Policy Directive

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Aggression, Seclusion & Restraint in Mental Health Facilities in NSW

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Summary	This document discusses interventions to be undertaken in NSW mental health facilities to minimise and manage disturbed behaviour. Its major focus is on the prevention of aggression. It also includes information about seclusion and restraint practices.
Replaces Doc. No.	Seclusion Practices in Psychiatric Facilities [PD2007_054]
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Director-General

This Policy Directive may be varied, withdrawn or replaced at any time. Compliance with this directive is **mandatory** for NSW Health and is a condition of subsidy for public health organisations.

POLICY STATEMENT

AGGRESSION, SECLUSION AND RESTRAINT: PREVENTING, MINIMISING AND MANAGING DISTURBED BEHAVIOUR IN MENTAL HEALTH FACILITIES IN NSW

PURPOSE

This document outlines the position of NSW Health about how staff working in mental health facilities manage behaviour that can potentially cause harm.

Consumers with mental illness are sometimes admitted to mental health inpatient units to keep them and those around them safe. Mental health staff use a variety of different methods to maintain a safe environment including options such as counselling, time out, seclusion and a range of physical holds. Mechanical restraints involving equipment are rarely used.

Mental health units demonstrate preferences in the use of these interventions, e.g. some use mechanical restraint while others would never consider this practice; some use seclusion while others do not (Bowers et al, 2007).

While seclusion and restraint are used in some mental health facilities to manage disturbed behaviour, others have found that these strategies can be safely avoided.

The NSW Mental Health Act 2007 [Section 68 (f)] states that *"any restriction on the liberty of patients and other people with a mental illness or mental disorder and any interference with their rights, dignity and self-respect is to be kept to the minimum necessary in the circumstances."*

It is the position of NSW Health that clinical and non-clinical staff working in mental health facilities in NSW will undertake all possible measures to prevent and minimise disturbed or aggressive behaviour and reduce the use of restrictive practices such as seclusion and restraint. When making decisions about strategies to manage disturbed behaviour, it is important that health workers do not put themselves, their colleagues or mental health consumers at unnecessary risk.

MANDATORY REQUIREMENTS

This document applies to mental health intensive care, high dependency, acute and non-acute inpatient units that service all age groups of mental health consumers. It also applies to the care of mental health consumers in Emergency Departments that are declared mental health facilities.

The principles and processes in the attached procedure are recommended for the care of all inpatients. Particular population groups may require additional care (see GL2012_005).

In non-declared mental health units such as Transitional Behavioural Assessment and Intervention Service (T-BASIS) Units, consent must be obtained for the use of restraint that is consistent with the NSW Guardianship Act 1987.

Local Health District policies, procedures, protocols, guidelines or other documents relating to the management of disturbed behaviour, including the use of seclusion and restraint, must be consistent with this policy and procedure and include an electronic reference to or hard copy of this document.

IMPLEMENTATION

Chief Executives must:

- Ensure that the principles and requirements of this policy and procedure are applied, achieved and sustained
- Ensure that all staff are made aware of their obligations regarding this policy and procedure through staff education
- Ensure that documented procedures and adequate controls are in place to monitor use of this policy and procedure
- Ensure that there are documented procedures in place to effectively respond to and investigate alleged breaches of this policy and procedure.

Managers must:

- Promote a recovery oriented, patient-centred culture within the mental health service
- Ensure that all mental health staff read and understand this document
- Monitor this document and ensure staff comply with its requirements
- Implement review mechanisms as outlined in this procedure on all mental health units
- Ensure audits on compliance with this document are conducted in the mental health service at least once each year.

Clinical staff in mental health facilities must:

- Read, understand and comply with the requirements of this policy and procedure
- Provide leadership in any interventions designed to manage disturbed or aggressive behaviour.

Non-clinical staff in mental health facilities must:

- Comply with the requirements of this policy and procedure
- Follow the direction of clinical staff in the management of disturbed or aggressive behaviour.

REVISION HISTORY

Version	Approved by	Amendment notes
January 2005 (PD2005_079)	Director General	Originally issued as Circular 94/127
July 2007 (PD2007_054)	Director General	Replaced PD2005_079 with updated information
June 2012 (PD2012_035)	Director General	Replaces PD2007_054 with updated information

ATTACHMENTS

1. *Aggression, seclusion and restraint: Preventing, minimising and managing disturbed behaviour in declared mental health facilities in NSW- Procedure*

Aggression, seclusion and restraint: Preventing, minimising and managing disturbed behaviour in mental health facilities in NSW

NSW GOVERNMENT | Health

PROCEDURE

Issue date: June 2012

PD2012_035

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1 BACKGROUND

1.1 About this document

This document replaces PD2007_054 *Seclusion Practices in Psychiatric Facilities*.

This procedure discusses interventions to be undertaken in NSW mental health facilities to minimise and manage disturbed behaviour. Its major focus is on the prevention of aggression. It also includes information about seclusion and restraint practices.

Reducing the use of seclusion and restraint has been identified as a major practice change initiative for Australian mental health services. The National Mental Health Seclusion and Restraint Project (NMHSRP) involved collaboration between State and Territory Governments and the Commonwealth to **reduce and, where possible, eliminate the use of seclusion and restraint in public mental health services**.

This document is based on the national documentation, principles and six core strategies of the NMHSRP and supports the reduction of seclusion and restraint in NSW Mental Health Services.

Summary of new information in this document

New information includes:

- Increased emphasis on seclusion and restraint reduction practices
- Adoption of the definitions, key principles and guidelines and core education and training priorities from the National Seclusion and Restraint Project – Suite of National Documentation endorsed 18.9.09
- References to Mental Health Act 2007 replace references to the Mental Health Act 1990
- Removal of the intravenous sedation section because it is no longer a common practice in mental health services
- A recommendation for face up restraint in some situations and time limits for face down restraint
- Increased review requirements following each aggressive incident, including collaborative review with the consumer and family
- Additional information about the care of specialist groups, including a guideline outlining the requirements for caring for older persons
- The ability of nurses to authorise seclusion/restraint. M.O.s will ratify the decision or end the intervention within an hour.
- Episodes of seclusion/restraint can be ceased before the M.O. reviews the consumer
- Improved monitoring of restraint
- The National Medication Chart, local observation chart and local fluid balance chart will be used instead of specialised seclusion observation charts to prevent duplication of information
- 1:1 nursing care for the first hour in seclusion/restraint
- References to CCTV as an additional monitoring device for seclusion have been removed. CCTV images do not allow sufficient attention to the physical health of the consumer

- Additional information about risk, including the risk to staff and the risk of sudden death
- Additional requirement for a member of a restraint team to be responsible for closely observing and managing the physical health of the patient
- Accordance with PD2010_026 *Recognition and management of patients who are clinically deteriorating.*

Balancing care and safety

Health workers, particularly those who work in mental health units and emergency departments, carry a greater risk of work-related aggression than workers in many other occupations. Some of this aggression is caused by a small minority of mental health consumers, though most mental health consumers pose no risk at all (Finfgeld-Connett, 2009: Victorian Government, 2004; Workcover, 2001).

In mental health there is a delicate balance between the need to prevent and manage aggressive behaviour so that staff, consumers and visitors are safeguarded, and the need to promote the health and welfare of consumers in the least restrictive manner (Livingston et al, 2010; Victorian Government, 2004; NSW Mental Health Act, 2007).

Promoting a safe workplace requires a complex equation of appropriate environmental, policy, staffing, training, emergency response, review and support mechanisms (Victorian Government, 2004; Workcover, 2001). Managing aggressive behaviour is one part of this equation; however, there is no universally agreed method of doing so (Finfgeld-Connett, 2009; Happell & Harrow, 2010; Laker et al, 2010; Livingston et al, 2010; Stubbs et al, 2009).

Seclusion and physical/manual restraint are used in some mental health inpatient units as a means of managing aggressive behaviour, though paradoxically their use carries some risk of physical and mental harm to health workers and consumers alike (Happell & Harrow, 2010; Stubbs et al, 2009).

A broad approach to aggression management that focuses on prevention strategies and considers individual, environmental and clinical variables is likely to yield the most effective results (Biancosino et al, 2009; Davison, 2005; Finfgeld-Connett, 2009; Livingston et al, 2010). When making decisions about strategies to manage disturbed behaviour, it is important that health workers do not put themselves, their colleagues or mental health consumers at unnecessary risk.

Many mental health consumers have experienced trauma at some point in their lives and this trauma can impact on their interactions with people and services (Jennings, 2004; SAMHSA).

> *"Traumatic experiences can be dehumanizing, shocking or terrifying, singular or multiple compounding events over time, and often include betrayal of a trusted person or institution and a loss of safety...Trauma includes physical, sexual and institutional abuse, neglect, intergenerational trauma, and disasters that induce powerlessness, fear, recurrent hopelessness, and a constant state of alert."*
> (National Centre for Trauma Informed Care, SAMHSA, accessed March 2011).

Some interactions, like seclusion or restraint, can trigger vulnerabilities from past trauma. Mental health services can avoid unintentionally re-traumatising vulnerable consumers by avoiding coercive practices and encouraging respectful collaboration with the consumer and the people close to them. During any incident involving seclusion or restraint, this principle can be supported by remaining as calm as possible, explaining the process, why it is being initiated and what is required for the process to cease.

Seclusion and restraint represent one end of a spectrum of responses to aggressive behaviour and the risk of imminent harm but are not considered forms of therapeutic treatment in NSW. The position of NSW Health is that a range of therapeutic interventions and broad risk management approaches for managing aggression will be utilised in place of seclusion and restraint whenever this is safely possible.

At all times, the clinician's primary goals will be to safely:

1. **engage** with the consumer
2. **identify** the causes of any behavioural disturbance
3. **treat** those causes appropriately

This practice, along with environmental, resource, educational and skill support, can prevent many episodes of seclusion and restraint and result in a safer workplace (Biancosino et al, 2009; Davison, 2005; Finfgeld-Connett, 2009; Livingston et al, 2010).

The Zero Tolerance approach to violence in the workplace emphasises effective clinical management and compassionate care of consumers. It requires people to consider their behaviour and its effect on others. Because mental illness and mental disorder can sometimes lead to diminished control, impulsivity and lack of ability to self regulate behaviour, the Zero Tolerance policy requires special consideration in mental health services.

Physical contact and restraint

It is important to be respectful of the personal space of all mental health consumers and mindful of any physical contact or touch. When giving care of any kind, prior negotiation of physical contact with the consumer is preferable.

Involuntary confinement and a feeling of lack of control can be distressing for anyone, particularly mental health consumers, and can preface an aggressive incident (Finfgeld-Connett, 2009). In situations when a consumer demonstrates signs of escalating aggression, all reasonable steps will be taken to seek resolution without physical contact. When this is not possible, short term physical/ manual restraint may occasionally be required.

Training in Local Health Districts (LHDs) will address the principles of physical/manual restraint to ensure these interventions are respectfully and safely applied.

Restraint position

There have been instances both in Australia and internationally in which young apparently healthy people have died suddenly while being held in a physical/manual restraint. The face down position in restraint has been implicated in these deaths.

In view of the possible connection between face down restraint and sudden death, Local Health Districts should provide appropriate training to staff on the use of restraint.

In NSW, in those rare circumstances when physical/manual restraint is required, face up restraint should be used where it is safe to do so.

Face down restraint should only be used if it is the safest way to protect the patient or any other person.

If face down restraint is used, it will be time limited. The maximum time a person will be held on the ground in face down restraint is approximately 2-3 minutes, the minimum amount of time necessary to administer medication and/or remove the person to a safer environment.

Mechanical restraint

Mechanical restraint devices include belts, harnesses, manacles, sheets, straps, mittens and other items used to restrict a consumer's movement.

NOTE: handcuffs are not an acceptable form of restraint in NSW Health facilities.

Mechanical restraint devices are not routinely used in NSW mental health facilities and their inclusion in this document is not a recommendation for increased usage. In facilities that use mechanical restraint devices, the equipment must be reviewed and approved for use by the relevant LHD governance committee(s) and specific policies and procedures must guide their use.

