must be evaluated for its efficacy following each event. This should include a review and analysis of procedures.

The interval between the physical restraint event and the evaluation will vary depending on circumstances and local policy.

The clinical review of the reasons for the physical restraint and its outcome should be done in partnership with the patient and whoever the patient requests to have present.

It may also be necessary to discuss the event with others in the treatment setting.

The review should include:

- How physical restraint was applied.
- Did it achieve its objectives, both short and long term.
- The outcome of the restraint from the patient's perspective (and initiate further investigation if requested by the patient).
- The outcome from a staff support and staff debriefing perspective.
- Any injury to any party arising as a possible result of the application of the restraint technique. This would be a matter referred to the physical restraint technique committee.
- The appropriateness of the intervention in this case, considering carefully other treatment options which would obviate the use of restraint.

On the basis of this, the review would recommend strategies/suggestions for improving the practise of physical restraint.

15. REPORTING AND RECORDING REQUIREMENTS

All Physical Restraint events must be reported and recorded. The format used should be in line with the guide-lines for reporting Incidents.

The reporting and recording of physical restraint should be routine clinical practice.

Every situation where physical restraint occurs must be recorded on an incident report and that report must be initiated immediately following the incident when restraint was used. Appropriate, accurate, recording of the restraint event should include:

1. the situation and time it occurred.
2. the means of intervention including the type of personal restraint or mechanical restraint techniques used.
3. if the restraint used was other than that approved, then the restraint method used should be described, and reasons given.
4. the staff/patient/others involved by name.

For an acceptable level of accuracy to be achieved, approved restraint methods must be accurately described, a minimum taught, and where possible diagrammatic explanations given in a physical restraint manual.

It may be useful, within a reporting system, to identify separately those forms which refer to physical restraint. Possibly a sticky label or different colour form could be considered, but the process and format should be an integral part of the special/critical incident reporting system.

Because of the serious nature of the incident (physical restraint) some overview of the process and practise should be assumed by the management, through the group or committee that is involved in designing, teaching and approving the restraint methods.

The group or committee which approves both restraint techniques and the teachers of the restraint techniques must also be responsible for examining practise and should provide, where possible, advice to management and clinical staff on the appropriateness of the application of the techniques in a reported incident.

The report required from this group or committee will be prompted by:

1. a restraint situation which resulted in some injury.
2. a request from the patient who was restrained.
3. a request from any clinician involved in checking the incident reports.
4. a request from management.
5. a request from a District Inspector or Official Visitor.

The following process described in flow chart form is suggested for use in the inpatient setting.

16. REPORTING/RECORDING PHYSICAL RESTRAINT

Physical restraint, both personal and mechanical, is included in the list of incidents that need to be reported using the incident process. The current system used in each unit must be completed whenever an incident of restraint occurs. Incident reporting guide-lines will be issued shortly. When they are available, the reporting of restraint should be in line with these guide-lines.

- Any complaint from the individual restrained regarding any aspect of the restraint procedure should also be dealt with through the routine complaints procedure.

- Standard clinical practise must include the routine placement of the completed incident report on the patients clinical file.

17. TRAINING

Training packages/programmes and refreshers should endeavour to place physical restraint within the context of the whole of an individual's contact with the Mental Health Service.

Each Mental Health service must designate members of staff who are trained to apply approved physical restraint techniques.

Training in physical restraint techniques must standards set out in this document together with those demanded by the respective "Approval Committees".

A register of "approved trainers" and successful trainees must be kept.

Refresher courses should be attended by designated members of staff at no greater than annual intervals.

Staff training is seen as critical both to the appropriate and safe use of physical restraint but also to minimising the use of physical restraint.

APPENDIX 1

HOW

YOU AND YOUR SKILLS

Understanding through self assessment/awareness. TALK AND LISTEN: Commonsense, decency, manners. Recognition of individual dignity and personal space. Group and individual counselling. Nursing Observations.

