Clinical : Mental Health
Proactive Release : 30 May 2019

22 May 2019

[redacted]

E-mail: [redacted]

Dear [redacted],

Official Information Act (1982) Request

I write in response to your Official Information Act request, received by us on 23 April 2019. You requested the following information:

Can you please provide data about the use of restraints in the Counties Manukau DHB for both Emergency and Mental Health services, and identify the service associated with this data?

1. **In particular, can you provide Minutes of meetings, or other Documents produced by the Restraint Minimisation and Safe Practice Group from 2008 through 2018, that provide trends of the use of mechanical and physical restraints?**
   - *E.g. the audits mentioned in your document "Procedure: RM & SP for Restraint and Enabler Use" provided to the Health Sector Users Network on 5 February 2018.*

2. **In addition, can you provide information during the calendar year 2008, and during the calendar year 2018, on the use of personal, and physical/ mechanical restraints in the CMDHB?**
   - *By physical/ mechanical restraints, I mean using appliances such as straps, ties or handcuffs to immobilise patients and by personal restraints, I mean use of body contact for the purpose of immobilisation.*
   - *This data should be kept in a Restraint Register, or in the Incident Reporting Service.*
   - *This data for 2008 and 2018 should specify the type of restraint used (e.g., wrist strap) and the length of time between start and finish of each individual mechanical/ physical restraint.*

CM Health services provide health services to in excess of 569,400 people residing in South Auckland, both in hospital and community settings. Obviously, many of these people are acutely unwell and/or in distress when they require care; and that can result in behaviours that our staff members need to manage and respond to. Our Emergency Department sees more than 118,000 presentations per year. The numbers below should be considered in the context of the size of the health services we provide.

CM Health, in line with the values of the organisation, has a philosophy to support all staff to achieve the intent of the Health and Disability Services (*Restraint Minimisation*) Standard NZS 8134.2:2008: whereby restraint should only be used in the context of ensuring, maintaining, or enhancing the safety of the patient, service providers, or others. We are working to ensure that patients and service users

receive and experience services in the least restrictive manner, whilst recognising that all staff and care providers have the right to perform their duties in a safe environment.

All use of restraint in delivery of care must be recorded in the Incident Reporting System (IRS). Whilst our current practice is to record all use of restraints in the IRS, that process only began in April 2008, and was rolled out across the organisation throughout the following 12 months. The information was previously held in ward specific registers, that were paper based, and are no longer available for collation.

Furthermore, the Incidents System went through significant changes in 2009/2010, in terms of how restraint incidents were classified. For example, 'Combination Personal & Mechanical Restraint' and 'Emergency Sedation' were removed as Specific Incident Type options in 2009, and additional options, such as 'Physical Restraint' and 'Seclusion WITH restraint' were added in 2010.

We have records in the incident management system of all instances of physical and personal restraint, when we use a physical hold to restrain a person – however, at this time there is no nationally consistent mandatory reporting on personal restraint use in Mental Health; and how services describe a 'hold' is different in each DHB.

As a result of these factors, we believe that the logging of restraint use incidents has 'matured' significantly between 2008 and 2018, and we do not believe that the data on Specific Incident Types should be compared just between snapshots of 2008 and 2018. Potentially a more accurate comparison can be made between 2012 and 2018 reporting, and by considering the annual reporting trends.

Lastly, we note that the incident system is primarily used to ensure that incidents are properly managed at the time, and immediately afterwards, as well as to facilitate organisational learning and continuous improvement of polies and processes. Statistical analysis of historical data is a secondary goal of the system.

Consequently, we are providing a summary (**attached**) of all data on reported Restraint use between 2008 and 2018, per year for the two services, by type of restraint (including mechanical, physical and personal) reported (rather than snapshots of 2008 and 2018). This summary does not include incidents occurring/ reported in other services and wards.

Further notes on the attached data:

- Mechanical restraints use does not occur in other CM Health hospital services, with the exception of the Critical Care Complex (CCC). There have been no reported incidents of use of Mechanical Restraints in either Mental Health or Emergency Department services since 2009.
- Soft-wrist restraints are used in CCC, and are also recorded in a Soft Wrist Restraint Register in the unit. We also expect CCC staff to fully record the rationale and circumstance related to use of restraints in each individual patient medical file, and to continuously evaluate progress and alternatives.
- The textual descriptions accompanying each incident report, as to the clinical rationale for use etc., are typically very detailed, and include individual private information – and we are withholding that detail – under section 9(2)(a) of the Act.

- The data fields on incident dates and the relevant service are mandatory fields. Restraint start/end times in the Incident System were not always specified. These time fields came into use in 2016.
- Personal Restraint can occur in a number of contexts, and patient position is noted in the incident report, including whether a patient is lying down, sitting or standing.
- Physical Restraint type is an optional field and includes use of tools such as: arm splint/ splinting board, bean bag(s), bedrail(s), pillow(s), and wheelchair with lap belt. These are primarily used as an enabler of care, rather than solely as a restraint.
- We urge caution in comparing DHB Incident report system data, due to different reporting systems, the scale and size of DHB services, variation in population needs, and the challenges of using raw numbers, rather than rates per 100,000 people.

Work by the Health Quality Safety Commission (HQSC), in conjunction with Te Pou, and all Mental Health services is focussing on improving Mental Health care outcomes and experience, including reducing use of seclusion, and this programme will see nationally consistent reporting on a number of measures related to use of personal restraint, seclusion and least restrictive care. Information about the programme is on the HQSC website.

With the above caveats, we note the following additional points on the total number of reported incidents related to personal restraints and seclusion that have occurred at Counties Manukau DHB for 2008-2018 for CM Health Mental Health Services and the Emergency Department.

- In 2018, of the total Personal Restraint incidents reports (including Seclusion with restraint), there were 419 incidents that had a duration time reported; the average time was 20 minutes, and the most common (mode) was 5 minutes. There were a further 66 without the time field completed, with this detail in the narrative text.
- As noted above, there has been no use of Mechanical Restraints reported in these services in CM Health since 2009.
- There has been organisational attention to reducing the use of Physical Restraints, as shown by the reduction in incident reports. In 2018, of the two (2) physical restraint incidents reported, both cited used of an enabler device (pillow/ splint).

The formation of a Restraint Minimisation and Safe Practice Group (and its predecessors) are DHB-wide working groups, which were first established in 2009, and for the last decade has worked on making changes to address this issue. The Restraint Minimisation and Safe Practice Group is a multi-disciplinary group, which meets monthly. The purpose of this committee is to align CM Health policy, procedure, practice and training with the Restraint Minimisation Standard - NZS 8134.2:2008.

In the Mental Health and Addiction service, all restraints (with or without seclusion) are reviewed weekly, by a multidisciplinary review group, which consists of Clinical Head (Psychiatrist), Nurse Unit Manager, Charge Nurses, Associate Charge Nurses, Clinical Nurse Director, Occupational Health, Consumer advisor, and Family/ Whaanau representative.

Collecting all of the Minutes of meetings, or other Documents produced by the Restraint Minimisation and Safe Practice Group for the last a decade, as requested, would generate a substantial amount of information, much of that is operational in nature, and are no longer current. This would be administratively complex, and require significant collation and review by a team focused on clinical safety for patients.