Staff must be provided with specific training and refresher training in the procedures for use of the equipment. All restraints must be kept clean, working and safe (including no hard/abrasive/sharp edges). The use of any such device must be carefully monitored and recorded in a Register.

Any consumer in a mechanical restraint device involving the restriction of all limbs will be given 1:1 nursing care.

At no time will a consumer in mechanical restraint be held in a locked room.

Care will be taken to protect the privacy and dignity of any person in a mechanical restraint device who is in a public area.

Further advice on restraint can be found in GL2012_005 Aggression, seclusion and restraint: Preventing, minimising and managing disturbed behaviour in mental health facilities in NSW: Guideline for implementation in mental health settings focused upon older people

Chemical restraint

"Chemical restraint" is a term used to describe a pharmacological method used solely to restrict the movement or freedom of a consumer. Chemical restraint through the overuse of sedation is not an acceptable form of restraint and is not used in NSW.

Medications used as part of a treatment plan to manage a mental disorder or mental illness are not considered chemical restraint. Emergency sedation or rapid tranquillisation that is used to manage disturbed behaviour resulting from a mental disorder or mental illness is not considered chemical restraint in NSW.

Sedative medication can be appropriately used for the management of disturbed behaviour. It is important that this practice is safely managed by adherence to evidence based guidelines.

1.2 Applicability

This procedure is to be used in mental health facilities in NSW for consumers of all age groups.

If there is a need for local supporting documents, they must include an electronic reference or hard copy of this procedure.

It is recognised that there may be rare occasions when it is necessary to deviate from this procedure. In these instances, reasons for the deviation must be noted in the consumer's health care record and included in a post-incident review.

1.3 Target audience

This document applies to members of the multidisciplinary team and non-clinical staff involved in managing aggressive behaviour in all public mental health facilities in NSW. It also applies to the care of mental health consumers in Emergency Departments that are declared mental health facilities. More specific responsibilities are outlined in the related Policy Statement.

1.4 Other relevant information

This document has been designed to be read in conjunction with:

NSW Health (2009) Mental Health for Emergency Departments: A Reference Guide

NSW Health PD2011_016 Children and Adolescents with Mental Health Problems Requiring Inpatient Care

NSW Health PD2007_061 Incident Management

NSW PD2011_077 Recognition and Management of Patient who is Clinically Deteriorating

NSW PD2009_027 Physical Health Care within Mental Health Services

NSW GL2009_007 Physical Health Care of Mental Health Consumers

NSW PD2005_593 Privacy Manual (Version 2) – NSW Health

NSW Health PD2007_040 Open Disclosure

NSW Health PD2005_315 Zero Tolerance Response to Violence in the NSW Health Workplace (under revision)

Department of Health and Ageing (2004) Decision-Making Tool: Responding to Issues of Restraint in Aged Care

NSW Health GL2008_017 Health Facility Guidelines – Australasian Health Facility Guidelines in NSW

Key Definitions used in this document can be found in **Appendix 2**

Key Principles that shape this document can be found in **Appendix 3**

A full reference list is provided in **Appendix 9**

2 PREVENTING DISTURBED BEHAVIOUR

Disturbed behaviour in mental health units can sometimes be linked to factors such as clinical symptomatology, interpersonal interactions, the environment and other causes. Some causes can be prevented (Davison, 2005; Finfgeld-Connett, 2009).

To prevent disturbed behaviour, it is important for managers and staff to incorporate risk identification and management into routine and ongoing team communications. A variety of means may assist this process including (but not limited to):

- Interacting with consumers, visitors and colleagues in a respectful, calm, professional manner
- Explaining procedures and providing clear information about mutual expectations of reasonable behaviour to consumers and visitors
- Supporting individual recovery goals
- Practising patient centred care that responds to the individual clinical needs of each consumer and promotes self regulation
- Genuinely engaging with and including consumers, families and carers in all aspects of care, including incident review processes (Finfgeld-Connett, 2009)
- Collaborating with each consumer/family to identify particular stressors and/or triggers as well as their current drug and alcohol use, previous trauma and history of aggression
- Using individually tailored, holistic care plans for each consumer that identify a range of strategies for preventing and dealing with stress, substance withdrawal (including nicotine) and disturbed behaviour
- Employing appropriate risk identification, assessment and management practices that apply to individual consumers, the unit environment and potentially stressful situations (such as Mental Health Review Tribunal hearings)
- Promoting good communication between all members of the multidisciplinary team about the risks that have been identified and strategies to manage that risk
- Implementing a predictable routine with a range of meaningful activities (Davison, 2005; Finfgeld-Connett, 2009)
- Promoting high levels of interaction between staff and consumers (Davison, 2005)
- Ensuring staff have access to training consistent with the core education and training priorities of the National Mental Health Seclusion and Restraint Project (**Appendix 5**)
- Building well designed units that provide ample space and privacy for the consumer but also encourage high levels of therapeutic contact between staff and consumers (Biancosino, 2009).

3 MINIMISING DISTURBED BEHAVIOUR

When a consumer shows signs of distress, agitation, anger or aggression or reports feeling this way, mental health clinicians are supported to intervene promptly and take a problem solving, flexible and therapeutic approach (Finfgeld-Connett, 2009).

When clinicians recognise that a consumer is becoming distressed or aggressive or when consumers report feeling this way, ward procedures must support them to employ a range of therapeutic interventions including (but not limited to):

- Encouraging self reflection
- Encouraging the consumer to let staff know when they are feeling distressed or agitated
- Intervening early when a person displays signs of agitation or notifies staff they are feeling agitated
- Spending 1:1 time with the consumer and actively engaging with them
- Employing active listening skills to hear what the consumer is trying to convey
- Using short, clear sentences in a lower tone of voice
- Promoting opportunities for contact with a friend or family member (as long as this is agreeable to the consumer and safe for all concerned)
- Activating the Safety Plan and using strategies negotiated with the consumer and/or family that help them manage stress or curb unacceptable behaviour
- Engaging the consumer in a physical activity
- Using sensory modulation equipment
- Providing feedback about the consumer's behaviour and how it impacts on other people
- Offering an opportunity for time out in an unlocked area where the consumer can be on their own to calm down (e.g. bedroom, quiet room)
- Employing a range of de-escalation techniques
- Offering PRN medication
- Offering appropriate/adequate nicotine replacement therapy (for smokers) to reduce symptoms of agitation or other strategies in line with *GL2009_014 Smoke-Free Mental Health Facilities in NSW – Guidance for Implementing*

Staff safety must be considered when deciding on the most appropriate interventions.

Mental Health services will ensure all members of the mental health team are able to perform a range of interventions to minimise disturbed behaviour consistent with the core education and training priorities in **Appendix 5**.

4 RESTRAINT AND SECLUSION PROCESSES

4.1 Risks

Physical/manual restraint should be an option of last resort to manage the risk of serious imminent harm because it involves risk to the physical and psychological health of both staff and consumers (Stubbs et al, 2009).

Between 12-40% staff and 5-18% consumers are injured as a result of physical/manual restraint. More staff are injured during physical/manual restraint than in aggressive incidents (Stewart et al, 2009; Stubbs, 2009). While there is evidence that the risk of staff injury is ameliorated by participation in aggression management training, decision making about using seclusion and/or restraint must take staff, consumers and visitors into account when considering the risks involved in using or not using the intervention.

4.1.1 Sudden death

There have been instances both in Australia and internationally in which young apparently healthy people have died suddenly while being held in a physical/manual restraint. Resuscitation attempts in these circumstances have rarely been successful.

The mechanism of death is unclear, but most deaths have been attributed to positional asphyxia or cardiac arrest (Alshayeb, Showkat & Wall, 2010; NSW Coroner's Court, 2011; Nunno et al, 2006). While some deaths involved apparent pressure on the neck, thorax or abdomen, the inappropriate application of restraint does not always appear to be a factor.

Studies of death in restraint universally note a period of violent, intense struggle. It has been hypothesised that death results from an interaction of circumstances that includes severe lactic acidosis from excessive muscle activity and a restraint position that reduces the ability to hyperventilate. Hyperventilation is a compensatory mechanism that helps reduce the excess arterial carbon dioxide produced in lactic acidosis (Alshayeb et al, 2010; Paterson et al, 2003). Cocaine and similar stimulant drugs may further promote metabolic acidosis and impair the body's normal regulatory responses (Hick, Smith & Lynch, 1999).

Several factors appear to be involved with sudden deaths in restraint:

- The face down (prone) position, particularly when wrists and ankles are restrained behind the back (O'Halloran & Frank, 2000; Chan et al, 2004)
- A period of combative struggle lasting 2 minutes or more
- Sudden and complete cessation of struggle

Other complicating factors that occur in some, but not all, deaths can include (Paterson et al, 2003):

- Obesity
- An underlying physical condition (e.g. asthma, sickle cell anaemia, cardiac condition)
- Acute mental disturbance

- Prescribed medication
- Illicit drug use, particularly cocaine or other stimulants

While all physical/manual restraint poses significant risk to consumers and staff, face down restraint has been identified as high risk (Hollins, 2010; NSW Coroner's Court, 2011). This risk has been found to increase the longer the person is held in that position (Norfolk, Suffolk and Cambridgeshire Strategic Health Authority, 2003).

In view of the possible connection between face down restraint and sudden death, Local Health Districts should provide appropriate training to staff on the use of restraint.

In NSW, in those rare circumstances when physical/manual restraint is required, face up restraint should be used where it is safe to do so.

Face down restraint should only be used if it is the safest way to protect the patient or any other person.

If face down restraint is used, it will be time limited. The maximum time a person will be held on the ground in face down restraint is approximately 2-3 minutes to allow sufficient time to administer medication and/or remove the person to a safer environment.

4.1.2 High risk consumers

Additional care is required for groups of consumers who may be more vulnerable to physical or psychological harm. **Appendix 6** contains further information about each of the following consumer groups that require close attention:

- People who are extremely aggressive or combative (see *4.1.1 Sudden death*)
- People intoxicated by alcohol or drugs, particularly stimulants
- Consumers with a known history of physical illness or injury including cardiac or respiratory disease (particularly asthma); obesity; sickle cell anaemia; musculo-skeletal or neurological injuries or pathologies; sensory or motor deficits affecting balance, mobility or strength; head or spinal injury; history of fracture, osteoporosis or seizures; or physical deformities
- Aboriginal and Torres Strait Islander Peoples
- Children and young people
- Older people (see GL2012_005)
- Pregnant women
- Consumers with a history of trauma/detention who may be retraumatised by the episode of seclusion (e.g. refugees)
- Consumers from culturally and linguistically diverse backgrounds who may have difficulty understanding what is happening.

Training for mental health staff involved in restraint and seclusion will include information about the particular risks and best management techniques for each of these consumer groups (see **Section 4.9:** Physical health care during restraint or seclusion).

4.2 Legal Implications

All staff will adhere to the principles of care outlined in the NSW Mental Health Act 2007, Section 68. The principles with particular relevance to this document include the need to:

- Provide the best possible care in the least restrictive environment
- Provide high quality treatment and care in accordance with professionally accepted standards
- Provide information to consumers about treatment, alternatives to treatment and treatment effects
- Ensure any medicine given to a consumer is prescribed for a therapeutic purpose and not as a punishment or for the convenience of others
- Ensure that any restrictions to a consumer's liberty and interference with their rights, dignity and self-respect is kept to a minimum
- Ensure consumers can collaborate with staff to develop their own treatment plans
- Ensure carers' rights are respected and that they are informed about changes to the consumer's care at the earliest opportunity.

There may be exceptional circumstances when duty of care is the primary justification to restrain a person in order to provide that person with medical care or treatment. In the use of restraint staff must be satisfied that the intervention is reasonable and accepted as safe, competent professional practice i.e. the least amount of restraint/force necessary to respond to the situation. Staff must also exercise reasonable care and skill to ensure the safety, comfort and humane treatment of consumers in restraint/seclusion.

