SECLUSION AND RESTRAINT - MENTAL HEALTH FACILITIES

PROCEDURE ©

DOCUMENT SUMMARY/KEY POINTS

This procedure applies to all SCHN staff working in all SCHN settings.

Seclusion and restraint must only be used as a last resort, after less restrictive alternatives have been trialled or considered. The principle of least restrictive practice is common across all settings. It means SCHN staff will maximise a person's choices, rights, and freedom as much as possible while balancing healthcare needs and safety for all.

The safety of staff must be maintained at all times, including during the planning, initiation, undertaking, monitoring and cessation of the seclusion and restraint of a person.

SCHN services must have systems that:

- Minimise and, where possible, eliminate the use of seclusion and restraint
- Govern the use of seclusion and restraint in accordance with legislation
- Report use of seclusion and restraint to the governing body
- Ensure the health and safety of workers and other persons so far as reasonably practicable

CHANGE SUMMARY

- This document has been modified to serve as an adjunct to the NSW Health Policy Document Seclusion and Restraint in NSW Health Settings PD2020_004.
- Changes and additions to definitions.
- Increased focus on health, safety and wellbeing of workers, including the potential risk to staff, patient and other persons involved in seclusion and restraint.
- Previous published version have been summarised for ease of use in Mental Health units at SCHN.

This document reflects what is currently regarded as safe practice. However, as in any clinical situation, there may be factors which cannot be covered by a single set of guidelines. This document does not replace the need for the application of clinical judgement to each individual presentation.

Approved by:	SCHN Policy, Procedures and Guidelines Committee	
Date Effective:	1st April 2024	**Review Period**: 3 years
Team Leader:	Clinical Nurse Consultant	**Area/Dept**: SCHN Mental Health Facilities

READ ACKNOWLEDGEMENT

- All clinical staff working in ED, Acute MH inpatient units are to read and acknowledge they understand the contents of this document.
- All other clinical staff are to be aware of this document.

RELATED DOCUMENTS

NSW Health Related Policy and Guideline Documents

- Seclusion and Restraint in NSW Health Setting PD2020_004
- Preventing and Managing Violence in the NSW Health Workplace – A Zero Tolerance Approach PD2015_001
- Management of Patients with Acute Severe Behavioural Disturbance in Emergency Departments: GL2015_007
- Engagement and Observation in Mental Health Inpatient Units: PD2017_025
- Review of Seclusion, Restraint and Observation of Consumers with a Mental Illness in NSW Health Facilities
- Violence Prevention and Management Training Framework for NSW Health Organisation PD2017_43

Relevant Position Papers and Guiding Principle Documents

- Minimising and, where possible, eliminating the use of seclusion and restraint: Royal Australian and New Zealand College of Psychiatrists, 2021 National Principles to Support the Goal of Eliminating Mechanical and Physical Restraint in Mental Health Services 2016

This document reflects what is currently regarded as safe practice. However, as in any clinical situation, there may be factors which cannot be covered by a single set of guidelines. This document does not replace the need for the application of clinical judgement to each individual presentation.

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1 Document Statement

Sydney Children's Hospital Network (SCHN) commitment to preventing seclusion and restraint aims to improve safety for people accessing mental health services as well as ensure the health and safety of workers and other persons so far as reasonably practicable.

This procedure outlines the principles, values and processes that underpin efforts to prevent, reduce and, where safe and possible, eliminate the use of seclusion and restraint at SCHN.

2 Definitions

SCHN recognises that language has an impact on people and the use of inclusive and contemporary terms can minimise stigma.

This Procedure is informed by current practice and consultation with people accessing NSW Health services and service providers. Key definitions for seclusion and restraint align with the National Safety and Quality Health Service Standards (2nd Edition).

Definitions may vary for legal purposes. Where there is variation, practice must be consistent with applicable legislative definitions and requirements.