Rather, we are providing key documents that show evidence of progress (**attached**), as we believe these are likely to be most useful. These documents include the Terms of Reference for the current group, and a summary presentation from 2009 proposing organisational priorities for improvement, the current organisation policies and procedure documents, and the assessment tool.

We also note that there is publicly available information on our work and progress over the last decade, summarised in reports such as the CMDHB Quality Accounts and the MoH Certification Reports. Links to these reports are:

- https://countiesmanukau.health.nz/about-us/performance-and-planning/planning-documents/
- https://www.health.govt.nz/new-zealand-health-system/my-dhb/counties-manukau-dhb/counties-manukau-health-quality-and-safety

CM Health has made a significant investment in organisation-wide staff education related to Restraint Minimisation and Enabler practices. All employees who have direct clinical contact with patients, visitors and members of the public complete the Restraint Minimisation and Safe Practice module. This training is incorporated within the Patient Safety Training completed at employee orientation, and annually via the Ko Awatea LEARN portal e-learning refresher modules. All new Mental Health in-patient services staff, Duly Authorised Officers, Crisis Team employees, and Security attend the Safe Practice Effective Communication (SPEC) four-day course and an annual two-day refresher course.

This is a complex area of health care provision, and there is and has been significant effort on a range of initiatives to improve procedures and experience for patients and staff over the last 10 years. This is occurring in the context of growing demand and complexity of health care. CM Health is dedicated to serving our patients and communities by ensuring quality focussed health care. The District Health Board takes the health, safety and welfare of all patients and staff extremely seriously.

Should you have further specific questions on the work occurring in CM Health, please contact us, and we can arrange further contact with the clinical leads in the area.

I trust this information satisfactorily answers your query. If you are not satisfied with this response you are entitled to seek a review of the response by the Ombudsman under section 28(3) of the Official Information Act.

Please note that this response or an edited version of this may be published on the Counties Manukau DHB website.

Yours sincerely,

Fepulea'i Margie Apa
Chief Executive

Appendix 1 - Summary Data
OIA 23042019 - Savage - restraint use

			Year										
Division	**Group**	**Specific Incident Type**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**
MEDICINE	ED ACUTE CARE SERVICES	*Combination Personal & Mechanical Restraint*	*1*										
		Combination Personal Restraint & Emergency Sedation	*9*	*2*									
		Environmental Management	*1*										
		Environmental Restraint			1	1	15		3			2	
		Mechanical Restraint	2										
		Personal Restraint	10	10	30	47	54	87	144	216	164	137	136
		Physical Restraint			7	8	3	1	2	3	1	2	1
		Procedural Restraint	*1*	*18*	*7*								
		Seclusion			*4*								
		Seclusion WITHOUT restraint					1		1	1		1	
	ED ACUTE CARE SERVICES Total		**24**	**30**	**49**	**56**	**73**	**88**	**150**	**220**	**165**	**142**	**137**
MENTAL HEALTH	MENTAL HEALTH	*Combination Personal & Mechanical Restraint*		*2*									
		Combination Personal Restraint & Emergency Sedation	*9*	*8*									
		Environmental Restraint		4	8	6	2	8	1	4	1	3	2
		Mechanical Restraint		1									
		Personal Restraint	22	64	134	199	291	243	265	257	179	133	232
		Physical Restraint			18	18	10	6	4	5	3	1	1
		Procedural Restraint	*5*	*29*	*7*								
		Seclusion	*20*	*34*	*14*								
		Seclusion WITH restraint			29	55	61	93	104	149	120	157	116
		Seclusion WITHOUT restraint			5	14	37	57	42	57	45	45	70
	MENTAL HEALTH Total		**56**	**142**	**215**	**292**	**401**	**407**	**416**	**472**	**348**	**339**	**421**
Grand Total			**80**	**172**	**264**	**348**	**474**	**495**	**566**	**692**	**513**	**481**	**558**

In current use:

Environmental Restraint — Where a service provider intentionally restricts a consumers normal access to their environment, (e.g. locking doors or denying access to a mobility device such as a wheelchair).

Personal Restraint — Where a service provider uses their own body to intentionally limit the movement of a consumer (e.g. by being held).

Physical Restraint — Where a service provider uses equipment, devices or furniture that limits the consumers normal freedom of movement, (e.g. the use of a belt or the position of a table or fixed tray).

Seclusion WITH/WITHOUT restraint — Where a consumer who declines to consent is physically placed using approved restraint techniques, alone into an approved supervised seclusion room at any time, for any duration with no means of exiting freely.

Restraint Minimisation and Safe Practice Group [RMSPG]

Terms of Reference

COUNTIES MANUKAU HEALTH

Purpose and Brief

Purpose

The overarching purpose of the RMSPG is to align CMDHB policy, procedure, practice and training with the Restraint Minimisation Standard. NZS 8341: 2008.

Role & Responsibilities

- Ensure policy and procedure relating to restraint is current and aligned to the current national restraint minimisation standard
- Develop an annual programme of work as required to ensure best practice standards are met
- Support speciality areas eg Mental Health Services with the development, consultation and communication of related policies and procedures.
- Support the review the development of procedures and guidelines for restraint minimisation and safe practice for each division within CM Health
- Support the implementation of policies and procedures relating to restraint minimisation and safe practice appropriately in the organisation
- Maintain a current register of approved methods of restraint and enabler use within CM Health
- Review all applications for approval of methods of restraint and enablers
- Provide regular 6 monthly reports to PMIG and Consumer Council
- Provide an Annual report on activity and use to the Clinical Governance Committee and Quality Monitoring Improvement Group
- Review and monitor data on restraint minimisation and safe practice use (including enablers)
- Monitor staff training on restraint minimisation and safe practice (numbers attending and evaluations) as available
- In partnership with Occupational Health and Safety act as a resource/elevate to higher level for addressing issues related to personal physical safety e.g. assaults
- Provide advice on the appropriate use of restraint and enablers
- Review and update all education and training related to restraint minimisation and safe practice for staff across the organisation to ensure currency and adherence to standards
- Maintain the RMSPG website to ensure its value as a resource.

Membership

Participants for membership of the group have been invited from the following:

- Consumer representative – optional as required
- Restraint Minimisation and Safe Practice Coordinator, Patient Safety and QAM
- Clinical Quality Co-ordinator [Nafessa]
- Clinical Director Patient Safety and Quality Assurance
- ARHOP representative
- People and Professional Development Manager [Denise]

	▪ Safe Practice and Effective Communication (SPEC) instructor ▪ Security Manager ▪ Associate Director Allied Health *Optional / as required attendees:* ▪ Legal representative ▪ Occupational Health and Safety Representative ▪ Maori advisor ▪ Pacific Island advisor ▪ Clinical Engineering representative as required ▪ Others co-opted as required **Circulation of minutes** Optional attendees as above Mental Health Services Governance Group Chair Consumer Council Patient Safety Groups as requested [Falls, PI, SMH] Clinical Governance Group Quality Managers & Risk Manager Chief Nurse Chief Medical Officer
Quorum	There must be a minimum of 6 of the membership present for a meeting to proceed
Meeting Frequency	Monthly at a minimum although work streams may meet more frequently. More frequent meetings can be organised at the discretion of the Chair.
Reporting Line	The chairperson will be appointed by consensus of the Committee and will be reviewed yearly or following resignation.
Review Date	Terms of Reference are reviewed and updated annually Last Updated: December 2018 Next review date: December 2019 First issued: May 2018

Policy: Restraint Minimisation and Safe Practice

Purpose

Counties Manukau Health (CM Health) is dedicated to serving our patients and communities by ensuring quality focussed health care.