The safety of staff, patients and other members of the public are of paramount importance and s190 of the Mental Health Act recognises that the authorised medical officer, and other staff, may have to take appropriate action to protect the safety of staff, patients and other members of the public during an aggressive incident that involves a risk of serious physical harm. Section 190 by implication recognises the need, for example under Occupational Health and Safety legislation, for workplaces to ensure the safety of staff and other members of the public. As such, it is important to consider the safety of employees at all times when deciding how to manage an aggressive incident.

Physical/manual restraint by a team, mechanical restraint and seclusion should only be used for people detained in a mental health facility under the NSW Mental Health Act 2007 or the Mental Health (Forensic Provisions) Act 1990. If one of these interventions is applied to a voluntary patient, they must be assessed by a Medical Officer (M.O.) as soon as possible after the event to review their status under the Mental Health Act.

Non-declared mental health facilities should have appropriate policies and procedures to ensure that if restraint is required within non-declared mental health units, such as Transitional Behavioural Assessment and Intervention Service (T-BASIS) units, then any necessary consent is obtained consistent with the NSW Guardianship Act 1987.

In general, children under the age of 14 cannot legally consent to any health care. For children under 14 years, voluntary admission to a mental health unit and the provision of treatment is on the basis of parental or equivalent legal guardian consent.

Restraint is commonly used in the paediatric environment to administer uncomfortable medical interventions, such as taking blood or dressing a wound. Staff are able to reasonably restrain a child if necessary to provide treatment that parents or guardians have consented to or is urgently required to save the child's life or prevent serious damage to the child's health provided the use of restraint is ancillary to the provision of treatment. The use of restraint in such situations will therefore not normally require a change in legal status from voluntary to involuntary. However, if restraint is being applied in order to prevent the child from harming themselves or another person on an on-going basis, then the child should be assessed by a medical officer to review their status under the Mental Health Act.

If restraint is applied to a voluntary patient aged 14 years or older, they must be assessed by a medical officer as soon as possible after the event to review their status under the Mental Health Act (see **Section 4.8.2**: Ratification by Medical Officer).

Seclusion is an extreme restriction to which parents are not expected to consent. It requires proper oversight of care under the Mental Health Act for consumers of all ages (see **Section 2**: Preventing disturbed behaviour).

In the event of restraint or seclusion, the family/primary carer should be notified as soon as possible (see **Section 4.4**: Carer notification).

4.3 Restrictions on the use of restraint and seclusion

Physical/manual restraint by a team of trained staff, mechanical restraint or seclusion can be used to manage the risk of serious imminent harm only when appropriate, safe alternative options have been considered and trialled. It can only be used for the briefest period required to allow the consumer to safely regain control of their behaviour.

The use of restraint and seclusion is guided by the following principles:

1. The safety and wellbeing of the person is vital
2. The safety and wellbeing of staff is vital
3. Seclusion or restraint is used for the minimum period of time
4. All actions undertaken by staff are justifiable and proportional to the consumer's behaviour
5. Any restraint used must be the least restrictive to ensure safety
6. The consumer is closely reviewed and monitored so that any deterioration in their physical condition is noted and managed promptly and appropriately

Seclusion will not be used:

- When the consumer is actively self harming
- As a routine procedure when a consumer is abusive, threatening or destructive of property
- As a routine procedure following physical restraint
- As a low stimulus environment – other options will be trialled first
- To prevent a consumer from absconding from a mental health unit
- As a punishment or threat.

A consumer can request voluntary isolation or quiet time alone if this is part of their care plan. This is not deemed seclusion because the door is not locked and exit is not restricted.

Restrictions on the use of mechanical restraint:

- A patient cannot be confined in a mechanical restraint device inside a locked room at any time
- A person held in a four limb restraint device will not be cared for in a public area
- Care will be taken to protect the privacy and dignity of any person in any other kind of mechanical restraint device who is in a public area.

4.4 Carer notification

The consumer's primary carer (as defined by NSW Mental Health Act 2007, Section 71) will be informed of any incident involving restraint/seclusion as soon as is reasonably possible after the event. They will be told the reason why this intervention was used, the period of time it was applied and any consequences of the intervention.

When there is no primary carer nomination, staff will take account of the consumer's preferences about contacting their family before making this contact. Clinical staff should consult the NSW Health Privacy Manual for any privacy concerns.

Family/carers of children and young people (under 18 years) involved in episodes of seclusion or restraint should be contacted as soon as possible regardless of the time of the event.

4.5 Staffing

When a consumer is physically/manually restrained or placed in seclusion, the following principles apply:

- The team managing the incident must be led by a senior nurse or Medical Officer (M.O.) who will coordinate the team, detail the role of each team member, note the time of commencement and completion of any physical/manual restraint and keep any face down restraint within the 2-3 minute limit. This clinician will also review the incident with the team afterwards.
- A senior nurse or M.O. will be responsible for protecting and supporting the head and neck of any consumer held in physical/manual restraint, for ensuring that the airway and breathing are not compromised, for monitoring vital signs and for coordinating any emergency response that may be necessary.

- Sufficient numbers of clinical staff must be present to safely and effectively manage the situation. Additional clinical and/or security staff may be required if there are specific safety concerns.
- To protect staff from allegations of abuse and to promote a feeling of safety for consumers, there should be a gender mix of staff during the intervention and during any exit/entrance to the seclusion room, e.g. if the consumer is female, it is best if a female staff member is present.
- In line with OHS requirements, staff need to be trained in de-escalation and aggression management/physical intervention strategies.
- The senior nurse on duty is responsible for ensuring that staff observing the consumer in mechanical restraint or seclusion are relieved regularly, preferably with no more than an hour at a time without a break.
- Conducting observation during a restrictive intervention such as seclusion or mechanical restraint involving restriction of all limbs is an important role requiring engagement and assessment skills and should be assigned to experienced nurses whenever possible.
- When handing over responsibility for observation, both clinicians will counter-sign an entry in the consumer's health care record detailing the consumer's condition at the time.
- At shift handover, if a consumer is in seclusion or a mechanical restraint involving restriction of all limbs, a senior nurse or M.O. from each shift will conduct a comprehensive review of the consumer (including mental state, physical state and risk assessment) to determine whether the episode of restraint or seclusion can cease.
- Each new staff member responsible for observations will be introduced to the consumer in seclusion and the reason for the change will be explained.

4.6 Impact of seclusion and restraint on others

People who have observed or are aware that a consumer has been restrained or secluded may experience distress, confusion, concern, anger or fear. They may also believe that the intervention was used as a punishment.

It is important to address the concerns of other consumers and anyone else who observed the incident (such as visitors, students, non-mental health staff on the unit). It is also necessary to provide reassurance that the aim is to maintain the overall safety of consumers, staff and visitors to the unit. Note that the consumer is receiving additional attention and support for a short period of time and will be returned to the unit as soon as this is safe.

People with particular concerns about an episode of seclusion or restraint can be offered counselling at a later date and/or provided with information about accessing the Official Visitors Program or the Health Care Complaints Commission.

4.7 Information to be provided to a person in seclusion or restraint

Consumers who have been in seclusion or restraint have subsequently reported that the intervention left them feeling worthless, isolated, frightened and unsure what was happening or when they would be released (Saltmarsh, 2010; Bonner et al, 2002).

To minimise these feelings, mental health staff will provide the following information to consumers in seclusion or restraint (**Note**: this information may need to be repeated):

- Reassurance that they are not being punished
- Feedback about how their behaviour affects other people
- The intervention is a short term measure to keep everyone on the unit safe
- The reasons for the decision to use the intervention
- The circumstances in which they may be released (e.g. agreement about acceptable behaviour)
- A credible agreement with these conditions at any time before or during the intervention will mean the intervention is ceased immediately
- That it is important to try to breathe deeply and relax their muscles
- What will happen during the intervention (e.g. observations, medical review, medications, toileting, food, drink)
- The arrangements for toileting, hygiene, food and drink during the intervention
- Information about any changes that have been made to their legal status in line with the requirements of the Mental Health Act, 2007.

4.8 Authorisation and ratification

The use of seclusion and restraint requires consideration and responsibility at a senior clinical level.

4.8.1 Authorisation

The use of physical/manual restraint by a team, mechanical restraint or seclusion must be authorised in the Register by the person who made the decision to use the intervention (often the senior nurse who leads the response team).

The authorisation for seclusion is valid from the time the seclusion room door is locked until it is unconditionally unlocked. The seclusion period is not broken when the consumer leaves the seclusion room to attend to personal hygiene or receive medication, food or fluids.

The authorisation for four limb mechanical restraint is valid from the time one limb is restrained until all limbs are unconditionally released.

The authorisation for other restraint devices is valid from the time the intervention is applied until it is unconditionally removed for a purpose other than a required brief release to meet care requirements.

4.8.2 Ratification by Medical Officer

Within one hour of commencement of seclusion or mechanical restraint, an M.O. will conduct a physical and psychiatric review of the consumer in order to ensure safety and either ratify or cease the intervention. If seclusion or mechanical restraint is continued, the M.O. will prescribe the level of observation required until the next review.

This M.O. will preferably be a consultant psychiatrist. If the consultant psychiatrist is not available to attend in person, the M.O. will phone them to discuss the consumer's physical and mental condition. The consultant psychiatrist will decide whether the intervention will be ratified or if it will be ceased and this will be recorded in the Register.

Seclusion or mechanical restraint can be ceased by the senior nurse on duty or M.O. at any time if the reason for the intervention has ended (e.g. if there is no longer an imminent risk of serious harm). Seclusion or mechanical restraint can be ceased prior to review by the M.O. In these circumstances, the M.O. will still review the consumer within one hour of the intervention to conduct a physical/psychiatric assessment and amend treatment as necessary.

Ratification is not required for physical/manual restraint, though consumers who have been held in a physical/manual restraint must be examined by an M.O. as soon as possible after the event.

4.8.3 Four hourly review

If seclusion or restraint continues following ratification, the M.O. will conduct further physical and psychiatric reviews at 4 hours from the intervention's commencement, then every 4 hours until the intervention is ceased. They will also conduct an urgent review if there are concerns for the person's safety. Each review will be documented in the Register and the health care record.

In rural/remote regions or sub-acute/non-acute units where an M.O. is not available, the senior nurse on duty can perform the examination and report the outcome to the M.O. via telephone. In these circumstances, an M.O. must review the consumer at the next available opportunity within 24 hours.

The examination will include an interview and physical examination to allow:

- Assessment of the consumer's behaviour and physical/mental health status
- Review of whether mechanical restraint or seclusion can be safely ceased
- Assessment of the effects of medication
- Reassessment of the medications prescribed
- Review of the type and frequency of physical observations required (taking into consideration the consumer's physical health status).

Nursing staff can request a review more frequently if there is a change in vital signs or other evidence of deteriorating physical or mental health.

The outcome of this review must be recorded in the Register and summarised in the consumer's health care record.

Any adverse outcome, such as physical injury or emotional trauma sustained as a result of the intervention, must be appropriately treated, recorded in the incident review system and the consumer's health care record and reported to the treating psychiatrist.

The primary carer must be notified of any adverse outcomes such as physical injury as soon as possible (unless this is contrary to the consumer's wishes).

For anyone under 18 years of age, the parents or guardian will be notified unless there are particular reasons this would be not in the child or young person's best interests.

4.9 Physical health care during restraint or seclusion

The use of restraint and seclusion is a risk to the physical health of all consumers. All consumers in restraint or seclusion require careful management and constant monitoring of their physical condition.

It is not always possible to predict which consumers are at greatest risk. Young, fit, apparently healthy people have been known to die in seclusion and restraint in rare circumstances (See *4.1.1 Sudden death*).

Additional attention is also required for pregnant women and consumers with a known history of physical illness, injury or trauma. These conditions may include cardiac or respiratory disease particularly asthma; obesity; sickle cell anaemia; musculo-skeletal or neurological injuries or pathologies; sensory or motor deficits affecting balance, mobility or strength; head or spinal injury; history of fracture, osteoporosis or seizures; physical deformities or history of physical, emotional or sexual abuse or assault.