Word/Term	Definition	Additional notes
Acute Sedation	Acute sedation is the temporary use of medication to reduce agitation, irritability, and Acute Severe Behavioural Disturbance (ASBD) for the purpose of assessment and treatment.	Acute sedation is not considered chemical restraint when it allows for assessment to be continued and treatment for the underlying condition to be commenced. NSW Health recognises that acute sedation may be experienced or perceived as coercive by people accessing services, carers, families and others. It is important that this practice is safely managed by expert clinical decision making around the level of sedation and by adherence to current clinical guidelines. The aim is to achieve an appropriate and safe level of sedation quickly with sufficient medication to manage ASBD and to facilitate an accurate assessment and appropriate management of the person's underlying condition. The level of sedation should ensure the person is drowsy, but they must be rousable.
Acute Severe Behavioural Disturbance (ASBD)	Behaviour that puts the person or others at immediate risk of serious harm. This may include threatening or aggressive behaviour, extreme distress and self-harm.	Examples of indicators of ASBD may include aggression, hostility, physical and verbal intimidation, hitting, spitting, cutting, kicking, throwing objects, damaging equipment, using weapons or objects as weapons, and highly disinhibited behaviours, including sexual disinhibition. While behavioural concerns associated with issues such as acquired brain injury, dementia or cognitive impairment may be longstanding, the use of the word 'acute' signals the need to address the behavioural concern now.

Carer	Carer is used to describe a person who provides ongoing unpaid support to a family member or friend who needs help because of disability, medical condition (terminal or chronic), mental illness or ageing. Carers may support their family member or friend when accessing NSW Health services.	Carer is defined under the NSW Carers (Recognition) Act 2010. Consent and information provision to a carer must be in line with the relevant legislation. Depending on legislation, such as Mental Health Act 2007, different terms include: Representative; primary caregiver; primary carer; person responsible; designated carer; principal care provider.
Worker	Any person working in a permanent, temporary, casual, termed appointment or honorary capacity within NSW Health such as: • A SCHN employee • Agency staff • Contractor, including VMOs • Student • Volunteer	Worker is defined in the NSW Work Health & Safety Act 2011. Within this procedure document when the term staff is used it is to be assumed to mean worker.
Chemical Restraint	The use of a medication or chemical substance for the primary purpose of restricting a person's movement.	The definition of chemical restraint is a challenging issue. This is partly due to the need to attribute a purpose to the use of the medication. Medication (including PRN) prescribed for the treatment of, or to enable treatment of, a diagnosed disorder, a physical illness or a physical condition in line with current clinical guidelines is not considered chemical restraint.
Least Restrictive Practices	Practices that maximise the autonomy, rights, freedom, wellbeing and safe care of the person as much as possible while balancing healthcare needs and safety for all.	Environments should be safe, supportive and least restrictive. Staff must not withhold access to spaces or items unnecessarily, unless there are safety reasons for people accessing services, staff and others.
Mechanical Restraint	The application of devices to a person's body to restrict their movement.	The use of mechanical restraints in children and adolescents within the SCHN is not supported under any circumstance.

Physical Restraint	The application by staff of 'hands-on' immobilisation or the physical restriction of a person to prevent them from harming themselves or endangering others, or to ensure that essential medical treatment can be provided.	While restraint is often used when people exhibit ASBD, the definition also includes the use of physical restraint while administering medical procedures (e.g., blood tests) and to facilitate some treatments (e.g., inserting nasogastric tubes, anaesthetics, intubation). Physically guiding or supporting a person, with their permission, to manage the same clinical procedures safely and effectively is distinguished from physical restraint by the degree of force applied and intention.
Restraint	The restriction of an individual's freedom of movement.	The scope of restraint in this procedure is physical and chemical restraint. These types of restraint are separately defined in this section for the purposes of this policy.
Seclusion	The confinement of a person, at any time of the day or night, alone in a room or area from which free exit is prevented.	The intended purpose, duration and location are not relevant in determining what is or is not seclusion. Seclusion applies even if the person agrees or requests the confinement. However, if voluntary isolation is requested by a person and they are free to leave at any time then this does not meet the definition of seclusion. The person's awareness that they are confined alone and denied exit is not relevant to the definition of seclusion. The structure and dimensions of the area to which the person is confined are not relevant. For example, if a person is confined alone and prevented from leaving a courtyard, safe assessment room, their bedroom or other area, this meets the definition of seclusion. If a staff member (or other) is with the person, this does not meet the definition of seclusion.

2.1 Legal and Legislative Framework

Refer to Seclusion and Restraint in NSW Health Setting

3 Key Requirements

Staff and services must recognise that while the use of seclusion and restraint as a last resort may be necessary to keep people safe, it can also be traumatic and harmful for staff, people accessing services, carers and families and must be minimised.

