**Canberra Health Services**

**Procedure**

**Restraint and/or Forcible Giving of Medication to a Person Detained under the Mental Health Act 2015**

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| Purpose |

The purpose of this procedure is to outline the process that all Canberra Health Services (CHS) staff must follow when considering the use of restraint or the forcible giving of medication for essential clinical care to people who are receiving care under the *Mental Health Act 2015* (the Act). This includes the appropriate care and monitoring of the person whilst restraint is in place .

Restraint can be a traumatic experience for people. All actions undertaken during the restraint process should be trauma informed, including treating people with respect and dignity, communicating what is happening and why and providing psychological support following restraint. The person’s treating team is responsible for ensuring that the person is told about what is happening and why in a manner that they can understand and that they are offered the opportunity of engaging in psychological support following the restraint.

CHS will minimise, or eliminate where possible, the use of restraint and forcible giving of medications, and if restraint or confinement are applied during a period of health care will meet requirements to practice safely and lawfully.

CHS endorses a culture that promotes the individual’s right to bodily privacy, freedom of movement, liberty, autonomy and dignity. CHS also recognises that children and young people, and people with disability, are afforded special human rights under international human rights law, and that this procedure should be applied consistently with those rights. Restraint may only be used as a measure of last resort, consistent with legislative requirements, and applied in a way that is proportionate to the risk of harm to the patient or others.

Types of restraint are:

* Chemical restraint – the use of medication or chemical substance for the primary purpose of influencing a person’s behaviour. Chemical restraint is not the use of medication prescribed for the treatment, or to enable the treatment, of a mental or physical illness.
* Environmental restraint – any action or system that limits a person’s ability to freely access the person’s surroundings or particular thing or engage in activity. Environmental restraint is not the use of reasonable safety precautions, such as a boundary fence.
* Mechanical restraint – use of a device to prevent, restrict or subdue the movement of all or part of a person’s body. Mechanical restraint is not the use of a seatbelt when travelling or the use of device for therapeutic purposes.
* Physical restraint – the use or action of force to stop, limit or subdue the movement of a person’s body or part of the person’s body. Physical restraint is not a reflex action of reasonable physical force and duration intended to guide or direct a person in the interest of person’s safety where there is an imminent risk of harm.

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| Alerts |

Restraint and/or forcible giving of medications, including for sedation, must only be taken as a last resort after all other available options to reduce or eliminate a risk of harm to the person and/or others has been considered or tried. CHS acknowledges that in extraordinary circumstances, a ‘measure of last resort’ may need to be the first action undertaken for clinical safety reasons and to protect a person from an imminent threat of serious harm.

The prone restraint position (face down restraint) should not be used. Prone restraint is a last resort option if it is the safest way to protect the person being restrained or any other person in the environment. If prone restraint is used, it must cease as soon as practical and must be time limited to a maximum of 3 minutes. This is sufficient time to administer medication and/or remove the person to a safer environment.

For persons being treated under the Act*,* restraint and/or the forcible giving of medication must be recorded in the persons electronic medical record (EMR). Restraint and/or forcible giving of medication can only be authorised by the Chief Psychiatrist/their delegate or the Emergency Medicine Specialist.

The Public Advocate must be informed of any use of restraint or forcible giving of medication in relation to a person being treated under theAct within 12 hours via email at [JACSPublicAdvocate-MentalHealth@act.gov.au](mailto:JACSPublicAdvocate-MentalHealth@act.gov.au)*.*

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| Scope |

This procedure provides guidance for staff about physical restraint, mechanical restraint and the forcible giving of medication for essential clinical care of a person under a Mental Health Order of the ACT. This procedure applies to children (under 15 years of age), young people (15 years to 17 years) and adults.

This document applies to the following CHS staff working within their scope of practice:

* Medical Officers
* Nurses and Midwives
* Allied Health Professionals
* Security Officers
* Wardspersons
* Students under direct supervision

This procedure does not apply to people:

* who are not patients of CHS, for example visitors, relatives, friends, and other members of the public (hospital by-laws provide for this situation). For restraint of non-patients refer to the *CHS Emergency Management Plans - Code Black Procedure* or *Security Services – Use of Force Procedure*.
* not being treated under the *Mental Health Act* 2015. Refer to *Restrictive Practices Procedure*.
* requiring seclusion, refer to S*eclusion of a Person Detained under the Mental Health Act 2015 Procedure*
* under arrest or a prisoner of ACT Police or Department of Correctional Services where statutory requirements exist, and obligation to public safety and maintaining custody override medical need, refer to *Management of People Subject to Section 309 of the Crimes Act 1900 Transferred to the Canberra Hospital (MHJHADS) Procedure* or *Urgent and Non-urgent Transfer of Physical Care to the Emergency Department – Alexander Maconochie Centre and Bimberi Youth Centre Procedure* .

**Note:** For this document, the term ‘person’ refers to patients, consumers, people or individuals under the care of Canberra Health Services.

