NZS 8134.2:2008

New Zealand Standard

Health and Disability Services (Restraint Minimisation and Safe Practice) Standards

Superseding NZS 8141:2001

NZS 8134.2:2008

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MINISTRY OF HEALTH
MANATŪ HAUORA

Appendix A

Ministry of Health's clarification of NZS 8134.2:2008 Health and Disability Services (Restraint Minimisation and Safe Practice) Standards *environmental restraint*

Environmental Restraint

It is apparent that routine locking of exit doors is occurring in some health and disability care facilities which are not designated 'locked units'.

The impact of locking devices on doors is restriction of a consumer's normal freedom of movement. This practice constitutes 'environmental restraint'.

Restraint must not be used as a routine measure. It is a serious intervention of last resort requiring robust clinical justification and oversight. All restraint use is subject to Part 2 of the Restraint Minimisation and Safe Practice Standards therefore in facilities other than those designated as a 'locked unit', whenever the use of locking devices on doors restricts a consumer's normal freedom of movement, the service provider must satisfy the requirements of the Standards. These requirements include the service provider demonstrating that:

(a) the use of restraint adheres to the principles of least restrictive practice and the rights, safety and dignity of the consumer are upheld
(b) there are clear organisational responsibilities and clinical justification for the use of restraint
(c) there are documented individual consumer restraint minimisation and safe practice assessments and evaluations including the clinical rationale for restraint use and the impact of restraint use
(d) the use of locking devices on doors does not restrict the normal freedom of movement of consumers for whom restraint is not intended
(e) they comply with fire and safety standards
(f) if the use of environmental restraint is not effective in maintaining the safety of the consumer or meeting the needs of the consumer then alternative management strategies will be investigated and utilised
(g) there are provisions to ensure the needs of consumers are re-assessed when clinically indicated, through an external assessment process, to determine the most appropriate level of care required.

<u>Locked units</u>
The following information is provided in the foreword of NZS 8134.2:2008:

'In a "locked unit" the locked exit is a permanent aspect of service delivery to meet the safety needs of consumers who have been assessed as needing that level of containment. Although by definition the locking of exits constitutes environmental restraint the requirements of this Standard are not intended to apply to the locking of exits in 'locked units', where the unit:

(a) is clearly designated a "locked unit";
(b) has clear service entry criteria against which consumers are assessed prior to entry;
(c) can ensure consumers using the service continue to meet the service criteria following entry; and
(d) can ensure any consumer that does not meet the service criteria has the means to independently exit the unit at any time.

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Therefore when all of (a) – (d) are met, the practice of locking exit doors in "locked units" is not covered by this Standard. However, in the absence of any of the above points, the locking of exit doors should be treated as environmental restraint.'

The following statement is provided by the P 8134 workshop committee:

The 'locked units' clause contained in the foreword of NZS 8134.2:2008 was intended to relate specifically to contracted services, such as those providing dementia level residential care, where locked exit doors are an accepted and permanent aspect of service delivery and where consumers are independently and comprehensively assessed prior to entry.

The practice of controlling exit doors in a 'locked unit' was deemed exempt from the requirements of the Restraint Minimisation and Safe Practice Standards as in these units there is no requirement to:

- minimise the practice of locking exit doors as this is a permanent aspect of service delivery
- demonstrate an approval process for the practice of locking exit doors as this is an accepted aspect of service delivery
- undertake individual consumer restraint minimisation and safe practice assessment and evaluation, in relation to the practice of locking exit doors, as prior to entry consumers are considered to have been independently and comprehensively assessed as requiring this level of containment.

Environmental restraint

The following information is provided in the foreword of NZS 8134.2:2008:

'Where a service provider intentionally restricts a consumer's normal access to their environment, for example, where a 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 wheelchair) denied.'

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NZS 8134.2:2008

New Zealand Standard

HEALTH AND DISABILITY SERVICES (RESTRAINT MINIMISATION AND SAFE PRACTICE) STANDARDS

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FOREWORD

The main intent of NZS 8134.2 is to reduce the use of restraint in all its forms and to encourage the use of least restrictive practices. It is crucial that providers recognise which interventions constitute restraint and how to ensure that, when practised, restraint occurs in a safe and respectful manner.

Restraint should be perceived in the wider context of risk management. Restraint is a serious intervention that requires clinical rationale and oversight. It is not a treatment in itself, but is one of a number of strategies used by service providers to limit or eliminate a clinical risk. Restraint should only be used in the context of ensuring, maintaining, or enhancing the safety of the consumer, service providers, or others. All restraint policies, procedures, practices, and training should be firmly grounded in this context.

This Standard covers all forms of restraint and supersedes NZS 8141:2001.

WHAT CAN YOU BUY

NZS 8134.2 *Health and disability services (restraint minimisation and safe practice) Standards* consists of this document plus:

(a) NZS 8134.2.1 – Restraint minimisation;

(b) NZS 8134.2.2 – Safe restraint practice;

(c) NZS 8134.2.3 – Seclusion.

