Chief Psychiatrist Restraint and Seclusion Standard

A Standard to Reduce and Eliminate where possible the Use of Restraint and Seclusion applied under the *Mental Health Act 2009*

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Government of South Australia
SA Health

Contents

1. Introduction

The *Mental Health Act 2009* (the Act) under Section 89 establishes the position of Chief Psychiatrist and under Section 90 provides the position with a number of powers and functions, including the power to issue standards.

The development of Standards provides the Chief Psychiatrist with a mechanism to carry out a number of statutory functions, such as monitoring the standard of mental health care, the treatment of patients, the use of restrictive practices and the administration of the Act. The implementation of Standards can also provide the Chief Psychiatrist with information including data that will inform other functions, such as promoting the continuous improvement of mental health service delivery and organisation, and advising the Minister on issues relating to mental health.

This Standard: *A Standard to Reduce and Eliminate where possible the use of Restraint and Seclusion applied under the Mental Health Act 2009,* describes expectations in relation to the use of restraint and seclusion in health services where a patient with mental illness may be assessed and treated in a health setting under *Mental Health Act 2009* powers – including ambulance, hospital or community mental health services.

The Chief Psychiatrist will inspect services for compliance with this Standard as part of their statutory obligations under the *Mental Health Act 2009*.

The reduction and elimination of seclusion and restraint requires sustained quality improvement programs. This standard expects that such a strategy is in place, and then focusses on the authorisation for restraint, and the review of such incidents after they have occurred.

The South Australian Standard has incorporated strategies and approaches from other jurisdictions, and the Chief Psychiatrist wishes to particularly acknowledge the guidance of documents produced by the UK National Institute of Clinical Excellence and the Pennsylvania Office of Mental Health and Substance Abuse, that have informed the structure and approach of this Standard.

2. Roles and Responsibilities

This standard applies to all those involved in the administration and operation of the *Mental Health Act 2009* across public and private settings. The responsibilities for implementing the standard apply to clinicians, clinical leaders, leaders who make policy, strategic and operational decisions, and to regulators.

The Standard applies to the following:

- In approved treatment centres, and authorised community mental health centres.
- Whenever a person is under the care and control of an ambulance officer, or health professional (*Mental Health Act 2009* s56) wherever the location.
- In any situation where a person is in hospital on a *Mental Health Act 2009* Inpatient Treatment Order. This will include but is not limited to the emergency department, general wards and Specialist Mental Health In-patient Units.
- In mental health services where a person is under a Community Treatment Order and a restrictive practice is used to administer treatment.

This current standard does not address the approval process for the use of restraint when air transport is used, but notes that existing policies and procedures exist to ensure the safety of individuals, health staff, air crew and aircraft. It remains an expectation that trauma informed practices are used and where restrictive practices are used in air transport the event will be reported to the Chief Psychiatrist.

Review of the operation of this standard is the responsibility of the Chief Psychiatrist. This standard will be supported by a toolkit to reduce and eliminate the use of restrictive practices.

3. Legislative and Policy Context

In mental health service settings restrictive practices are the use of interventions and practices that have the effect of restricting the rights or freedom of movement of a person with a mental illness.

Restrictive practices regulated by this standard include mechanical restraint, physical restraint, chemical restraint and seclusion, but there is a broad range of other restrictive practices that may occur in inpatient and residential settings and in all cases the relevant guiding principles and requirements of the *Mental Health Act 2009* should be upheld including:

S 7 (ac) mental health services should (subject to this Act or any other Act) be provided in accordance with international treaties and agreements to which Australia is a signatory;

S 7 (b) (b) mental health services should be provided on a voluntary basis as far as possible, and otherwise in the least restrictive way and in the least restrictive environment that is consistent with their efficacy and public safety, and at places as near as practicable to where the patients, or their families or other carers or supporters, reside;

S7 (h) restrictive practices should be used only as a last resort for safety reasons and not as a punishment or for the convenience of others;

The expectations of this standard are binding on providers regulated by the *Mental Health Act 2009.*

This Standard is made within the framework of the:

- *UN Convention on the Rights of Persons with Disabilities*
- *UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment* and its Optional Protocol (OPCAT)
- *UN Convention on the Rights of the Child.*

Restrictive practices under the *Mental Health Act 2009* can only be applied when an appropriate *Act* power is used so that the person is under the care and control of a health practitioner. This includes powers under s56 of the *Mental Health Act 2009*, Community Treatment Orders for the administration of treatment, and Inpatient Treatment Orders.