For all consumers in restraint or seclusion, it is essential to:

- Assess, monitor and record level of consciousness and immediately report any changes to an M.O. for appropriate action in line with *PD2010_026 Recognition and Management of a Patient who is Clinically Deteriorating.*
- Assess, monitor, record and manage any possible alcohol/drug withdrawal, medication side effect or physical injury (e.g. head injury). **Note**: appropriate/adequate Nicotine Replacement Therapy may help the consumer regain control of their behaviour.
- Ensure satisfactory hydration and nutrition status (i.e. assess status at regular intervals, provide food at usual meal times).
- Record all food and fluid provided during the intervention (including a fluid balance chart if the intervention lasts more than two hours or if there is evidence of dehydration or metabolic disturbance).
- Provide a supply of fresh, clean drinking water in the seclusion room or else offer water regularly (suggested minimum each hour).
- Provide regular opportunities to wash and use the bathroom. On these occasions, the bathroom door should remain unlocked or be able to be unlocked from the outside.
- It is recommended that life support equipment such as emergency defibrillators can be accessed within 3 minutes (Davison, 2005; NICE, 2005).
- If a period of seclusion lasts more than four hours, consideration will be given to interrupting the seclusion to allow the consumer to walk around outside the seclusion room. If this occurs without incident, the seclusion episode will be discontinued.

- If the consumer is in a mechanical restraint, staff working in a team will attempt to release restraints each hour for a minimum of 10 minutes to allow range of motion exercises and skin integrity checks. If necessary, limbs can be released one at a time.

Note: All the above activities will be undertaken by appropriately trained and experienced staff with due regard for staff safety at all times. Any deviation from these processes that is required for clinical or safety reasons must be documented in the consumer's health care record and included in a review of the incident.

4.9.1 Care during physical/manual restraint

Evidence based UK recommendations about physical/manual restraint indicate that all restraint positions are potentially dangerous and recommend protecting the consumer's head and airway and preventing pressure to the neck, thorax, abdomen, back or pelvic area (NICE, 2005).

Emergency equipment must be kept close at hand and in working condition when any person is restrained or held in seclusion. Clinical staff must be familiar with the use of the equipment and with local emergency procedures.

During physical/manual restraint, a nurse or medical officer must be assigned the responsibility of care for the consumer's physical health during the intervention. This clinician will closely monitor the breathing, behaviour and skin colour of the consumer. They will also care for the consumer's head and airway and ensure no pressure is applied to the neck, thorax, abdomen or pelvic area.

It is particularly important to be vigilant about the physical condition of that small sub-group of consumers who are extremely agitated and combative (see *4.1.1 Sudden death*). Emergency medical attention may be required for these consumers.

It is recommended that the clinician responsible for physical health of the consumer considers the information listed in the checklist below and reports any changes in physical condition in line with *PD2010_026 Recognition and Management of Patients who are Clinically Deteriorating*.

Dynamic Risk Assessment (Adapted from Hollins, 2010)

Behaviour	1. Are they struggling excessively? 2. Has the struggle suddenly stopped? 3. Is the person communicating with you?
Airway	4. Can they get air in? 5. Is there any pressure to their neck? 6. Is there an item blocking their airway? 7. Is their mouth or throat free from vomit? 8. Are there any signs of airway obstruction? i.e. Gurgling/gasping sounds; verbal complaints or difficulty speaking
Breathing	1. Are they able to breathe? 2. Is their chest free to move? 3. Is their abdomen free from pressure? 4. Are there signs they are having difficulty breathing? i.e. An increased effort to struggle or

	heightened distress/anxiety
Circulation	1. Can blood be circulated efficiently? 2. Are their limbs free from pressure? 3. Are there any signs of tissue hypoxia? i.e. pale/grey/blue skin colouring to the lips, nail beds or earlobes? 4. Are there reported symptoms of compartment syndrome? i.e. pain, pins and needles, lack of pulse and/or paralysis
Deformity	1. Is there a risk of injuring any joints, limbs or other skeletal/muscular structures? 2. Is the spine in correct alignment? 3. Are the joints of the upper and lower limbs free from end-of-range stress? 4. Is the patient complaining of discomfort or pain to any part of their body?
Existing medical condition or injury?	1. Is there anything known about this person's medical history that influences risk? 2. Any known respiratory disease? 3. Any known cardiac or vascular disease? 4. Any other relevant pathology or injury?

4.10 Observations

The aim of observation is to engage with the consumer to the extent that the nurse is able to ensure the consumer's physical safety and continually assess behaviour with a view to ceasing the intervention as soon as possible.

Observations will be undertaken by appropriately trained and experienced nursing staff with due regard for staff safety. Any deviation from these processes that is required for Occupational Health and Safety reasons must be documented in the consumer's health care record and included in a review of the incident.

1:1 observations will be undertaken for the first 60 minutes (i.e. a nurse will remain in visual contact with a consumer at all times during seclusion or at arm's length distance away from a consumer in a four limb mechanical restraint).

The M.O. who ratifies the intervention will prescribe the level of observation required after the first 60 minutes in line with local protocols (many mental health services require 1:1 observation for the entire period of seclusion/four limb mechanical restraint). The minimum level of observation will be every 15 minutes.

Whenever the consumer is awake, observations **must involve verbal communication** to allow ongoing mental state assessment and prevent a feeling of isolation. Clinicians engaging with the consumer will use these opportunities to continue de-escalation and offer the consumer alternatives to mechanical restraint or seclusion.

Visual observations will be recorded for all consumers in four limb mechanical restraint or seclusion. These observations may be recorded from outside a seclusion room provided the consumer can be seen clearly enough to allow monitoring of:

- Level of consciousness* (consider use of the Glasgow Coma Scale)

- Respirations (including assurance of unobstructed breathing, cyanosis)*
- Position (to ensure safety and comfort)
- Skin Integrity (e.g. colour, bruising, swelling)
- Behaviour

A physical examination will be undertaken without delay if staff cannot be certain that the consumer is breathing.

For consumers at additional risk during the intervention (See **Section 4.1** Risks), those who have been sedated and those who may have consumed drugs or alcohol, oxygen saturation*, blood pressure* and pulse* must also be recorded a minimum of every ten minutes for the first half hour and half-hourly thereafter.

Note: observations with an asterisk will be recorded in the consumer's observation chart. Other observations will be recorded in the Register.

Emergency responses will be activated in accordance with *PD2010_026 Recognition and Management of Patients who are Clinically Deteriorating* as necessary.

Before entering a seclusion room to attend to physical observations or assist the consumer, a risk assessment must be performed to identify anything that can be used as a weapon, ensure the consumer is within sight (to avoid ambush), consider exit points, take note of hazards such as fluid on the floor and other potential risks.

4.10.1 Sleeping, altered level of consciousness and observation

In some circumstances, particularly when the consumer has been sedated, it can be difficult to determine if they are asleep or have an altered Level of Consciousness (L.O.C.). Consumers with an altered L.O.C. require airway protection and careful monitoring appropriate to the level of unconsciousness. The Glasgow Coma Scale is recommended to determine L.O.C.

In line with the determination that seclusion/mechanical restraint will be ceased when the risk of serious and imminent harm has abated, consumers who fall asleep in seclusion/restraint will be roused and returned to their bed.

To reduce the risk of an adverse event, consumers who have received parenteral (intramuscular or intravenous) medication will be closely monitored. The M.O. will prescribe the level of observation required – observations and vital signs will be recorded a minimum of every 15 minutes for the first two hours.

4.11 Clothing and personal items in seclusion

- To assist a consumer to calm themself, they may be allowed personal items as long as they do not compromise their safety or the safety of others (e.g. paperbacks, newspapers, comics, soft toys).

- A consumer in seclusion will retain their own clothing unless this compromises their safety or the safety of others (e.g. remove belts, ties, drawstrings, shoelaces and similar items that can be used to harm self or other).
- No person will be placed naked into seclusion unless this compromises their safety or the safety of others. If the consumer removes their clothing while in seclusion, staff will make efforts to maintain their dignity by offering alternative clothing, sheets etc, minimising the number of staff attending to the consumer and ensuring staff caring for the consumer are of the same gender as the consumer.
- A frisk search will be performed to prevent risk if there is a determination by the authorised medical officer or, if that officer is not available, the nurse in charge, that a person being placed in seclusion or mechanical restraint is at risk of serious physical harm. Harmful items will be removed.

4.12 Ceasing Restraint or Seclusion

- Restraint or seclusion will end as soon as the consumer has regained behavioural control and the immediate risk of serious harm has passed.
- Following a comprehensively documented assessment of the consumer in which it is considered that the immediate risk of serious harm has passed, an episode of seclusion or restraint can be ceased at any time by any of the following:
    - the consultant psychiatrist
    - the medical superintendent
    - the M.O.
    - the senior nurse on duty
    - the operational nurse manager
- On ceasing restraint or seclusion, the senior nurse on duty must ensure that a risk assessment is completed and the consumer's care plan is updated
- Upon cessation of the intervention, the senior nurse must notify the consultant psychiatrist, M.O. or operational nurse manager
- The primary carer (in line with privacy requirements) must be notified as soon as is reasonably possible (i.e. not in the middle of the night unless this arrangement has been made in advance).

4.13 Exceptional circumstances

In most cases, mechanical restraint or seclusion is only required for a short time.

There may be rare and specific situations (e.g. when a consumer puts themself or another person at serious risk of imminent harm through displays of repeated aggression that they are unable to control and that cannot be ameliorated through alternative strategies) that will require prolonged or repeated episodes of care in a secure environment away from other consumers.

Staff safety requirements are particularly important when caring for such consumers (see **Section 4.2** Legal implications).

For the exceptional circumstances of prolonged or repeated episodes of seclusion or mechanical restraint, the following actions are required:

- Alternative options, such as transfer to a high dependency unit either within or outside the treating mental health service, will be considered and implemented whenever possible.
- Strategies to ensure staff safety during interactions with the consumer are essential. This may mean that additional staff are required.
- A comprehensive review will be conducted at each shift handover as outlined in **Section 4.8.3**. If is found at this review that there is no risk of imminent serious harm and the intervention can be safely ceased, clinicians conducting the review will contact the medical superintendent to discuss its cessation.
- The treating team, including the medical superintendent, will conduct a comprehensive assessment of the consumer ideally every 24 hours but at least once every 2 working days. The primary carer will be invited to attend the assessment.
- If the consumer and/or carer cannot participate in this assessment, they will be advised of changes to the care plan and other information as outlined in **Section 4.7**.
- The outcomes of the assessment will be documented in the health care record and the consumer's care plan will be reviewed to ensure the following is stipulated:
    - precipitants to the disturbed behaviour and strategies to minimise these
    - a graded series of individualised responses to deal with the consumer's behaviour
    - the rationale for the continuation of mechanical restraint or seclusion
    - the expected path of treatment/duration of mechanical restraint or seclusion
    - a description of the person's mobility status and expected actions to support or improve this (this is most relevant to consumers in mechanical restraint)
    - the clinical needs of the consumer and strategies to address these needs.

4.13.1 Repeated episodes of restraint or seclusion

Any return to seclusion or mechanical restraint after an initial intervention has ceased is recorded in the Register as a new event.

When a consumer has had more than one episode of seclusion or restraint of any kind during an admission, the incidents will be reviewed as a matter of urgency within 24 hours (see **Section 6**), the consumer will be reassessed as described above and their care plan will be amended accordingly.

4.13.2 Prolonged episodes of mechanical restraint or seclusion

Following assessment as outlined above, the medical superintendent of the unit will decide when a consumer requires a prolonged episode of mechanical restraint or seclusion. The medical superintendent must document and sign for this decision in the consumer's health care record. This decision will be reviewed at each comprehensive reassessment.

It is preferable that an independent psychiatrist who is not responsible for the consumer's care provides a second opinion and advice to the medical superintendent; however, the responsibility for continuing the intervention rests with the medical superintendent.

When the consumer requires a prolonged intervention, their care plan will also include opportunities:

- for regular contact with both staff and other people (e.g. family, other consumers, multidisciplinary team, chaplain)
- to leave seclusion or be released from restraint, spend time in daylight, access outdoor spaces and exercise
- to keep in touch with the wider world through newspapers, magazines etc.
- for entertainment and diversion.