CM Health takes the health, safety and welfare of all patients and staff extremely seriously.

Staff will ensure that patients receive and experience services in the least restrictive manner whilst recognising that all staff have the right to perform their duties without tolerating abuse or acts of aggression.

Note: This Policy must be read in conjunction with Procedure: Restraint Minimisation and Safe Practice for Restraint and Enabler Use. Or Procedure: Restraint Minimisation – Personal Restraint Mental Health Inpatient Services and the Safe and Appropriate Use of Bedrails Guideline.

Philosophy

It is the philosophy of CM Health, in line with the values of the organisation, to support health professionals and support staff to achieve the intent of the Health and Disability Services (Restraint Minimisation) Standard NZS 8134. 2008: which is that Restraint and/or Enablers should only be used in the context of ensuring, maintaining, or enhancing the safety of the patient, service providers, or others.

Scope

This policy is applicable to:

- All CM Health employees and visiting health professionals working in any CM Health Facility (note: students and contractors are excluded from performing restraint).
- Specific clinical areas must have procedures/guidelines, consistent with this policy, that reflect the contextual issues in a particular setting.

Approval of Restraints and Enablers

- All Restraints and Enablers used at CM Health must be approved by the Restraint Minimisation and Safe Practice Group (RMSPG).

Policy

- Restraint is a serious intervention that requires clinical rationale and oversight. It is based on sound clinical judgement with clear justification for use.
- Restraint shall be perceived in the wider context of risk management; it is not a treatment within itself but one of a number of strategies used by service providers to limit or eliminate a clinical risk.
- Restraint should only be used as a last resort after alternative less restrictive interventions have been attempted e.g. de-escalation, interpreters, cultural support. It will be used for the shortest time possible.
- CM Health does not support the use of Chemical Restraint.
- CM Health does not support the use of bed rails as a method of Restraint.
- Enablers can only be used voluntarily for positioning, mobility or comfort.
- Incidents resulting from Restraint/Enablers will be reported in the Incident Reporting System (IRS).
- Audits of restraint and enabler use will be tabled at the Restraint Minimisation and Safe Practice Group quarterly meetings as well as discussed within Services as appropriate.

Documentation

- Restraint use must be recorded in the IRS. The exception to this is the use of soft wrist restraints e.g. Critical Care Complex, however, an auditable record of its use must be current and available.
- An e-version of the information required in the folder is available on Paanui by clicking on this link: https://cmhealth.hanz.health.nz/Patient%20Safety/RestraintMinimisationandSafePractice/Pages/default.aspx

Education

- All CM Health employees with patient contact will receive information/training related to Restraint Minimisation and Safe Practice at a level that supports safe practice in their role, discipline and service.

Definitions

Terms and abbreviations used or are relevant for this document are described below:

Term	Definition
Restraint	The use of any intervention by a service provider that limits a patient's normal freedom of movement.
Type of Restraint:	Where a service provider uses their own body to

Personal Restraint	intentionally limit the movement of a consumer e.g. holding a patient.
Type of Restraint: **Physical Restraint**	Where a service provider uses equipment, devices or furniture that limits a patient's normal freedom of movement e.g. fixed trays, lap belts or specialised seating.
Type of Restraint: **Environmental**	Where a service provider intentionally restricts a patient's normal access to their environment e.g. locking devices on doors, removing mobility aids e.g. wheelchair.
Seclusion	Where a patient is placed alone in a designated room or area, at any time and for any duration, from which they cannot freely exit. Seclusion only occurs in the inpatient Mental Health Services at CM Health.
Enabler	Equipment, devices or furniture, voluntarily used by a patient following appropriate assessment by a health professional, that limits normal freedom of movement. The least restrictive option is used with the intent of promoting independence, comfort and/or safety (consented to by the patient or their legal representative).
Chemical Restraint	**CM Health does not support the use of Chemical Restraint** NZS 8134: 2008 Health & Disability 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." Chemical restraint is defined as the intentional use of medication to control a person's behaviour when no medically identified condition is being treated, **or** where the treatment is not necessary for the identified condition **or** amounts to excessive treatment for the identified condition **or** where the intended effect of the drug is to sedate the person for convenience sake or purposes of punishment Use of medication as a form of 'chemical restraint' is in breach of this standard.
Bed rails	**CM Health does not support the use of bed rails as a Restraint.** Bed rails can be used as an Enabler in specific circumstances. The inappropriate use of bed rails is associated with significant risks to the patient. Staff must be familiar with the Safe and Appropriate Use of Bed Rails Guideline before using this equipment as an enabler.
Transportation of patients	The temporary use of bed rails or safety belts for patient safety when a patient is in transit from one place to another is not considered restraint as long as a staff member is present. When transporting a patient by

	vehicle land transport requirements must be met e.g. the wearing of seat belts. If the bed rail remains in use once on a ward, then an assessment must be completed and documented in the clinical record.
Technical positioning and planned safe holding	**Is not considered to be Restraint** Adults, children and young persons are often held or their ability to move is limited while an investigation or procedure occurs. This is referred to as technical positioning and planned safe holding. It is expected that the need for this will be essential to the procedure, included in the relevant procedure along with safety requirements, education needed to ensure patient safety and informed consent requirements will be met.
Family	Members of a patient's close or extended family or whaanau; partners; friends; health advocates; guardian or other representatives nominated by the patient.
Non Clinical Intervention	Use of restraint recommended and applied by law enforcement officers i.e. police/prison officers, for reasons other than clinical treatment, is not covered by this policy. Police/prison officer have full responsibility for safe law enforcement Restraint. These situations are governed by Criminal Law including the Trespass Act 1980 and the NZ Crimes Act 1961.
Locked Units	In a locked unit the locked exit is a permanent aspect of service delivery to meet the safety needs of patients who have been assessed as needing that level of containment. Although by definition the locking of exits constitutes Environmental Restraint the requirements of NZS8134.2 are not intended to apply to designated locked units that have entry and exit criteria and can ensure any patient who does not meet the criteria has the means to independently exit at any time.
SPEC	Safe Practice, Effective Communication (SPEC) is a four day training course focusing on effective Communication de-escalation and approved Restraint techniques.
Communicating Effectively	Workshop exploring our communication preferences and how our style impacts on others including review of key principles of AI²DET and introduction of the three steps to better health literacy
Restraint Minimisation E-Learning Package	E-learning session accessed online by health professionals.
Safe Use of Bed Rails E Learning Module	E-learning session accessed online by health professionals.