NZS 8134.2 comprises part of NZS 8134:2008 and may be purchased as a set, that is loose-leaf, four-hole punched, and shrink wrapped for insertion in a binder with room for NZS 8134.0 *Health and disability services (general) Standard*, NZS 8134.1 *Health and disability services (core) Standards*, and NZS 8134.3 *Health and disability services (infection prevention and control) Standards.*

ETHICAL AND LEGAL CONSIDERATIONS

Practice is guided by ethical principles that include acting for the consumer's good (beneficence), avoiding harm to the consumer (non-maleficence), avoiding harm to self and others, and respecting the dignity of the consumer and the consumer's human rights.

The Standard should be implemented in ways that respect these and other ethical principles and at all times promote the interests, safety, and well-being of all involved.

Any unauthorised restriction on a consumer's freedom of movement could be seen as unlawful. Organisations should develop clear policies and procedures to guide service providers in the implementation of the Standard, and seek legal advice if necessary.

Seclusion and restraint shall not be used by providers for punitive reasons.

MEDICATION

The term chemical restraint is often used to mean that rather than using physical methods to restrain a consumer at risk of harm to themselves or others, various medicines are used to ensure compliance and to render the person incapable of resistance. Use of medication as a form of 'chemical restraint' is in breach of NZS 8134.2.

All medicines should be prescribed and used for valid therapeutic indications. Appropriate health professional advice is important to ensure that the relevant intervention is appropriately used for therapeutic purposes only.

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RESTRAINT MINIMISATION AND SAFE PRACTICE

GENERAL

The use of restraint is a clinical decision. It is not a treatment in itself but is one of a number of strategies used at a particular time with a particular goal in mind. Restraint should be used only in the context of good clinical practice. Practices and training in restraint should ensure that any techniques are firmly grounded in this context.

NZS 8134.2 *Health and disability services (restraint minimisation and safe practice) Standards* expect restraint to be used only after all less restrictive interventions have been attempted and found to be inadequate. Proactive approaches should be used at all times. Where reactive strategies become necessary, de-escalation should be used before restraint. More intrusive interventions such as restraint should only be used where they are indicated. However, the reduction of restraint will rely on good assessment and planning processes, which provide early identification of a possible need for restraint and therefore assist in planning interventions that best reduce the likelihood of restraint being required.

It is crucial that organisations subject their use of restraint to rigorous internal and external review by consumers, family/whānau, professionals, and relevant professional bodies.

ENABLERS

Both enablers and restraint limit the normal freedom of movement of the consumer. 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. Where the intent is to promote independence, comfort and safety, and the intervention is voluntary, this constitutes an enabler.

Additionally, the use of enablers should be the least restrictive option to safely meet the needs of the consumer.

Services that have no reported restraint use do not need to comply with NZS 8134.2.2 or NZS 8134.2.3. However, if and when a restraint event occurs NZS 8134.2.2 automatically applies to that event.

INDICATION FOR RESTRAINT USE

Restraint is a serious intervention that requires clinical rationale. It should not be undertaken lightly and should be considered as one of a range of possible interventions in the care setting, and always in the context of the requirements of this Standard, and current accepted good practice. Restraint should be applied only to enhance or maintain the safety of consumers, service providers, or others.

Service provider training and competency is critical, both to the appropriate and safe use of restraint, and to minimising the use of restraint.

ETHICAL AND LEGAL CONSIDERATIONS

Any unauthorised restriction of a consumer's freedom of movement could be seen as false imprisonment and could result in an action for assault. Organisations should develop clear policies and procedures to guide service providers and seek legal advice to ensure the practice they are specifying is legal.

OBSERVATION AND CARE DURING RESTRAINT

The organisation's policies and procedures should guide services in ensuring adequate and appropriate observation, care, dignity, respect, and on-going assessment occurs to minimise the risk of harm to consumers during restraint.

The frequency and level of observation and assessment should be appropriate to the level of risk associated with the restraint procedure, and the setting in which it is occurring. They should reflect current accepted good practice and the requirements of this Standard.

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NIGHT SAFETY ORDERS

'Night safety orders' are not covered by this Standard. 'Night safety orders' is a term used to describe the practice of locking the entry to a consumer's bedroom overnight at the request of the consumer or locking the entry to an inpatient unit or residential service at night for the general safety of all. Organisations need to develop clear policies and procedures to guide them in these practices particularly in the event of a fire.

NOTE – Night safety orders are not covered by NZS 8134.2.

LOCKED UNITS

In a 'locked unit' the locked exit is a permanent aspect of service delivery to meet the safety needs of consumers who have been assessed as needing that level of containment. Although by definition the locking of exits constitutes environmental restraint the requirements of this Standard are not intended to apply to the locking of exits in 'locked units', where the unit:

(a) Is clearly designated a 'locked unit';

(b) Has clear service entry criteria against which consumers are assessed prior to entry;

(c) Can ensure consumers using the service continue to meet the service criteria following entry; and

(d) Can ensure any consumer that does not meet the service criteria has the means to independently exit the unit at any time.

Therefore when all of (a) – (d) are met, the practice of locking exit doors in 'locked units' is not covered by this Standard. However, in the absence of any of the above points, the locking of exit doors should be treated as environmental restraint.

SECLUSION USED AS 'TIME OUT'

Seclusion should not be used as a component of a consumer's service delivery plan to modify unwanted behaviour. Seclusion may only be used to manage safety.

