Minimising Restrictive Practices Tool

Clinical Scenarios: When is it restraint?

This tool presents a series of clinical scenarios designed to assist clinicians in understanding the nuances of restraint application in different patient situations (excluding Mental Health). Each scenario emphasises the unique nature of patient care, recognising that individual circumstances and clinician judgment play significant roles in decision-making.

It is crucial to acknowledge that every patient's condition and each clinician's approach may vary significantly. As such, this resource is not an exhaustive guide but rather a complementary tool to aid in navigating complex situations. For guidance on how to manage scenarios and safely apply restrictive practices, please refer to the SA Health Minimising Restrictive Practices Policy and Clinical Guideline.

The following terms are used throughout this tool:

- s.32 – Section 32 of *Guardianship and Administration Act 1993*
- Consent Act – *Consent to Medical Treatment and Palliative Care Act 1995 SA*
- Person Responsible - as defined within *Consent to Medical Treatment and Palliative Care Act 1995 SA* Part 2A ss14

Clinical Scenarios and Discussion

An unaccompanied minor attends the emergency department with a mild concussion post a fight. They become agitated and demand to leave.

In this situation, the absence of a legal authority through the consent of a legal guardian or the presence of police or child protection, removes the healthcare provider's ability to restrain or detain the child against their will. Without proper legal authority, using restraint on the minor would not be appropriate, ethical, or legally justifiable. Efforts should be made to contact other friends or family members to provide support for the child to remain for medical treatment and ensure a safe discharge. If the child's safety is of concern, early discussion with Child Protection and Police should occur.

Legal Authority – No legal authority to restrain.

Sedation of an older person who develops hyperactive delirium while hospitalised for another condition:

Sedation involving the administration of medication for the purpose of improving comfort is consistent with the definition of medical treatment in the Consent Act and is performed under the supervision of a medical practitioner. Accordingly, consent may be given by a "person responsible" under the Consent Act.

Legal Authority – Consent Act. Consent can be obtained through a 'person responsible'.

Admission of a patient who has a diagnosis of dementia in a locked hospital ward for unrelated medical treatment:

This patient is effectively detained. However, there are some distinguishing features of this patient's detention from that of a consumer within an aged care facility:

- The locking mechanism is simply released for persons without cognitive impairment.
- The patient is in a hospital ward, under the supervision of a medical practitioner.
- The hospital ward is not this patient's residence.

The fact that a person with cognitive ability would be able to unlock the door is unlikely to be a significant factor, having regard to the fact the patient remains detained. In these circumstances, an order under s.32 is required to authorise this patient's detention in the ward. On presentation to the hospital conversations should be had relating to s.32 authority. If there is significant risk of harm to the patient, consultation with guardians should occur regarding the detainment while the s.32 is sought. Noting during this interim period there is no legal authority to detain.

Legal Authority – No legal authority to restrain unless s.32 with special powers is in place.

Holding a consumer with uncontrolled physical and hand movements for dental treatment:

In this case, the consumer's hands must be held in some way to prevent them from receiving an injury from medical instruments and to protect the dentists. Assuming that some force is required to restrain them, restraint in this case would require authorisation under s.32 of the Guardianship Administration Act. It does not appear that the need for restraint is momentary or unexpected and is likely to arise in other circumstances of required care.

Legal Authority – No legal authority to restrain unless s.32 with special powers is in place.

Holding a patient with a diagnosis of dementia to clean faeces with intermittent use of pressure:

The assumption is that intermittent use of pressure is a reference to the action of wiping in order to clean the patient and holding involves rolling the patient onto their side. Unless the patient resists the action of rolling and wiping, consider that such care is consistent with the definition of medical treatment in Consent Act and may be consented to by a person responsible. Further, it is likely that such action, being necessary basic care, is not likely to be a criminal offence.

Legal Authority – Consent Act. Consent can be obtained through a 'person responsible'. However, it is important to note that if force is required to complete this action, this becomes physical restraint and s.32 with special powers would need to be in place.

Physical hold of a child with a diagnosis of autism attempting to injure themselves:

The assumption in this scenario is that the child is either requiring medical treatment or at risk of causing injury to themselves. If treatment is not required at the time of the child attempting injury, the parent should be the person to employ their usual restrictive methods. If healthcare workers are to be involved due to the need for medical treatment, consent from the parent or legal guardian must be obtained.

Legal Authority – Consent Act. Consent can be obtained through the parent or legal guardian.

When is it restraint?

These examples are not all-inclusive and clinical, ethical, and human rights factors must always be considered when identifying a restrictive practice.