4. Principles of practice and service delivery

This Standard adopts the following principles and acknowledges that the underlying philosophy in care is collaboration between consumers, carers and staff, to allow for facilitation and empowerment. This Standard requires their adoption in mental health service settings and wherever people with mental illness may be treated. The principles are:

- recognise the inherent rights of a person to personal dignity and freedom in accordance with international rights instruments;
- mental health services will recognise and enable patient autonomy and choice in treatment and care;
- mental health services will adopt a least restrictive environment for treatment and care;
- mental health services will recognise and value the importance of allowing patients to guide their own recovery;
- the use of restrictive practices is not therapeutic and should not ever be regarded as a therapeutic practice;
- If seclusion or restraint is used for children and young people, staff involved must be aware of the particular vulnerability to significant psychological trauma from these practices for this age group
- the use of restrictive practice increases the risk of trauma and may trigger symptoms of past experience of trauma
- restrictive practices should only be used after reasonable attempts to use alternate means of calming and de-escalation to enable a person to regain self- control are unsuccessful;
- the use of restraint and seclusion is regarded as an exception and extreme practice for any person;
- all forms of restrictive practice should only be used temporarily in a behavioural emergency;
- restrictive practices when used, are implemented for the least amount of time possible and recorded, monitored and reviewed;
- any use of restrictive practices must have tight safeguards in place that focus on minimising risk to consumers, staff, and others; and on empowerment, collaboration, preserving and promoting dignity, decency, humanity and respect; and considers the needs of people from Aboriginal or Torres Strait Islander and Culturally and Linguistically Diverse backgrounds and;
- an effective restrictive practice policy will provide the framework to improve staff safety by preventing episodes of violence, and by employing effective procedures and training for staff who administer restrictive practices as a last resort.

Comfort rooms and sensory modulation are included as a treatment modality. Acute and rehabilitation inpatient psychiatric settings should have access to a comfort room and sensory modulation equipment. Emergency departments and short stay wards should have access to sensory modulation equipment. The comfort room and level of sensory modulation equipment should meet the minimum standards for such rooms and equipment, attested to by a statement by the Senior Occupational Therapist of each service. Such facilities should be subject to an annual review to ensure that standards are maintained. These statements are to be available to the Chief Psychiatrist on request.

An improved therapeutic environment lowers the frequency of restraint and seclusion use. Acute short-stay units and rehabilitation inpatient psychiatric settings should have access to a range of activities and resources to support a therapeutic environment. The range of activities and programs should be evaluated at a minimum annually in conjunction with consumers.

Restraint prevention strategies will be included in the Consumers Care and Treatment Plan and should consider consumer co-morbidities, past trauma, and preferences about restrictive practices should this be needed as a last resort. This may include the engagement of Ngangkari's specifically for Aboriginal and Torres Strait Islanders, appropriate interpreters as

required and family / carer engagement for all.

Services will have a strategy to support the physical and emotional wellbeing of staff caring for people who are threatening and abusive in the context of care delivery.

Reducing the use of restrictive practices provides safety for both consumers and staff, by preventing episodes of agitation and reducing the need for physical interventions should agitation occur, the circumstances that may lead to staff injury can be reduced.

5. Mandatory Elements

The following elements are **mandatory service practice requirements of this Standard**:

1. Services administering the *Mental Health Act 2009* will have in place a quality improvement strategy to prevent and minimise the use of restraint and seclusion, and to implement trauma informed care.

2. Staff will be trained by their health service in the prevention of restrictive practices. It is expected that all mental health staff will have this training, along with non-mental health staff who may manage distress and agitation secondary to mental illness in emergencies. This training should also include training in trauma informed care.

3. Services will adhere to the authorisation, review and reporting requirements for restrictive practices described in this Standard.

4. Within each health service the accountability for the initiation, usage and termination of restrictive practices is defined, along with the oversight by clinical and service leaders responsible for clinical governance.

5. Staff who apply restraint or seclusion will have training in the use of these practices.

6. Carers, family members, guardians or other significant persons will be engaged by the treatment team to minimise the use of restrictive practices and will be informed of each episode of restraint and seclusion, unless it is not considered in the person's best interest to do so (in accordance with the *Mental Health Act 2009 s106* Confidentiality and disclosure of information).

7. Services will offer debriefing to those affected by episodes of restraint and seclusion, including the consumer, carer and staff. Debriefing will be provided by a person skilled to do so, and who was not involved in the incident. Consumers will be provided access to a support person for these conversations (as per *Mental Health Act 2009* s47 which describes a patient right to be supported) unless they choose not to do so.