SIGNS

Increase in motor agitation. Voice pitch, volume, pace and content related to thoughts. Tense abrupt replies often with gesture. Muscle tension, fists clenched, sudden cessation of activity/inappropriate affectation/expanding body space

SYMPTOMS

Query physical cause, eg organic brain syndrome, post-epileptic confusion, diabetic coma, drunkenness, drug abuse, hysterical behaviour, general fear, phobia, history of violence.

ENVIRONMENT

Relaxed and friendly. Activities to reduce boredom. Noise level acceptable. Unit secure and routines clearly stated.

IF SUCH SIGNS ARE APPARENT

Attention to these points will normally prevent violent situations developing. However, despite your efforts, the risk of violence can remain.

WHAT DO YOU DO?

Call for Assistance

Is assistance immediately available?

NO

Do not attempt to restrain alone - risk to you and client

Avoid physical contact until help arrives

Has help arrived?

NO

YES

YES

Approach calmly

Is client responsive

NO

YES

Discuss the situation. Offer assurance and don't react to verbal abuse. Call in appropriate authority if necessary - supervisor, doctor, administrator - to attempt to resolve problem.

Is client satisfied with assistance offered

NO

YES

Continue to offer to discuss situation

Situation resolved

Remove discreetly, any potential weapons

Place substantial object between yourself and client

Withdraw from situation if necessary - still try to maintain observation

Decide an appropriate strategy

YOU LET IT HAPPEN

?

YOU RESTRAIN THE CLIENT

Property less important than people but some limit to amount of damage caused has to be set before it becomes a danger. Staff must go to assistance of another client or staff member who is being attacked. Staff should avoid grappling with client if the idea is to minimise damage

HOW

Use the approved form of restraint for your unit.

Has this strategy worked

NO

YES

Incident now resolved. Client transferred to quiet, less stimulating environment. Senior nursing and medical staff informed.

Special Adverse Incident report and review completed.

APPENDIX 2
SUBMISSIONS RECEIVED

- District Inspectors:
  - David Bates, Hamilton
  - Sandy Barry, Auckland
  - P. J. R. Comber, Levin
  - Rob Newberry, Wellington
  - Roy Peach, Napier
  - Richard Rainey, Nelson

- Northland Area Health Board
  - Mike Carpenter and nursing staff

- Waiora Waikato, Waikato Area Health Board
  - John Graham, Operations Manager

- Tairawhiti Area Health Board
  - Dr M Kingston

- Hawkes Bay Area Health Board
  - David McDougall, Psychiatric Unit Manager

- Manawatu Wanganui Area Health Board
  - Rosemary Nonu-Reid, Charge Nurse
    National Secure Unit, Lake Alice Hospital
  - Patrick Leung, Staff Nurse/Forensic Nurse Specialist
    National Secure Unit, Lake Alice Hospital
  - Seelall Singh,Staff Nurse/Forensic Nurse Specialist
    National Secure Unit, Lake Alice Hospital
  - Keith Roffe, Manager Forensic Services

- Wellington Area Health Board
  - John Holloway, Domiciliary Nurse, Community Mental Health Services
  - Mark Gingell, Clinical Nurse Specialist, Porirua Hospital
  - Andrew Curtis-Cody, Unit Manager, Lomond/Craig, Porirua Hospital
  - Joanna MacDonald, Clinical Director, Hutt Adult Mental Health

- Nelson Marlborough Area Health Board
  - Heather Verstraeten, Nurse Advisor

- Otago Area Health Board

- Aotearoa Network of Psychiatric Survivors

- Mike Sulkowski, Mental Health Consumers Union, Wellington

- GROW
  - Valerie Glasgow

- Patient's Rights Advocacy
  - Mrs J. H. Sketchley

- Manic Depressive Society
  - Gillian Creighton
- Centre 401
  - Margaret Deuchar
- Polytechnics
  - Brian Pickering and Alex Smyth, Waiariki Polytechnic
  - Jenny Gordon, Southland Polytechnic, Invercargill.