Particular attention must be given to:

- Aboriginal people and families
- People with disabilities

- People with mental health issues or substance misuse
- People with medical conditions (including pregnancy)
- People with identified trauma
- Children and young people
- Refugees
- LGBTQI people
- CALD groups
- People who are at risk of self-harm or suicide
- Staff at risk of vicarious trauma

3.1 Prevention

SCHN services must ensure adequate staff numbers, peer support and appropriate skill mix to maintain a safe workplace for people accessing services, staff, and others.

Proactive approaches that take steps to address the person's needs (e.g., communication strategies, sensory preferences, positive behaviour support plans) are encouraged.

SCHN staff must collaborate with the person, their carers and families (as applicable), to understand potential triggers which may cause the person to become distressed and unsafe. Safety planning is intended to identify individual strengths, self-soothing techniques, and helpful strategies for staff to use to attempt to de-escalate potential risk. Trauma informed care principles must guide the prevention of seclusion and restraint.

SCHN staff must have appropriate access to mandatory training to prevent and respond to potential and actual aggression and violence in line with PD2017_043 Violence Prevention and Management Training Framework for NSW Health Organisations. This includes understanding the key causes and components of difficult, challenging, or disturbed behaviour, prevention and de-escalation.

3.2 Use of Seclusion and Restraint

NSW Health organisations must develop local protocols to guide the use of seclusion and restraint.

Least Restrictive

Staff must only use seclusion and restraint:

- Where there is a legal basis to do so
- As a last resort to prevent serious harm
- To allow administration of lawful medical treatment
- After less restrictive alternatives, including prevention strategies, have been trialled or considered
- Proportionate to the risk of harm.
- For the minimum duration necessary

- It is safe to do so

Staff must not place themselves or others at unnecessary risk in carrying out their duties. In practice, there may be times when the duty of care to people accessing services may require intervention but at no time is the duty of care to override a staff member's right to safety.

4 Risk of Seclusion and Restraint

Seclusion and restraint are restrictive practices and must only be considered as a last resort. All restraint and seclusion involves risk, and staff must ensure they make an assessment of risk prior to initiating same.

NSW Health staff should avoid prone restraint. Safety Notice 006/23 must be followed if prone restraint is used.

4.1 Contraindications of Restraint

When compromised health or physical condition of the patient poses risks that outweigh the benefits to be gained from restraint or risk to staff outweigh benefits to patients.

4.2 Risks of Restraint

In all restraints there are risks to the individual restrained and the staff carrying out the restraint.

Particular risks have been identified in patients with:

- Physical health issues (obesity, asthma, cardiac disease, and metabolic disorders)
- Patients who have been engaged in physically exhausting combative struggle for longer than two minutes
- Patients who suddenly cease struggling or indicate difficulty in breathing.
- Intoxicated patients

Risk of harm to staff may include the following:

- Body stressing due to forces applied for prolonged periods or awkward positioning
- Psychological
- Fatigue
- Musculoskeletal
- Falls and slips
- Aggression

Staff must have completed NSW Health VPM training prior to involvement in a restraint. Staff must be aware of the risk of psychological harm to themselves and others.

Prior to Restraint

1. The team leader/Coordinator role is identified and communicated to team.
2. Assess the patient's current behaviour and ongoing risk of harm to self or harm to others.
3. Verbal de-escalation is the first line response where safe to do so.
4. Refer to Patient's individual management plan where available.
5. If possible, suggest the patient move to a quieter, less visual environment for privacy. Staff should also remove other patients and visitors to allow privacy and reduce agitation.
6. If patient is very agitated or verbally aggressive do not physically touch them as this may trigger a physical attack.
7. Second line, offer Oral Medication/PRN medication as charted or can be prescribed as rapid sedation. Refer to Acute Severe Behavioural Disturbance in Emergency Departments.
8. Assess the patient's current medical status for conditions which may place them at risk during a restraint. e.g., respiratory or cardiac conditions, obesity, metabolic disorders.
9. Where practicable inform the Nurse Unit Manager (NUM) or after-hours nurse manager that a patient needs to be restrained. Keep the NUM/coordinator and parent/guardian advised.
10. Senior mental health clinician is to be notified for review of mental state and the need for further intervention i.e., medication/sedation can be assessed.
11. It is responsibility of the coordinator, to ensure that there is an adequate number of staff present to physically restrain the patient. Request assistance prior to attempting restraint if adequate staff are not at hand. Assistance may be sought from security or other members of the health care team.
12. Ensure any staff arriving to assist is given relevant information and brief patient history.
13. Inform the patient in a calm manner that there is a need to contain them for safety and this will require staff temporarily restraining them. Continue to communicate with the patient throughout the restraint.