Associated Documents

Document ID:	A17357	**CMH Revision No:**	2
Service :	Risk Management and Quality Assurance	**Last Review Date :**	18/12/2018
Document Owner:	Chief Medical Officer (CMO) - Executive Management	**Next Review Date:**	18/12/2021
Approved By:	Clinical Governance Group (CGG)	**Date First Issued:**	14/09/2010
Counties Manukau Health			

NZ Legislation	NZ Crimes Act 1961 NZ Bill of Right Act , 1990 Health and Disability Act 2001 Code of Health and Disability Services Rights 1996 Protection of Personal and Property Right Act 1988 Mental Health (Compulsory Assessment and Treatment) Act 1992. Human Rights Acts 1993 Health and Safety in Employment Act 1992
CM Health Policies and Procedures	Policy: Tikanga Best Practice Policy: Informed Consent Policy: Management of aggressive behaviour in the workplace Policy: Visitors Policy: Security CM Health Vision and Values Procedure: Restraint Minimisation and Safe Practice for Restraint and Enabler Use Procedure: Restraint Minimisation – Personal Restraint Mental Health Inpatient Services Policy: Incident Management and Reporting Procedure: Incident Management and Reporting Policy: Management of Consumer Complaints and Feedback Procedure: Management of Consumer Complaints and Feedback
NZ Standards	Restraint Minimisation and Safe Practice Standard NZS 8134.2 :2008 Health and Disability Services (general) Standard NZS 8134. 0: 2008. Health and Disability Services (core) Standards NZS 8134.1: 2008. Restraint of Children with Disabilities, or Medical Conditions, in Motor Vehicles NZS 4370:2013
Organisational Procedures	Safe and Appropriate use of Bedrails Guideline Assessment and Care of Patients Presenting to EC at risk of Suicide or in an Agitated State (Procedure) Restraint Minimisation – Personal Restraint Mental Health Inpatient Services
Other related documents	Management of Adults with Severe Behavioural Disturbance (Guideline) Restraints - Critical Care Complex (Guideline) Dealing with Violent and/or Abusive Patient (Guideline) Management of Challenging Behaviour in Pukekohe and Franklin Memorial Hospitals (Guideline)

Procedure: Restraint Minimisation and Safe Practice for Restraint and Enabler Use.

Definition/Description

The purpose of this procedure is to describe the process of Restraint Minimisation and Safe Practice for Restraint and Enabler use within Counties Manukau Health (CM Health).

This document is to be read in conjunction with CM Health Restraint Minimisation and Safe Practice Policy.

Note: This procedure must be read in conjunction with Policy: Restraint Minimisation and Safe Practice and Safe and Appropriate Use of Bedrails Guideline

People involved and Responsibilities

This applies to all CM Health employees with patient contact (full-time, part-time and casual) including visiting health professionals working in any CM Health facility (note: students and contractors are excluded from performing restraint).

Security staff trained in the Safe Practice Effective Communication (SPEC) course (with annual updates) can be called to assist for Personal and Environmental Restraint under the Registered Health Professionals instructions.

The Restraint Minimisation and Safe Practice Group (RMSPG) authorises the use of restraints and enablers in CM Health and meets regularly to review the use of restraints and enablers to ensure their appropriate use and identify improvement opportunities.

Note: Personal Restraint for Mental Health Inpatient Services will refer to Procedure: Restraint Minimisation – Personal Restraint Mental Health Inpatient Services

Objectives

To ensure enablers are only used voluntarily and not for restraint.

To ensure restraint is used as a last resort after alternative less restrictive interventions have been attempted.

Procedure

Enabler Use

Initiation

- When requested by patient, family/whaanau or registered health professional for providing comfort, positioning or mobility.
- Complete the Bedrail Decision Checklist sticker and place this in the patient's clinical record.

Monitoring

- Regular visual checks of the patient are to be maintained. The call bell must be within the patient's reach or in a supervised area.
- Monitoring times will be documented in the plan of care.
- The assessment supporting enabler use will be documented in the clinical record and will include the name of the patient, family/whaanau who was informed.

Evaluation

- An evaluation of the effectiveness of the use of enablers will be undertaken and documented in the patient clinical record.

Procedure

Physical Restraint Use

Initiation

- Restraint use will be initiated after assessment and discussion by the clinical team.

- The decision making process will be clearly documented in the clinical notes and an individualised care plan developed to ensure all the patient's needs are met whilst restraint is being used.

- A patient-centred goal will be developed in the patient's plan of care outlining the use, monitoring and evaluation of restraint use.

- Wherever possible discussion and consent process will include the patient and family/whaanau. Continuation of restraint will be discussed at any family/whaanau meetings.

- Restraint will be initiated only when the environment is safe and appropriate for initiation and when adequate resources are in place.

Monitoring

- Patient checks are to be maintained at a minimum of every 30 minutes unless more or less frequent checks are clinically indicated (e.g. mental health area).

- The call bell must be in reach of the patient or the patient must be in a supervised area.

- Monitoring requirements will be documented in the care plan/daily intervention.

Documentation

- The restraint is to be logged in the Incident Reporting System (IRS).

- Documentation in the patient clinical record or care plan/daily intervention is required including monitoring times.

- Monitoring form for physical restraint must be completed.

Evaluation

- An evaluation of the effectiveness of the use of restraint will be undertaken and documented in the patient's clinical record.

- Audits to assess the effectiveness and relevance of

restraint use will be undertaken regularly to facilitate professional development of practice and appropriate use.

Procedure

Personal and Environmental Restraint Use

Initiation

- Restraint use will be initiated after assessment and discussion by the clinical team.
- Exceptional circumstances will require emergency restraint. This must be initiated by a registered health professional.
- The decision making process will be clearly documented in the clinical notes and an individualised plan of care developed to ensure all the patient's needs are met whilst restraint is being used.
- A patient-centred goal will be developed in the patient's plan of care outlining the use, monitoring and evaluation of restraint use.
- Wherever possible discussion and consent process will include the patient and family/whaanau.
- Restraint will be initiated only when the environment is safe and appropriate for initiation and when adequate resources are in place.

Monitoring

- Staff will remain with the patient at all times.
- Security guards will follow the direction of a registered health professional.

Documentation

- Personal and environmental restraints must be reported on the IRS including the type and position of restraint.
- The decision making process will be clearly documented in the patient clinical notes or care plan/daily intervention is required including the rationale, goal, process and evaluation of the restraint.

Evaluation

- An evaluation of the effectiveness of the use of restraint will be undertaken and documented in the patient's clinical record.

- Audits to assess the effectiveness and relevance of restraint use will be undertaken regularly to facilitate professional development of practice and appropriate use.

Resources

- Guideline: Safe and Appropriate use of Bedrails which includes the Bedrail Decision Guide and Bedrail Intervention Guide.
- Restraint Minimisation and Safe Practice E Learning Package
- Safe Use of Bedrails E Learning Package

Definitions

Terms and abbreviations used or relevant for this document are described below:

Term	Definition
Restraint	The use of any intervention by a service provider that limits a patient's normal freedom of movement.
Type of Restraint: **Personal Restraint**	Where a service provider uses their own body to intentionally limit the movement of a consumer e.g. holding a patient.
Type of Restraint: **Physical Restraint**	Where a service provider uses equipment, devices or furniture that limits a patients normal freedom of movement e.g. fixed trays, lap belts or specialised seating.
Type of Restraint: **Environmental**	Where a service provider intentionally restricts a patients normal access to their environment. e.g. locking devices on doors, removing mobility
Seclusion	Where a patient is placed alone in a designated room or area, at any time and for any duration, from which they cannot freely exit. Seclusion only occurs in the inpatient Mental Health Services at CM Health.

