

Night Safety Procedures

Transitional Guideline

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MANATŪ HAUORA



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Preface

Night safety procedures is the practice of locking a patient in their bedroom overnight for the purposes of safety. This practice is based on a 1995 Ministry of Health document *Night Safety Procedures*.

The procedure, as it is currently constructed, is no longer fit for purpose and the Ministry of Health is working towards a phasing out of its use. As I have been advised that it is not immediately possible to stop using night safety procedures, we need to ensure patients receive adequate standards of care and monitoring and that practice is consistent with current expectations. This transitional guideline is being issued with that in mind.

Dr John Crawshaw
Director of Mental Health

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Introduction

Patients under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Mental Health Act) are subject to a range of restrictions. It is imperative that patients receive adequate standards of care and monitoring and that services provided do not breach their rights. Care must be provided in the least restrictive environment whilst being proportionate to the assessed risks.

A night safety procedure is the practice of locking a patient in their bedroom overnight for the purposes of safety. The practice has no therapeutic function and constitutes (at the very least) a form of environmental restraint.

Night safety procedures have been based on a 1995 Ministry of Health document *Night Safety Procedures*. Reducing and eventually eliminating the use of seclusion and restraint is a priority action in *Rising to the Challenge, the Mental Health Addiction Services Action Plan 2012–2017*. In line with that direction, the Ministry of Health is working towards phasing out the use of night safety procedures and, as such, the Ministry's 1995 Night Safety Procedures document is no longer fit for purpose.

In regions where night safety procedures are still in use, it has been reported that they are considered an essential component to providing a safe environment. Reasons cited include issues with building design and lines of vision, staffing levels, and the level of risk that patients present with.

Purpose of this document

The Ministry is issuing these transitional guidelines to assist Directors of Area Mental Health Services (DAMHS), and others in mental health and secure disability services, who continue to use night safety procedures to work towards eventual elimination. This transitional guideline replaces the *Night Safety Procedures* document issued in June 1995 by the Ministry of Health.

While this guideline is developed primarily in relation to the use of night safety procedures for patients under the Mental Health Act, in some instances these practices are in use in intellectual disability hospital level secure services. For this reason the transitional guideline will also apply to hospital level secure services under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (ID(CC&R) Act).

Context

This practice guideline should be read within the context of the following legislation:

- Mental Health (Compulsory Assessment and Treatment) Act 1992
- Criminal Procedure (Mentally Impaired Persons) Act 2003
- Health and Safety at Work Act 2015
- Intellectual Disability Compulsory Care and Rehabilitation Act 2003.

This practice guideline reflects the requirements of the:

- Health and Disability Services (Restraint Minimisation and Safe Practice) Standards (NZS 8134.2:2008).
- Health and Safety at Work (General Risk and Workplace Management) Regulations 2016.

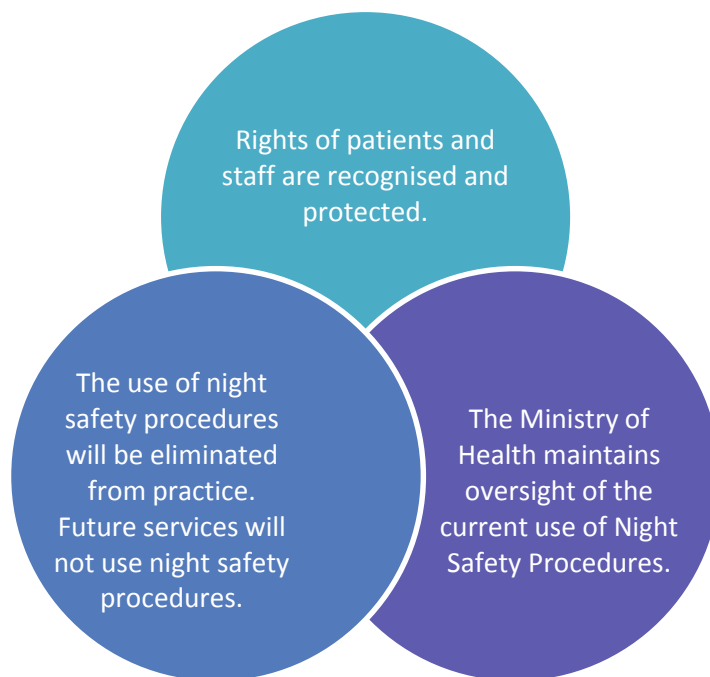
This document is intended to complement the following guidelines, accessible from the Ministry of Health's website, www.health.govt.nz:

- Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992
- Guidelines for Forensic Mental Health Services
- A Guide to the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003.