For older people, frail, disabled or medically unwell consumers in prolonged interventions, it is important to consider:

- physiotherapy to enhance mobility
- referrals to specialist medical officers as necessary (e.g. geriatrician or rehabilitation physician)
- the relative risks of falls if not restrained versus the risks of restraint – this also needs to be discussed with the consumer's Primary Carer or Guardian.

5 DOCUMENTATION

Each episode of restraint and seclusion must be recorded using the following:

- Incident Reports such as IIMS
- The consumer's health care record including monitoring and medication charts
- The Restraint/Seclusion Register
- Locally mandated forms.

5.1 Incident reports

- An incident report will be completed for every episode of aggression
- The incident number will be noted in the consumer's health care record and in the Register
- The events leading to the aggressive episode and all interventions that were undertaken to deal with it (including any kind of restraint or seclusion) must be included in the incident report.

5.2 The health care record

Any incidents of seclusion or restraint of any kind must be documented in the consumer's health care record as close as possible to the time of the incident (more than one entry can be made to ensure all information is captured).

The following information must be included in the consumer's health care record for all aggressive incidents when restraint or seclusion has been used (a copy of the Register can be placed in the notes to prevent duplication of some information):

- Incident number
- Precipitants to the event, including the environment at the time, interactions between the consumer and staff, family or other consumers, any behavioural disturbance etc
- The assessment process including reasons for restraint/seclusion
- Alternative interventions trialled and confirmation that restraint/seclusion was used as a last resort
- Any medications that were administered to the consumer before, during and immediately after the incident (recorded in the medication chart)
- Observations (recorded on the observation chart)
- Any adverse events relating to the incident
- Any contact with the primary carer or other people about the incident (including date and time of the advice and the name of the person notifying)
- Post-incident interviews and processes
- A notation that the consumer's care plan has been updated following the incident
- Authorisation of the intervention

- The consumer's behaviour during the intervention
- Clinical examinations conducted during the intervention
- Food and fluid intake (**note:** a fluid balance chart is required if the intervention is of 2 hours duration or longer)
- Precise times of entry and release from mechanical restraint or seclusion, including any time the consumer is taken to the bathroom or elsewhere
- A management/care plan for the intervention, including its anticipated duration
- A summary of the termination process including:
    - The consumer's condition and behaviour at the time of cessation
    - The precise time the intervention ceased
    - The name and position of the person who made the decision to terminate the intervention
    - Others who were notified the intervention was ceased.

5.3 Register

A Register must be maintained that records each episode of seclusion or physical/manual or mechanical restraint. The Register is to be completed and signed by nursing and medical staff responsible for authorising and ratifying the intervention, and those responsible for observing and reviewing the consumer during the intervention.

Recording will commence as soon as an episode of restraint or seclusion has been initiated.

<u>The Register will be completed for every episode of seclusion, every episode of physical/manual restraint and every episode of mechanical restraint.</u>

The Register will be reviewed along with the consumer's health care record in the incident review following each episode of seclusion, physical/manual restraint by a team or mechanical restraint.

The Register and any trended information compiled from it will be made available to Official Visitors for review.

The Register can be paper based or electronic. An example of information to be included in the Register is included in **Appendix 8**.

5.4 Forms

Mental Health Services can mandate the use of forms related to seclusion and restraint reduction (such as post-incident interview forms, consumer safety plans etc).

6 POST - INCIDENT PROCESSES

6.1 Review

Several types of review are required following an aggressive incident including:

1. Collaborative review with the consumer and family (can include post incident narratives with consumer workers)
2. Incident review processes in the unit
3. Clinical Governance processes

The outcomes of all reviews will be communicated to the team on the mental health unit and through the organisation so that lessons can be learned from each aggressive incident.

6.1.1 Collaborative review with the consumer and family

Consumers who have experienced seclusion or restraint have found it helpful to discuss the event with staff afterwards (Bonner et al, 2002). Following an aggressive incident or the use of seclusion or restraint, a member of the clinical team will offer to discuss the incident with the consumer. The consumer's primary carer will be offered the opportunity to participate. **Note:** the consumer and the primary carer have the right to decline to participate in this meeting.

This review should generally be conducted within 24 – 48 hours of the event, though these time frames can be altered to suit individual circumstances.

This meeting should be conducted in such a way as to allow:

- Open and honest discussion. This can include expressing regret about the situation in line with *PD2007_040 Open Disclosure*
- The consumer to tell their story about what happened before, during and after the intervention
- Collaboration on alternative strategies to help the consumer manage extreme emotions and disturbed behaviour
- Sensitive feedback about the reasons for the use of restraint/seclusion from the staff's perspective (care must be taken not to appear overly critical)
- A review of the consumer's mental and physical state
- A review of the consumer's care plan.

This review will be communicated to other staff, documented in the consumer's health care record and their care plan will be amended accordingly.

Some consumers may choose to speak with a consumer worker about the event and post incident narratives with consumer workers may be available in some mental health services. In these situations a member of the clinical team must still offer the opportunity to meet with the consumer and/or their family to discuss the incident.

6.1.2 Incident review processes in the unit

Mental health units must have processes to allow the multidisciplinary mental health team to rigorously review aggressive incidents and relevant data so that the circumstances surrounding the event can be understood and relevant changes can be made to the unit's routine and practices. It is recommended that consumer and carer representatives attend incident review meetings as their unique perspective has been demonstrated to influence the use of restrictive interventions (Foxlewin, Fox and Kipling, 2010).

Incident review processes will incorporate feedback to the consumer and family, carer, unit staff and senior management levels. Minimum information for these reviews includes:

- Information contained in the Register and the consumer's health care record, including medication, observation and fluid balance charts
- Feedback from consumers and staff involved in the incident
- The consumer's physical and mental health care during and after the incident
- Clinical or safety reasons for deviation from the requirements of this document or local protocols
- Adverse events associated with the incident involving consumers/staff/others
- Recommended actions to address any issues identified
- Feedback to staff and the consumer/family about any changes to processes in the unit or the environment as a result of the incident review. **Note:** It is important that all members of the team who have contact with consumers are made aware of any changes.

Reflective interviews with staff involved in the incident must be undertaken in a non-blaming, confidential and supportive manner and include the following information:

- Details of the events prior to and during the incident, including interactions between consumers, staff and other people on the unit
- Circumstances in the unit at the time that may have had an impact (e.g. staffing issues, other consumers, external pressures etc)
- Any attempted interventions and why they didn't work
- Consideration of what else the team might have tried in the circumstances
- Interventions that were used (e.g. restraint, medication, seclusion) and their outcomes
- Acknowledgement of what was done well and effectively
- Any recommendations for change to local procedures or environment
- Discussion about the way the incident was managed including:
    - decision-making processes used by the team
    - communication within the team during the event
    - management of the consumer during the incident
    - any adverse events that occurred during the episode
    - how well the incident was documented.

6.1.3 Clinical Governance processes

Information about the use of restraint/seclusion in the service must be a standing agenda item at the Mental Health Clinical Governance meeting (or equivalent). This meeting should include a consumer and/or carer representative.

Actions for this forum include:

- Monitoring and analysis of restraint/seclusion usage for each unit each month
- Setting and monitoring targets or KPIs to reduce restraint and seclusion
- Reviewing the service's performance as outlined in the six monthly InforMH report on seclusion data
- Developing, implementing and monitoring systems/strategies to continually reduce the frequency of restraint and seclusion
- Providing feedback to the clinical staff on any conclusions or recommendations of the committee relating to the use of restraint/seclusion.

6.2 Post-incident support

While the review processes are designed to support staff and consumers/families involved in aggressive incidents, these events can be extremely traumatic and some consumers and staff may require further support.

In such circumstances, consumers will be offered supportive counselling. This can occur both within the inpatient setting and following discharge.

Members of staff will be offered additional support from their team manager, their clinical supervisor or the Employment Assistance Program (EAP).

6.3 Complaints

There may be instances in which consumers or carers feel that inappropriate care was provided during the incident. Clinicians should attempt to discuss the incident and resolve these issues at the time if this is possible. The collaborative review process can provide another opportunity to address the consumer's or carer's concerns.

If this is not possible, the complaint will be managed in line with the requirements of *PD2006_073 Complaint Management Policy* and *GL2006_023 Complaint Management Guidelines.*

6.4 Official Visitors and the use of restraint and seclusion

A core role of Official Visitors is to audit the Register at each monthly visit and monitor compliance with NSW Health policy. Official Visitors must be supplied with the Register and the monthly summary of restraint/seclusion data.

Aggressive incidents recorded in the Register are cross-referenced against the individual consumer's health care record and the incident report.

Official Visitors note the number of incidents recorded per month, the number of consumers involved and the duration of any intervention.

Official Visitors are concerned the seclusion room has access to natural light and affords the consumer privacy whilst facilitating staff monitoring.

6.5 Data

Mental Health Units will include aggressive incidents as a standing agenda item in a regular meeting that is open to all team members. This meeting will:

- Set targets or KPIs to reduce the use of restraint and seclusion in the unit and monitor its performance against these
- Record and examine trends in the use of restraint/seclusion in the unit
- Review the unit's performance against other similar services (from InforMH data)
- Present information from all review and audit processes
- Develop and implement strategies based on this information to reduce aggression and the use of the restraint and seclusion on the unit.

6.5.1 Seclusion data

Each Mental Health Unit that uses seclusion will need to collate data each month and forward this information to InforMH every six months. Information to be collected includes:

- Number of episodes of seclusion in the unit
- Total number of hours of seclusion
- The number of consumers with at least one episode of seclusion
- The number of consumers with at least two episodes of seclusion
- Number of consumers with episodes of seclusion lasting more than 4 hours

InforMH will negotiate with NSW Health about the collation of any additional data that may be required.

InforMH will provide a report to NSW Health and Local Health Networks each six months.

6.6 Audits

Audits of the consumer and carer experience of seclusion are recommended.

An audit to ensure compliance with this policy and procedure (which can include the Register, incident review process and the health care records of consumers involved in restraint/seclusion) must be undertaken at least annually to ensure appropriate standards of care.

It is recommended that services use the NMHSRP Audit Tool (**Appendix 7**).

7 LIST OF APPENDICES

1. Implementation Checklist
2. Definitions
3. NHMSRP Key Principles of Restraint and Seclusion
4. NHMSRP Core Education and Training Priorities
5. NHMSRP Six Core Principles for Seclusion and Restraint Reduction
6. Special Groups of Consumers
7. NHMSRP Audit
8. Restraint/Seclusion Register (example)
9. Reference List

8 Appendix 1: Implementation Checklist

Assessed by:		Date of Assessment:	
IMPLEMENTATION REQUIREMENTS	**Not commenced**	**Partial compliance**	**Full compliance**
1. Training is available to mental health staff involved in managing aggression in line with Appendix 5	❑	❑	❑
	Notes:		
2. Clinical Governance processes outlined in this procedure are in place	❑	❑	❑
	Notes:		
3. Unit based incident review processes outlined in this procedure are in place	❑	❑	❑
	Notes:		
4. Audits to review compliance with this document are conducted annually (minimum)	❑	❑	❑
	Notes:		

9 Appendix 2: Definitions

Restraint: the restriction of an individual's freedom of movement by physical or mechanical means. This applies to consumers receiving specialist mental health care regardless of the setting. Key elements:

1. The safety of the consumer and others is paramount.
2. The restraint is used for urgent intervention only where all other interventions have been tried, or considered and excluded.
3. Restraint is used for the shortest period necessary.
4. Minimal amount of force necessary is used.

Implications:

1. Staff participating in the use of restraint are trained in safe restraint practices that have been endorsed by the appropriate clinical governance body of the specialist mental health service.
2. Services have a range of interventions/strategies for managing acutely disturbed behaviour prior to considering the use of restraint.
3. Physical restraint for the purpose of administering medication and/or electro convulsive therapy is to be regarded as restraint.
4. It is expected that all episodes of restraint will be recorded and reported for review and audit.