DOMESTIC SECURITY

Domestic security is the practice of locking external doors at night for general security.

NOTE – Domestic security is not covered by NZS 8134.2.

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APPLICATION

All services shall meet NZS 8134.2.1. NZS 8134.2.2 and NZS 8134.2.3 will be assessed as being not applicable to a service where restraint and seclusion are not used.

NZS 8134.2.2 is only relevant for services where restraint (including the use of seclusion) is used. However, services shall comply with this Standard if and when a restraint event occurs, in relation to that event and any subsequent events.

Services shall comply with NZS 8134.2.2 and NZS 8134.2.3 where seclusion is used.

NZS 8134.2.1	Restraint minimisation	All services shall meet this Standard
NZS 8134.2.2	Safe restraint practice	All services where restraint is used (including seclusion) shall meet this Standard.
NZS 8134.2.3	Seclusion	All services which use seclusion shall meet this Standard.

NZS 8134.2, NZS 8134.2.1, NZS 8134.2.2, and NZS 8134.2.3 are to be read in conjunction with NZS 8134.0 *Health and disability services (general) Standard*, as this contains the definitions and audit framework information applicable across the health and disability suite.

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REFERENCED DOCUMENTS

Reference is made in this document to the following:

NEW ZEALAND STANDARDS

NZS 8134.0:2008 Health and disability services (general) Standard

NZS 8134.1:2008 Health and disability services (core) Standard

JOINT AUSTRALIAN/NEW ZEALAND STANDARD

AS/NZS 4360:2004 Risk management

OTHER PUBLICATIONS

Ministry of Health. *He korowai oranga: Māori health strategy*. Wellington, Ministry of Health, 2002.

Ministry of Health. *Seclusion under the Mental Health (Compulsory Assessment and Treatment) Act 1992*. Wellington: Ministry of Health, 2008.

NEW ZEALAND LEGISLATION

Code of Health and Disability Services Consumers' Rights 1996 (the Code)

Health and Disability Services (Safety) Act 2001

Health and Disability Commissioner Act 1994

Intellectual Disability (Compulsory Care and Rehabilitation) [ID(CCR)] Act 2003

Mental Health (Compulsory Assessment and Treatment) [MH(CAT)] Act 1992

Protection of Personal and Property Rights Act 1988

LATEST REVISIONS

The users of this Standard should ensure that their copies of the above-mentioned New Zealand Standards are the latest revisions. Amendments to referenced New Zealand and Joint Australian/New Zealand Standards can be found on http://www.standards.co.nz.

WEBSITES

Health and Disability Commission	http://www.hdc.org.nz
New Zealand Legislation	http://www.legislation.govt.nz
Office for Disability Issues	http://www.odi.govt.nz

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RELATED DOCUMENTS AND GUIDELINES

RELATED STANDARDS AND HANDBOOKS

When interpreting this Standard, it may be helpful to refer to the following:

NEW ZEALAND STANDARD AND HANDBOOK

NZS 8134.3:2008	Health and disability services (infection prevention and control) Standard
SNZ HB 8134.5:2005	Health and disability sector standards – Proposed audit workbook and guidance for residential services for people with dementia

AUSTRALIAN STANDARD

AS 2828:1999 Paper-based health care records

NEW ZEALAND LEGISLATION

Births, Deaths and Marriages Registration Act 1995

Building Act 2004

Children, Young Persons and their Families Act 1989

Coroners Act 2006

Crimes Act 1961

Criminal Justice Act 1985

Employment Relations Act 2000

Health (Retention of Health Information) Regulations 1996

Health Act 1956

Health Practitioners Competence Assurance Act 2003

Human Rights Act 1993

Injury Prevention, Rehabilitation and Compensation Act 2001

Local Government Act 2002

Medicines Act 1981

New Zealand Bill of Rights Act 1990

New Zealand Building Code (NZBC) and Compliance Documents

New Zealand Public Health and Disability Act 2000

Official Information Act 1982

Privacy Act 1993

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RELATED DOCUMENTS

Drinka, T J K. & Clark, P G. (2000). *Health care teamwork: interdisciplinary practice & teaching*. Westport, CT: Auburn House, 2000.

Mental Health Commission. *Our lives in 2014, A recovery vision from people with experience of mental illness.* Wellington: Mental Health Commission, 2004.

Mental Health Commission. *Procedural guidelines for physical restraint*. Wellington: Ministry of Health, 1993.

Mental Health Commission. *Seclusion in New Zealand mental health services*. Wellington: Mental Health Commission, 2004.

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Ministry of Health. *Consent in child and youth health – Information for practitioners.* Wellington: Ministry of Health,1998.

Ministry of Health. *Guidelines for the support and management of people with dementia – National advisory committee on health and disability*. Wellington: Ministry of Health, 1997.

Ministry of Health. *He taura tieke: measuring effective health services for Māori*, Wellington: Ministry of Health, 1995.

Ministry of Health. *Seclusion under the Mental Health (Compulsory Assessment and Treatment) Act 1992*. Wellington: Ministry of Health, 2008.

Ministry of Health. *Standards for needs assessment for people with disabilities,* Wellington: Ministry of Health, 1994.