Type of Restraint		Not Restraint	Restraint
Physical	Holding a limb	– The patient does not resist the action and it is required to complete care (i.e., change an IV line) – Providing comfort, support, or guidance (including supporting balance or redirection) – To attend to ADLs and no force used	– To prevent the patient from harming someone or themselves – If force is required to provide required care to a patient
	Using your body to block an exit	– To protect a patient from an external risk due to the context of a discreet situation (i.e code black)	– To prevent voluntary exit
Chemical	Administration of sedative	– Scheduled prescribed dose for the consumer for medical treatment or diagnosed condition.	– To subdue a person's behaviour
Mechanical	Hand mittens	– Used for warmth or protection from self-harm, with patient consent (or appropriate guardian)	– To prevent the patient from scratching or injuring themselves, as prescribed by a medical professional, but without the patient's consent
	Recliner or Comfort (cloud) chair	– Providing comfort and relaxation to a patient who prefers or requires the chair.	– Using the recliner chair to restrict the patient's movement or freedom without a legitimate medical reason
	Wheelchair seatbelt	– The patient has decision making capacity and requests it	– To prevent the patient from leaving the wheelchair
	Over-way	– To assist a patient with eating or accessing their table	– To prevent the patient from standing. – To restrict a patient's access to their belongings or activities.
	Bed rails	– Infant/Toddler cot sides for children – The patient (or appropriate guardian) requests bed rails up	– To prevent a person leaving the bed – The patient cannot consent to bed rails being placed up
Environmental	Bed/Furniture against wall	– Optimising the use of space and minimising potential hazards	– Using furniture or bed placement to physically block or restrict a patient's movement
	Locked ward	– The authorised locking of a ward for the safety of all patients or staff, with accessible unlocking mechanism (i.e ICU, paediatric wards) – A patient with decision making capacity who is voluntary but cannot physically unlock ward (i.e cannot reach due to wheelchair height)	– Using locked wards as a measure to restrict patients' freedom or mobility. – Refusing to unlock a ward for a patient who has decision making capacity
	Door closed on room	– Providing a patient with decision making capacity, or physical ability to open the door, privacy or to reduce noise or distractions. – As per authorised procedures (infection control)	– Closing the door to confine or isolate the patient without legitimate reasons

Least restrictive

This section is designed to help clinicians choose the least restrictive option when restraint is unavoidable. It is essential that all minimising strategies have been attempted and documented in line with the Minimising Restrictive Practices Policy and Clinical Guideline.

A 23-year-old involved in a motor vehicle accident is brought to the emergency department with multiple injuries. Despite receiving pain management, the patient becomes disoriented and agitated, attempting to remove medical devices, and causing potential harm to themselves and others.

Legal Authority – Consent Act (part 2A required for medical treatment)

Restrictive Practices (to be used as a last resort):

Environmental – Not applicable to this scenario.

Chemical - Administer sedation. Consent from the person responsible or a legally authorised representative should be obtained prior to administration.

Physical – Use physical holding of the patient's limbs and comforting techniques.

Mechanical- The use of soft limbs holders on the limb the patient is using to remove medical devices.

In this scenario the mechanical restraint along with ongoing comforting techniques is the least restrictive as it balances the patient's safety while minimising physical force and potential further harm. It would be essential to continuously assess the patient for signs of injury or escalating distress.

Chemical restraint is not recommended on patients with potential head injuries and physical restraint will require more force and may potentially injure the patient further. Once the patient has calmed or assessment/treatment complete and patient no longer in a state where serious permanent injury could occur, restraints must be removed.

A 6-year-old child with a diagnosis of autism is admitted to a ward with no legal guardians present. The child becomes distressed and starts trying to bite staff and hit their head on furniture.

Legal Authority – Consent Act (parent or legal guardian consent)

Restrictive Practices (to be used as a last resort):

Environmental – Remove or pad furniture and potentially harmful objects within the child's immediate surroundings. Add bean bags, pillows or other padded objects to patient's room.

Chemical – Sedation (Not recommended for children)

Physical – Use gentle physical holding and comforting techniques, such as a rear hug while sitting on a bean bag or chair to prevent self-harm while providing reassurance and comfort.

Mechanical – Not applicable for a 6-year-old child. Mechanical restraints, such as shackles, are not suitable for children and should not be used.

The first step is to contact the legal guardians to determine usual strategies implemented at home and obtain consent for possible interventions from the moment of admission. Being

consistent and following behaviour support plans for crisis management is the most effective way to manage escalating children. It's always important to create a calm and low-stimulation environment by reducing excessive noise and bright lights.