8. Peer workers or other representatives with lived experience will be involved in restraint and seclusion reduction initiatives.

These mandatory requirements will apply to all patients treated under the provisions of the *Mental Health Act 2009* in all parts of an approved treatment centre or authorised community mental health centre. Non mental-health Divisions are expected to be compliant, however it is recognised that this compliance may require the support and access to consultation-liaison psychiatry services.

6. Restrictive Practices under the *Mental Health Act 2009*

6.1 Physical Restraint

6.1.1 Indication:

Physical restraint is only to be used in emergency situations where an individual's behaviour presents an imminent or immediate risk of physical harm to self or others. All less restrictive interventions must have been considered and/or trialled and have been unsuccessful in reducing the risk.

6.1.2 Authorisation for Physical Restraint

The initiation of physical restraint is only to be on the order of a medical practitioner or nurse practitioner where available or if not available, the most senior clinician on duty. Where a medical practitioner or nurse practitioner is not available in person, phone contact should be made with them. (The order can be written in a case note, or health services may wish to generate a form for this purpose.)

Prior to the use of physical restraint for aggressive behaviour which presents an immediate danger to self and/or others, ensure the individual (unless clinically contraindicated) has previously been given a choice of treatment options to enable them to regain self-control over the injurious behaviour. The reason for restraint shall be communicated clearly to the person.

Continuation of the restraint will be determined by the clinician in charge of the team responding to the incident.

6.1.3 Physical Restraint Procedure

Health services are to maintain a policy and procedure that describes the prevention of restraint, the techniques used for physical restraint and the roles and responsibilities of team members in the administration of physical restraint. (The policy and procedure to prevent restraint may either be stand-alone or part of other policies and procedures focussed on least restrictive practice and trauma informed care.)

The following guidance is based on the UK National Institute of Clinical Excellence, Violence and Aggression Guidelines 2017, and is incorporated into this standard.

- health services should ensure that physical restraint is undertaken by staff who work closely together as a team, understand each other's roles and have a clearly defined lead;
- do not use physical restraint in a way that interferes with the service user's airway, breathing or circulation, for example by applying pressure to the rib cage, neck or abdomen, or obstructing the mouth or nose;
- do not use physical restraint in a way that interferes with the service user's ability to communicate, for example by obstructing the eyes, ears or mouth;
- undertake physical restraint with extra care if the service user is physically unwell, disabled, pregnant or obese;

- aim to preserve the service user's dignity and safety as far as possible during physical restraint;
- do not routinely use physical restraint for more than 10 minutes;
- consider chemical restraint or seclusion as alternatives to prolonged physical restraint (longer than 10 minutes);
- ensure that the level of force applied during physical restraint is justifiable, appropriate, reasonable, and proportionate to the situation and applied for the shortest time possible;
- one staff member should lead throughout the use of physical restraint. This person should ensure that other staff members are:
    - able to protect and support the service user's head and neck, if needed
    - able to check that the service user's airway and breathing are not compromised
    - able to monitor vital signs supported throughout the process.
    - Able to monitor and maintain effective communication with the service user and;
- monitors the service user's physical and psychological health for as long as clinically necessary after using physical restraint.

Prone Restraint and Floor Restraint: These practices can be dangerous, life threatening and have been banned in some jurisdictions overseas.

While not prohibited for adults in SA, the use of prone restraint and floor restraint is to be avoided if at all possible.

Prone Restraint is not to be used for children.

The following standard in SA applies based on the 2017 *National Institute for Health and Care Excellence (NICE)* guidelines: When using physical restraint, avoid taking the service user to the floor, but if this becomes necessary:

- use the supine (face-up) position if possible **or**
- if the prone (face-down) position is necessary, use it for as short a time as possible.

Observations: Persons subjected to physical restraint will be subject to continuous observation of their medical state. Noting the risk of restraint asphyxia, where restraint lasts longer than 5 minutes, 5 minutely observations of facial colour, pulse, and respirations will be undertaken with the use of pulse oximetry where available. Health services shall have an observation protocol to check the mental health and physical health of a person who is restrained.

Duration: Physical restraint should not routinely occur for longer than 10 minutes

Debriefing / Post Incident Conversation: Will be offered to the person who has been restrained and staff involved. A record will be kept of the offer of the debriefing, whether it was accepted and the outcome. A record should also be kept of disclosure of the incident to carers, and the follow-up of emotional wellbeing of staff.