Ministry of Health. *Standards for traditional Māori healing*. Wellington: Ministry of Health, 1999.

Neal, L J. 'Neal theory of home health nursing practice.' *Journal of Nursing Scholarship* 31, no. 3 (1999): 251 – 252.

WEBSITES

Mental Health Commission	http://www.mhc.govt.nz
Ministry of Health	http://www.moh.govt.nz
Nationwide Health and Disability Advocacy Service	http://www.hdc.org.nz/advocacy
New Zealand Guidelines Group	http://www.nzgg.org.nz
New Zealand Health Information Service	http://www.nzhis.govt.nz

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NZS 8134.2.1:2008

New Zealand Standard

Health and Disability Services (Restraint Minimisation and Safe Practice) Standards – Restraint minimisation

Superseding NZS 8141:2001

NZS 8134.2.1:2008

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HEALTH AND DISABILITY SERVICES (RESTRAINT MINIMISATION AND SAFE PRACTICE) STANDARDS

2.1: RESTRAINT MINIMISATION
WHAKAITINGA TAUTĀWHI

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FOREWORD

The main intent of NZS 8134.2 is to reduce the use of restraint in all its forms and to encourage the use of least restrictive practices. It is crucial that providers recognise which interventions constitute restraint and how to ensure that, when practised, restraint occurs in a safe and respectful manner.

Restraint should be perceived in the wider context of risk management. Restraint is a serious intervention that requires clinical rationale and oversight. It is not a treatment in itself but is one of a number of strategies used by service providers to limit or eliminate a clinical risk. Restraint should only be used in the context of ensuring, maintaining, or enhancing the safety of the consumer, service providers, or others. All restraint policies, procedures, practices, and training should be firmly grounded in this context.

This Standard covers all forms of restraint and supersedes NZS 8141:2001.

NZS 8134.2 *Health and disability services (restraint minimisation and safe practice) Standards* includes referenced and related documents and guidelines, guidance on restraint minimisation and safe practice, and on the application of the Standard, along with the following Standards:

(a) NZS 8134.2.1 – Restraint minimisation

(b) NZS 8134.2.2 – Safe restraint practice

(c) NZS 8134.2.3 – Seclusion.

Each is to be read in conjunction with NZS 8134.0 *Health and disability services (general) Standard*, as this contains the definitions and audit framework information applicable across the health and disability suite

ETHICAL AND LEGAL CONSIDERATIONS

Practice is guided by ethical principles that include acting for the consumer's good (beneficence), avoiding harm to the consumer (non-maleficence), avoiding harm to self and others, and respecting the dignity of the consumer and the consumer's human rights.

The Standard should be implemented in ways that respect these and other ethical principles and at all times promote the interests, safety, and well-being of all involved.

Any unauthorised restriction on a consumer's freedom of movement could be seen as unlawful. Organisations should develop clear policies and procedures to guide service providers in the implementation of the Standard, and seek legal advice if necessary.

Seclusion and restraint shall not be used by providers for punitive reasons.

MEDICATION

The term chemical restraint is often used to mean that rather than using physical methods to restrain a consumer at risk of harm to themselves or others, various medicines are used to ensure compliance and to render the person incapable of resistance. Use of medication as a form of 'chemical restraint' is in breach of this Standard.

All medicines should be prescribed and used for valid therapeutic indications. Appropriate health professional advice is important to ensure that the relevant intervention is appropriately used for therapeutic purposes only.

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GUIDANCE

G 1.2 This may include but is not limited to:

(a) Collaborative assessments, which include input from the consumer and/or their family/whānau, that identify:

(i) Current and possible future risks

(ii) Any existing underlying causes of relevant risk related behaviour

(iii) Any triggers that may increase the likelihood of a relevant risk related behaviour

(iv) Any signs and symptoms that may indicate a relevant risk related behaviour or condition is present

(v) Assistance given to the consumer in the past that may have avoided the use of restraint;

(b) Collaborative care planning, which includes input from the consumer and/or their family/whānau, that includes:

(i) Any relevant advance directives

(ii) How future crises will be best avoided and as necessary managed

(iii) How any underlying causes of relevant risk related behaviour will be remedied or managed

(iv) How triggers that may increase the likelihood of a relevant risk related behaviour will be avoided;

(c) Consumers and/or their family/whānau are informed of the organisation's restraint policy;

(d) Referral to other services as appropriate.

G 1.3 This may include but is not limited to:

(a) Consumer assessment;

(b) Identifying when enablers are agreed to be used for the individual consumer;

(c) Monitoring to ensure consumer safety;

(d) Evaluation within the consumer's service delivery plan.

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RESTRAINT MINIMISATION
WHAKAITINGA TAUTĀWHI

Outcome 1 Consumers receive and experience services in the least restrictive manner.

Standard 1 **Services demonstrate that the use of restraint is actively minimised.**

Criteria The criteria required to achieve this outcome shall include the organisation ensuring:

1.1 The service has policies and procedures that include, but are not limited to:

(a) The commitment to restraint minimisation, which may include but is not limited to:

(i) The service's philosophy on restraint

(ii) How the service communicates its commitment to restraint minimisation

(iii) How the service ensures its commitment is carried out in practice;

(b) The definition of restraint which is congruent with the definition in NZS 8134.0;

(c) The process of identifying and recording any restraint use is transparent and comprehensive;

(d) How it will meet the responsibilities specified in NZS 8134.2.2 if and when restraint is used;

(e) The definition of an enabler which is congruent with the definition in NZS 8134.0;

(f) The process of assessment and evaluation of enabler use.