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| Section 1 – Human Rights Principles |

1. The use of restraint should be authorised by the Chief Psychiatrist/their delegate or the Emergency Medicine Specialist in consultation with a person’s guardian, enduring power of attorney or other substitute decision maker (if applicable).
2. Assessment and treatment must be provided in the least restrictive way and in the least restrictive environment that is consistent with the person’s proper care and protection, treatment efficacy and public safety.
3. Restraint or forcible giving of medication limits a person’s rights under the *Human Rights Act 2004* including rights to equality (s 8), bodily privacy (s 12), freedom from from forced medical treatment (s 10(2)), freedom of movement (s 13), rights to liberty and security (s 18), and rights to humane treatment when deprived of liberty (s 19). Children and young people have rights to additional protections that are needed because of their vulnerability (s 11(2)).
4. Decisions to apply restraint or forcibly give medication must be reasonable, justifiable and proportionate. This requires that all alternative options to the use of force or restraint are considered and that the least restrictive means to achieve safety or the care objective is employed. The individual circumstances and characteristics of the person must be given consideration during this assessment of whether use of force or restrain is reasonable, justifiable and proportionate.
5. Failure to act or make deicions in a way that is reasonable, justifiable and proportionate may result in a breach of a person’s human rights, and may be a ground for a Supreme Court action, or complaint to the Health Services Commissioner.
6. CHS staff will respond to challenging behaviour, including behaviour that limits the ability to safely provide care, in ways that engage with the person, and respect the individual’s rights, dignity, autonomy and decision-making capacity, while effectively managing risk to the person, health care professionals and others. Refer to *Challenging Behaviour Guideline*.
7. Restraint is a potentially harmful non-therapeutic intervention.
8. Restraint must not be used:

* as an alternative to adequate staffing, equipment or facilities to safely carry out the practice
* as a punishment
* for the convenience of others
* as a substitute for adequate surveillance.

1. The use of restraint should be a last resort and must only be authorised where:

* alternative strategies have failed to achieve or maintain safety for the person experiencing distress, health care professionals or others
* alternative strategies have failed to enable safe provision of treatment, for example medications required by an Inpatient Treatment Order
* behaviours and actions are assessed to be imminently or actually harmful to a person or others, or
* the health practitioner believes a failure to do so could put the person, health care professionals or public at a significant health or safety risk.

1. If restraint is used as the last resort, the wellbeing and safety of the person and health care professionals must be supported by:

* assessment and processes that ensure that there is proper authority to do so, and take into consideration the person’s decision-making capacity, mental and physical state, the level of risk and the ability of the service to apply restraint safely
* using restraint in accordance with current evidence and clinical guidelines, applicable law, and also applied in the safest, least restrictive and most respectful, humane way and for the least possible time
* implementing strategies, such as de-escalation and de-briefing for all people present during and after the application of restraint, in order to minimise the duration of the restraint, the harm and trauma, and optimise recovery.

1. Disclosure of the use of restraint in relation to a person should be made to a nominated person, substitute decision-maker, person responsible, guardian, relative, carer or friend of the person as soon as it is practicable, and where it is safe and appropriate to do so.
2. There is a legislative requirement to inform the Public Advocate of any use of restraint or forcible giving of medication in relation to a person being treated under theAct within 12 hours via email at [JACSPublicAdvocate-MentalHealth@act.gov.au](mailto:JACSPublicAdvocate-MentalHealth@act.gov.au)*.*
3. Organisational leadership, clinical governance and training and education underpin improvements to care in response to systematic review of episodes of restraint and to implementation of evidence- based best practice.

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| Section 2 – Legal Considerations of Restraint |

For information about the use of restraint on a person who is not being treated under the *Mental Health Act* 2015, refer to the *Restrictive Practices Procedure.*

Staff must not use restraint, except as a measure of last resort, in which case any instance of restraint of the person must be in accordance with legislative requirements, and in a manner which provides that any limitation of the person’s human rights is reasonable, necessary and proportionate to the risks sought to be addressed.

This procedure provides information for CHS staff about how to comply with the *Mental Health Act* 2015 restraint requirements. Staff should also read the *Mental Health Act* 2015 and be aware of their responsibilities under this legislation.

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| Section 3 – Roles and Responsibilities |

All staff must comply with this procedure and related policies and legislation to ensure their professional and legal obligations are met, and that they provide evidence based quality care.

Managers must ensure staff have access to, and are able to interpret and apply this policy and related legislation. Managers must provide staff with education related to the use of restraint and restraint devices.

1. **CHS Chief Executive Officer (CEO) and their delegates are responsible for:**

* Ensuring that across CHS use of restraint is minimised, health professionals and managers are aware of legal considerations and potential consequences, and any use is in accordance with this procedure, and legislative and other relevant policy requirements
* Ensuring appropriate training and support is provided to health care professionals across CHS to implement this procedure.
* Supporting the establishment, and review of systems and associated processes for best practice minimisation of restraint at CHS, including reporting systems
* Coordinating timely reporting of relevant information to:
  + external bodies (such as the Official Visitor or Public Advocate).
  + Internal governing bodies including the Restraint, Seclusion and Restrictive Practices Committee

1. **Executive Directors, Executive Group Managers and Executive Branch Managers are responsible for:**

* Promoting this procedure, accompanying tools and relevant safe work procedures
* Supporting health care professionals to meet their obligations under this procedure, legislation and other relevant policy documents, including reporting and review, complaints management, open disclosure, informed consent and education and training
* Ensuring that an evaluation strategy is in place to monitor restraint practice and outcomes, and design appropriate quality improvement activities.

1. **Clinical Development Nurses and Educators are responsible for:**

* Ensuring that health care professionals, and teams have access to education and training appropriate to their roles.

