Waitematā
District Health Board
Best Care for Everyone

Specialist Mental Health and Addiction Services
Level 3, 44 Taharoto Road
Private Bag 93-503, Takapuna
Auckland 0622
Telephone: (09) 487-1500
Freephone: 0800 80 9342
Facsimile: (09) 487-1333
Visit: www.waitematadhb.govt.nz

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[redacted]

Dear [redacted]

Re: Official Information Act request – use of physical/mechanical restraints by mental health services

Thank you for your Official Information Act request received by Waitematā District Health Board (DHB) on 6 May 2019, requesting information about the use of physical/mechanical restraints within our mental health services. You indicated that you were seeking information about how the use of restraints in New Zealand mental health facilities has changed since their minimisation became a priority in 2009, to compare to their usage in Japan.

Before responding to your specific questions, it may be useful to provide some context about our services to assist your understanding. Waitematā DHB serves a population of 630,000. The Specialist Mental Health and Addiction Services is the largest service of this kind in the country, by volume of service-users seen. The speciality comprises Adult Mental Health Services, Child Youth and Family Mental Health Services, Takanga a Fohe (Pacific mental health and addictions), Whitiki Maurea (Kāupapa Māori mental health and addictions), the Regional Forensic Psychiatry Service (covering Northland and greater Auckland regions) and Community Alcohol and Drug Services (CADS). All of our addictions services cover the Auckland region. Mental Health Services for Older Adults sits within Waitematā DHB's Speciality Medicine and Health of Older People Division.

Can you please provide data about the use of physical/mechanical restraints in your District Health Board for mental health services and identify the service associated with this data?

By physical/mechanical restraints I mean using appliances such as straps, ties or handcuffs to immobilise patients.

In particular, can you provide minutes of meetings or other documents from 2008 through 2018 that provide trends of the use of physical/mechanical restraints, produced by or for your committee that has the duty of overseeing restraint use?

In addition, can you provide information during the calendar year 2008 and during the calendar year 2018 on the use of physical/mechanical restraints in the mental health services of your DHB? This data should be kept in a Restraint Register or in a computer database. This data for 2008 and 2018 should specify the type of restraint used (e.g., wrist strap, bed straps) and the length of time between

start and finish of each individual mechanical/physical restraint. Obviously the presentation of this data should be anonymised for the protection of privacy.

In response, I can advise that mechanical restraint is rarely used and only when there are no other options for protecting the safety of the person or others. Waitematā DHB does not use mechanical restraints in Older Adult or Adult Mental Health inpatient units. As there is limited use of mechanical restraint in the Regional Forensic Psychiatry Services, it is not possible to provide trend information, so we have provided the data that is presented to Waitematā DHB's Behaviours of Concern Committee below. The structure of committees in relation to restraint and the guidelines for mechanical restraint can be found in our Restraint Minimisation Policy (May 2018) (See Appendix).

Mechanical restraint is always terminated as soon as it is safe for the service-user and the staff to do so. In most cases, mechanical restraint is only maintained for brief periods. The table below shows a lengthy restraint in 2018. It has been identified that, in this case, the service-user was not able to be safely managed in any other way.

Table: Forensic Services – Mechanical Restraints Duration and Equipment Type 2008-2018

Calendar Year	Restraint Duration (minutes)	Equipment Type
2008	0	
2009	100	lockable leather belt
	5	lockable leather belt
2010	10	lockable leather belt
	5	velcro wrist cuffs
2011	10	lockable leather belt
	30	lockable leather belt
	145	lockable leather belt
	25	lockable leather belt
	50	lockable leather belt
2012	25	lockable leather belt
2013	20	lockable leather belt
	15	lockable leather belt
2014	0	
2015	0	
2016	35	lockable leather belt
	60	lockable leather belt
	25	lockable leather belt
	45	lockable leather belt
2017	0	
2018	10	lockable leather belt
	80	lockable leather belt
	60	velcro ankle cuffs
	5	lockable leather belt
	15	lockable leather belt
	390	lockable leather belt

I trust this information will satisfy your request. Waitematā DHB, like other agencies across the state sector, supports the open disclosure of information to assist the public's understanding of how we are delivering publicly-funded healthcare.