1.2 The service ensures risk assessment processes and the consumer's service delivery plans support the delivery of services that avoid the use of restraint. This shall include, but is not limited to assistance given to the consumer in the past, which may have prevented the use of restraint.

1.3 Where enablers are used the organisation ensures service providers are guided in their safe and appropriate use.

1.4 The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety. ➤

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GUIDANCE

G 1.5 This may include but is not limited to:

(a) Education tailored to both current and new service providers;

(b) A method of assessing the level of knowledge gained by service providers;

(c) Defining how often service providers are required to undertake education.

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1.5 Ongoing education, relevant to the service setting, is provided to service providers, which includes, but is not limited to:

(a) The service's restraint definition, restraint minimisation policy and process for identifying and recording restraint use;

(b) The service's enabler use policy and procedure;

(c) The service's responsibility to meet NZS 8134.2.2 if and when restraint is used;

(d) Alternative interventions to restraint;

(e) Prevention and/or de-escalation techniques.

Threats of restraint or seclusion shall not be used to achieve compliance.

1.6 Services that have no reported restraint use do not need to comply with NZS 8134.2.2 and NZS 8134.2.3. However, if and when a restraint event occurs, NZS 8134.2.2 automatically applies to that event.

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NZS 8134.2.2:2008

New Zealand Standard

Health and Disability Services (Restraint Minimisation and Safe Practice) Standards –

Safe restraint practice

Superseding NZS 8141:2001

NZS 8134.2.2:2008

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NZS 8134.2.2:2008

New Zealand Standard

HEALTH AND DISABILITY SERVICES (RESTRAINT MINIMISATION AND SAFE PRACTICE) STANDARDS

2.2: SAFE RESTRAINT PRACTICE
TIKANGA TAUTĀWHI HAUMARU

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FOREWORD

The main intent of NZS 8134.2 is to reduce the use of restraint in all its forms and to encourage the use of least restrictive practices. It is crucial that providers recognise which interventions constitute restraint and how to ensure that, when practised, restraint occurs in a safe and respectful manner.

Restraint should be perceived in the wider context of risk management. Restraint is a serious intervention that requires clinical rationale and oversight. It is not a treatment in itself but is one of a number of strategies used by service providers to limit or eliminate a clinical risk. Restraint should only be used in the context of ensuring, maintaining, or enhancing the safety of the consumer, service providers, or others. All restraint policies, procedures, practices, and training should be firmly grounded in this context.

This Standard covers all forms of restraint and supersedes NZS 8141:2001.

NZS 8134.2 *Health and disability services (restraint minimisation and safe practice) Standards* includes referenced and related documents and guidelines, guidance on restraint minimisation and safe practice, and on the application of the Standard, along with the following Standards:

(a) NZS 8134.2.1 – Restraint minimisation

(b) NZS 8134.2.2 – Safe restraint practice

(c) NZS 8134.2.3 – Seclusion.

Each is to be read in conjunction with NZS 8134.0 *Health and disability services (general) Standard*, as this contains the definitions and audit framework information applicable across the health and disability suite

ETHICAL AND LEGAL CONSIDERATIONS

Practice is guided by ethical principles that include acting for the consumer's good (beneficence), avoiding harm to the consumer (non-maleficence), avoiding harm to self and others, and respecting the dignity of the consumer and the consumer's human rights.

The Standard should be implemented in ways that respect these and other ethical principles and at all times promote the interests, safety, and well-being of all involved.

Any unauthorised restriction on a consumer's freedom of movement could be seen as unlawful. Organisations should develop clear policies and procedures to guide service providers in the implementation of the Standard, and seek legal advice if necessary.

Seclusion and restraint shall not be used by providers for punitive reasons.

MEDICATION

The term chemical restraint is often used to mean that rather than using physical methods to restrain a consumer at risk of harm to themselves or others, various medicines are used to ensure compliance and to render the person incapable of resistance. Use of medication as a form of 'chemical restraint' is in breach of this Standard.

All medicines should be prescribed and used for valid therapeutic indications. Appropriate health professional advice is important to ensure that the relevant intervention is appropriately used for therapeutic purposes only.

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GUIDANCE

G 2.1.1 This may include but is not limited to:

(a) Approval process including consultation with and/or advice from:

(i) Consumers, family/whānau, peer, advocate and/or legal representative;

(ii) Internal and external health professionals relevant to the practice setting;

(iii) Cultural input;

(iv) Specialist/technical input relevant to the practice setting;

(b) Approval determination should consider, but is not limited to:

(i) Whether this is the least restrictive intervention available for the proposed indications;

(ii) The legal and ethical implications of the application of any restraint; and

(iii) Whether related policies, procedures, protocols, or guidance meet the requirements of this Standard and current, accepted good practice standards.