Note: handcuffs are not an acceptable form of restraint in NSW Health facilities

Chemical restraint: "Chemical restraint" is a term used to describe a pharmacological method used solely to restrict the movement or freedom of a consumer. Chemical restraint through the overuse of sedation is not an acceptable form of restraint and is not used in NSW.

Medications used as part of a treatment plan to manage a mental disorder or mental illness are not considered chemical restraint. Emergency sedation or rapid tranquillisation that is used to manage disturbed behaviour resulting from a mental disorder or mental illness is not considered chemical restraint in NSW.

Sedative medication can be appropriately used for the management of disturbed behaviour. It is important that this practice is safely managed by adherence to evidence based guidelines.

Mechanical restraint: the application of devices (including belts, harnesses, manacles, sheets and straps) on a consumer's body to restrict his or her movement. This is to prevent the consumer from harming him/herself or endangering others or to ensure the provision of essential medical treatment. It does not include the use of furniture (including beds with cot sides and chairs with tables fitted on their arms) that restricts the consumer's capacity to get off the furniture except where the devices are used solely for the purpose of restraining a consumer's freedom of movement. The use of a

medical or surgical appliance for the proper treatment of physical disorder or injury is not considered mechanical restraint.

Physical/manual restraint: the skilled hands-on immobilisation or the physical restriction of a consumer to prevent the consumer from harming him/herself or endangering others or to ensure the provision of essential medical treatment.

Prolonged restraint: episodes of continuous restraint longer than 4 hours or cumulative hours in restraint greater than 24 hours in a one week period.

Prolonged seclusion: episodes of continuous seclusion longer than 12 hours or cumulative hours in seclusion greater than 24 hours in a one week period.

Repeated restraint or seclusion: more than one episode of restraint or seclusion during an admission. Any return to seclusion or mechanical restraint after an initial intervention has ceased is recorded as a new seclusion event.

Seclusion: the confinement of the consumer at any time of the day or night alone in a room or area from which free exit is prevented. Key elements:

1. The consumer is alone
2. The seclusion applies at any time of the day or night
3. Duration is not relevant in determining what is or is not seclusion
4. The consumer cannot leave of their own accord.

Implications:

1. The intended purpose of the confinement is not relevant in determining what is or is not seclusion
2. Seclusion applies even if the consumer agrees or requests the confinement
3. The awareness of the consumer that they are confined alone and denied exit is not relevant in determining what is or is not seclusion
4. The structure and dimensions of the area to which the consumer is confined is not relevant in determining what is or is not seclusion. The area may be an open area e.g. courtyard.
5. Seclusion does not include confinement of consumers to High Dependency sections of gazetted mental health units, unless it meets the definition.

Time out: the consumer is asked to stay in a room or area for period of time without the door being locked and understands that they may leave.

10 Appendix 3: Key Principles of Restraint and Seclusion[1]

Principle 1: Protection of fundamental human rights

- A sensitive assessment of the needs and risks for the consumer is undertaken at the time of admission, identifying and implementing strategies that ensure restraint and seclusion are only used where absolutely necessary and as a last resort.
- Wherever possible, consumers and their carers should be involved in collaborative decision-making about the options for the management of disturbed/violent behaviour.
- Restraint and seclusion is intended to prevent harm to the consumer, staff or others.
- The clinical decision to use restraint/seclusion should only be taken when all other less restrictive options have been tried, or considered and excluded.
- Restraint/seclusion should not be used as a punishment or threat, as part of an individual treatment and care plan, or because of staff shortages.
- Restraint/seclusion should be used for the shortest possible time and must adhere to the principle of care in the least restrictive manner.

Principle 2: Protection against inhumane or degrading treatment

- During restraint and seclusion, there should be continuing attention to the consumer's dignity, privacy and self-respect.
- During restraint and seclusion, the individual needs of the consumer are recognised, including sensitivity to cultural, spiritual, language and gender concerns.

Principle 3: Right to highest attainable standards of care

- The physical and emotional safety of consumers is maintained throughout the restraint/seclusion process through competent, timely and appropriate observation and monitoring.
- Staff involved in restraint or who are caring for consumers in seclusion must have undergone appropriate training and have a sound knowledge of relevant legislation and preventative consumer care interventions including de-escalation and/or conflict resolution.
- Policies and procedures on restraint/seclusion practices are available and accessed by all staff who may potentially be involved in the seclusion of a consumer.
- Education and training is provided to update the knowledge and practice skills of all staff who may potentially be involved in the use of restraint/seclusion, including risk assessment and alternative interventions.

Principle 4: Right to medical examination

- Following all episodes of restraint, the consumer must be examined by a medical practitioner and any adverse outcome, such as physical injury or emotional trauma sustained as a result of the seclusion, must be appropriately treated, recorded and reported.
- During all episodes of seclusion, the consumer must be examined by a medical practitioner at least every four hours and any adverse outcome, such as physical injury or emotional trauma sustained as a result of the seclusion, must be appropriately treated, recorded and reported.

[1] Australian National Seclusion and Restraint Project (2009). *National Suite of Documentation*.

Principle 5: Documentation and notification

- All episodes of restraint/seclusion must be documented in the consumer's clinical record and, where appropriate*, the carer must be notified as soon as possible of the reason for the seclusion and of any adverse outcome, such as any injury that may have been sustained. (*in accordance with the NSW Mental Health Act 2007).
- In NSW it also a requirement to record episodes of restraint and seclusion in a Register (see **Appendix 8** for example of information to be included in a Register).

Principle 6: Right to appropriate review mechanisms

- The consumer is provided with the opportunity for debriefing with a psychiatrist or senior mental health clinician at the earliest possible time. In NSW a consumer consultant, advocate, peer worker or similar can conduct a peer narrative in addition to support provided by clinicians.
- A timely review of every episode of restraint/seclusion is required to determine the appropriateness of the intervention and its application, and to identify alternative interventions. The consumer's perspective must form part of the review process. The outcomes of the review must inform the individual treatment and care plan for the consumer.
- All services should regularly review the rates of restraint and seclusion, the practices of restraint and seclusion and any adverse events that may have occurred during restraint/seclusion.
- Services should ensure that aggregated restraint and seclusion reports are provided to the quality and safety oversight committee (e.g. clinical governance committee) for the service or area health service on a regular basis in order to advise the service and clinicians on conclusions or recommendations.

Principle 7: Compliance with legislation and regulations

- Restraint and seclusion policies, procedures and protocols must comply with the jurisdictional legislation, regulations and reporting requirements.

11 Appendix 4: Six Core Strategies

1. Leadership towards Organisational Change

This core strategy is considered essential in the implementation of seclusion and restraint reduction initiatives. It involves ensuring that an organisation is adequately prepared and demonstrates committed leadership at all levels to implement change. This strategy includes:

- an organisational lead who provides strategic direction
- mission statement, vision, values and philosophy of care encompass individual consumer focus and principles of recovery
- formation of a seclusion and restraint reduction governance committee
- development of a unit work plan (performance improvement plan) involving multidisciplinary team approach which is to be accessible to all staff
- development and review of relevant policies, procedures and guidelines with a broad consultation process
- formation of Working Groups/Reference Groups as required
- seclusion and restraint included as standard item on various key committees meetings ranging from the service unit through to the Executive/Council
- review of every seclusion and restraint event
- weekly team review meeting which analyses every seclusion and restraint event
- regular audit of documents and accountability
- communication strategy
- utilising data to inform service reform
- monitoring and improving workforce development issues
- appropriate staff training in leadership and management

2. Use of Data to Inform Practice

This strategy involves the collection and use of data by an organisation at the individual unit level.
The strategy includes:

- development of a data tool (with clear instructions) to collect relevant event information on seclusion and restraint including unit information (unit name, day, shift, staff members involved in the event), consumer information (demographics, medication) and event details and tracking of injuries related to the event in both consumers and staff
- the collection of data to identify the unit seclusion and restraint use baseline
- the continuous collection of data relating to the event (including validation, analysis and reporting)
- setting flags in the data collection system at milestones (for example, the introduction of a new initiative)
- setting realistic improvement targets
- development of performance indicators
- monitoring incidents and trends/changes over time and making that information available
- undertaking benchmarking activities across unit/organisation as appropriate
- education of staff on the interpretation and use of data as a quality improvement tool.

3. Workforce Development

This strategy involves the development and delivery of intensive and ongoing staff training and education activities relating to the seclusion and restraint reduction strategies. To emphasise the importance of this strategy, training/education activities have been included under each of the six core strategies.

The strategy includes the use of the 7 Key Principles and 9 Core Training and Education Priorities to reduce seclusion and restraint developed by the Core Training and Education and Working Group of the NMHSRP. The 9 Core Training and Education Priority areas are:

- organisational approach to reducing seclusion and restraint
- consumer, carer and staff perspectives
- therapeutic workplace culture
- understanding aggression and challenging behaviours
- risk assessment and management
- legal and ethical aspects of seclusion and restraint
- therapeutic strategies
- therapeutic communication
- emergency responses.

4. Use of Seclusion and Restraint Prevention Tools

This strategy reduces the use of seclusion and restraint through the use of a variety of tools and assessment that are integrated into the facility policies and procedures and each individual consumers care /management plan. The strategy relies heavily on the concept of individualised treatment and recovery model as well as prevention and early intervention. It includes the development and use of assessment tools to:

- identify risk of violence and seclusion and restraint history
- identify high risk factors for injury (self and others)
- identify history of trauma

In addition it includes the use of

- de-escalation/safety plan (identify triggers and preferred de-escalation options)
- first person, non discriminatory language in speech
- comfort and sensory rooms stocked with appropriate/suitable equipment
- other environmental changes including décor, artworks etc
- meaningful structured treatment activities designed to teach people self management skills

It also requires the development and delivery of staff training on the appropriate use of seclusion and restraint prevention tools and interventions.

5. Consumer Roles in Inpatient Settings

This strategy involves the meaningful inclusion of consumers, carers, family and advocates in various roles within the organisation to assist in the reduction of seclusion and restraint.

This strategy includes:

- involvement in individual care/management/safety plans
- involvement in debriefing activities post seclusion or restraint events
- involvement in the event oversight, monitoring and review processes

Consider extending this to apply to all (major) events where there is violence or aggression, not just seclusion and restraint:

- involvement in the development of policies, procedures, strategies and training associated with seclusion and restraint reduction
- consumer and carer perspective elements within the staff training program

Additionally it includes:

- use of peers in positions of support, companionship and/or advocacy
- representation on various working/reference groups and committees
- employment within the organisation/unit with clear roles and responsibilities, and the support and oversight at executive level

It also includes the development and delivery of training to consumers and carers.

6. Debriefing Techniques

This strategy involves the thorough analysis of every seclusion and restraint event recognising that the knowledge gained from the review activity is used to update the care/management/safety plan for the individual as well as to inform policy, procedures and practices to avoid repeats in the future. The strategy is also intended to attempt to mitigate the adverse and potentially traumatising effects of a seclusion or restraint event for the involved staff, consumer and all witnesses. The strategy involves:

1. **An initial "post-event" debriefing** *(immediately after or shortly after – needs to be determined due to differing views)* led by the senior supervisor to:

- ensure that everyone is safe
- consult with staff, consumers and witnesses to capture sufficient information to assist with later analysis/review
- ensure that appropriate protocols/procedures are in place for continued monitoring
- assist in returning the unit milieu to the pre event status
- identify potential needs for policy and procedure review

2. **A therapeutic intervention or "talk session" with the consumer** at a time considered appropriate (determined with due consideration of the consumer and the event). This is intended to:

- provide information to the consumer about the event (assisting in understanding)
- provide emotional support and validate the consumer's feelings associated with the event
- discuss alternatives to prevent a similar event in the future and use the outcome to update the consumers care/management/safety plan
- repair or improve the rapport
- identification of issues which may require specialised interventions

3. **A formal debriefing** which occurs one to several days following the event which is attended (as far as possible) by the staff involved and the treatment team, including the attending doctor. This is intended to enable a rigorous problem solving process to identify what went wrong, what knowledge was unknown or missed, what could have been done differently and how to avoid seclusion/restraint in future.