1. **Managers of clinical staff are responsible for** (where relevant):

* Supporting the implementation of this procedure
* Reviewing all episodes of restraint in their area
* Ensuring that appropriate follow-up takes place including discussion with person, their carer and families in accord with *Open Disclosure Procedure*
* Supporting health care professionals, persons and others to participate in activities to promote their personal recovery. Refer to *Psychological Support for Staff – A Manager’s Guide Guideline* and *Approval of External Counselling Sessions- MHJHADS Procedure.*

1. **All CHS employees are responsible for:**

* Adhering to the principles, recommended practice and intent of this procedure
* Being aware of their recording and reporting obligations to the Public Advocate in regard to every instance of reatraint and or forcible giving of medications
* Undertaking relevant initial and ongoing training to ensure that they have relevant skills and knowledge to provide care in accordance with this procedure
* Participating in quality improvement activities to minimise restraint and the harm that may arise, improve multidisciplinary teamwork and person centred care, participate in planning and training and/or practice of team responses to a situation requiring the use of restraint
* Participating in activities to promote their personal recovery from episodes of restraint. If relevant participate in activities that promote the recovery process for people and carers.

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| Section 4 – Restraint under the Mental Health Act 2015 |

Restraint within a mental health setting is not best practice and is not used as a regular treatment option for people detained under the Act by Mental Health Services or the Paediatric Adolescent Ward.

A person may develop an Advanced Agreement or Advance Consent Direction, or appoint a Nominated Person, when they have decision making capacity to do so (see *Advance Agreement, Advance Consent Direction and Nominated Person Procedure* for further information). The existence of such documents may be available on Mental Health, Alcohol and Drug Services, Justice Health, Integrated Care eRecord (MAJICeR) or denoted via a My Rights, My Decisions Wallet Card or similar documentation. Whenever the situation allows, reasonable efforts should be made to ascertain if a person has such documentation and, if so, to follow the preferences documented. If it is not possible to check for the existence of an Advance Agreement and/or Advance Consent Direction prior to providing emergency treatment, care or support, the reasons for this must be documented in the person’s clinical record.

The permissible use of restraint on a person subject to the Mental Health Act must be in accordance with the legal framework set out in the Mental Health Act 2015. The provisions of the Mental health Act which regulate the use of restraint only apply to people who are being treated or involuntarily detained under the Act. They do not apply to voluntary consumers of mental health care and treatment in health facilities.

Restraint may only be applied to a person being treated or involuntarily detained under the Act with application of the minimum action that is necessary, reasonable and proportionate to the risk, when the following applies:

* Under a Psychiatric Treatment Order and/or Forensic Psychiatric Treatment Order:
  + to prevent the person from causing harm to themselves or someone else, or
  + ensure that the person remains in custody

Refer to *Care of a Persons subject to Psychiatric Treatment Orders (PTOs) with or without a Restriction Order (RO) procedure*.

* Under a Community Care Order and/or Forensic Community Care Order:
  + to prevent the person from causing harm to themselves or someone else, or
  + to ensure the person remains in custody under the order

Restraint must be authorised by the Care Coordinator except in the case of a Forensic Community Care Order, when it must be authorised by the Chief Psychiatrist.

* Under an Emergency Action within the Emergency Department:
  + Under s80(3) of the *Mental Health Act* 2015 a Medical Officer or Mental Health Officer may apprehend a person and take the person to an approved mental health facility if the medical officer or mental health officer believes on reasonable grounds that:

1. the person has a mental disorder or mental illness, and either:
   1. the person requires immediate treatment care or support, or
   2. the person’s condition will deteriorate within 3 days to such an extent that the person would require immediate treatment, care or support, and
2. the person has refused to receive that treatment, care or support, and
3. detention is necessary for the person’s own health or safety, social or financial wellbeing, or for the protection of someone else or the public, and
4. adequate treatment, care or support cannot be provided in a less restrictive environment.

Restraint must be authorised by the person in charge of the Mental Health facility (Assistant Director of Nursing during business hours or the most senior nurse on the unit after hours) or the Emergency Medicine Specialist within the Emergency Department.

* Under an Emergency Detention:
  + if a person is apprehended and taken to a mental health facility under s80 of the *Mental Health Act 2015*
  + to prevent the person from causing harm to themselves or someone else, and/or
  + to ensure the person remains in custody under the order.

Restraint must be authorised by the person in charge of the Mental Health facility (Assistant Director of Nursing during business hours or the most senior nurse on the unit after hours) or the Emergency Medicine Specialist within the Emergency Department.

Forcible giving of medication, using force and assistance that is necessary and reasonable, can only occur:

* Under a Psychiatric Treatment Order and/or Forensic Psychiatric Treatment Order:
* if the Chief Psychiatrist determines that a person be given medication for the treatment of a mental illness
* Under a community care order:
* if the Community Care Order authorises the giving of medication for the treatment of the persons mental illness
* Under an Emergency Dction or Emergency Detention:
* if the medical officer believes on reasonable grounds that the detained person should be given medication for the treatment of the person’s mental disorder or mental illness.

Staff must immediately notify by phone either the Chief Psychiatrist, Care Coordinator, the person in charge of the mental health facility (Assistant Director of Nursing during business hours or the most senior nurse on the unit after hours), the Emergency Medicine Specialist within the Emergency Department, or within Paediatrics during business hours the Child and Adolescent Mental Health (CAMHS) Consultant Psychiatrist of the need for restraint.

Staff must inform the Public Advocate of the ACT within 12 hours of every instance of involuntary restraint or forcible giving of medication to any person who is being treated under the *ACT Mental Health Act 2015*. The Public Advocate must be informed by sending a copy of the restraint form in the electronic clinical record (ECR) via email to [JACSPublicAdvocate-MentalHealth@act.gov.au](mailto:JACSPublicAdvocate-MentalHealth@act.gov.au).