G 2.1.3 This may include but is not limited to:

(a) The frequency for reviewing approval is determined by the nature and level of risk posed, both to consumers and service providers when the approved restraint is applied. Each restraint type should be reviewed at least every two years;

(b) An approval review process is documented and followed;

(c) A system is implemented to alert the organisation to future approval review dates; and

(d) A process exists to obtain comprehensive feedback from consumers, family/whānau, service providers, and other key stakeholders.

G 2.2.1 Assessments should help identify key factors, which contribute to the possibility that restraint might be considered. A service provider should consider the following factors, which may influence the decision to use restraint or not:

(a) The consumer's physical and psychological health, including any adverse health effects;

(b) The consumer's gender and culture;

(c) The degree of risk to the individual, others, and the environment;

(d) The consumer's service delivery plan;

(e) The experience of the individual and possible compromise to the future therapeutic relationship; and

(f) Legal considerations for the use of restraint.

G 2.2.2 Input may include the use of 'advance directives'.

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Outcome 2 Consumers receive services in a safe manner.

RESTRAINT APPROVAL AND PROCESSES
TE WHAKAAETANGA ME TE HĀTEPE WHAKAITA

Standard 2.1 **Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.**

Criteria The criteria required to achieve this outcome shall include the organisation ensuring:

2.1.1 The responsibility for the restraint process and approval is clearly defined and there are clear lines of accountability for restraint use.

2.1.2 Approved restraints will be documented, along with alternatives to restraint, and made known to service providers.

2.1.3 The approval for each restraint type is reviewed regularly.

ASSESSMENT TE AROMATAWAI

Standard 2.2 **Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.**

Criteria The criteria required to achieve this outcome shall include the organisation ensuring:

2.2.1 In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to:

(a) Any risks related to the use of restraint;

(b) Any underlying causes for the relevant behaviour or condition if known;

(c) Existing advance directives the consumer may have made;

(d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;

(e) Any history of trauma or abuse, which may have involved the consumer being held against their will;

(f) Maintaining culturally safe practice;

(g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer);

(h) Possible alternative intervention/strategies.

2.2.2 In assessing whether restraint will be used, the consumer and/or the family/whānau is informed and their input sought as practical.

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GUIDANCE

G 2.3.1 This may include but is not limited to:

(a) Policies and procedures identifying how often assessment for the continuation of restraint occurs;

(b) Consumer's service delivery plans identify factors which indicate that the restraint is no longer required;

(c) Written guidance for service providers on the steps to take when a restraint has to be discontinued for safety reasons;

(d) Restraint should be discontinued when:

(i) There is no longer any justification to continue using restraint

(ii) The risks to the consumer or service providers outweigh the benefit of its use.

G 2.3.2 Appropriate alternative interventions will vary depending on the type of restraint being considered and current accepted good practice. De-escalation should always be attempted prior to initiating restraint where indicated.

When determining whether a restraint is safe and appropriate to use, the service provider should consider the following:

(a) Is there a less restrictive method of achieving the desired outcome?

(b) Is there a likelihood of serious harm to the consumer, service providers, or others (whether physical, psychological, or cultural) if the restraint is not applied?

(c) Does the risk of serious harm to the consumer, service providers, or others (whether physical, psychological, or cultural) when applying or removing the restraint outweigh the necessity for its use?

(d) Are the organisation's policies and procedures being followed?

(e) The consumer's service delivery plan and any known 'advance directive'?

Service providers should follow written plans (based on consultation with family/whanāu and significant others) when the use of restraint requires the removal of objects/items of cultural significance, for example a headscarf.

G 2.3.3 The greater the risk associated with the use of a restraint, the greater the degree of monitoring will be required.

The frequency and extent of monitoring of a consumer during restraint is documented in the organisation's policies and procedures and the consumer's individual service delivery plan.

Monitoring requirements consider all aspects of the restraint use, including:

(a) The physical support needs of the consumer, for example, health, nutrition, hygiene, comfort, and safety;

(b) The psychological needs of the consumer, for example, support, reassurance, company, privacy, respect and dignity, orientation to time and place, and communication;

(c) The cultural needs of the consumer, for example, access to culturally appropriate support, access to family/whānau, peers, advocate, legal representative, and respectful removal of cultural objects.

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SAFE RESTRAINT USE WHAKAMAHI WHAKAITA HAUMARU

Standard 2.3 Services use restraint safely

Criteria The criteria required to achieve this outcome shall include the organisation ensuring:

2.3.1 The need for continued use of the restraint is continually monitored and regularly reviewed, to ensure it is applied for the minimum amount of time necessary.

2.3.2 Approved restraint is only applied as a last resort, with the least amount of force, after alternative interventions have been considered or attempted and determined inadequate. The decision to approve restraint for a consumer should be made:

(a) Only as a last resort to maintain the safety of consumers, service providers or others;

(b) Following appropriate planning and preparation;

(c) By the most appropriate health professional;

(d) When the environment is appropriate and safe for successful initiation;

(e) When adequate resources are assembled to ensure safe initiation.

2.3.3 The frequency and extent of monitoring of the consumer during restraint is determined by the risks associated with the consumer's needs and the type of restraint being used.