This includes the proactive publication of anonymised Official Information Act responses on our website from 10 working days after they have been released.

If you feel that there are good reasons why your response should not be made publicly available, we will be happy to consider this.

Yours sincerely

Dr Susanna Galea-Singer
Director
Specialist Mental Health & Addictions Services

Restraint Minimisation – Adult and Auckland Regional Forensic Mental Health Services

Contents

1. Overview

Purpose

This document outlines the approach to restraint minimisation and safe practice in Adult and Forensic Mental Health Services Inpatient Units.
This Policy should be read in conjunction with the Health and Disability Services (Restraint Minimisation and Safe Practice) Standards. (NZS 8134.2:2008).

Scope

Applies to Specialist Mental Health and Addiction Adult and Forensic Inpatient Units

1.1 Definitions

Advance Directive	An advance directive is the giving or refusing of consent to treatment in the future. It is a statement to others, usually in writing, setting out your treatment preferences if you experience another episode of mental illness that leaves you unable to decide or communicate your preferences at the time. (HDC)
Collaborative Recovery Plan/Unified Care Plan	An individualised plan which is consistent with the values of 'Recovery' and written in partnership with the service user and the clinician.

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De-briefing	Purposeful conversations with Service Users and staff involved in an incident in order to review the event and establish strategies to avoid it reoccurring and providing an acknowledgement of the distress and trauma which may have been associated with the event.
De-escalation	A complex interaction between the clinician and the service user during which the sometimes highly aroused service user is redirected from an unsafe course of action to a supported and calmer emotional state. (NZS 8134,2:2008) .
Early Warning Signs (EWS)	Behaviours or thoughts, which an individual identifies that are recognised as indicating a return in signs or symptoms of mental illness.
Restraint	Restraint is any intervention by a service provider that limits the freedom of movement of a service user

Environmental restraint	This is where a service intentionally restricts a service user's normal access to their environment, (NZS 8134.2:2008) i.e. locking of doors and fencing.
Mechanical restraint (Regional Forensic Psychiatry Service only)	Any restrictive device (e.g., mechanical restraint, plastic/cloth tie, vest, or physical confinement) used to restrict a person's free movement.
Personal restraint	Where a service provider uses their own body to intentionally limit the movement of a service user (NZS 8134.2:2008).

Safe Practice and Effective Communication (SPEC)	Training for all mental health clinicians involved in Restraint practices will be in accordance with the National Guidelines developed by the SPEC Governance Group, endorsed by the Director and Chief Advisor of Mental Health
Sensory Modulation	The capacity to regulate and organise the degree, intensity, and nature of responses to sensory input in a graded and adaptive manner. This allows the person to achieve and maintain an optimal range of performance and to adapt to challenges in everyday life
Trauma	Trauma may be defined as the experience of violence and victimisation including sexual abuse, emotional abuse, physical abuse, severe neglect, loss, domestic violence and/or the witnessing of violence, terrorism or disasters
Trauma informed care	Trauma informed care is care which recognises the neurological, biological, psychological, and social effects of trauma and violence on an individual, and uses a collaborative and supportive approach, and recognises that restraint can intensify trauma.
Trigger	Stimulus events, situations, or circumstances that precede a response.

2. Aims and Principles

2.1 Aim

Service users will be supported to manage their distress in a proactive manner without the use of restraint. Staff will apply restraint ONLY when all other interventions have been unsuccessful & for the shortest time possible.

2.2 Principles

- All staff will treat service users with respect, by;

  - informing people of their rights
  - listening to their perspectives
  - validating concerns
  - using polite, thoughtful and valuing language
  - offering choice where possible

- Restraint has the potential to cause loss of dignity, and mana.
- Trauma informed care principles will be applied at all times with the understanding that many service users have a history of trauma and this will impact on their experiences of restraint.
- Tools which are shown to reduce the likelihood of restraint will be used.
- Distress and tensions are identified and minimised or removed.
- Service users will be involved in the development of their own recovery and/or collaborative recovery plans and sensory preferences and this information will be used to minimise distress.
- All restraint events are evaluated (NZS 8134.2:2008) by the local Restraint Minimisation Committee.
- Restraint may only be applied in an inpatient unit.