Review of incident: The treatment team will meet with senior clinicians of the unit or service

to review the incident the next day, and to prepare plans to reduce and eliminate this intervention for the particular person who was restrained or other person's in similar circumstances. In the situation where restraint has been used in Ambulance Services, a next day review will still be conducted. However the aspects, timing and nature of the review will vary subject to the separate agreement with SA Ambulance Service (SAAS) and the Chief Psychiatrist.

Two or more incidents of any form of restraint or seclusion: If a person has been mechanically restrained, physically restrained or secluded on two or more occasions in the current admission, the treatment plan is to be reviewed by at least 2 disciplines at a senior level of the service.

Reporting of restraint: All restraint is to be reported in the incident reporting system, including the duration of the event. Any event where the use of physical restraint results in serious harm or death is to be reported as a sentinel event as per the National Safety and Quality Health Service Standard.

6.2 Mechanical Restraint

6.2.1 Indication

As per physical restraint: Mechanical restraint is only to be used in in emergency situations where an individual's behaviour presents an immediate risk of physical harm to self or others, and less restrictive interventions have failed.

Whereas physical restraint is expected to last 10 minutes or less, mechanical restraint can be approved for up to 30 minutes in the first instance. (Any extensions to this time should be described in the SLS report generated and be subject to review.) Mechanical restraint may not exceed 6 consecutive periods of 30mins each.

The use of mechanical restraint in inpatient psychiatric settings is considered an extraordinary event. Consideration was given to prohibiting its use, but it is recognised that there will be extremely rare occasions where mechanical restraint will be used to protect the safety of the person and others.

In inpatient settings, the following higher threshold applies (based on the NICE 2017 guidance) mechanical restraint only as a last resort and for the purpose of:

- managing extreme violence directed at other people or
- limiting self-injurious behaviour of extremely high frequency or intensity

6.2.2 Authorisation for the Application of Mechanical Restraint Devices

Authorisation for the application of mechanical restraint to a person in a hospital setting will only be on the order of a medical practitioner or nurse practitioner where available or if not available, the most senior clinician on duty. Where a medical practitioner or nurse practitioner is not available in person, phone contact should be made with them. (The order can be written in a case note, or health services may wish to generate a form for this purpose.)

The order will attest that there are no other less restrictive ways to manage a person's agitation.

Each authorisation for mechanical restraint is for a period of 30 minutes, up to a maximum

of 6 authorisations to a total of 3 hours.

When an order has expired the person must be reviewed by a medical practitioner or nurse practitioner where available, or if not available, the most senior clinical staff member on site. Verbal and telephone orders will only be accepted in extenuating circumstances.

Approval for the use of restraints by ambulance:
A paramedic or medical practitioner can approve the use of mechanical restraints when required to protect the safety of the person, health workers and the public. This approval lasts for the duration of the transport.

At the hospital, the hospital procedure of medical practitioner approval is required from the time of arrival (even if transfer of care from ambulance to Emergency Department is delayed.)

Observations: Persons subjected to mechanical restraint will be subject to 1:1 observation and support by a health professional.

Health services shall have an observation protocol to check the mental state and physical state of a person who is restrained.

Duration: Mechanical restraint is approved under this policy for a maximum of 3 hours. For patients in emergency departments who are subject to mechanical restraint, and cannot be transferred to an appropriate unit due to bed unavailability, restraint can be extended beyond 3 hours, if required, to avoid the risk of injury to the person and staff. Health services should have an escalation protocol so that executives responsible for bed allocation are aware of this extension, and an incident report for extended mechanical restraint made.

Debriefing / Post Incident Conversation: Will be offered to the person who has been restrained and staff involved. A record will be kept of the offer of the debriefing, whether it was accepted, and the outcome. A record should also be kept of disclosure of the incident to carers, and the follow-up of emotional wellbeing of staff. The staff debrief is not documented in the patients notes.

Review of incident: As per physical restraint review.

Two or more incidents of any form of restraint or seclusion: If a person has been mechanically restrained, physically restrained or secluded on two or more occasions in the same episode/admission, the treatment plan is to also be reviewed by a multi-disciplinary team that includes at least 2 disciplines at a senior level of the service.