Note: The organisation is to ensure that staff involved with, and witnesses to, the event are also provided with appropriate debriefing processes.

The strategy also requires the development and delivery of staff training on the appropriate use of seclusion and restraint debriefing techniques.

12 Appendix 5: NMHSRP - Core Education and Training Priorities

The table below lists the strategies and accompanying components that are critical for a restraint and seclusion reduction strategy. Some of these components may be offered in existing mental health services training programs. Not all components will be provided through a formal training program. Other educational modes such as clinical supervision, organisational meeting forums, and staff development opportunities may also include some of these components. The table is intended for use as a checklist.

STRATEGY	COMPONENTS
1. An Organisational Approach to Reducing Seclusion and Restraint For initiatives such as reducing seclusion and restraint to be successful, a systematic methodology that involves staff, carers and consumers at all levels is required and needs to be communicated through training and education. Integrating the initiative into existing organisational structures and processes ensures sustainability of the initiative and must be supported by ongoing training and education.	1.1. Organisational Readiness 1.2. Leadership (at all levels: medical, nursing/allied health, admin) 1.3. Change Management 1.4. Identifying enablers and barriers 1.5. Strategic Plan, Vision Statement 1.6. Communication Strategy 1.7. Use of Data 1.8. Consumer and carer involvement 1.9. Multidisciplinary (team approach) 1.10. Orientation for staff
2. Consumer, Carer and Staff Perspectives As in all mental health training and education activities there is an expectation that consumer, carer and staff perspectives will inform practice. It provides an opportunity to explore and appreciate other perspectives which at times may be very opposing.	
2.1. Consumer Perspective	2.1.1. Trauma Informed Care 2.1.2. Lived (consumer) experience 2.1.3. Recovery 2.1.4. Person centred care 2.1.5. Cultural respect, sensitivity and safety
2.2. Carer Perspective	2.2.1. Trauma Informed Care 2.2.2. Lived (carer) experience 2.2.3. Recovery 2.2.4. Person centred care 2.2.5. Cultural respect, sensitivity and safety 2.2.6. Communication (timely information)
2.3. Staff Perspective	2.3.1. Personal experiences 2.3.2. Reflective practice (including fear and apprehension) 2.3.3. Clinical supervision 2.3.4. Support options 2.3.5. Anticipating and planning care 2.3.6. Trauma Informed Care

3. Therapeutic Workplace Culture Every organisation has a kind of personality - the culture. The culture determines how the organisation performs and how the staff interpret and respond to their experience within the organisation. Moulding a therapeutic culture is the responsibility of all staff and creating and maintaining a therapeutic workplace culture does not just happen - it involves considerable thought and planning. Training and education to facilitate the reduction of seclusion and restraint must provide staff with opportunities to examine their workplace culture and how it influences practice.	3.1. Definition of "workplace culture" 3.2. Understand the impact of workplace culture 3.3. Explore aspects of a therapeutic culture 3.4. Compare coercive and custodial culture with therapeutic culture 3.5. Apply understanding of "therapeutic culture" to the experience of aggression and reducing seclusion
4. Understanding Aggression and Other Challenging Behaviou Staff require understanding of the nature of aggression/violence and other challenging behaviours and critical events to be able to assess the client and circumstances, to address the factors related to the behaviours and events, and also to deliver the relevant, least restrictive intervention in the event of crisis.	4.1. Theories of aggression/violence and other challenging behaviours 4.2. Antecedents of aggression/violence and other challenging behaviours 4.3. Dynamic constructs of inpatient aggression/violence and other challenging behaviours
5. Risk Assessment and Management Training and education can assist staff to make informed and transparent risk assessments that can suggest early intervention and prevent escalation to crisis.	5.1. Principles of risk assessment and management 5.2. Risk assessment/predictive tools 5.3. Personal Safety/transition Plans
6. Legal and Ethical Aspects of Seclusion and Restraint Full understanding of the restrictive and traumatic nature of seclusion and restraint practices can only be developed in the context of understanding the various ethico-legal and moral positions associated with these practices. Establishing an ethical approach to practice is an á priori focus of professional development associated with this aspect of mental health work.	6.1. Civil and criminal implications of assault 6.2. Negligence 6.3. Principles of the Mental Health Act (with attention given to seclusion and relevant sections) 6.4. Effective documentation 6.5. Providing ethical care to clients and carers 6.6. Post incident debriefing
7. Therapeutic Strategies The most pertinent question to ask in the intent to reduce seclusion and restraint is "*How to engage clients in a manner that is both respectful and meaningful in terms of their recovery?"* as this changes the focus into one where staff become pro-active. Of necessity all elements related to client recovery should come under scrutiny, this includes ways to divert client attention and tension as well as ways to engage them in their own recovery processes. Offering clients the means to establish hope and meaning, take control and make choices is highly assisted if staff are familiar with and able to suggest a range of therapeutic and purposeful strategies.	7.1. Orientation and information processes for consumers/carers 7.2. Every day interactions with clients and carers 7.3. Therapeutic engagement with clients and carers 7.4. The Structured Day and meaningful activities (e.g. psychosocial interventions, physical activity) 7.5. Sensory modulation 7.6. Safe places/comfort rooms 7.7. Post incident debriefing/support 7.8. Appropriate use of pharmacological interventions 7.9. Appropriate inclusion of therapeutic strategies in planned care

8. Therapeutic Communication Within mental health our primary work is delivered through the medium of communication. Skill in communication across age, gender and culture is something that ought not be assumed or taken for granted but rather constantly explored and refined.	8.1. Principles of communication 8.2. Core interpersonal skills 8.3. Principles and techniques of verbal de-escalation 8.4. Responding to criticism 8.5. Conflict resolution 8.6. Cultural appropriateness and use of interpreters in therapeutic encounters
9. Emergency Response While education and training to reduce seclusion and restraint have a focus on early and least restrictive intervention in consultation with the client and carer, attention must also be given to safe, humane and ethical emergency intervention for those times when restraint and seclusion are required.	9.1. Risks associated with emergency intervention 9.2. Emergency use and risks of medication 9.3. Break away 9.4. Team restraint 9.5. Safe seclusion practices

13 Appendix 6: Special Groups of Consumers

All consumers in restraint or seclusion require careful management and care in accordance with the general principles of care outlined in this document. Additional care is required for groups of consumers that may be more vulnerable to physical or psychological harm and for these groups is it is critical to **adopt non-restrictive means of managing disturbed behaviour whenever this is possible**. The following consumer groups require particular attention:

1. Aboriginal and Torres Strait Islander People
2. Intoxicated people
3. Children and young people
4. Older people
5. Pregnant women
6. Consumers with a known history of physical illness or injury
7. People with a history of trauma/detention who will be retraumatised by the episode of seclusion (e.g. refugees, people who have been abused at any stage of their life)
8. People from culturally and linguistically diverse backgrounds.

1. Aboriginal and Torres Strait Islander People

Within NSW Health, the term 'Aboriginal' is used in preference to 'Aboriginal and Torres Strait Islander' in recognition that Aboriginal people are the original inhabitants of NSW. This section refers to the principles of care for both Aboriginal and Torres Strait Islander peoples.

The Aboriginal concept of health is holistic and encompasses physical and mental, cultural and spiritual health. Connection to land is central to wellbeing. Because of this, seclusion and restraint are potentially more traumatic for Aboriginal Australians.

When thinking about managing disturbed behaviour in an Aboriginal consumer, the following must be taken into consideration:

- As connection to land is of utmost importance, being locked in a seclusion room without windows or access to the outside world can cause significant distress, even though this distress may not always be observable.
- Establishing and maintaining rapport and trust is of vital importance because Aboriginal people can experience an historical attitude of mistrust or suspicion towards health services due to the removal of children and negative contact with government services.
- Aboriginal consumers and their families must be treated with respect and sensitivity to the cultural, spiritual, family and community factors that contribute to their mental health and wellbeing.
- Disempowerment is characterised by increased rates of mental distress and disorders, so self-determination is extremely important. Aboriginal consumers and their families must be involved in decisions related to their care.

- Because family and community connectedness is key in promoting recovery and mental well being for Aboriginal people, efforts must be made to assist Aboriginal consumers who choose to maintain close contact with a family or community member during the hospitalisation. This may mean a more flexible approach to visiting hours.
- Aboriginal consumers must be offered access to Aboriginal mental health workers or other Aboriginal health staff upon admission and also at critical points of care such as during crisis response. Local community organisations may be able to assist if there is no Aboriginal health worker on site.
- Death from suicide represents a high proportion of Aboriginal deaths in custody. Confinement in seclusion is similar to confinement in a police or prison cell and suicide risk must be assessed and managed carefully.

2. Intoxicated people

There are increased risks when people in physical/manual restraint, mechanical restraint or seclusion are intoxicated, particularly with stimulants (see **Section 4.1** Risks and **Section 4.9** Physical care).

3. Children and young people

Children and young people in inpatient units can be prone to exhibiting disturbed behaviour for the following reasons:

- Normal age related limitations in cognition, impulse control, defence mechanisms and interpersonal skills
- Comorbid disorders e.g. developmental delays, speech and language disorders, learning difficulties and secondary mental health disorders particular to a younger population (e.g. separation anxiety)
- Loss of connection with friends and family (person to person connections as well as limitations on social networking/ mobile phone use)
- Restrictions in play and recreational spaces in the hospital
- Different educational requirements in hospital (e.g. not their usual school, some children may not regularly attend school and are unused to the rigor and discipline).

Children may be particularly prone to experiencing trauma as a result of coercive interventions. In addition to all requirements of this policy directive, special considerations for managing the behaviour of children and young patients include:

- Staff working with patients under 18 years of age must work closely with the family/carers of the child or young person whenever this is possible
- Families/carers must be informed of any episode of seclusion or restraint
- The needs of children and young people generally require a higher staff to patient ratio than adults
- Children and young patients in seclusion must have continual visual observation

- Physical observations must be recorded every 15 minutes during seclusion or restraint
- Any education staff (Department of Education and Communities) on the unit must be included in mental health education sessions about managing disturbed behaviour.

4. Older people

Older people may experience disturbed behaviour resulting from medical and other reversible factors as well as from psychiatric symptomatology. Restrictive interventions pose particular risks to older people, including falls, serious injury, increased duration of hospitalisation and death. See GL2012_005 for more specific information on caring for older persons with disturbed behaviour.

Seclusion is rarely used for older people; a range of interventions that can be considered restraint are used more frequently. The Department of Health and Ageing (2004) *Decision-Making Tool: Responding to Issues of Restraint in Aged Care* lists a range of restraints and should be used to inform clinical decisions about using restraint in older people.

In addition to all requirements of this policy directive, particularly **Section 4.13**, special considerations in managing the behaviour of older people include:

- Adapt any physical/manual or mechanical restraint to the degree of frailty of the individual
- Give priority to the examination, treatment and review of potential acute physical health problems, including delirium
- The risk of managing disturbed behaviour must be balanced against the risk of falls or entrapment associated with any restrictive intervention, such as removing mobility aids or using bed rails
- The use of restraint in a non-declared Mental Health Unit (such as Transitional Behavioural Assessment and Intervention Service [T-BASIS] Units) will usually require either consent from a Guardian who has been specifically given relevant restrictive powers by the Guardianship Tribunal or urgent application to the Guardianship Tribunal to request the authorisation necessary to consent to the use of the restraint.

Vest restraints can cause injury or death and MUST NOT be used for older people

5. Pregnant women

Seclusion and restraint can pose serious risks to the safety of the woman and the fetus. It is recommended that mental health services and maternity services work collaboratively with the woman to plan care, including how to potentially manage disturbed behaviour, whenever this is possible.

If it is necessary to restrain or seclude a pregnant woman, staff must take into consideration:

- The distress and possible struggle associated with a seclusion and/ or restraint episode can precipitate adrenalin and cortisol overload and cardiac rhythm disturbances

- Holding a pregnant patient in the seated position on a chair, bed or bean bag is preferential to holding in any other position
- Ideally, pregnant patients should be positioned in the left lateral position (on her left side) to reduce the likelihood of compression of the aorta and vena cava
- Pregnant patients must not be restrained in the prone position (face downwards) as this could lead to airway obstruction and respiratory distress
- Restraint in the supine (face upwards) position is contraindicated for extended periods of time during pregnancy
- The need to identify and manage any medical risk factors and update the consumer's care plan with this information
- The need for close attention to observations as set out in **Section 4.10**.