2.3.4 Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:

(a) Details of the reasons for initiating the restraint, including the desired outcome;

(b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;

(c) Details of any advocacy/support offered, provided, or facilitated;

(d) The outcome of the restraint;

(e) Any injury to any person as a result of the use of restraint;

(f) Observations and monitoring of the consumer during the restraint;

(g) Comments resulting from the evaluation of the restraint.

2.3.5 A restraint register or equivalent process is established to record sufficient information to provide an auditable record of restraint use. ➤

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GUIDANCE

G 2.3.6 For all restraints this may include, but is not limited to:

(a) A record of education is kept for each service provider, which details when competency is retested;

(b) Service provider competency is assessed regularly;

(c) New staff receive training before using restraints;

(d) Education adequately covers:

(i) How to recognise the possible physical, psychological, and cultural risks associated with each restraint

(ii) The minimisation/avoidance of restraint including how to respond to escalation (focusing on preventing its use and only using restraint as a last resort)

(iii) Recognition of the increase in consumers' needs in relation to their rights, dignity, privacy, personal and cultural safety during restraint

(iv) Consideration of the increase in family/whanāu needs in relation to their rights, dignity, privacy, personal and cultural safety during restraint

(v) Recognition of the need for timely access to cultural expertise and knowledge during restraint

(vi) Involving the consumer in all aspects of the restraint process and their family/whānau as far as reasonably practicable

(vii) Individual planning of care that recognises the increased or special needs of consumers during restraint

(viii) Effective risk assessment and decision-making on restraint

(ix) Legislative and documentation requirements

(x) The organisation's policies and procedures

(xi) The use of effective debriefing strategies following a restraint episode

(xii) Value of peer support and advocacy for the consumer.

Additionally, where personal restraint is approved for use, education may include, but is not limited to:

(e) The organisation's philosophy, goals, and methods for reducing restraint;

(f) Relevant techniques for physically holding a consumer;

(g) Communication techniques, including de-escalation skills, which avoid/reduce the need for restraint.

G 2.4.3 Every consumer has a right to have a support person of their choice. This may include but is not limited to family/whanāu, peer, advocate, or a legal representative.

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2.3.6 Each service provider has an individual record of education and competency in relation to restraint minimisation and safe practice.

EVALUATION AROTAKENGA

Standard 2.4 Services evaluate all episodes of restraint.

Criteria The criteria required to achieve this outcome shall include the organisation ensuring:

2.4.1 Each episode of restraint is evaluated in collaboration with the consumer and shall consider:

(a) Future options to avoid the use of restraint;

(b) Whether the consumer's service delivery plan (or crisis plan) was followed;

(c) Any review or modification required to the consumer's service delivery plan (or crisis plan);

(d) Whether the desired outcome was achieved;

(e) Whether the restraint was the least restrictive option to achieve the desired outcome;

(f) The duration of the restraint episode and whether this was for the least amount of time required;

(g) The impact the restraint had on the consumer;

(h) Whether appropriate advocacy/support was provided or facilitated;

(i) Whether the observations and monitoring were adequate and maintained the safety of the consumer;

(j) Whether the service's policies and procedures were followed;

(k) Any suggested changes or additions required to the restraint education for service providers.

2.4.2 Where an episode of restraint is ongoing the time intervals between evaluation processes should be determined by the nature and risk of the restraint being used and the needs of the consumers and/or family/whanāu.

2.4.3 Following each episode of restraint or at defined intervals, the consumer and where appropriate their family/whānau, receives support to discuss their views on the restraint episode.

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GUIDANCE

G 2.5.1 This may include but is not limited to:

(a) Quality review being conducted by suitably skilled service providers;

(b) Analysis of any regular audits conducted and restraint register information;

(c) Feedback from consumer, family/whānau, service providers, and others;

(d) Consideration of any current guidance and good practice standards.

Where restraint is regularly used, this is reviewed regularly (for example, six-monthly).

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RESTRAINT MONITORING AND QUALITY REVIEW
AROTAKE KOUNGA ME TE AROTURUKI WHAKAITA

Standard 2.5 Services demonstrate the monitoring and quality review of their use of restraint.

Criterion The criterion required to achieve this outcome shall include the organisation ensuring:

2.5.1 Services conduct comprehensive reviews regularly, of all restraint practice in order to determine:

(a) The extent of restraint use and any trends;

(b) The organisation's progress in reducing restraint;

(c) Adverse outcomes;

(d) Service provider compliance with policies and procedures;

(e) Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice;

(f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation;

(g) Whether changes to policy, procedures, or guidelines are required; and

(h) Whether there are additional education or training needs or changes required to existing education.

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NZS 8134.2.3:2008

New Zealand Standard

Health and Disability Services (Restraint Minimisation and Safe Practice) Standards – Seclusion

Superseding NZS 8141:2001

NZS 8134.2.3:2008

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NZS 8134.2.3:2008

New Zealand Standard

HEALTH AND DISABILITY SERVICES (RESTRAINT MINIMISATION AND SAFE PRACTICE) STANDARDS

2.3: SECLUSION
NOHO MŌWAI

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Restraint should be perceived in the wider context of risk management. Restraint is a serious intervention that requires clinical rationale and oversight. It is not a treatment in itself but is one of a number of strategies used by service providers to limit or eliminate a clinical risk. Restraint should only be used in the context of ensuring, maintaining, or enhancing the safety of the consumer, service providers, or others. All restraint policies, procedures, practices, and training should be firmly grounded in this context.