6.2.3 Reporting of Mechanical Restraint

All restraint is to be reported on an incident reporting system (Safety Learning System or equivalent). I.e. duration of episode, type of restraint, device used and reason for restraint. This is to be completed by a clinical staff member involved in the restraint episode. Any event where the use of mechanical restraint results in serious harm or death is to be reported as a sentinel event as per the National Safety and Quality Health Service Standard.

In addition – because of the rarity of use - all episodes of mechanical restraint in a psychiatric inpatient setting are to be subject to reporting and then a review in an appropriate incident review committee.

The occurrence of mechanical restraint in an inpatient unit under provisions of the *Mental Health Act 2009* should also be brought to the attention by way of written notice to the Office of the Chief Psychiatrist at the time that it occurs, and subsequent advice to the Office should be provided about the outcome of the incident review committee.

A similar requirement for additional written notice to the Office of the Chief Psychiatrist applies to the use of mechanical restraint for people under the age of 18 who have a mental illness. This should occur regardless of the location, is to be reported at the time it occurs. The outcomes of a review are to be reported to the Office of the Chief Psychiatrist.

6.2.4 Approval of Restraint Devices

Mechanical restraints used under the powers of the *Mental Health Act 2009* require the approval of the Chief Psychiatrist for their use.

For this purpose a service wishing to use a device should submit information about the device and how it will be used and maintained. Information about the device should include a copy of the manufacturer's instructions, the circumstances where it will be used, details of the staff who will make the decision to apply the device, and training provided to staff who apply the device.

A procedure for the storage of the device, cleaning between use, and inspections for wear and tear should also be provided.

Where a specific device has already been approved in one SA service, a service provider in another service need only submit details of how the device will be used in their service, rather than making a full re-submission.

The Chief Psychiatrist approval process will involve a small team of safety and quality staff, a consumer and carer who will: inspect the device, review the documentation about its use, review manufacturer's instructions of the device and if necessary seek feedback from clinicians, consumers and carers if the device has already been used locally and such feedback is available. In addition to approval, comment and feedback will be given to the service about their submission.

6.2.5 Mechanical Restraint Free Environments

The Office of the Chief Psychiatrist will maintain a list of units that have been designated mechanical restraint free centres.
Such designation will:

- Be achieved by safely eliminating the use of mechanical restraint for a period of 12 months, while maintaining or improving safety of consumers and staff, and no longer maintains mechanical restraint equipment on its premises
- Be published on the Chief Psychiatrist's website
- Be accompanied by a certificate provided to the unit, noting that the unit has successfully eliminated the use of mechanical restraint

6.3 Seclusion

6.3.1 Indication

Seclusion is only to be used in emergency situations where an individual's behaviour presents an immediate risk of physical harm to self or others, and less restrictive interventions have

failed.

Unless clinically contraindicated, prior to the use of seclusion the individual shall be given a choice of treatment options that may assist with limiting the environmental stimuli and their consequent effects on the person's emotional status. This includes the use of sensory modulation and time in comfort rooms.

The reasoning for the use of seclusion shall be communicated clearly to the individual.

6.3.2 Authorisation for Seclusion in Hospital

Authorisation for the application of seclusion to a person in a hospital setting will only be on the order of a medical practitioner or nurse practitioner where available or if not available, the most senior clinician on duty. Where a medical practitioner or nurse practitioner is not available in person, phone contact should be made with them. (The order can be written in a case note, or health services may wish to generate a form for this purpose.)

In emergency situations where it is necessary to contain risk, the most senior clinical person on duty can make an order for immediate seclusion with an expectation that a medical practitioner or Nurse Practitioner will review the person as soon as possible to either write an order or discontinue seclusion.

The order for seclusion will attest that there are no other less restrictive ways to manage a person's agitation.

The duration of each order shall not exceed 30 minutes, specify "up to" 30 minutes, and include criteria for releasing the person from seclusion.

When an order has expired the person must be reviewed every 30 minutes by the most senior clinical practitioner working on the unit, who endorses the continuation of the order. Additional reviews and endorsement of the seclusion order are to occur by a medical practitioner or nurse practitioner at each 2 hour mark. An additional review by a consultant psychiatrist is required after 4 hours which will be face to face when on site, and otherwise a clinical discussion involving the consultant psychiatrist, will meet this criteria.

Individuals are to be removed from the seclusion room immediately once the danger to self or others is no longer imminent. An exception to this requirement applies to Emergency Departments where the primary cause of a person's agitation is substance intoxication or withdrawal, and if the person is sleeping or resting a choice may be made to allow the person to continue to sleep or rest in the seclusion room rather than escorting them to another room. (The seclusion formally ends when the door is unlocked and opened, if it is the case that the person would not be prevented from leaving the seclusion room if they were to wake up and attempt to leave.)