Enabler	Equipment, devices or furniture, voluntarily used by a patient following appropriate assessment by a health professional, that limits normal freedom of movement. The least restrictive option is used with the intent of promoting independence, comfort and or safety (consented to by the patient or their legal representative).
Chemical Restraint	**CM Health does not support the use of Chemical Restraint** NZS 8134: 2008 Health & Disability 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." Chemical restraint is defined as the intentional use of medication to control a person's behaviour when no medically identified condition is being treated, or where the treatment is not necessary for the identified condition or amounts to excessive treatment for the identified condition or where the intended effect of the drug is to sedate the person for convenience sake or purposes of punishment Use of medication as a form of 'chemical restraint' is in breach of this standard.

Bed rails	**CM Health does not support the use of bed rails as a Restraint.** Bed rails can be used as an enabler in specific circumstances. The inappropriate use of bed rails is associated with significant risks to the patient. Staff must be familiar with the Safe and Appropriate Use of Bed Rail Guideline before using this equipment as an enabler.

Transportation of patients	The temporary use of bed rails or safety belts for patient safety when a patient is in transit from one place to another is not considered restraint as long as a staff member is present. When transporting a patient by vehicle land transport requirements must be met e.g. the wearing of seat belts. If the bed rail remains in when on the ward, then an assessment must be completed and documented in the clinical record.
Technical positioning and planned safe holding	**Is not considered to be Restraint** Adults, children and young persons are often held or their ability to move is limited while an investigation or procedure occurs. This is referred to as technical positioning and planned safe holding. It is expected that the need for this will be essential to the procedure, included in the relevant procedure along with safety requirements, education needed to ensure patient safety and informed consent requirements will be met.
Family	Members of a patient's close or extended family or whaanau; partners; friends; health advocates; guardian or other representatives nominated by the patient.
Non Clinical Intervention	Use of restraint recommended and applied by law enforcement officers i.e. police/prison officers, for reasons other than clinical treatment, is not covered by this policy. Police/prison officer have full responsibility for safe law enforcement Restraint. These situations are governed by Criminal Law including the Trespass Act 1980 and the NZ Crimes Act 1961.
Locked Units	In a locked unit the locked exit is a permanent aspect of service delivery to meet the safety needs of patients who have been assessed as needing that level of containment. Although by definition the locking of exits constitutes environmental Restraint the requirements of NZS8134.2 are not intended to apply to designated locked units that have entry and exit criteria and can ensure any patient who does not meet the criteria has the means to independently exit at any time.

SPEC	Safe Practice, Effective Communication (SPEC) is a four day training course focusing on effective Communication de-escalation and approved Restraint techniques.
Communicating Effectively	Workshop exploring our communication preferences and how our style impacts on others including review of key principles of AI²DET and introduction of the three steps to better health literacy.
Restraint Minimisation E-Learning Package	E-learning session accessed online by health professionals.
Safe Use of Bedrails E Learning Package	E-learning session accessed online by health professionals.

Associated Documents

Other documents relevant to this policy are listed below:

NZ Legislation	NZ Crimes Act 1961 Mental Health (Compulsory Assessment and Treatment) Act 1992 Human Rights Act 1993 Health and Safety in Employment Act 1992 Health
CMDHB Clinical Board Policies	Restraint Minimisation and Safe Practice (Policy) Informed Consent (Policy) Security Department (Policy)
NZ Standards	Restraint Minimisation and Safe Practice Standard NZS 8134:2; 2008 Health and Disability Services (General) Standard NZS 8134, 0; 2008 Health and Disability Services (Corel) Standard NZS 8134, 1; 2008

Organisational Procedures	Safe and Appropriate Use of Bed Rails Guideline Assessment and Care of Patients Presenting to EC at risk of Suicide or in an Agitated State (Procedure) Restraint Minimisation – Personal Restraint Mental Health Inpatient Services
Other related documents	Management of Adults with Severe Behavioural Disturbance (Guideline) Restraints - Critical Care Complex (Guideline) Dealing with Violent and/or Abusive Patient (Guideline) Management of Challenging Behaviour in Pukekohe and Franklin Memorial Hospitals (Guideline)

Procedure: Restraint Minimisation – Personal Restraint Mental Health Inpatient Services

Purpose

The purpose of this procedure is to;

- Ensure that the standards for safe practice and restraint minimisation are adhered to.
- Maximise safety and minimise risk to service users and staff when undertaking a restraint.

Note: This procedure must be read in conjunction with CMH Restraint Minimisation Policy

People involved and responsibilities

This procedure may be carried out by any inpatient or acute staff. Staff members involved in restraint must have attended CMH Safe Practice and Effective Communication Training.

- A Registered Nurse is responsible for overseeing the process of restraint. Registered Nurse's take full clinical responsibility for all restraint procedures
- All restraints must be undertaken using no less than three staff members.
  - 'Number One' is responsible for Communication, Co-ordination and airway/physical wellbeing of the patient and staff.
  - 'Numbers Two' and Three: Follow Instructions from Number One, be committed to the task, immobilise the limbs, observing and communicating to Number One.
  - Extra Staff: Follow instructions from Number one (ie. moving patient to seclusion area, medications, communicating with medical staff, assisting with Restraint Process).

Restraint can only be used:

- With a service user whose behaviour indicates that he /she is seriously at risk to self or others.
- Where it is necessary to give a planned prescribed medication to an individual who is resistive and there is therapeutic justification for provision of this medication.
- When the service user is under the Mental Health Act

Objectives

The aim of this procedure is to:

- Clarify the process for personal restraint whilst adhering to the expected standard of least restrictive practice.
- Clarify the roles and responsibilities of staff involved in restraint.
- Maximise safety for service users and staff in situations where risks of injury are imminent
- Minimise risk when administering medication vital to the person's wellbeing

Standards to be followed:

- Practice is guided by ethical principles that include acting for the service users good, avoiding harm to the them, avoiding harm to self or others and respecting the dignity of the person
- Personal restraint should only be applied for the minimum time possible to establish safety or self control or to deliver essential treatment
- Education is reviewed against best practice standards annually
- Best practice is maintained through mandatory annual education updates
- All personal restraint will be reviewed against the Health and Disability standards through a robust review process
- All Registered Nurses must be competent in the recognition, prevention and management of the risk of restraint asphyxia

Note
Any use of personal restraint must be in accordance with relevant legislative framework
Personal restraint is a hands-on method of restraint. Full restraint always requires a minimum of three appropriately trained staff to ensure safety of all involved.
Any unauthorised restriction on a patient's freedom of movement could be seen as unlawful
Staff working in the community should not undertake personal restraint of service users. If de-escalation techniques are not effective, and restraint is required, staff should withdraw from the situation, ensure safety and initiate emergency procedures. The only exception to this would be in circumstances or situations where imminent harm is likely and the community staff are in a position to perform a safe restraint. Staff need to be aware of the legal framework supporting restraint in a community setting, the Crimes Act.
Staff working in acute settings in the community should only undertake physical restraint to assist police (in emergency situations) or clinical staff (on an admission to an inpatient setting.)