Statement of principle

1. Locking a patient in their room is a restrictive practice, and constitutes a use of force. The use of all restrictive practices, including night safety procedures, must be justified on an individual basis and must be for the shortest time possible. Restrictive practices must be guided by ethical principles that include acting for the patient's beneficence, avoiding harm to the patient, avoiding harm to self and others, and respecting the dignity of the patient. Blanket use of night safety procedures in forensic units is unacceptable.
2. Like seclusion, the decision to use night safety procedures is based on a duty of care. Night safety procedures should only be required for the management of risk to patients. They should only be used when no other safe and effective intervention is possible. Night safety procedures should not occur as part of a routine admission or therapeutic procedure, or be administered as discipline, or as a replacement for adequate levels of staff or resources.
3. Forensic services may legitimately need to restrict a person's movement at night for the purposes of safety by locking the door to their room. Services may also require the restriction of movement at night. Examples of this may include patients only being able to access certain parts of the units but not others (eg, the communal lounges). This a form of environmental restraint and should be recorded and monitored as such.
4. Services should work to address the environmental issues that drive the use of night safety procedures, such as building design and lines of vision.

Outcomes and criteria



Outcomes

There are three outcomes intended by this document. The accompanying criteria outline the requirements that services must meet to comply with this practice guidance.

1. The use of night safety procedures will be eliminated from practice by 30 December 2022. Future services will not use night safety procedures.
2. Rights of patients and staff are recognised and protected.
3. The Ministry of Health maintains oversight of the current use of night safety procedures.

Background

Providing for safety and order may reasonably require the use of restrictive practices and this may take different forms. The Mental Health Act and the ID(CC&R) Act provide wide discretionary powers for the use of restrictive practices.

The powers for providing compulsory assessment and treatment under the Mental Health Act and compulsory care under the ID(CC&R) Act should be read consistently with the rights in the New Zealand Bill of Rights Act 1990 (NZBORA) and the Code of Health and Disability Services Consumers' Rights 1996 as far as possible.

Rights

The rights of people detained in mental health and hospital level secure disability facilities in New Zealand are set out in a range of international standards and guidelines in New Zealand law and policy (refer Appendix). Unauthorised restriction on a patients' rights could be considered unlawful. Additionally, minimum rights and entitlements are set out in law which apply to all employees.

The Mental Health Act incorporates a number of patients' rights; it has inbuilt protection of the rights of patients and proposed patients as does the ID(CC&R) Act. These rights supplement the rights affirmed in the NZBORA and the rights enjoyed by all health service patients under the Health and Disability Services Consumers' Code of Rights (Code of Rights).

New Zealand has a number of mechanisms in place to ensure the protection of every person's rights. Mental health services are required to demonstrate their respect for these rights through a number of monitoring mechanisms, including District Inspectors and the National Preventive Mechanisms under the Optional Protocol on the Convention Against Torture (OPCAT). Torture and other cruel, inhuman or degrading treatment or punishment is absolutely prohibited under New Zealand and international law.

Regulations: The Health and Disability Standards

The use of restraint and seclusion in mental health services is governed by the Health and Disability Services (Restraint Minimisation and Safe Practice) Standards (NZS 8134.2:2008) (Standards).

The Standards reflect best practice and require that services demonstrate that the use of restraint is actively minimised. They also state that practice must be guided by ethical principles that include acting for the patient's beneficence, avoiding harm to the patient, avoiding harm to self and others, and respecting the dignity of the patient and the patient's human rights. The 2008 Standard excludes night safety procedures from its scope. However, current best practice reflects that night safety procedures should not be used unless they can be justified on an individual basis. The 2008 Standard is currently being reviewed to ensure it does reflect best practice.

Employment standards: Health and Safety at Work Act 2015

The Health and Safety at Work Act 2015 provides a legislative framework to secure the health and safety of workers and workplaces.