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(b) NZS 8134.2.2 – Safe restraint practice

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The term chemical restraint is often used to mean that rather than using physical methods to restrain a consumer at risk of harm to themselves or others, various medicines are used to ensure compliance and to render the person incapable of resistance. Use of medication as a form of 'chemical restraint' is in breach of this Standard.

All medicines should be prescribed and used for valid therapeutic indications. Appropriate health professional advice is important to ensure that the relevant intervention is appropriately used for therapeutic purposes only.

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GUIDANCE

G 3 *Seclusion is a form of restraint that can only be used within the Mental Health (Compulsory Assessment and Treatment) [MH (CA and T)] Act 1992, and the Intellectual Disability (Compulsory Care and Rehabilitation [ID(CCR)] Act 2003.*

Seclusion can be legally implemented subject to the conditions specified in the MH (CA and T) Act. The legal basis of seclusion for consumers under MH (CA and T) Act is set out in s71 of the Act and s148 of ID(CCR) Act. Seclusion should be used for as short a time as possible and is best conceived as a safety mechanism rather than a therapeutic intervention or treatment. The decision to seclude should be an uncommon event, used as a final alternative and subject to strict review. The information in NZS 8134.2.3 is provided with the expectation that although seclusion is legal, services will be proactive in reducing and minimising/avoiding its use.

Seclusion should not occur as part of a routine admission procedure or for punitive reasons. The MH (CA and T) Act requires that, except in an emergency, seclusion shall be used only with the authority of the responsible clinician. If not involved in the immediate decision, the responsible clinician must be informed of the seclusion as soon as possible, at least at the start of the next working day, and should review the decision. A doctor must assess the secluded consumer as soon as possible; this should be within two hours. The specificity of the assessment shall be appropriate to the level of risk and likelihood of harm occurring to the consumer. Wherever practicable, the two clinicians involved should be the consumer's own nurse and doctor.

The ID (CCR) Act requires that, except in an emergency, seclusion may only be used with the authority of a care manager who must ensure the care recipient is not secluded for longer than is necessary to achieve the purpose of secluding the care recipient.

G 3.1.1 *Procedural guidelines for the use of seclusion can be found on http://www.moh.govt.nz.*

G 3.1.2 *Seclusion should only be used to prevent violent behaviour compromising safety.*

G 3.1.4 *Seclusion should only be used with great caution, and with intensive monitoring in the following circumstances:*

(a) Where the consumer has had escalating requirements for medication and there is:

(i) Evidence of serious recent side effects

(ii) Likelihood of serious side effects;

(b) Physical deterioration;

(c) Where the consumer is in need of intensive assessment and/or observation, especially where there is a history suggestive of trauma, ingestion of unknown drugs/substances, or organic diagnosis.

G 3.2.4 *In addition to the environment being safe, wherever possible:*

(a) Doors should open outwards;

(b) While in seclusion consumers should be able to wear their own clothing and retain some of their personal possessions if their safety is not compromised.

(c) Items are provided if required by the consumer, if their safety is not compromised.

(d) A means of orientation (time, date, news, and other information) is provided;

(e) The service provider facilitates timely access to washing, showering, and toilet facilities in or adjacent to the area;

(f) There is access to a safe external area to assist with reintegration.

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Outcome 3 *Consumers receive services in the least restrictive manner.*

Seclusion shall only be used by services with approved seclusion facilities. All use of seclusion shall comply with NZS 8134.2.2 and NZS 8134.2.3.

SAFE SECLUSION USE WHAKAMAHI MŌWAI HAUMARU

Standard 3.1 **Services demonstrate that all use of seclusion is for safety reasons only.**

Criteria The criteria required to achieve this outcome shall include the organisation ensuring:

3.1.1 *The service has policies and procedures on seclusion that meet the requirements contained in 'Seclusion under the Mental Health (Compulsory Assessment and Treatment Act 1992' (MoH).*

MHA* & ID**

3.1.2 *Consumers are subject to the use of seclusion when there is an assessed risk to the safety of the consumer, to other consumers, service providers, or others.*

3.1.3 *There exists a legal basis for each episode of seclusion.*

3.1.4 *Any factors that may require caution must be assessed for each episode.*

3.1.5 *The likely impact the use of seclusion will have on the consumer's recovery and therapeutic relationships is considered and documented.*

APPROVED SECLUSION ROOMS RŪMA MŌWAI KUA WHAKAAEA

Standard 3.2 **Seclusion only occurs in an approved and designated seclusion room.**

Criteria The criteria required to achieve this outcome shall include the organisation ensuring:

3.2.1 *The seclusion room provides adequate lighting, room temperature, and ventilation.*

3.2.2 *The seclusion room allows the observation of the consumer and allows the consumer to see the head and shoulders of the service provider.*

3.2.3 *The seclusion room provides a means for the consumer to effectively call for attention.*

3.2.4 *The seclusion room contains only furniture and fittings chosen to avoid the potential for harm.*

* applies to mental health and addiction services only

** applies to intellectual disability services only

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