Restraint procedure at a secure dementia unit (10HDC01231, 23 April 2013)

Home and hospital ~ Secure dementia unit ~ Registered nurse ~ Falls ~ Restraint minimisation standards ~ Staff training ~ Communication ~ Rights 4(1), 4(2)

An 85-year-old man, resident in a secure dementia unit for two months, fell frequently during this time and was often agitated and aggressive. Few observations were taken during his stay, and his care and management were not evaluated regularly.

On multiple occasions, staff used a lap-belt to restrain the man. His wife strongly objected to the use of restraint and communicated her wishes to staff several times. The procedure required by national Health and Disability Services standards, and the unit's restraint policy, was not followed. In particular, there was no discussion with family about the use of restraint by appropriate health professionals before restraint was initiated. The man's agitation increased after he was restrained.

The unit was responsible for ensuring that the man received safe and appropriate care. The fact that multiple staff used restraint but did not follow the appropriate procedure indicates systemic failures. By failing to comply with the relevant standards, the unit breached Right 4(2). The unit also breached Right 4(1) for not having appropriate documentation and incident reporting systems in place, for failing to ensure its staff communicated effectively with each other about the man's care (including about restraint), and for failing to ensure its staff evaluated his progress or responded appropriately to his falls and aggression.

The nurse manager, who was also the restraint minimisation coordinator, was responsible for managing the unit, educating staff in restraint minimisation, and ensuring the restraint policy was followed. She failed to complete and evaluate the man's support plan, or to manage and respond to his falls and aggression appropriately. She also failed to ensure that staff received appropriate training in restraint minimisation and failed to act appropriately in response to her staff restraining the man. Accordingly, she breached Right 4(1).

A second, experienced RN, was responsible for restraining the man on at least two occasions without following the restraint policy. Consequently, she did not provide services with reasonable care and skill, and breached Right 4(1).