Initiating Seclusion or Restraint

- The decision to use seclusion or restraint must be made using all available information. This includes assessing the known clinical history of allergies and adverse effects of medication(s) where acute sedation is used.
- All staff included in restraints must have completed appropriate Violence Prevention Management (VPM) restraint training.
- for a restraint are determined by the type of restraint and the clinical needs to ensure the safety of staff, patients and others. For a team restraint a minimum of five people are required.

- The amount of force used during any restraint must always be the minimum amount necessary and proportionate to the risk.
- If seclusion and restraint is initiated, SCHN staff must cease their use as soon as the reason for the intervention has ended and it is safe to do so.
- SCHN staff must ensure that any interference with a person's privacy and dignity is kept to the minimum necessary to protect the safety of all, especially when restraint occurs in public areas and shared treatment areas or rooms.
- Placing people in the prone position entails a significantly increased risk of harm to the person. There have been instances of sudden death, often associated with the administration of parenteral medication while in prone restraint.
- NSW Health staff should aim to avoid prone restraint Safety Notice 006/23 must be followed if prone restraint is used.
- Staff are to avoid restraining in a way that interferes with the person's airways, breathing or circulation, for example by applying pressure to the rib cage, neck or abdomen or by obstructing the mouth or nose.
- Staff must avoid bending the person's head or trunk towards the knees if they are seated.
- The restraint of a patient or an individual in clinical care areas is the role of the clinical team, with supplementary support, if this is necessary, provided by security staff at the direction of clinical staff.
- Clinical staff will endeavour to manage incidents without security intervention as long as safe to do so. This is in recognition of the unique developmental needs of children and young people.
- Security staff may also be required to provide supplementary safety support during the seclusion of a person but must never be required to replace a clinical staff member where clinical observations are required.

During Restraint

When a decision has been made to proceed with the restraint:

1. It is essential to have a coordinated team approach.
    - **i.** A coordinator for the restraint should be allocated, they must have completed NSW Health approved violence and prevention management training. They may be the first staff member on the scene, someone who is confident and competent to lead a restraint or has the best rapport with the patient.
    - **ii.** The team leader should assign roles for each staff member participating in the restraint, i.e., left arm, left leg, right arm, right leg, head, medication and documentation.
    - **iii.** One staff member should be allocated to continue verbal de-escalation with the patient during the restraint; this will usually be the person at the head of the patient. This may be the team leader or allocated to another staff member. This

person should be the only person to speak to the patient to avoid confusion and facilitate a calm environment.

iv. If at any time the patient regains control or agrees to comply with directions, the restraint should be discontinued in a safe manner.

2. Constant observation of the patient's breathing and circulation must be done.
3. Vital signs are to be taken and recorded every 10 minutes unless unsafe to do so.
4. Emergency equipment must be kept close at hand and in working condition when any person is being restrained.
5. Comfort measures and the patient's dignity should be considered at all times. Cover the patient with a sheet or attend to their clothing to protect privacy. Pillows under their head may be given to assist with comfort and prevent head banging.
6. Staff fatigue and injury should monitored during restraint and swapping of staff or discontinuing restraint should be considered.

Ratifying and Subsequent Clinical Reviews of the Use of Seclusion and Restraint

- Seclusion and restraint are often initiated at short notice, in response to an emergency situation.
- To ensure a robust clinical review, all use of seclusion and restraint must be ratified by a senior clinician as soon as possible, but not more than one hour after the practice was initiated. The outcome of the review will be to cease the practice or to ratify its continuation. The review must be documented in the young person's electronic medical record.
- If seclusion or restraint has been ceased prior to ratification, the person is to be examined by a medical officer as soon as possible after the event.
- After the initial ratification, a senior clinician must review the person as frequently as possible but not less than every four hours, until the intervention is ceased.
- An additional review by a medical officer must take place at each shift handover.
- If seclusion or restraint continues for 24 hours or more, an additional review, which includes multidisciplinary involvement, must take place.
- The senior clinician ratifying or reviewing the practice must not have been involved in the decision to initiate seclusion and/or restraint. SCHN requires ratification and reviews to be carried out by staff with seniority and skills in risk management, clinical safety and trauma informed care.
- The senior clinician may vary depending on time of day, context, local resources and available skill mix. Examples include a staff specialist, Visiting Medical Officer, nurse unit manager. Reviews are to be carried out in-person or, where required, via phone or videoconference.
- SCHN staff must make every effort to ensure that the person's needs are met, and the person's dignity is protected by the provision of appropriate facilities and supplies,

including bedding and clothing appropriate to the circumstances, food and drink and adequate hygiene and toilet arrangements.