The obligation to keep records and notify the Public Advocate rests with the person that authorised the restraint. Depending on the circumstances that person will be the Chief Psychiatrist, the Care Coordinator, the Team Leader of the shift or the Emergency Medicine Specialist.

For more information on decision making in relation to restraint, and its application please follow the steps outlined in Sections 3 to 8 below and see Attachment 1 – Restraint Decision Process Flow Chart.

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| Section 5 – Assessment of the Person Prior to Restraint |

Staff must first consider correction of any underlying cause(s) of behaviour of concern that may rule out the need for restraint. Underlying causes to be considered include co-morbid diseases or conditions, or the person having dual diagnoses.

In case of an emergency, refer to Section 8. Examples of underlying cause(s) experienced by the person may be frustration, anger, distress, emotional, clinical deterioration or physical discomfort.

Other potentially corrective actions include:

* for persons being treated in mental health facilities, checking the person’s At Risk Category (ARC) in relation to the level of observation required. For Paediatric patients use Paediatric Clinical Risk Assessment and Management (PCRAM) on the Paediatric Behavioural Assessment, Observation and Management (PBOAM) Form (number 37032)
* referring to the person’s Advanced Consent Direction and/or Advance Agreement for de-escalation techniques that are known to work for them, such as who to contact to sit with them
* contacting the person’s next of kin, carer, substitute decision maker or nominated person who may be able to sit or stay with the person and provide support and negate the need for restraint
* recognising the development of challenging behaviour – this includes behavioural assessment, the patient’s triggers or contributing factors, level of distress and risk of challenging behaviours, using screening and assessment tools as appropriate and available
* acting early to de-escalate – this includes a range of verbal and non-verbal strategies that are based around good communication and continuing to de-escalate throughout the incident
* regularly communicating with the person about the situation and explain why a particular course of action is taken in a respectful, positive and collaborative manner
* engaging early with patients and carers so that where possible, individualised support plans and behaviour support plans, are implemented for patients known to be at risk of challenging behaviours, in particular those who have been restrained or secluded in the past
* providing care in a way that upholds the patient’s healthcare and human rights. Including respecting the person’s age, culture, language and spiritual differences and allowing for differences in health literacy
* assigning a familiar staff member or a sitter/observer to the person taking into consideration the presence of gender appropriate staff and application of gender diverse practices (for example a staff member of the same gender the person identifies with may need to be present even if not involved in the intervention) as well as the person’s needs including cultutral, spiritual and language considerations as much as possible.
* decreasing sensory stimulation
* providing a physical, social and emotional environment, and formal and informal activities that avoid triggers and support prevention, care and recovery.

For issues where language is a barrier to communication, staff must follow the procedures outlined in the *ACT Language Services Policy* and *Language Services – Interpreters and Translated Materials Procedure*.

Once the above considerations have been investigated, the treating team must complete a comprehensive assessment prior to the application of restraint. The person’s carer (if applicable) should be included in the assessment. The assessment must include an evaluation of the person’s medical, physical, emotional, social, and psychological wellbeing, and include consideration of the person’s disability (and the extent to which this may impact on the person’s wellbeing and/or their presentation at a particular time).

The assessment must be documented in the person’s ECR. If possible and practical and if the person provides the authority for their inclusion, the person’s next of kin, substitute decision maker or nominated person should be included in the assessment. Consider the following during the assessment:

* level of consciousness
* confusion
* effect of medication, for example morphine
* withdrawal from alcohol, drugs, nicotine
* intoxication
* hypoxia
* emotional disturbance (fear, anger, frustration, misunderstanding)
* history of trauma and/or distress and the person’s triggers
* age and stage of development of the child or young person(if applicable)
* the child or young person’s age, sex, physical and mental health and any history of abuse.

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| Section 6 – Application of Physical Restraint, Mechanical Restraint and the Forcible Giving of Medication |

Restraint or the forcible giving of medication is only permitted as a last resort when all other reasonable efforts, as outlined in Section 5, at meeting the person’s clinical need without restraint have been unsuccessful. Restraint interventions must be proportionate to the risks being averted and must consider the least intrusive and invasive, and most dignified method.

Where possible, the decision to use restraint should be a collaborative decision that involves the person, their next of kin, carer or substitute decision maker and/or nominated person, medical staff, nursing staff and other relevant members of the treating team.

It will be necessary to check a consumer’s legal status prior to a restrictive practice being authorised. For persons being treated under the Act, the Chief Psychiatrist, Care Coordinator, the person in charge of the mental health facility (Assistant Director of Nursing during business hours or the most senior nurse on the unit after hours), or within Paediatrics during business hours the Child and Adolescent Mental Health (CAMHS) Consultant Psychiatrist or the Emergency Medicine Specialist within the Emergency Department, holds the authority to apply restraint.

Children and Young People

Within the Paediatric ward, if a Psychiatrist is not immediately available and the child or young person is in immediate danger of harming themselves or others, *authority to restrain can be sought from the psychiatry registrar or paediatric registrar* in collaboration with senior nursing staff. The Chief CAMHS Psychiatrist or after hours Chief Psychiatrist must be contacted and their authorisation documented in the young person’s file as soon as is practicably possible. If the young person is not being treated under the Act, authorisation of restraint must be by a medical officer as per *Restrictive Practices Procedure*. In an emergency please refer to Section 8.

The use of force on a child or young person should not be conducted where it can be observed by another child or young person.

In urgent circumstances where the staff member believes on reasonable grounds that not using force would create a risk of injury to staff, the child or young person in therapeutic protection, or anyone else, the use of force can be applied in view of another child or young person.