A key aspect of the Act is the creation of a new duty holder, known as a Person Conducting a Business or Undertaking (PCBU). The Act covers Crown organisations, including district health boards. PCBUs have primary responsibility ('primary duty of care') for the health and safety of their workers and any other workers they influence or direct. The PCBU is also responsible for the health and safety of other people at risk from its work, including patients. The Health and Safety at Work Act creates offences relating to breaches of health and safety duties.

Outcome 1

The use of night safety procedures will be eliminated from practice by 30 December 2022. Future services will not use night safety procedures.

Criteria

To achieve these outcomes services will meet the following criteria:

- 1.1 Services will consider future options to avoid the use of night safety procedures.
- 1.2 Services will consider whether additional education or training need is required to assist staff in providing care in the least restrictive environment, proportionate to the assessed risks.

Outcome 2

Rights of patients and staff are recognised and protected.

Criteria

To achieve these outcomes services will meet the following criteria:

- 2.1 Services only utilise night safety procedures when indicated following assessment on an individual basis.
- 2.2 Night safety procedures are only used after alternative less restrictive interventions have been considered or attempted or deemed inappropriate.
- 2.3 Demonstrate an appropriate balance between the rights of patients and of staff and other patients.
- 2.4 The use of night safety procedures are evaluated in collaboration with the patient.
- 2.5 Night safety procedures are discussed by the multidisciplinary team and approved by the responsible clinician.

Quality

Services conduct regular reviews of all night safety procedures to determine:

- 2.6 the extent of night safety and any trends
- 2.7 the organisation's progress in reducing night safety
- 2.8 adverse outcomes
- 2.9 service provider compliance with policies and procedures
- 2.10 whether night safety is necessary, safe, of an appropriate duration, and appropriate in light of patient and service provider feedback and current accepted practice
- 2.11 whether changes to policy procedures or guidelines are required.

Outcome 3

The Ministry of Health maintains oversight of the current use of night safety procedures.

Criteria

3.1 To achieve these outcomes services will meet the following criteria.

Reporting

3.2 Policies for the use of night safety procedures and a plan for phasing out their use are provided to the Director of Mental Health for review. Policies should address:

- a) the indications for use of a night safety procedure
- b) approval of night safety procedures
- c) consent processes
- d) frequency of review
- e) observation and care standards
- f) criteria for ending the use of night safety procedures
- g) policy for recording night safety procedures (including whether consent was obtained or not)
- h) services will report their use of night safety procedures to the Director of Mental Health quarterly via DAMHS reporting, beginning with the quarter beginning 1 April 2018 (this will be added to the Ministry's quarterly reporting template as an interim reporting mechanism. Developments are underway to improve seclusion reporting for ID secure units and DHBs will be kept informed).

3.3 Quarterly reporting will include:

- a) number of individuals subject to a night safety procedure, number of times per individual (in nights) and total number of patients on the ward
- b) the indications for the use of night safety procedures
- c) approval procedures
- d) monitoring mechanisms
- e) details of consent, including whether it was given, the date and how long it applies for
- f) sufficient detail to provide an accurate account of:
 - i. the indication for use
 - ii. the intervention
 - iii. the duration
 - iv. the outcome
 - v. the alternatives attempted.

Appendix 1: Relevant international and domestic legal/regulatory frameworks (overview)

Human rights treaties

Convention Against Torture & Cruel, Inhuman and Degrading Treatment or Punishment (CAT)	Convention on the Rights of Persons with Disabilities (CRPD)	International Covenant on Civil and Political Rights (ICCPR)	Optional Protocol to ICCPR ratified by New Zealand in 1989 and 2nd Optional Protocol in 1990 aimed at abolishing the death penalty	International Covenant on Economic, Social, and Cultural Rights (ICESCR)
Ratified in New Zealand 1989	Ratified in New Zealand 2008	Ratified in New Zealand 1978	Established the Human Rights Committee, to which New Zealand is required to submit regular periodic reports to the Committee on what legal, judicial, administrative and other steps they have taken to fulfill their obligations under the Covenant	Ratified in New Zealand 1979
Established the Committee against Torture which can hear individual complaints	Optional Protocol to CRPD acceded to by New Zealand in October 2016	Article 9.1. Right to liberty, except in accordance with law, right not to be detained arbitrarily. A 12.1. liberty of movement, A 22.1. freedom of association, Article 10. 1. All persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person.	The 1st Optional Protocol also allows for individual complaints to be heard by Human Rights Committee	The right to the highest attainable standard of physical and mental health
Optional Protocol ratified in New Zealand in 2007	Countries who have become party to the Convention are obligated to submit regular reports to the Committee on how the rights of the Convention are implemented			Optional Protocol 2008 NOT ratified by New Zealand
Established Dual Monitoring System: International Subcommittee for prevention of Torture & National Preventative Mechanism's on a national level	The Independent Monitoring Mechanism (IMM) for the implementation of the Convention on Rights of Persons with Disabilities (CRPD) was established in New Zealand in 2011			Established the Committee on Economic, Social & Cultural Rights to which New Zealand is required to submit periodic reports, monitors the implementation of the International Covenant on Economic, Social and Cultural Rights by its States parties
	The IMM consists of three independent partners: the Ombudsman, the Human Rights Commission and the Convention Coalition			