In this case environmental restraint is the least restrictive, removing furniture which the child could injure themselves on and adding padded equipment such as pillows or beanbags to the room. This allows a safe space for the child to fall and may limit their movement within the room to safe areas. Physical restraint through gentle holding should only be used as a last resort to prevent immediate harm to the child or others. Ideally the rear hug position while seated in a bean bag or chair should be completed by a parent, guardian, or trusted family member, however if none present and consent obtained, this can be performed by a staff member if safe to do so. Consider draping a weighted blanket over their torso while in this position, continuing to maintain comfort and reassurance.

In the following two scenarios, if a s.32 with special powers order is not in place, there is no legal authority for restrictive practices, and all assessments and interventions must follow the Minimising Restrictive Practice Clinical Guideline

An 80-year-old patient living with dementia is admitted to a geriatric ward in a hospital. The patient has a history of being inquisitive into spaces and becoming agitated, especially during the evening hours. They frequently attempt to get out of bed and leave the room, posing a risk of falls and injury and upsetting other patients by entering their rooms. The patient resists care and hits out at staff when redirection is attempted.

Legal authority – s. 32 with special powers.

Restrictive Practices (to be used as a last resort):

> Environmental Restraint - Use a locked door or access-controlled system to prevent the patient from leaving the ward or unit.
>
> Chemical Restraint - Administer sedative medication to calm the patient during episodes of agitation and inquisitive/intrusive behaviour.
>
> Physical Restraint – Hold the patient's hand/s to provide comfort and reassurance during moments of agitation, or to guide and redirect behaviours.
>
> Mechanical Restraint - Use a bed enclosure to limit the patient's ability to get out of bed and be inquisitive.

Firstly, creating a calming and familiar environment by personalising the patient's room with familiar objects and pictures is an effective way to minimise restraint from the moment of admission. In this case, the least restrictive option would involve a combination of environmental and physical restraint. Using a locked door or access-controlled system to prevent the patient from walking outside the ward without supervision. Utilise bed alarms or motion sensors to alert staff when the patient attempts to get out of bed, allowing for timely interventions to support and redirect the patient's behaviour/ expression of unmet need.

If possible, assign an extra staff or support family members to attend to provide one-on-one support during periods of increased agitation or challenging behaviours tendencies. The need to provide some physical restraint through holding a hand that is attempting to hit or physically redirecting a patient back to their room may be present and should be completed alongside verbal redirection, gentle touch, and comforting strategies to engage the patient positively.

A 30-year-old male patient with a significant intellectual and developmental disability, who is wheelchair bound, is admitted to the hospital. He has a history of self-injurious behaviour and agitation towards others, especially in unfamiliar or stressful situations. The patient becomes highly agitated, begins biting himself, and hitting staff when clinical care required.

Legal Authority – s. 32 with special powers

Restrictive Practices (to be used as a last resort):

> Environmental Restraint – Providing a patient with a safe room with necessary modifications such as padded bed rails or low bed, positioning their wheelchair away from hazardous locations in the room and removing access to harmful objects.
>
> Chemical Restraint - Sedation, considered only when other measures fail and there is a serious risk of harm.
>
> Physical Restraint - Using techniques that consider the patient's frailty, such as holding their arms to their sides, ensuring minimal force is applied and explicitly avoiding harmful techniques like pulling the arms behind their back.
>
> Mechanical Restraint - Not appropriate due to high risks, unless absolutely necessary as a last resort in extreme cases.

Firstly, an effective way to minimise any restrictive practice, is to maximise the patient's comfort through effective pain relief and adherence to both the patient's existing and any new hospital Positive Behaviour Support Plan. Addressing these needs can often reduce distress and prevent the need for restraint.

In this scenario, environmental restraint is the least restrictive option and examples such as room modifications and positioning while in their wheelchair is to be implemented. However, in cases where the patient is actively harming himself and staff, further restrictive practices such as physical restraint may be necessary. As always, any form of restraint should only occur for the shortest period of time and as minimally as possible, for this reason grouping clinical care together to avoid agitating the patient more frequently is recommended.

To ensure the safety and dignity of the patient, harmful techniques, such as pulling the arms behind the back, must be strictly avoided, as these can cause pain, distress, and potential injury. Instead holding the patients' arms or shoulders from the front or side, using minimal force is a more appropriate form of short-term physical restraint.

Chemical and mechanical restraint remain the last option, used only when other interventions fail, and the patient poses an immediate, serious risk. The focus should always be on ensuring safety while minimising the use of restraint, with a plan to reduce restrictions and alleviate the cause of distress as soon as possible.

For more information

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