The decision to use restraint will:

- Only be made as a last resort to maintain safety for service users, staff or others (Workplace Violence Prevention, 2006).

- Follow appropriate planning, using WDHB approved team approach

3. Activities Supporting Restraint Minimisation

3.1 Advance Directives

Advanced Directives will be known, will inform decisions and will be adhered to whenever possible.

3.2 Assessment

Assessments which will inform restraint minimisation practices will be undertaken and documented in the clinical file at the point of admission and updated regularly and whenever new information becomes available.
The assessment will include:

- Medical conditions
- Psychiatric conditions
- Substance use / history
- Previous history of trauma
- Triggers and early warning signs
- History of violence
- History of vulnerability
- History of restraint and/or seclusion
- Cultural needs
- Sensory preferences

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3.3 Monitoring & Safety Plans

- Monitoring of Service Users mental state occurs at each clinical contact.
- Instances of agitation, aggression or conflict will be discussed with the Service User and documented in the clinical file.
- All service users will have an Inpatient Care Plan or a safety plan within the Unified Care Plan.

3.4 Early Warning Signs and Triggers

Service Users early warning signs and triggers are known and documented in the Inpatient Care Plan/Unified Care Plan.
Documentation will include strategies to respond to early warning signs and minimise the likelihood of exposure to known triggers.

Strategies will include:

- **Engagement in meaningful activities**

  Service Users will be provided with opportunities to engage in in rewarding activities can help to reduce experiences of frustration/or aggression and enhance recovery (e.g. exercise, creative expression, sensory exploration, therapeutic discussions).

- **Cultural considerations**

  A cultural assessment or consultation will be offered to all Service Users

3.5 Restraint

If a Restraint occurs the following activities must be undertaken:

- **Effective Communication**

  Service Users will be informed of the reasons why restraint is indicated, and strategies available to end the restraint episode as quickly as possible.
  Service users must be informed of their rights as early as possible.

- **Monitoring during restraint**
  - Staff must ensure the service user's airway is clear and unobstructed at all times
  - One staff member should be identified (Number One) to ensure there is constant communication with the service user, informing them of what is happening
  - If there are physical concerns then physical observations (BP, P, O2) should be taken
  - Holds should be released at the earliest opportunity

Mechanical Restraint:

- is restricted to the Regional Forensic Psychiatry Service
- may only be initiated by the Service User's Responsible Clinician (or On-Call Consultant, if after-hours), in consultation with the multi-disciplinary team
- must be discussed with the Clinical Director RFPS (DAMHS) prior to initiation
- Refer to Appendix 1 for procedures

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3.6 Post restraint de-briefing/notifications

De-briefing includes:

- **Service User de-brief:** This should occur when the service user has had time to recover from the physical and emotional impact of the restraint. The Consumer Advisor for the service must be consulted and may be the appropriate person to lead the de-brief. (Appendix 2)
- **Service User Witness de-brief**: This should be offered to any service users who have witnessed a restraint event, at the earliest opportunity.
- **Staff de-brief:** This should be led by the senior nurse on the unit and occur as soon as practicable after termination of the restraint. (Appendix 3)
- **Family/Whanau notification:** The identified contact person (family/whanau/caregiver/friend) must be notified of any restraint episode and this contact documented in the clinical file.
- **Service User medical review:** Medical staff should be requested to provide a physical examination if there are indications that injury may have occurred, or if the restraint has been unusually long.

4. Structures and Processes Supporting Restraint Minimisation

4.1 Behaviours of Concern Committee

A WDHB Organisational Committee which maintains oversight of compliance with the current Restraint Minimisation Standard. This committee receives an annual report from the MHSG Restraint Minimisation and Safe Practice Committee.

4.2 MHSG Restraint Minimisation and Safe Practice Steering Committee

The Restraint Minimisation and Safe Practice Steering Committee provides leadership and support for all restraint minimisation activities within MHS divisions. This committee receives and considers restraint review reports, training reports and reviews trends provided by the Restraint Coordination Committees.