New Zealand legislation

Crimes of Torture Act 1989	Crimes Act 1961 and Crimes Amendment (3) Act 2011	Mental Health (Compulsory Assessment and Treatment) Act 1992	New Zealand Bill of Rights Act (NZBoRA) 1990	Human Rights Act and Human Rights Amendment Act 1993, 2001	Health and Safety at Work Act 2015	Intellectual Disability Compulsory Care and Rehabilitation Act 2003
<p>Amendment added Part 2 which enables New Zealand to comply with OPCAT</p>	<p>s151A Duty to provide necessities and protect from injury</p> <p>s195A III-treatment or neglect of child or vulnerable adult</p> <p>s195A Failure to protect child or vulnerable adult – could apply to not protecting other patients from injury</p>	<p>s66 Right to treatment</p> <p>s71 Right to company and seclusion</p> <p>s75 complaint of breach of rights</p>	<p>s9 Right not to be subjected to torture or cruel treatment, s18 Freedom of movement, s22 Liberty of the Person; Everyone has the right not to be arbitrarily arrested or detained, s23(5) Rights of Persons Detained; Everyone deprived of liberty shall be treated with humanity and with respect for the inherent dignity of the person.</p>	<p>Part 1A s21 (1) prohibited grounds of discrimination; sex, colour, race</p>	<p>Creates offences relating to health and safety duties</p>	<p>s55 Right to company, subject to s60 which allows the use of seclusion under limited circumstances– if it is necessary for the health and safety of the care recipient or others or seriously compromises the care and wellbeing of others</p>
<p>A new Part 2 of the Act was inserted to provide for visits by the Subcommittee and for the designation of National Preventive Mechanisms and a Central National Preventive Mechanism (see OPCAT)</p>	<p>Complaints processed in New Zealand courts; maximum penalty of 10 years' imprisonment</p>	<p>Complaints addressed by District Inspectors Mental Health Review Tribunal</p>	<p>Complaints addressed in New Zealand courts New Zealand Ombudsman Human Rights Committee</p>	<p>Established the Human Rights Commission (national)</p>	<p>s5 Application of Act to the Crown, including DHBs. Part 2, s36 PCBU have 'primary duty of care' for the health and safety of its workers and others at risk from its work</p>	<p>Complaints addressed by District Inspectors</p>

New Zealand Health & Disability Services Standards (gazetted 2008, came into force 2009)

Use of restraint is governed by the Health & Disability Services (Restraint Minimisation and Safe Practice) Standard NZS8134.2.2008
(Note: Night Safety Orders are not covered by the standard)

Services are monitored for compliance by HealthCERT

The Code of Health and Disability Services Consumers' Rights 1996

Right 1: the right to be treated with respect,
Right 2: the right to freedom from discrimination, coercion, harassment, and exploitation,
Right 3: the right to dignity and independence,
Right 4: the right to services of an appropriate standard

Complaints about a breach of these rights can be made;
Directly to provider, Directly to Health & Disability Commissioner,
Directly to Professional bodies,
Directly to Health & Disability Consumer Advocates

Health and Safety at Work (General Risk and Workplace Management) Regulations 2016

PCBUs have duties to ensure, so far as is reasonably practicable, that the workplace is without risks to the health and safety of any person

Outline additional duties on PCBUs relating to risk management and monitoring of exposure and health of those it is responsible for