Procedure

Procedure	**Action**
Education	Ongoing education is provided to all identified CMH Mental Health staff. This includes, communication, de-escalation, break away techniques. Personal restraint techniques are taught to those working in Inpatient units and acute roles and Duly Authorised Officers. **Specific training objectives :** **Registered Nurses and Doctors will be able to;** • Use the required skill and expertise to assess/anticipate 'at risk' service user behaviour, monitor behaviour and initiate

Procedure	Action
	activities to minimise the need for intervention. **All clinical staff will be able to :** • Take appropriate action to control the situation to minimise the possibility of injury. • Maintain, as far as possible, a safe environment for all service users, family whaanau and staff. • Ensure that the specific needs of service users during each stage of de-escalation and restraint are recognised. • Ensure relevant cultural advice and/or guidance is sought in order to maintain and practice cultural safety.
Assessment	On admission a risk assessment will be undertaken for all service users to establish whether they are at risk of perpetrating or being vulnerable to acts of violence or aggression using an approved aggression/vulnerability scale Dynamic Appraisal of Situational Aggression (DASA), The Vulnerability Checklist. If identified at presenting with significant risk, a plan will be developed in consultation with the service user, multi-disciplinary team, and discussed when appropriate with the family/whaanau. The plan will detail strategies for managing distress, de-escalation techniques and prevention measures. The plan can include: • sensory modulation • CBT or DBT strategies • distraction techniques • calming or self soothing activity • relaxation • Following the Acute Behavioural Guidelines • other identified coping strategies Where there is a possibility that restraint may be required, consideration must include the following and a plan must be developed to mitigate risks : • Previous trauma history and de-escalation preference. • Possible alternative interventions/strategies. • Prior personal restraint experience of the individual and possible compromise to the future therapeutic relationship.
Situations of Extreme Caution	Personal restraint should be used with extreme caution in the following circumstances and all efforts made to maintain the person in an upright position. • Where it compromises the physical well-being of the

Procedure	Action
	individual. (Known physical issues, health problems, excessive weight, intoxication alcohol or drugs, when last eaten, pregnancy, etc). • When the individual is in possession of a weapon. (Section 41 Crimes Act 1961). Additional support/emergency responses must be activated • Where it compromises the psychological wellbeing of the user with particular attention to vulnerable individuals.

Step	Action
1. Initiating Restraint	When de-escalation has been unsuccessful, or restraint is planned to deliver essential treatment, and restraint is assessed as the only safe mechanism to prevent harm, adequate staffing must be assembled to initiate restraint. A Registered Nurse must take responsibility for the restraint process including the monitoring of both the service user and staff involved, and for documentation of the incident A Registered Nurse must take lead responsibility for the restraint process including delegating roles to safely manage the incident, the ward setting and the other service users in the unit. The Associate Charge Nurse Manager (ACNM) or Nurse In Charge on the shift should be informed immediately and attend the incident. The least restrictive intervention should be chosen to match the level of risk. Except in an emergency, restraint should only be initiated when a plan has been agreed upon and the team is ready.
2. **Application**	The ACNM or other senior nurse present will identify and designate a restraint team. The team will be directed by 'Number One' who is responsible for Communication, Co-ordination, airway / physical management and the wellbeing of the patient. 'Numbers Two' and 'Three': must follow Instructions from 'Number One', be committed to the task, immobilise the limbs, observing and communicating with 'Number One'. Extra Staff: Must follow instructions from 'Number one' (ie. moving the person to the retreat area, administering medications, communicating with medical staff, assisting with the Restraint Process).

Step	Action
	Only approved restraint techniques will be utilised. The principle of least restrictive practice will apply at all times To establish the level of intervention required, continuous assessment must be carried out by the lead Registered Nurse. One of the following holds will be utilised as directed by Number one. *Only the following holds approved for use in CMH are to be utilised* **Escort Hold** • Support Hold Level 1 • Support Hold Level 2 • Support **Secure** Hold Level 3 • Secure Hold Level 4 Not fixed • Secure Hold Level 4 **Fixed**
3. Monitoring of Restraint	When the person is restrained, checks must be made to ensure they have a clear airway and that no pressure is applied to the neck, chest, lower back or abdomen. Throughout the procedure 'Number One' will lead the communication with the person. This should include, where appropriate an explanation for the intervention. During this process, acknowledgement and management of any distress should be addressed.
4. Ending Restraint	This should be managed in a gradual manner under the direction of a Registered Nurse. This will follow an ongoing assessment and evaluation of risk and outcomes to ensure the service user is reintegrated into the least restrictive environment. The person must be supported post-restraint including integration back into the ward environment.
5. Documentation	Every situation where personal restraint occurs must be recorded in the restraint register, including patient details, type of restraint, timeframe and outcome. In addition - on each separate occasion an incident form using Risk Pro will be completed with use of force clearly identified. Full documentation of the incident including the Restraint Process and follow up must be recorded in the Patient's Clinical Notes. Risk Assessment and Care Plans are to be updated following incidents
6. Defusing/	Following a Restraint Incident, all staff involved must attend a

Step	Action
Debriefing	defuse lead by the ACNM or delegated other prior to the end of their shift. This must occur as soon as possible after the event. (See: Staff Critical Incident Defusing and Debriefing Policy). Service users involved in a Restraint Incident must be offered the opportunity to debrief following the incident. Specific staff have been trained as debriefers in Gaining Patient Perspective'. A charge nurse or the ACNM can assist to arrange for a staff member to talk to the person: The process for the debrief with the service user is to occur at an appropriate time to discuss: The need for restraint / what alternatives could have prevented the restraint / how the person feels about the process / and what supports are required A record of the debriefing should be made within clinical notes using the typing template restdb\. Any identified strategies to prevent future restraint should also be documented in a management plan within the clinical notes.
7. Evaluation of Restraint	Discussion will include: • Review of the environmental factors / background triggers that may have triggered the need for restraint. • Alternatives that were attempted, including de-escalation techniques. • Effectiveness of restraint process (including techniques used). • Whether the restraint met the outcomes of the intervention • Whether any injury occurred to staff or the service user involved in the restraint. • Service user, family / whaanau and staff requirements or needs following the restraint • The availability of cultural support. • Agreement of whether a formal review is required.