- SCHN staff must consider staffing and skill mix required to undertake increased observations and perform reviews. Senior medical staff must be considered alongside nursing and allied health provision to provide appropriate multidisciplinary skill mix.

Observations and Engagement During Seclusion and Restraint

- SCHN requires high levels of clinical care, monitoring and reporting when seclusion and restraint are used. Any deterioration in a person's physical condition, mental state or cognitive state must be managed promptly.
- The patient's behaviour should be recorded using the Care Level/behavioural assessment checklists and subsequent summary in patient's progress notes.
- When a patient has had more than one episode of seclusion in any given admission, the incidents will be reviewed within 24 hours and the patient's care plan amended accordingly.
- For the safety of the person, clinical staff must continuously observe, and where possible, engage with a person in seclusion for the duration of the practice. Therapeutic supervision level one (Care Level 1) will be undertaken for the entire duration of the seclusion event.
- Patients who have received medication must have their vital signs closely monitored. The M.O. will prescribe the physical health monitoring required at a minimum of every 15 mins during time of seclusion. For people at higher risk during the intervention, more frequent and additional monitoring may be indicated, for example where acute sedation has been used.
- Clinical monitoring must include vital signs (respiratory rate, blood pressure, temperature and pulse rate). The frequency of monitoring vital signs must be determined by the Clinical Team, parameters set and reviewed when required.
- It may not be possible to monitor all of the vital signs if, by doing so, safety of the staff or person being secluded is compromised. However, in those circumstances, continuous visual observation is required to ensure safety. If vital signs cannot be taken, staff must ensure the reasons are documented in the person's electronic medical record.
- Observations must be conducted in person and must not be undertaken using closed circuit television (CCTV).

Cessation of the Seclusion/Restraint

- The seclusion and/or restraint should be ceased as soon as the level of risk has subsided.
- Upon cessation of the seclusion/restraint the senior nurse must notify the consultant psychiatrist, M.O. NUM or Hospital Coordinator.
- Parents/carers must be notified as soon as possible following any seclusion or restraint.

- All patients must have a physical exam when settled and agreeable to monitor for and address any injuries.

Documentation for Restraint and Seclusion

- Restraints and/or seclusion event must be timed and recorded in the Restraint Register. The Registers are to be completed and signed by nursing and medical staff.
- Physical observations must be recorded every 10 minutes during a restraint or 15 mins during a seclusion using the local agreed documentation for vital signs observation unless risk assessment indicates otherwise.
- The patient's behaviour should be recorded using the Care Level/behavioural assessment checklists and subsequent summary in patient's progress notes.
- Summary in the patient's electronic medical record must clearly state the precipitating risk issues for the use of the interventions. Persons notified must also be documented.
- The reasons for any deviation from the above must be clearly documented in the patient's progress notes.
- A Clinical IIMS report needs to be completed regarding the incident, and the incident report number must be recorded in the patient electronic medical record and Seclusion/Restraint register.
- A Staff IIMS report must also be completed if a staff member is injured during the restraint procedure, if the incident is a near miss or if staff are emotionally affected by the events.

Post Incident Review and Debriefing

- Patients must be offered supportive counselling following the restraint and/or seclusion.
- A collaborative review with the patient and family should occur within 48 hours of the event. This review should be documented in the patient's file and communicated to other staff. This review should ideally be undertaken by the NUM or any senior clinician.
- A reflective interview (debriefing) with staff must occur following every restraint event. This must be done in a non-blaming and supportive manner and ideally facilitated by the NUM or delegate.
- In addition to the above staff should be offered additional support from their manager, clinical supervisor or the Employment Assistance Program (EAP) if they continue to experience difficulties associated with the incident.