4.3 Restraint Coordination Committees (Adult Mental Health Services/Regional Forensic Psychiatric Services)

These committees promote the reduction of restraint and progress toward restraint-free mental health services by engaging with the Six Core Strategies. They are tasked with identifying any issues arising for service users, staff or the service and provide recommendations to the Service Improvement Team and reports to the Restraint Minimisation and Safe Practice Steering Committee.

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4.4 Restraint Review

All restraints are review by the Clinical Charge Nurse (CCN), Clinical Nurse Specialist (CNS) or Unit Manager (UM) to ensure that documentation is accurately completed. This includes:

- Clinical practice is in accordance with Restraint Minimisation principles.
- Trends and patterns are identified, analysed and reported to the local Restraint Coordination Committee and Service Clinical Governance.
- Trends and patterns are fed back to staff in approved forums i.e. staff meetings, quality meetings.
- Documentation is completed via the following:

Place for Documentation	Description of Documentation
Clinical notes The template is accessed by typing **restraint** in the HCC clinical notes	• Reasons for initiation of restraint • The availability of gender matched staff • The impact restraint had on the service user • Details of alternative interventions attempted prior to the use of restraint • Details of advocacy/support offered/provided • Observations and monitoring of the service user during the restraint episode
Restraint & Seclusion form	Electronic form available in the HCC system is completed by allocated Registered Nurse
Incident Reporting	Electronic RiskPro form available via the intranet is completed by individual staff member and/or Registered Nurse/Shift Co-ordinator for: • any injury to any person as a result of the use of restraint. • any damage to the building / facility
Restraint register	RFPS only - All restraints must be recorded in the RiskPro reporting system
Service user debrief form (Appendix 2)	Electronic form available in the HCC system is completed by the person who conducted the debrief (enter service user debrief\ to bring up the form template)
Operational Debriefing Form (Appendix 3)	Paper form available in the filing cabinet is completed by the Clinical Charge Nurse, Unit Manager or delegate on the shift the event occurred. Form is given to the CNS on completion.

4.5 Staff Training in Safe Practice and Effective Communication (SPEC)

- SPEC trainers are sourced from within the clinical setting and approved by the Restraint Minimisation and Safe Practice Steering Committee
- Regional Forensic Psychiatric Services require all clinical staff working in the Mason Clinic units to be trained in Calming and Restraint (C&R) practice.
- Adult Mental Health Services require all clinical staff working in the acute adult and older adult inpatient units to be trained in Complete Intervention Training (CIT) practice.
- Attendance at annual updates is required to support ongoing currency and competency of practice.
- Training records are kept for all staff

- Training in the use of prone (floor) and the wrist lock restraint types will be phased out eliminated over the next two years. This will result in the elimination of prone and wrist locks by 2020.

5. References & Associated Documents

Waitemata DHB Policy/ Procedure	• Seclusion Procedure – Adult MHS • Seclusion Review Panel – ToR – AMHS • Restraint & Safe Practice Steering Committee – TOR - AMHS • Incident Reporting • Defusing and Debriefing • Restraint – Mechanical (2005) • Sensory Modulation Guidelines
Legislation	• Mental Health (CAT) Act, 1992 • Health & Disability Services (Safety) Act, 2001 • IDCCR Act, 2003 • CP(MIP) Act, 2003
Codes	• Code of Health and Disability Services Service users' Rights, 1996 (The Code)
Standards	• Restraint Minimisation and Safe Practice Standard: NZS8134:2008
References	• Huckshorn, K. (2005). Monitoring Injury Rates in S/R Reduction Projects, National Executive Training Institute Presentation. • Mason approach - e-learning tool. WDHB • National Association of State Mental Health Program Directors (NASMHPD) (2001). Reducing the Use of Seclusion and Restraint Part II: Findings, Principles, and Recommendations for Special Needs Populations. • NASMHPD (2006). Training Curriculum for the Reduction of Seclusion and Restraint. • National Technical Assistance Centre (NTAC) (2007). Improving Safety and Reducing Violence: Implementing Trauma Informed Care Training Curriculum. • Te Pou (2007). Best Practice in the Reduction and Elimination of Seclusion and Restraint. Seclusion: Time for Change. Auckland, Te Pou o Te Whakaaro Nui • Te Pou (2014). Debriefing following seclusion and restraint; A summary of relevant literature. Auckland, Te Pou o Te Whakaaro Nui • NZMA and HDC definition at: http://www.hdc.org.nz/publications/resources-to-order/leaflets-and-posters-for-download/advance-directives-in-mental-health-care-and-treatment-%28leaflet%29