Physical need to be met during seclusion:
An individual's physical needs shall be met promptly. Nursing staff shall provide an opportunity for personal care, including fluids, bathroom use, hygiene care and appropriate meals.

Door to be unlocked and open if possible: If a person can be secluded with the door unlocked and open with a nursing staff member at the door this is to be preferred if it is safe to do so. It is recognised that progressing to a locked door immediately may be required when there is a risk of extreme violence, or a person is not known well and may be at risk of unpredictable behaviour – in particular persons who are stimulant intoxicated and secluded in emergency departments. A person is still considered to be secluded in an unlocked room if

they would be physically prevented from leaving the room, or would have their door locked if they attempted to leave.

Observations: The person is to receive 1:1 continuous direct observation by a nursing clinician who will record the person's behaviour and physical condition at 15-minute intervals during the seclusion incident.

Duration: The duration of seclusion should be minimised.

Debriefing / Post Incident Conversation: Will be offered to the person who has been secluded and staff involved. A record will be kept of the offer of the debriefing, whether it was accepted, and the outcome. This includes a record of open disclosure as required, of the incident to carers, and the follow-up of emotional wellbeing of staff.

Review of incident: The treatment team will meet with senior clinicians of the unit to review the incident the next day and to prepare plans to reduce and eliminate this intervention for the particular person who was secluded or other persons in similar circumstances.

Two or more incidents of any form of restraint or seclusion: If a person has been mechanically restrained, physically restrained or secluded on two or more occasions in the current admission, the treatment plan is to be reviewed by at least 2 disciplines at a senior level of the service.

Reporting of seclusion: All seclusion is to be reported in the incident reporting system.

Seclusion rooms: Any room designated as a seclusion room can only be used for this clinical purpose, and should not be used as an interview room or waiting room. This is in recognition that some people with mental illness may have had past experience of seclusion that is traumatic, and should not be exposed to the seclusion environment unless it is clinically required for seclusion.

6.4 Chemical Restraint

6.4.1 Indication

Chemical restraint is only to be used in emergency situations where an individual's behaviour presents an immediate risk of physical harm to self or others, and less restrictive interventions have failed.

Each service shall maintain a chemical restraint protocol, describing the clinical indications for each medication, contraindications, progressive escalation and the level of physical monitoring required.

Clinicians are expected to follow the local guideline, unless clinical reasoning is provided for deviating from that guideline in a specific clinical situation.

6.4.2 Prohibition of Long Term Chemical Restraint

In mental health settings chemical restraint is only to be used for short periods in emergencies. This may be administered by oral tablet or syrup, sub-lingual, intramuscularly (IM), sub-cutaneous (SC) or intravenously (IM).

At other times psychotropic medication can only be used for clinical and therapeutic purposes – the choice of drug and the dosage must correlate with the therapeutic indication. Drugs or

higher doses of drugs that create continuous sedation to manage behaviour are prohibited.

6.4.3 Authorisation for Chemical Restraint

Chemical restraint may be initiated by practitioners who have the authority to prescribe controlled substances – paramedics, nurse practitioners and medical practitioners.

It can be administered by those practitioners and registered nurses.

It may be prescribed as a one off medication, or in hospital and residential settings as a when required "PRN" medication.

6.4.4 Chemical Restraint Procedure.

Health services are to maintain a procedure for chemical restraint and monitoring of sedated patients.

Local protocols are to be approved by the relevant clinical governance mechanisms of the health service. It is expected that they will guide all practitioners in a range of settings.

The risks of chemical restraint – over-sedation, respiratory depression, collapse, head injuries and death, means that similar levels of oversight are required for chemical restraint as other forms of restraint. It also requires collaboration between specialties.

This standard does not seek to determine the details of prescribing practice, but does wish to ensure that local services have collaborated to have a best practice protocol available that is regularly reviewed.

Debriefing/ Post incident Conversation: Will be offered to the person who has been chemically restrained and to staff. A record will be kept of the offer of the debriefing, whether it was accepted, and the outcome. This includes a record of open disclosure of the incident to carers, and the follow-up of emotional wellbeing of staff.

An exception will be the administration of oral medication by PRN where there has not been a significant event precipitating the provision of the medication.