Re-establishing Patient Rapport

Staff should attempt to re-establish therapeutic rapport with the patient as this will provide an opportunity for individuals who have acted out to work toward change and growth.

Below are guidelines (COPING) to follow when attempting to re-establish rapport.

- Control: Make sure that staff and the person who acted out are back under emotional and physical control before the incident is discussed.

- Orient: Orient yourself to the basic facts. What happened? Be nonjudgmental in listening to the perspective of the individual who acted out.
- Patterns: Look for a pattern of past behaviour. What triggers the behaviour?
- Investigate: Investigate alternatives to the inappropriate behaviour and resources that could be helpful in making behavioural changes
- Negotiate: Negotiate a contract with the patient. Make sure that the person understands what she can do instead of displaying inappropriate behaviour.
- Give: Return control to the person who acted out. Give back the responsibility to control their behaviour, along with staff support and encouragement.

Mechanical Restraint (Emergency Department only)

SCHN do not use any form of mechanical restraint. Occasionally, children will present to the Emergency Department with mechanical restraints already in use applied by Emergency service transporting them to the ED.

NSW Health define Mechanical restraint devices as: belts, harnesses, manacles, sheets, straps, mittens and other items used to restrict a consumer's movement. NOTE: handcuffs are not an acceptable form of restraint in NSW Health facilities however young people arriving in the care of Police may have their handcuffs removed in agreement with the Police.

Staff should adhere to the following guidance when caring for a young person arriving in mechanical restraint.

1. The restraints devices are the property of the Emergency Response teams who transported the young person to ED.
2. Any young person arriving to ED with mechanical restraints should have 1;1 nursing for the duration restraints remains in place and under no circumstances be placed in locked room – in accordance with Seclusion and Restraint in NSW Health Setting: PD2020_004.
3. Nursing staff should assess physical observations including assessing circulation and risk of injury at points of restraint.
4. All efforts are to make to respect the young person's privacy and dignity.
5. The patient is under the care of the ED Medical team and ultimately any decision surrounding the ongoing use or removal of mechanical restraints is made by the ED Staff Specialist assigned to the patient. Ideally, with consultation with the mental health team for advice and support

The Mental Health team will always recommend that any mechanical restraints are removed as soon as deemed safe to do so. In removing mechanical restraints, the responsible Emergency Medicine Consultant should, with support of the attending Mental Health clinician, ensure an alternative safety plan is agreed and put into action should the young person continue to present a risk to self or others; this may include physical restraint or use

of sedation in accordance with Management of patients with Acute Severe Behavioural Disturbance in Emergency Department GL2015_007.

Governance of Seclusion and Restraint

- Staff must adhere to the legal framework authorising the use of seclusion and restraint.
- Staff must notify a senior manager (or on-call manager) if seclusion is used, as soon as practicable.
- The SCHN Clinical Incident Management Procedure requires Staff to notify all identified incidents, near misses and complaints in the incident management system (IIMS) or IMS+. Staff must include information about seclusion and restraint in these reports, where applicable.
- Where an adverse event occurs related to seclusion and restraint, NSW Health organisations must implement open disclosure, as required under the NSW Health Open Disclosure Policy (PD2014_028).

Monitoring the Use of Seclusion and Restraint

Staff must document all episodes of seclusion and restraint and debriefing sessions in the Electronic Medical Record in proportionate detail to enable a review of practice.

- Records should include: IIMS incident number (where seclusion or restraint is part of a reportable incident)
- Antecedents
- Adherence to prevention strategies
- Alternative least restrictive interventions trialled or considered
- Reason for seclusion or restraint
- Staff who initiated the use of seclusion or restraint
- Aboriginal identification
- Authorisation
- Location of seclusion or restraint episode
- Medication offered or administered
- Frequency of observations
- Any physical injury
- Notification of family or carer
- Clinical examinations undertaken and outcomes
- Food and fluid intake
- Start and finish time of seclusion and/or restraint
- Active practices to reduce duration
- Debriefing, including service user and family/carer feedback
- Identification of future prevention and Intervention strategies
- Multidisciplinary review
- Review of care plan
- Reviews by senior staff

SCHN services must collect data and report on episodes of seclusion and restraint in accordance with Seclusion and Restraint in NSW Health Settings 2020, legislative requirements and the National Safety and Quality Health Service Standards (2nd edition).