Definitions

Term/Abbreviation	Description
Restraint	The use of any intervention by a service provider that limits a service user's normal freedom of movement.
Personal Restraint	Where a service provider uses their own body to intentionally limit the movement of a patient e.g. holding a patient
De-escalation	The act of reducing intensity of (arousal)

Defusing	Defusing is a group meeting of those involved in or affected by a critical incident. It is often the first formal intervention shortly after an incident where staff can discuss the incident in a personal way in a safe, supportive environment. Information is provided to those involved. It is usually held at the work site, but away from the scene of the incident. It may be followed up by a debriefing session, the defusing process may eliminate the need to provide a formal debriefing, or may enhance the effectiveness of the debriefing.
Debriefing	Debriefing is a structured and facilitated group meeting of identified staff generally held 72 hours or more following a critical incident. The decision to hold a debriefing is made at the defusing session. It can help accelerate the normal recovery process through raised awareness, education and stress management. The debriefing is facilitated by a recognised (trained) Critical Incident facilitator and follows a formal structured process, as per guidelines in the CISM Resource manual.
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 adapt to challenges in daily life.
CBT	Cognitive behavioural therapy
DBT	Dialectical behavioural therapy
ACNM	Associate Clinical Nurse Manager

Associated Documents

Other documents relevant to this procedure are listed below:

NZ Legislation	Crimes Act 1961 Mental Health (Compulsory Assessment & Treatment) Act 1992 Human Rights Act 1993 NZ Bill of Right Act , 1990 Health and Disability Act 2001 Code of Health and Disability Services Rights 1996 Protection of Personal and Property Right Act 1988 Health and Safety in Employment Act 1992
NZ Standards	Restraint Minimisation and Safe Practice Standard NZS 8134.2 :2008 Health and Disability Services (general) Standard NZS 8134. 0: 2008. Health and Disability Services (core) standards NZS 8134.1: 2008
CMH Policies / Procedures	Counties Manukau DHB (Provider arm) Restraint minimisation & safe practice policy Counties Manukau DHB (Provider arm) Safe Management of Health Information Policy & Procedures Staff Critical Incident Defusing and Debriefing Policy). Sensory modulation protocol

References

Document ID:	A7377	**Version:**	3.0
Department:	Core Adult Inpatient Mental Health Services	**Last Updated:**	17/04/2019
Document Owner:	Clinical Director - Mental Health Services	**Next Review Date:**	16/04/2022
Approved by:	Mental Health Clinical Governance Group	**Date First Issued:**	01/05/2004
Counties Manukau Health			

Health and disabilities services Restraint Standard NXS 8134:2008

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Te Pou o te Whakaaro Nui (2015). Towards restraint-free mental Health practice.

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Dix, R & C. Betteridge. (2001). Seclusion in psychiatric intensive care, Edited by M.D.Beer, C Patton & S.M.Pereira. London: Greenwich Medical Media Limited.

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COUNTIES MANUKAU HEALTH

Affix patient identification label here

PHYSICAL RESTRAINT ASSESSMENT

Assessment Completed Date:
Name of person REQUESTING Restraint:

Relationship to the patient: Patient / Family / Whaanau / Registered Nurse (circle one)

Previous use of Physical Restraint? (circle) Yes No

Issues leading to restraint assessment

Clinical Assessment completed prior to restraint implementation: (Tick) Yes ☐ No ☐
Referred to: OT (date) PT (date)

De-escalation Techniques
Suggestions include: toilet programme, lowered bed (if patient is unable to transfer independently), medical review, environmental change – noise/clutter/furniture/room, OT/Activity Programme, family intervention, aromatherapy, music, translator services, cultural, spiritual support

De-escalation Techniques Considered / Trialled / Used	**Successful?**	**Date**	**Comment**
_____	**(circle) Yes No**	_____	_____
_____	**(circle) Yes No**	_____	_____
_____	**(circle) Yes No**	_____	_____

Restraint Used: (Note: See Enabler Assessment for **Voluntary** Use).

Seating with tray table ☐ Specialised seating ☐
Lap belts on chair ☐ Soft Limb Restraint ☐
Other: _____ ☐

Potential benefit and risks of using Physical Restraint ---

Patient and/or Family/Whaanau consent: Date:
Name and signature:

Initiating Clinician: Name: Signature:
Designation:

- ***Document in plan of care?*** ***(circle) Yes No***
- ***Incident Reporting System (IRS) record completed?*** ***(circle) Yes No***
- ***Monitoring Times Documented in plan of care?*** ***(circle) Yes No***

Assessed By: (signature) Date

Reviewed: Date: Signature: Date: Signature: Date: Signature:

PHYSICAL RESTRAINT GUIDELINES

Restraint Used	Definition	Indications for Use
Lap Belts	A webbing belt. It should be positioned across the hips so that it does not ride up under the patient's arms. The patient can not remove this independently.	To prevent the patient from slipping off a chair. To prevent the patient getting up and falling. As indicated by initial assessment
Specialised Seating	A chair designed so the patient can not get up out of independently.	To prevent the patient from slipping off a chair. To prevent the patient getting up and falling. As indicated by initial assessment
Tray Tables	Tables that may be fixed to a chair that the patient is unable to remove and prevents independent transfers out of the chair.	To enable a patient to engage in activities e.g. reading, eating. To prevent the patient getting up and falling. As indicated by initial assessment
Soft Limb Straps	Soft straps with Velcro where the length can be adjusted. Wrist straps or ankle straps.	Prevent discontinuation of life support therapy. Prevent removal of essential monitoring devices. As indicated by initial assessment

Note

Specialised Seating and Lap Belts can be for Enabler OR Restraint Use. Both Enablers and Restraint limit the normal freedom of movement of the patient. 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.

Prior to Implementation

Physical Restraint Assessment is completed and discussed with patient, MDT and family/whaanau.

Observation / Documentation requirements

- The call bell will be within reach at all times or in a supervised area.
- The patient will be visually checked regularly.
- If the patient is distressed or unsettled further intervention/investigation initiated. Removal of restraint to be considered and documented.
- Documentation in the clinical notes/plan of care/daily intervention on the desired outcome, duration, frequency of checks, risks and what alternatives where tried.
- Evaluation of the Restraint strategy to be included as part of family meetings.

Restraint Minimisation and Safe Practice Information Pamphlet

- A Restraint Minimisation and Safe Practice Information Pamphlet can be given to the Patient, Family/Whaanau and explained as soon as practicable. Click here to access the pamphlet.

Risks of using Physical Restraint MAY include*:

Direct Injury
May include:
- Nerve injury
- Ischemic injury
- Asphyxiation
- Death

Indirect Injury
May include:
- Decline in social behaviour, cognition and mobility
- Disorientation
- Pressure Sores
- Bladder/bowel incontinence

Experience of Restraint
May Include:
- Loss of freedom and control
- Restriction on ability to move
- Physical discomfort
- Distressed

References:

Joanna Briggs Institute (2002) "Physical Restraint - Part 1: Use in Acute and Residential Care Facilities. Best Practice", Volume 6, Issue 3. Blackwell Publishing Asia, Australia.

Royal College of Nursing. (2010). *Restrictive physical intervention and therapeutic holding for children and young people Guidance for nursing staff*. London.