6. People with a history of physical illness or injury

The use of restraint and seclusion poses an additional risk to consumers with a known history of physical illness or injury, including cardiac or respiratory disease, musculo-skeletal or neurological injuries or pathologies, sensory or motor deficits affecting balance, mobility or strength such as asthma, head or spinal injury, history of fracture, osteoporosis, seizure disorder, history of physical, emotional or sexual abuse or assault, physical deformities, cardiac problems and obesity.

Additional care is required with these groups.

7. People with a history of trauma/detention

Restrictive interventions such as seclusion and restraint can retraumatise consumers who have experienced torture or trauma, such as refugees, asylum seekers and victims of abuse, including child abuse and domestic violence. Extreme care must be taken in the management of disturbed behaviour in this group of consumers.

It is advisable to consult with the NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS) on admission about any consumers with a background involving torture and trauma. It may also be helpful to involve STARTTS to support the consumer after an incident involving disturbed behaviour/seclusion or restraint.

8. Consumers from Culturally and Linguistically Diverse Backgrounds

Care of consumers from Culturally and Linguistically Diverse Backgrounds (CALD) requires a culturally sensitive approach as outlined in the Multicultural Mental Health Plan 2008-2012 (PD2008_067).

When considering a restrictive intervention such as seclusion or restraint, it is important to make additional efforts to ensure the person is provided with an explanation they can understand. It may be necessary to access an interpreter in line with the requirements of *PD2006_053 Interpreters – Standard Procedures for Working with Health Care Interpreters.* The interpreter could be accessed on admission if a risk of aggression is identified as well as during or after the intervention.

14 Appendix 7: NMHSRP Seclusion Practices Audit Tool

DOMAIN: INDIVIDUAL CLINICAL CARE **Standard 1: Consumers are provided with high quality care** *(Document source: Retrospective clinical record review)*	**Yes**	**No**	**Partial**	**Comments**
1.1 The admission assessment identifies any history of acutely disturbed behaviours and records strategies for managing the potential for such behaviour.				
1.2 There is evidence that a multidisciplinary assessment and corresponding care plan is developed in partnership with the consumer and their carer that documents how risk factors for seclusion will be addressed.				
1.3 The clinical record documents that the provision of care is sensitive to the particular concerns of the consumer e.g. history of trauma, gender, culture and language.				
1.4 The clinical record documents consideration and use of alternative strategies to reduce the likelihood of seclusion; there is evidence that seclusion has been used only as an intervention of last resort.				
1.5 There is evidence in the clinical record that all relevant statutory forms are completed to ensure legislative requirements are met and appropriate clinical observations and monitoring occurred.				
1.6 There is evidence in the record that the consumer has appropriate access to bedding, food and fluids, and that personal hygiene needs are met.				
1.7 There is evidence in the record that the consumer is provided with post seclusion debriefing.				
1.8 There is evidence in the record that an independent psychiatrist's opinion is obtained if further seclusion occurs beyond the review by the treating team.				

DOMAIN: CLINICAL SUPPORT SYSTEMS **Standard 2: The mental health service demonstrates its commitment to continuous quality improvement and improving and supporting good standards of consumer care** (*Source: staff survey/interview, clinical support systems and evidence of continuous quality improvement, risk management systems*)	**Yes**	**No**	**Partial**	**Comments**
2.1 There is a system in place to ensure all seclusion episodes are reviewed for appropriateness and standards of care; each episode of seclusion results in a treating team review to identify opportunities for improvement of care.				
2.2 Clinical supervision is available to support staff in providing high standards of care; staff debriefings are utilized to discuss issues of safety and provide incident review.				
2.3 There is evidence that seclusion data and related data information systems are used to support and improve care delivery.				
2.4 Aggregated data is presented for review at the clinical governance/clinical quality committee or equivalent on a regular basis.				
2.5 Unit routines and expectations are documented and available and are explained to consumers and carers at orientation.				

DOMAIN: ORGANISATIONAL SUPPORT **Standard 3: The organisation ensures that formal structures and delegation practices are in place to support safe, quality care.** (*Source: evidence of policies and procedures and strategic operational planning and directions*)	**Yes**	**No**	**Partial**	**Comments**
3.1 Separate quiet areas are available for use by consumers as needed.				
3.2 Restraint specific policies and procedures are available and consistent with national restraint guidelines (principles and procedures).				
3.3 The organisation has a restraint reduction plan outlining goals and actions; there is evidence that the plan is regularly evaluated.				
3.4 There is evidence of addressing restraint practices that includes: ▪ practice and systems change required to reduce the use of restraint ▪ individual and/or group clinical supervision for staff to ensure opportunities for learning ▪ training and education program in relation to restraint ▪ staff sensitivity to consumer experiences and concerns ▪ education on post restraint debriefing of consumers and carers ▪ legal and compliance requirements for restraint use				
3.5 Mandatory training is provided to staff on restraint reduction systems of care.				
3.6 There is evidence of orientation and training for new employees specific to restraint practices.				

Restraint Practices Audit Tool

DOMAIN: INDIVIDUAL CLINICAL CARE **Standard 1: Consumers are provided with high quality care** *(Document source: Retrospective clinical record review)*	**Yes**	**No**	**Partial**	**Comments**
1.1 The admission assessment identifies any history of acutely disturbed behaviours and records strategies for managing the potential for such behaviour.				
1.2 There is evidence that a multidisciplinary assessment and corresponding care plan is developed in partnership with the consumer and their carer that documents how risk factors for restraint will be addressed.				
1.3 The clinical record documents that the provision of care is sensitive to the particular concerns of the consumer e.g. history of trauma, gender, culture and language.				
1.4 The clinical record documents consideration and use of alternative strategies to reduce the likelihood of restraint; there is evidence that restraint has been used only as an intervention of last resort.				
1.5 There is evidence in the clinical record that all relevant statutory forms are completed to ensure legislative requirements are met and appropriate clinical observations and monitoring occurred.				
1.6 There is evidence in the record that the consumer has appropriate access to bedding, food and fluids, and that personal hygiene needs are met.				
1.7 There is evidence in the record that the consumer is provided with post restraint debriefing.				
1.8 There is evidence in the record that an independent psychiatrist's opinion is obtained if further restraint occurs beyond the review by the treating team.				

DOMAIN: CLINICAL SUPPORT SYSTEMS **Standard 2: The mental health service demonstrates its commitment to continuous quality improvement and improving and supporting good standards of consumer care** (*Source: staff survey/interview, clinical support systems and evidence of continuous quality improvement, risk management systems*)	**Yes**	**No**	**Partial**	**Comments**
2.1 There is a system in place to ensure all seclusion episodes are reviewed for appropriateness and standards of care; each episode of seclusion results in a treating team review to identify opportunities for improvement of care.				
2.2 Clinical supervision is available to support staff in providing high standards of care; staff debriefings are utilized to discuss issues of safety and provide incident review.				
2.3 There is evidence that seclusion data and related data information systems are used to support and improve care delivery.				
2.4 Aggregated data is presented for review at the clinical governance/clinical quality committee or equivalent on a regular basis.				
2.5 Unit routines and expectations are documented and available and are explained to consumers and carers at orientation.				

DOMAIN: ORGANISATIONAL SUPPORT **Standard 3: The organisation ensures that formal structures and delegation practices are in place to support safe, quality care** *(Source: evidence of policies and procedures and strategic operational planning and directions)*	**Yes**	**No**	**Partial**	**Comments**
3.1 Separate quiet areas are available for use by consumers as needed.				
3.2 Seclusion specific policies and procedures are available and consistent with national seclusion guidelines (principles and procedures).				
3.3 The organisation has a seclusion reduction plan outlining goals and actions; there is evidence that the plan is regularly evaluated.				
3.4 There is evidence of addressing seclusion practices that includes: ▪ practice and systems change required to reduce the use of seclusion ▪ individual and/or group clinical supervision for staff to ensure opportunities for learning ▪ training and education program in relation to seclusion ▪ staff sensitivity to consumer experiences and concerns ▪ education on post seclusion debriefing of consumers and where appropriate* carers ▪ legal and compliance requirements for seclusion use				
3.5 Mandatory training is provided to staff on seclusion reduction systems of care.				
3.6 There is evidence of orientation and training for new employees specific to seclusion practices.				

15 Appendix 8: Restraint /Seclusion Register

This sample Register can be used in mental health services or declared mental health facilities.
Services that do not use this document must include all information in this document in their local Register.

Health Service Logo	Family Name:_____ MRN:_____ Given Names:_____ Date of Birth: _____ Sex:_____ *Affix Consumer Label here*
Mental Health Unit:	**Incident Number:**
Legal Status:	**Diagnosis:**
Consultant Psychiatrist:	
Alternative Interventions The following alternatives have been attempted with this consumer:	
☐ Environmental changes (e.g. pt location, time out)	☐ Diversional activities (e.g. quiet room, music, games)
☐ De-escalation	☐ Safety Action Planning
☐ Increased Level of Observations	☐ Other (please state)
Indications for use of restraint/seclusion (please tick all reasons) **Notes:** (record a brief description of the consumer's behaviour and other factors that led to the use of seclusion/restraint)	

Intervention

Date of intervention:			**Time of commencement:**		
Date intervention ceased:			**Time of cessation:**		
Location of intervention					
Restraint	☐ No restraint used ☐ Physical restraint by a team ☐ Mechanical restraint (note type):				
Names and positions of staff involved	1.	2.	3.	4.	5.
Authorising Officer	Name	Position	Signature	Date	Time
M.O. Ratification (to occur within 1 hour of commencement of intervention) ☐ Intervention to continue ☐ Intervention to cease	Junior M.O. Name	Position	Signature	Date	Time
	Senior M.O. Name	Signature (complete if able to assess the consumer in person)	Method of assessment ☐ in person ☐ via telephone	Date	Time
	Assessment of consumer's physical and mental condition				
M.O. Review **4 hours** ☐ Intervention to continue ☐ Intervention to cease	Junior M.O. Name	Position	Signature	Date	Time
	Senior M.O. Name	Signature (complete if able to assess the consumer in person)	Method of assessment ☐ in person ☐ via telephone	Date	Time
	Assessment of consumer's physical and mental condition				

M.O. Review **8 hours** ☐ Intervention to continue ☐ Intervention to cease	Junior M.O. Name	Position	Signature	Date	Time
	Senior M.O. Name	Signature (complete if able to assess the consumer in person)	Method of assessment ☐ in person ☐ via telephone	Date	Time
	Assessment of consumer's physical and mental condition				
M.O. Review **12 hours** ☐ Intervention to continue ☐ Intervention to cease	Junior M.O. Name	Position	Signature	Date	Time
	Senior M.O. Name	Signature (complete if able to assess the consumer in person)	Method of assessment ☐ in person ☐ via telephone	Date	Time
	Assessment of consumer's physical and mental condition				

Food and fluid consumed during the intervention must be recorded in the consumer's health care record. For any episode of seclusion or restraint lasting 2 hours or more, a Fluid Balance Chart must be maintained. Check box if FBC commenced: ☐

Observations outlined in PD2012_035 Section 4.10 must be recorded on the consumer's observation chart every ten minutes for the first half hour and then at least half hourly. Any changes in condition must be managed in accordance with PD2010_026 Recognition and Management of Patient who is Clinically Deteriorating.

Intervention Release

Note the date and time of any release from seclusion or restraint. For restraint, note the limb released and its colour, range of movement, circulation and skin integrity.

Date	Time	Type of intervention	Limb	Limb colour	Range of Movement	Circulation	Skin Integrity	Staff Name	Signature

Behavioural Observations

Record the consumer's behaviour (verbal, physical) every 10 minutes for the first half hour then at least every half hour thereafter.

Date	Time	Behaviour	Staff Name	Sign

16 Appendix 9: Reference List

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