SCHN services must make information and data about the use of seclusion and restraint available to staff, people accessing services and their carers and family to support quality improvement and aid preventive approaches.

- The Seclusion/Restraint register must be available for review by the Official Visitors
- An audit to ensure compliance with this procedure must be undertaken at least annually to ensure appropriate standards of care i.e. Restraint Audit Tool (Appendix 1)
- All Incidents of restraint and seclusion are reported directly to:
  - The NSW Ministry of Health via inforMH
  - Local Emergency Department & Mental Health Department meetings
  - Network Quarterly Emergency Mental Health Meeting
  - Quarterly Critical Incident Committee, Psychological Medicine, SCHN
  - Mental Health Quality and Safety Committee

Notification

Where legally permitted and after considering privacy requirements, SCHN staff must make every effort to notify the following persons (as applicable to the person and legal status) about the use of seclusion and restraint and the reasons for using it as soon as practicable:

- A designated carer
- A guardian
- A parent/carer if the person is under the age of 16 years
- Other, as appropriate and identified by local protocols (e.g., senior executive)

Debriefing

SCHN services must have protocols for debriefing after the use of seclusion or restraint, including safe and appropriate involvement of people who have been secluded or restrained, their carers/parents and family (as applicable) and staff.

Debriefing processes are intended to provide an opportunity to identify systemic practices and individual factors that provoke or trigger incidents. Debriefing is to maximise learning, minimise any potential traumatising effects and identify strategies to prevent future incidences.

Prohibited Practices

NSW Health staff must not:

- Use seclusion and restraint as a form of discipline, punishment, or threat
- Use seclusion or restraint as a means to reduce behaviours not associated with immediate risk of harm
- Use seclusion for people who are actively self-harming or suicidal

5 Additional Requirements for Specific Settings

Declared emergency departments and mental health units.

As defined under the Mental Health Act 2007.

All mental health inpatient services must have 24-hour, everyday on-site supervision from accountable management representatives. This supervision must include in-person rounding on every shift.

In SCHN mental health units and emergency departments, each seclusion and restraint episode must also be recorded in a dedicated Register to allow for reporting.

The Register must include:

- A separate entry for each episode of seclusion or restraint
- IIMS incident number (where seclusion or restraint is part of a reportable incident)
- Details of the person being secluded or restrained, including identification of Aboriginal people.
- Date of seclusion and restraint episode
- Type of seclusion and restraint episode
- Time started and time ended.

The register is to be kept in a secure location, noting adherence to privacy legislation and policy. The register may be an electronic version as determined by NSW Health.

SCHN must submit seclusion and restraint data from all mental health units and declared emergency departments to the NSW Ministry of Health.

SCHN must provide Official Visitors access to all records relating to seclusion and restraint, including monthly summary information and seclusion and restraint Registers.

6 References

1. Seclusion and Restraint in NSW Health Settings 2020
2. National Safety and Quality Health Service Standards (2nd Edition)
3. SCHN Clinical Incident Management Procedure
4. National Safety and Quality Health Service Standards (2nd Edition).
5. Management of patients with Acute Severe Behavioural Disturbance in Emergency Department, GL2015_007.
6. SCHN practice guideline *Acute Severe Behavioural Disturbance in Emergency Departments*
7. Safety Notice 006/23: Use of Prone Restraint and Parenteral Medication in Healthcare Settings
8. Violence Prevention and Management Training Framework for NSW Health Organisations. PD2017_043

Appendix 1: Restraint Audit Tool

Standard 1

Consumers are provided with high quality care

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

Standard 2

The mental health service demonstrates its commitment to continuous quality improvement and improving and supporting good standards of consumer care

	Yes	No	Partial	Comments
2.1 *There is a system in place to ensure all restraint episodes are reviewed for appropriateness and standards of care; each episode of restraint results in a treating team review to identify opportunities for improvement of care.*				
2.2 *Clinical supervision is available to support staff in providing high standards of care; staff debriefings are utilized to discuss issues of safety and provide incident review.*				
2.3 *There is evidence that restraint data and related data information systems are used to support and improve care delivery***.**				
2.4 *Aggregated data is presented for review at the clinical governance/clinical quality committee or equivalent on a regular basis.*				
2.5 *Unit routines and expectations are documented and available and are explained to consumers and carers at orientation.*				

Standard 3

The organisation ensures that formal structures and delegation practices are in place to support safe, quality care

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