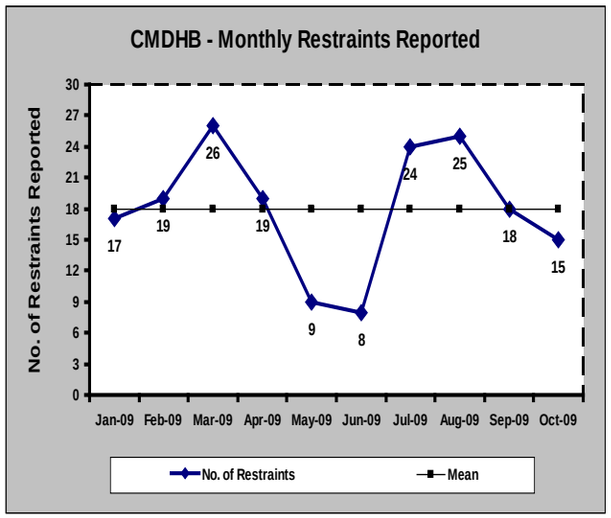
Te Pou o te Whakaaro Nui. (2015). Towards Restraint Free Mental Health Practice: supporting the reduction and prevention of personal restraint in mental health inpatient settings. Download from www.tepou.co.nz

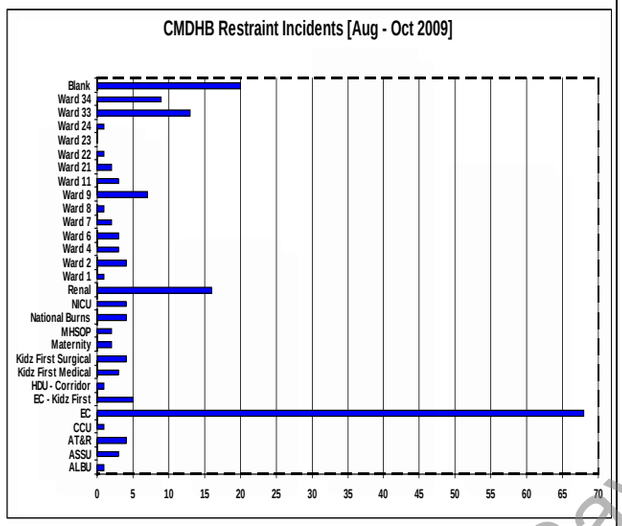
Goal: To ensure compliance with Health and Disability Standards: Restraint Minimisation and Safe Practice

Problem Definition

•Health and Disability Standards - Failure to achieve Standards for Certification in June 2009.
•Corrective Action Plan – Dec 2009 progress report required

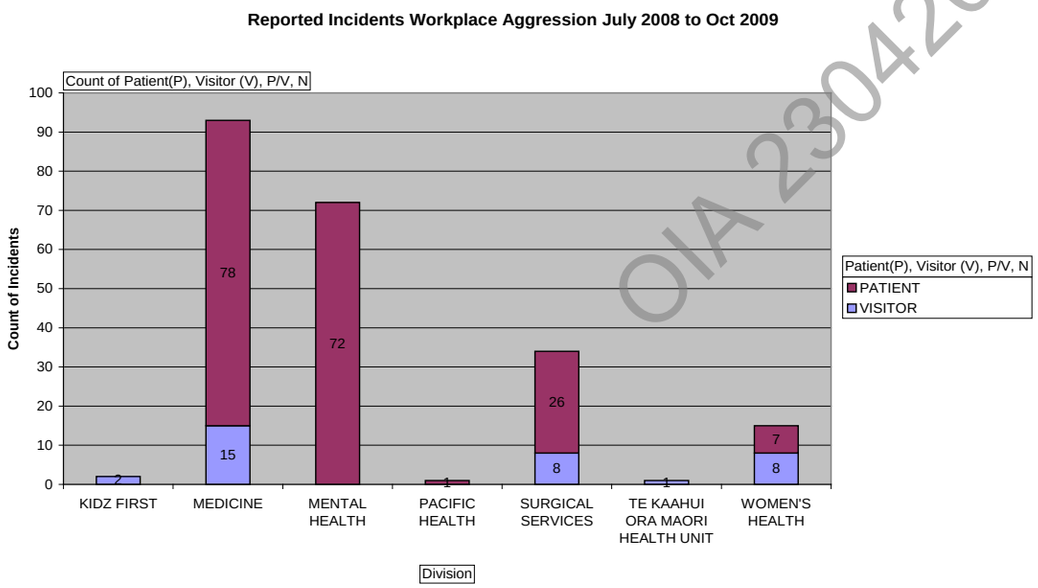
Problem Analysis



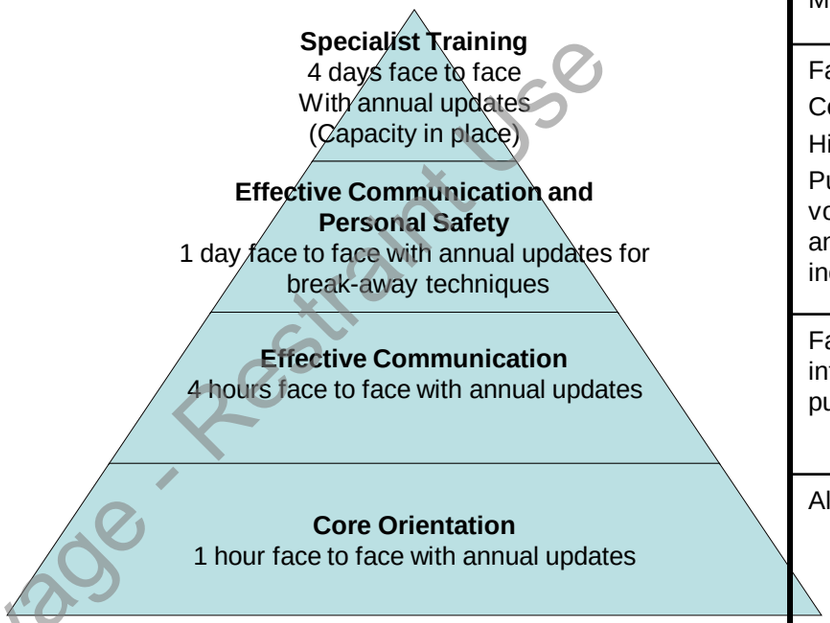


Health and Disability Standards Gap and Corrective Action Plan Analysis

•No governance for Restraint minimisation and safe practice
•No current training model outside of Mental Health



Proposed Plan



Criteria	Delivery
Staff expected to undertake personal restraint: MH, Security	Face to Face 4 days 2 days Annual
Face to face Contact with High volume Public plus high volume of violent and aggressive incidents	Face to Face 1 day 1 day annual
Face to face interactions with public	Face to Face 4 hours 4 hrs annual
All CMDHB Staff	Welcome day A.U.D E-learning 1 hour 1 hr annual

Workforce analysis

Workforce Components	Head Count
Allied Health	664
Care and Support	751
Corporate & Other	1276
Medical	907
Midwifery	88
Nursing	2587
Technical & Scientific	400
Total	6673

For staff requiring level 2 Effective Communication and De-escalation. This needs to be delivered in smaller groups which can facilitate some competency development ina workshop type setting. This requires 2 trainers for a period of 4 hours. To deliver this to 3000 staff would require 120 sessions and inclusive of preparation and evaluation time would require 1.15 FTE of training capacity

To deliver level 3 training this requires 2 trainers for a period of 8 hours. These sessions can be delivered to a maximum of 20 staff per session.
(increasing session size requires addition trainer)
120 staff would require .1 fte of training capacity.

DRMOG Recommendations

•CMEC consider Core Orientation as a priority for urgent implementation
•Detailed analysis of ED training needs and priority roll out for training
•Support development of detailed business case for the implementation of the proposed organisational wide training model