Application of restraint

A restraint intervention must only be implemented by staff that are trained in its safe application and monitoring. It is compulsory for staff working within Mental Health, Justice Health, Alcohol and Drug Services, Paediatric Department and Ward Services to complete approved Occupational Violence training that specialises in managing and responding to aggressive and challenging behaviour.

If restraint or the forcible giving of medication is essential for clinical care to occur, staff must take into consideration the following:

* all best practice alternatives are taken prior to the application of restraint
* the safety and personal dignity of the person at all times
* minimise the risk of injury to the person and staff
* the presence of gender appropriate staff and application of gender diverse practices, (for example, a staff member of the same gender the person identifies with may need to be present even if not involved in the intervention)
* the person’s needs including cultural, spiritual, and language considerations as much as possible
* the person’s best body alignment to ensure minimal pressure is applied to the torso or head during physical restraint
* the person’s airway and respiration must be protected and the person must never be held face down when in the prone position
* the person’s skin surfaces are protected to maintain tissue integrity
* mechanical restraint and physical restraint techniques must avoid direct pressure on bony prominences and joints and applied in accordance with the manufacturer’s instructions
* where possible, the grip should be on clothing rather than flesh with all care taken not to inflict pain or undue force
* restraint is only maintained for as long as there is a clinical need or the person is in or presents an immediate danger, and
* for restraint of a child or young person, as soon as practical explain the procedure to the parent/carer.

For all episodes of restraint a Medical Officer, the Chief Psychiatrist, CAMHS Psychiatrist, Care Coordinator or Emergency Medicine Specialist, must make an entry in the person’s clinical record that includes:

* a description of the significant behaviours of the person that warranted the decision to apply restraint
* a description of the alternative steps taken to avoid the use of restraint, the reasons for the steps taken, and their effectiveness
* an individualised care plan including the type of restraint to be used, its purpose, proposed period of use and timelines for release of restraint, review and evaluation
* identification of any risks associated with the use of the restraint and appropriate measures to address identified risks
* the date and time restraint was applied, the staff member who made this decision and the staff member who took this action
* the explanation given to the person about the reason for restraint and a description of the person’s response
* the forcible giving of medication and why the medication was required to be administered
* observations and evaluation of the person’s airway, skin and circulation during the episode of restraint
* the effect of the restraint on the person
* the date and time the Office of the Public Advocate of the ACT was notified (see Section 2 for more information)
* the date and time the restraint was ceased
* any further follow up that was taken or may be required, and
* what psychological support was offered to the person, staff and members of the public who may have witnessed the event.

**Note** any person who is being treated under the Act requires the restraint to be recorded in the persons ECR.

Clinical handover using ISBAR format should be provided to medical and nursing staff on the next shift. Refer to *Clinical Handover Procedure.*

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| Section 7 – Monitoring and Care of the Person during Restraint |

For safety reasons, the person who is under restraint must have constant supervision and observation by staff. A Clinical Risk Assessment form (adults), or Paediatric Behavioural assessment, observation and management form (children and young people), must be completed (located on the Forms Register) and noted in the person’s observation chart and ECR.

As a minimum requirement, staff must check the person every hour throughout the episode of restraint and document on the person’s observation chart:

* Blood pressure (BP)
* Heart rate (HR)
* Respiratory rate (RR)
* Temperature
* Level of Consciousness, and
* Oxygen saturation (where equipment is available).

Staff must also:

* provide reassurance and social contact to the person
* check body alignment and positioning remains appropriate
* check the person’s airway is not compromised
* provide care for prevention of pressure areas, if required
* examine the person during restraint for the development of adverse effects (for example, pressure sores, abrasions, other tissue damage)
* ensure the person is hydrated and offer the person fluids if permitted based on clinical condition
* provide the person with regular toileting
* release the person’s limbs from mechanical restraint at least once per hour to prevent injury from immobilisation and allow repositioning
* complete a mental state examination of the person and record the results in their ECR.

While restraint is applied to a person a Medical Officer must examine and document findings of the person at least once every four hours. If the person being restrained displays signs of, or voices physiological compromise such as difficulty breathing, the restraint must be ceased immediately and alternatives sought. A Senior Medical Officer, Registrar or Consultant, Chief Psychiatrist, Care Coordinator or person in charge of the mental health facility (Assistant Director of Nursing during business hours or the most senior nurse on the unit after hours), must be contacted to assess the person.

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| Section 8 – Communication with the Person and their Next of Kin, Substitute Decision Maker or Nominated Person |

If a person provides their consent to share their information, staff should contact the person’s next of kin, carer, substitute decision maker and/or nominated person and advise them of the restraint as soon as practicable, including:

* the type of restraint used
* the length of time restraint will be or has been used
* the forcible giving of medication
* strategies in place to reduce the need for restraint in the future
* a full explanation of the indications, potential risks and benefits
* alternatives investigated prior to the restraint intervention
* the support the person and family members, next of kin, or designated representative (if applicable) will receive following cessation of the use of restraint.

Consent by a child or young person

Until the age of 18 years, consent is usually obtained from a parent or legal guardian, however staff should aim to involve the child or young person in the discussion and decision making.

Older children and young people may provide consent if determined to be Gillick competent.

In determining whether an older child or young person is capable of providing consent, staff need to consider whether they have sufficient understanding and intelligence to:

* Comprehend the medical advice being given, including the nature, consequences and implications of the proposed examination, treatment or procedure
* Comprehend the potential risks to health with or without the examination, treatment or procedure and
* Manage the emotional impact of either accepting or rejecting the advised examination, treatment or procedure.