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Appendix 1 - Guideline for use of Mechanical Restraint

1) A decision to initiate mechanical restraint should be made:
   - If urgent: by the RN overseeing the Service User's care and in consultation with the Senior Nurse on Duty. The responsible clinician or on-call registrar/consultant is then notified a.s.a.p.
   - If time permits: in consultation with the Service User's responsible clinician (or on-call registrar or consultant, if after-hours).
   - If in the community, only with the explicit approval from the DAMHS and Director of Mental Health

2) When not in use, the authorised equipment is to be stored in a designated area. For Kauri, this is the High Care Area; in Rata the Unit Managers office.

3) Once the decision is made to apply mechanical restraints, the Service User is to be placed on Constant Observations by a *minimum* of 2 staff members, of which one is a Registered nurse, in the High Care area.

4) The senior nurse/nurse-in-charge on duty is to arrange staffing resources. Staffing should be gender appropriate where possible and there will always be at least one female nurse present to provide care for a female service- user.

5) Nursing staff will continuously assess the comfort and safety of the service-user by observing colour and temperature of hands and/or feet in restraint. Every hour that the service-user is awake each limb will be released in turn from mechanical restraint. Staff will restrain the limb whilst applying passive exercise.

6) The responsible clinician, on-call psychiatric registrar, or on-call psychiatrist is required to attend and complete an examination of the Service User within two hours of the initiation of mechanical restraint.

7) If the decision to continue with mechanical restraints is made, the assessing doctor must prescribe this for the Service User in the appropriate authorised form with a corresponding written entry in the clinical notes, and notify the Clinical Director, RFPS.

8) If there are concerns for the physical condition of the Service User a medical officer (or on-call medical officer after hours) is to attend the unit as soon as possible and conduct a physical examination of the Service User.

9) The key to the mechanical restraint lock is to remain with the equipment during storage, and on the staff assigned for constant observation when in use constant observation staff when in use.

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Appendix 2 Service User debriefing form following Seclusion/Restraint

Service User Debrief following a Seclusion or Restraint Incident

Name of Person Conducting the Debrief: _____

Name of Person who was restrained or secluded: _____

Service User name:	Incident Date: Time: Debrief Date: Time:
Service User's view of the incident – what happened for you?	
Leading up to the incident – what was going on for you? E.g. anything that caused distress or frustration for you, from today or even past few days, any worries that stand out for you?	
What was the risk to others, from your point of view? Do you see why people felt unsafe?	
What could we do for you to ensure we can avoid incidents in future? e.g. sensory modulation preferences, preferred staff, communication style, distractions, family involvement, spiritual support, peer support , cultural support	
Do you feel valued and safe in our environment?	

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Appendix 3: Seclusion/Restraint Operational Debriefing Form (Staff)

Seclusion / Restraint Operational Staff Debriefing Form

☐ Restraint ☐ Seclusion		
Date:	Time:	Service User:
Staff: Staff Injuries (if so, what): ☐ Yes ☐ No Documentation Required: ☐ Risk Pro ☐ HCC Clinical notes ☐Update Care Plan ☐ Restraint/Seclusion Register		
Who was involved?		
What happened?		
Where did it happen e.g. bedroom/dining room/lounge		
Why did it happen?		
Is there anything we could learn from this that might reduce the likelihood of it occurring again? i.e. What could be done differently		
Any follow up or support required: ☐ EAP ☐Option to work in another area ☐ Occ Health ☐ Other By Whom:		

Name of Person Conducting the Debrief: _____

PLEASE GIVE TO CNS or CCN once completed