Review of incident: This will occur for incidences requiring IM, SC or IV chemical restraint situations (regardless of whether or not a reportable behavioural incident has occurred), or oral chemical restraint associated with a reportable behavioural incident**.**

Many incidents will already be marked for review as they may have been preceded by other forms of restraint or seclusion. Other incidents of emergency chemical restraint will also be subject to review if IM or IV chemical restraint is given, or oral chemical restraint is associated with a reportable behavioural incident. The treatment team will meet with senior clinicians of the unit to review the incident the next day and to prepare plans to reduce and eliminate this intervention for the particular person who was chemically restrained or other persons in similar circumstances.

Ambulance services are exempt from this next day individual case review requirement for adult patients, and for young people under 18 where the cause of agitation is substance abuse, but are asked to have in place a regular review of chemical restraint use in these circumstances under the *Mental Health Act 2009*, and consider strategies to significantly reduce use.

Emergency departments are exempt from this requirement if the person subject to *Mental Health Act 2009* powers was agitated due to substance intoxication or withdrawal. However are asked to have in place a regular review of chemical restraint use under the *Mental Health Act 2009*, and consider strategies to reduce this use.

All use of IM, IV, SC or oral chemical restraint following a reportable behavioural incident for people under the age of 18 are to be subject to a next day review by relevant services.

Review of chemical restraint other than the emergency situations described above: Repeated use of as required 'PRN' medications to cause restraint, should be subject to review by the treatment team in regularly scheduled ward rounds and multidisciplinary team review meetings.

Reporting of restraint: IM and IV use of chemical restraint will be the subject of an incident report in the incident reporting system.

6.5 Young People, Restraint and Seclusion

It is important in this standard to recognise that children and adolescents have different needs to adults. These needs and in particular their developmental stage and requirements must be held at the forefront of each restraint and seclusion decision. The principle of all practices being in the best interests of the child must be upheld.

A child safe environment is 'safe and friendly'; where children feel respected, valued and encouraged to reach their full potential.' This standard requires all health services to have child safe environment policies and procedures that are understood and practised across all levels of the organisation.

Children and adolescents need to be recognised as individuals and can present with wide backgrounds and narratives that affect their behaviour and risks to self and others. Treatment must be focussed on the least restrictive options for care and particular consideration must be given to:

- verbal and non-verbal de-escalation;
- focus on child safety;
- use of current behaviour or communication plans for the child;
- consider underlying diagnoses including neurodevelopmental diagnoses and adverse childhood experiences as well as current trauma and;
- seclusion and restraint should be a last resort for this cohort of patients. As health practitioners we observe the United Nations Convention on the rights of the child which names; safety, freedom from violence, and those children with a disability should receive special care and support.

The decision to restrain a child must occur after all attempts have been made to address their distress including de-escalation practices, provision of developmentally appropriate calming interventions, liaison with parents/carers, sensory modulation tools and spaces.

Each health care service that provides health services to children and adolescents must have a child friendly space where minors can be reviewed.

Debriefing/ Post incident Conversation: Carers/family members must be involved as far as possible in decisions around restraint and seclusion of a minor including a developmentally appropriate post incident conversation (debrief) session with the minor and support from family/caregivers.

Parents/guardians cannot consent to a minor being secluded or restrained, relevant legislation

must be followed when utilising any restrictive practices.

All restraints must be the appropriate size, make and type for the size of the child / young person.

As per guidelines for adult restraint these must be placed on by trained staff, in the safest method possible for the shortest time possible.

Observations: The young person is to receive 1:1 continuous direct observation by a nursing clinician who will record the young person's behaviour and physical condition at 15-minute intervals during the seclusion / restraint incident.

Health services shall have an observation protocol to check the mental state and physical state of a young person who is restrained.

7. Restrictive Practices under the *Guardianship and Administration Act 1993.*

This standard applies to the prevention and application of restrictive practices under the *Mental Health Act 2009.*

There are occasions in hospital settings where a patient who is subject to a *Mental Health Act 2009* inpatient treatment order may also be subject to *a Guardianship and Administration Act (GAA) 1993* order with special powers that authorise a provider under GAA s32 (1) (c) to use such force as may be reasonably necessary for the purpose of ensuring the proper medical or dental treatment, day-to-day care and well-being of the person. The authorisation of these powers is by the South Australian Civil and Administrative Tribunal (SACAT).

For example, if restraint is administered in conjunction with electroconvulsive therapies, it can only be with such GAA powers granted by SACAT, and cannot be with *Mental Health Act 2009* powers.

It is expected that all steps will be taken to minimise and eliminate where possible the use of restraint in such circumstances.