Staff should encourage the child or young person to communicate with parents or guardians, unless there are concerns around their safety or wellbeing, however where the child or young person requests confidentiality, and/or if the need for examination, treatment or a procedure is identified, the staff should consider Gillick Competence of the child or young person to seek legally valid consent. The views (if known) of the parent or guardian to the proposed examination, treatment or procedure, and any alternatives should also be considered. Documentation should clearly include the staff members’s determination of Gillick competence.

Refer to *Informed Consent – Clinical Policy* for further information.

Person without decision making capacity

Where it has been identified that the person does not have the decision-making capacity to provide consent themselves, a substitute decision maker can provide consent. Refer to *Informed Consent – Clinical Policy* or *Advance Agreements, Advance Consent Directions, and Nominated Persons under the Mental Health Act 2015 Procedure*..

Communicating information about an episode of restraint

Information about the episode of restraint may be confronting and staff must communicate to the person or their family members, carer, next of kin, designated representative or nominated person in a respectful manner and ensure all information is understood.

In some situations, language may be a barrier and staff must use an accredited interpreter for languages other than English or for Auslan. Please see the *ACT Language Services Policy* and *Language Services – Interpreters and Translated Materials Procedure* .

For Aboriginal and Torres Strait Islander peoples, the Aboriginal and Torres Strait Islander Liaison Service should also be consulted as appropriate and to assist in communication with the person and/or their family to help resolve any issues. Contact MHJHADS Liaison service on extension 44137 or [CHS.ALO-MHJHADS@act.gov.au](mailto:CHS.ALO-MHJHADS@act.gov.au) . CHS service on extension 42055 or [ALOservice@act.gov.au](mailto:ALOservice@act.gov.au) .

When a person, their next of kin, carer, substitute decision maker or nominated person are concerned or unhappy about their care, or the use of restraint:

1. They should be encouraged and supported by staff to raise these issues with the treating team as they occur.
2. If any concerns are not addressed by the treating team, staff should facilitate a discussion with the Director of Nursing or Clinical Director within the Division.
3. If this does not resolve their concern, escalation should occur to the Executive of the Division, then to Chief Operating Officer and if still not resolved then to Chief Executive Officer of Canberra Health Services.
4. Any concerns raised out of hours should be addressed by the out of hours After Hours Hospital Manager.

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| Section 9 – Care of the Person and Staff Post Restraint |

Restraint can be a traumatic experience and staff should provide psychological support to:

* the person, particularly if the restraint was an emergency or the person was not competent at the time of restraint
* their next of kin, carer, substitute decision maker and/or nominated person
* any consumer or visitor or other person who may have witnessed the restraint.

The support offered does not need to include a formal debrief as, in some circumstances, this may add to the person’s trauma.

Psychological support includes:

* listening to the person about how they feel and what they experienced
* answer any questions the person may have.

Post restraint psychological support can be provided by:

* peer recovery workers
* a staff member of the person’s choosing
* the person can be referred onto appropriate support services, for example, to a social worker, psychologist or counsellor.

For Aboriginal and Torres Strait Islander people, staff must contact the Aboriginal and Torres Strait Islander Liaison Service to assist in communication with the person and/or their family. Contact MHJHADS Liaison service on extension 44137 or [CHS.ALO-MHJHADS@act.gov.au](mailto:CHS.ALO-MHJHADS@act.gov.au) . CHS liaison service on extension 42055 or [ALOservice@act.gov.au](mailto:ALOservice@act.gov.au) .

Any person being treated under the Act, must be offered a post restraint review within 72 hours with oversight of a Senior Medical Officer (Senior Registrar or Consultant), and/or a Consultant Psychiatrist.

Staff must record the support offered and any outcomes in the person’s ECR. If the person chooses not to engage in psychological support the attempts to offer psychological support debrief must be recorded in the person’s ECR.

**Mointoring of person**

A person needs to be monitored closely post restraint. Following all episodes of restraint the person must be examined by a Medical Officer in consultation with a Consultant Psychiatrist to:

* establish any adverse outcome, either physical or emotional, sustained as a result of the restraint
* learn from the person’s experience of restraint to avoid a reoccurrence
* implement treatment of any adverse outcomes, and
* record and report adverse outcomes.

**Staff support**

Staff involved in an episode of restraint are to be offered support, refer to *Psychological Support for Staff – A Manager’s Guide Guideline.* Staff can also be involved in the post restraint review to reflect on and evaluate their actions. As a part of the restraint episode review, the Assistant Director of Nursing or Director of Nursing for the ward and the Clinical Director must ensure that a debrief session has been offered to all staff involved.

**Review of restraint**

All episodes of restraint in a mental health setting must be reviewed in the MHJHADS Restraint, Seclusion and Restrictive Practices meeting and include the outcomes and learnings.

In Paediatrics, this review will take place within a month at Multidisciplinary Team meetings with appropriate staff (including CAMHS) present. These meetings are held Monday and Thursday 1030 and will be minuted. The outcome of the review will be circulated to all staff to ensure ongoing efforts to maintain high standards of care.

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| Section 10 – Restraint as a Necessity and in an Emergency Situation |

The application of restraint to a person, without consent, where the treatment is immediately necessary to preserve life or human safety, is lawful under the defence of ‘necessity’. This includes a situation where a person lacks capacity to give consent to the treatment.

For the defence of necessity to apply:

* restraint on the person must be reasonable and proportionate to the gravity and risk of harm
* the nature and duration of the restraint, and must be materially connected to the provision of treatment, and
* the decision to use restraint on the person is one of last resort, when all other appropriate alternatives have failed or can reasonably be expected to fail.

It is acknowledged that in extraordinary circumstances, a ‘measure of last resort’ may need to be the first action undertaken for clinical safety reasons and to protect a person from an imminent threat of harm.

In all cases, the use of restraint, including the surrounding circumstances, the reasons for the restraint and all other alternatives tried, must be documented in the person’s ECR.

Every effort should be made, as far as practicable in the circumstances, to obtain authority or consent for the use of restraint from an appropriate source prior to the use of restraint. Refer to *Advance Agreement, Advance Consent* *Directions and Nominated Persons under the Mental Health Act 2015 procedure.*

In an emergency, the Senior Nurse on duty must obtain a telephone order for the use of restraint (and/or the forcible giving of medication) as soon as is practicable from the Senior Medical Officer responsible for the person. In Paediatrics the responsible officer will be the CAMHS Psychiatrist or on call after hours Psychiatrist.

Under the Act, authorisation must be obtained from a Chief Psychiatrist, CAMHS Psychiatrist, Care Coordinator, person in charge of the mental health facility (Assistant Director of Nursing during business hours or the most senior nurse on the unit after hours) or from the Emergency Medicine Specialist if within the Emergency Department.

If required out of hours, the Senior Nurse must obtain the telephone order.

The person who has authorised the restraint must document the following details in the person’s clinical record:

* the reason for the restraint
* manner of the restraint
* people who were involved
* all alternatives that have been utilised and failed, and
* length of time of the application of restraint.

The authorising Medical Officer must sign all telephone orders within 12 hours.

In the event of an emergency evacuation, staff must manage a person who is restrained in accordance with the Emergency Management Plans located on the CHS Health Hub under Security/Fire Safety/Emergency Plans.

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| Evaluation |

**Outcome**

People detained under the Mental Health Act 2015 and assesed as requiring restraint or forcible administration of medication are managed as per this procedure.

**Measures**

* Annual review of consumer feedback about restraint or forcible administration of medication.
* Annual review of staff accident and incident report (SAIR) related to application of restraint or forcible administration of medication.
* Monthly review of episodes of restraint at Restraint Seclusion and Restrictive Practices Committee (MHJHADS) and Multidisciplinary Team meeting (Paeditrics) to identify what could be done better.

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| Related Policies, Procedures, Guidelines and Legislation |

**Policies**

* Informed Consent (Clinical)
* Clinical Records Management
* Incident Management – Clinical
* Occupational Violence
* Open Disclosure
* Work Health and Safety
* Nursing and Midwifery Board of Australia Requirements of Practice

**Procedures**

* Infection Prevention and Control Healthcare Associated Infections Clinical
* Patient Identification and Procedure Matching
* Clinical Handover
* Clinical Records Management
* Consumer Feedback Management
* Incident Management – Clinical
* Occupational Violence
* Advanced Agreements, Advance Consent Directions and Nominated Persons under the Mental Health Act 2015
* Seclusion of a Person Detained under the Mental Health Act 2015
* Restrictive Practices
* Alerts Management
* Responding to Consumer use of Alcohol and/or Other Drugs

**Legislation**

* *Health Records (Privacy and Access) Act* 1997
* *Human Rights Act* 2004
* *Work Health and Safety Act* 2011
* *Carers Recognition Act 2021*
* *Common Law*
* *Crimes Act 1900 (ACT)*
* *Guardianship and Management of Property Act 1991*
* *Mental Health Act 2015*
* *Powers of Attorney Act 2006*
* *Work Health and Safety Regulation 2011*
* *Work Health and Safety Codes of Practice*

**Other**

* Australian Charter of Health Care Rights
* [ACT Charter of Rights for people who experience mental health issues](http://www.health.act.gov.au/c/health?a=sendfile&ft=p&fid=1318389674&sid=)
* [Mental Health Statement of Rights and Responsibilities 2012](http://www.health.gov.au/internet/mhsc/publishing.nsf/Content/8F44E16A905D0537CA257B330073084D/$File/rights.pdf)

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‘Standard for the Use of Restraint for Nurses and Midwives’, Nursing Board of Tasmania, 2008

‘Guidelines for the Use of Restraint in WA’, Nurses and Midwives Board of Western Australia, 2009

‘Decision-making Tool: Responding to issues of restraint in Aged Care’, Australian Government Department of Health and Ageing, 2004

‘Ending Seclusion and Restraint in Australian Mental Health Services (Position Statement)’, National Mental Health Consumer & Carer Forum (NMHCCF), 2010

‘Joanna Briggs Institute Best Practice Information Sheet, Pressure Ulcers - Prevention of pressure related damage’, Volume 12 (Issue 2), 2008

‘Joanna Briggs Institute Best Practice Information Sheet, Physical Restraint Part 1 -

Minimisation in Acute and Residential care Facilities’, Volume 6 (Issue 3), 2002 <http://connect.jbiconnectplus.org/ViewSourceFile.aspx?0=4326>

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Government of South Australia, 2022. Restrictive Practices in health care website accessed at: <https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/clinical+resources/clinical+programs+and+practice+guidelines/safety+and+wellbeing/restrictive+practices+in+health+care/restrictive+practices+in+health+care> Accessed on 28/04/2022

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| Definition of Terms |

**Capacity:** The term capacity is used in this document to mean a person is capable of:

* Understanding the nature and effect of decisions about consent and communicating the understanding verbally or non-verbally
* Freely and voluntarily making decisions about consent
* Communicating the decisions verbally or non-verbally, and
* Retaining the information, their decision and their consent.