The patient remains a patient under the *Mental Health Act 2009*, and it is expected that all of the strategies and requirements of this Standard, aimed at minimising and eliminating restraint will continue to be used, even when the restrictive practice authorisation comes from the GAA.

This is in addition to any other requirements of the GAA, or the specific detail in a SACAT order relating to when and how a restrictive practice can be used.

8. National Safety and Quality Health Service Standards

 National Standard 1 Clinical Governance	 National Standard 2 Partnering with Consumers	 National Standard 3 Preventing & Controlling Healthcare-Associated Infection	 National Standard 4 Medication Safety	 National Standard 5 Comprehensive Care	 National Standard 6 Communicating for Safety	 National Standard 7 Blood Management	 National Standard 8 Recognising & Responding to Acute Deterioration
☒	☒	☐	☒	☒	☒	☐	☒

This Chief Psychiatrist Standard is relevant to National Standards 1, 2, 4, 5, 6 and 8, as described in more detail below.

Standard 1 – Clinical Governance

The clinical governance and safety and quality systems that are required to maintain and improve the reliability, safety and quality of health care and improve health outcomes for consumers.

Standard 2 – Partnering with Consumers

The systems and strategies to create a person-centred health system by including consumers in shared decision making, to ensure that consumers are partners in their own care, and that consumers are involved in the development and design of quality health care.

Standard 4 – Medication Safety

The systems and strategies to ensure that clinicians safely prescribe, dispense and administer appropriate medicines to informed consumers, and monitor use of the medicines.

Standard 5 – Comprehensive Care

The integrated screening, assessment and risk identification processes for developing an individualised care plan, to prevent and minimise the risks of harm in identified areas.

Standard 6 – Communicating for Safety

The systems and strategies for effective communication between consumers, carers and families, multidisciplinary teams and clinicians, and across the health service organisation.

Standard 8 – Recognising and Responding to Acute Deterioration

The systems and processes to respond effectively to consumers when their physical, mental health or cognitive condition deteriorates.

9. Definitions

Chemical restraint Chemical restraint refers to the use of drugs or chemicals for the specific and exclusive purpose of controlling acute or episodic aggressive behaviour of a patient which restricts the person's freedom of movement by rendering the person sedated or semi-stuperous.

Drugs administered on a regular basis, as part of the treatment plan and for the purposes of treating the symptoms of mental, emotional or behavioural disorders and for assisting the patient/resident in gaining self-control over his impulses, are not to be considered chemical restraints.

Least restrictive The concept of allowing the consumer to be cared for in an environment which places the least amount of restriction on freedom of movement while maintaining their safety and the safety of others.

Mechanical Restraint The application of devices (including belts, harnesses, manacles, sheets and straps) on a person's body to restrict their movement. This is to prevent the person from harming themself 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 person's capacity to get off the furniture except where the devices are used solely for the purpose of restraining a person'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.

Peer worker is someone who provides social, emotional and practical support to clients in need. This is enhanced by their personal experience, enabling them to make a strong connection with those who are going through similar experiences. Other titles of a peer worker, may be known as, but not limited to; consumer or carer consultant.

Post incident conversation often referred to as debriefing, this is a trauma informed process conducted with a person following any potentially traumatising event.

Physical Restraint The application by health care staff of hands-on immobilisation or the physical restriction of a person to prevent the person from harming him/herself or endangering others or to ensure the provision of essential medical treatment.

Restraint The restriction of an individual's freedom of movement by physical or mechanical means. This applies to person's receiving specialist mental health care.

Seclusion is defined as the confinement of a person, alone in a room or area from which free exit is prevented. (*National Documentation, MHSRP, 2009*). Includes the presence of staff proximal to the room to prevent exit as well as the locking of a door.

Trauma Informed Care is a strengths based delivery approach "that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasises physical, psychological, and emotional safety for both providers and survivors and that creates opportunities for survivors to rebuild a sense of control and empowerment". (Hooper, Bassuk & Olivet, 2010, p 82)[1].

10. Associated Policy Directives / Policy Guidelines and Resources

Mental Health Act 2009

[1] Hopper, E.K., Bassuk, E.L, & Olivet, J. (2010). Shelter from the storm: Trauma-informed care in homeless service settings. The Open Health Services and Policy Journal, 3, 80-100

11. Document Ownership and History

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For more information

Property Name
Division etc
Address Line 1
Address
Telephone:
www.sahealth.sa.gov.au

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