The type of assessment required to determine someone’s capacity will vary depending on the type of decision being made.

**Carer:** a person is a carer if the person provides personal care, support or assistance to a person who has a mental disorder or mental illness.

**Care Coordinator:** Effective 5 April 2019 the Care Coodinator appointed under *Mental Health Act* 2015 is Chief Psychiatrist ACT Health Directorate..

**Chemical restraint:** The use of medication or chemical substance for the primary purpose of influencing a person’s behaviour. Chemical restraint is not use of medication prescribed for the treatment or to enable the treatment of a mental or physical illness.

**Child:** For the purposes of this document a child is someone who is under 15 years of age.

**Environmental restraint** – any action or system that limits a person’s ability to freely access the person’s surroundings or particular thing or engage in activity. Environmental restraint is not the use of reasonable safety precautions such as a boundary fence.

**Forcible Giving of Medication** is medication given to a person against their will when under restraint. This is considered immediately necessary by the treating team for a person’s health and safety and/or the safety of others.

**Mechanical Restraint** use of a device to prevent, restrict or subdue the movement of all or part of a person’s body. Mechanical restraint is not the use of a seatbelt when travelling or the use of device for therapeutic purposes. Mechanical restraint is not a regular treatment option used by Adult Mental Health Services (AMHS) and can only be used by AMHS staff under the direction and supervision of the ACT Chief Psychiatrist.

**Mechanical** **device** **restraint** is any device, material or equipment, attached to, near or adjacent to a person’s body which cannot be controlled or easily removed by the person. A mechanical device restraint deliberately prevents, or intends to deliberately prevent, a person’s free body movement to a position of choice and/or a person’s normal access to their body.  
  
Mechanical restraint may include the use of posy vests, belts and wrist straps. Use of any other material that has not been specifically designed, manufactured and undergone a quality control processfor the use of restraint must not be used for the purpose of restraint under any circumstances. For example, bed sheets, bed rails, bandages and bedside tables.

**Nominated person:** A person with a mental disorder or mental illness, who has decision-making capacity, may, in writing nominate someone else to be their nominated person. The NP cannot consent on the person’s behalf (unless they have that power in another role such as Power of Attorney).

**Patient Special:** is one on one constant observation and care of a person. A special is strictly one on one for the designated person and is not to respond to any other call buttons or emergencies, or to leave the person or the immediate vicinity of the person.

**Physical restraint** the use or action of force to stop, limit or subdue the movement of a person’s body or part of the person’s body.Physical restraint is not a reflex action of reasonable physical force and duration intended to guide or direct a person in the interest of person’s safety where there is an imminent risk of harm. Physical restraint is a short term measure only.

**Restraint** is the interference with, or restriction of, an individual's freedom of movement. Restraint is defined as any device, material or equipment attached to or near a person’s body and which cannot be controlled or easily removed by the person and which deliberately prevents or is deliberately intended to present a person’s free body movement to a position of choice and/or a person’s normal access to their body. Restraint by threat is the direct or implied threat to use restraint against a person. Restraint includes any chemical, drug, medication or other substance that may imapri or impede a person’s normal functioning.

**Restraint alternative** is considered to be any intervention that is used in place of a restraint device or reduces the need for physical restraint.

**Substitute Decision Maker**: Where it has been identified that an adult consumer does not have the decision-making capacity to provide consent to treatment or procedures themselves the following substitute decision makers can provide consent:

* Health Attorney
* The Attorney, under an Enduring Power of Attorney
* Guardian, if approved
* Chief Psychiatrist or Community Care Coordinator (where there are issues relating to mental health or mental dysfunction and the consumer is under a Mental Health Order).

**Supervision** is the assignment of a nurse or an appropriately trained member of staff to a client to ensure safe and constant supervision with regular attention to the care of the person’s needs.

**Treating Team** includes the Medical Officer, Consultant Psychologist, Consultant Psychiatrist Senior Nurse, nursing staff, Emergency Medicine Specialist, interdisciplinary team and other relevant healthcare providers.

**Young Person** – for the purpose of this document a young person is someone who is aged 15 to 17 years and admitted to the Paediatric Adolescent ward. Once the person turns 17 years old, they are treated at CHS an adult patient/consumer.

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| Search Terms |

ACAT, ACT Civil and Administrative Tribunal, Forcible giving of medication, Mechanical, Mental Health Act 2015, Physical Restraint, Public Advocate, Restraint, Restraint Decision Process, restrictive practices,

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| Attachments |

Attachment 1: Restraint Decision Process Flow Chart

**Disclaimer**: *This document has been developed by Canberra Health Services specifically for its own use. Use of this document and any reliance on the information contained therein by any third party is at his or her own risk and Canberra Health Services assumes no responsibility whatsoever.*

*Policy Team ONLY to complete the following:*

|  |  |  |  |
| --- | --- | --- | --- |
| *Date Amended* | *Section Amended* | *Divisional Approval* | *Final Approval* |
| *19/05/2022* | *Complete review* | *Katie McKenzie, a/g ED MHJHADS* | *CHS Policy Committee* |
|  |  |  |  |

*This document supersedes the following:*

|  |  |
| --- | --- |
| *Document Number* | *Document Name* |
| *CHS16/025* | *Restraint of a Person* |
|  |  |

## Attachment 1: Restraint Decision Process Flow Chart

