SA Health
Clinical Guideline No: CG008

# Minimising Restrictive Practices Clinical Guideline

Version 1.1

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Government of South Australia
SA Health

# Contents

# 1. Name of clinical guideline

Minimising Restrictive Practices

# 2. Introduction

The Minimising Restrictive Practices clinical guideline supports SA Health services to act on the mandatory requirements outlined within the Minimising Restrictive Practices Policy. It aims to facilitate minimising, or eliminating where possible, the use of restrictive practices to ensure patients are provided with the highest quality of care in accordance with their human rights and decision-making capacity.

**Out of Scope**

This clinical guideline does not apply to:

- Any patient placed under a legal authority under the *Mental Health Act 2009* (SA) for treatment, this includes inpatient treatment order, community treatment order or care and control. Refer to the Chief Psychiatrist Restraint and Seclusion Standards
- People who are not patients or consumers receiving treatment of the health service. Refer to Fact Sheet - Preventing and Responding to Challenging Behaviour by a person who is not a current consumer/patient
- Registered residential aged care facilities, and residential aged care beds within multi-purpose sites Refer to Aged Care Quality and Safety Commission Restrictive Practices for Providers website
- Registered National Disability Insurance Scheme (NDIS) service providers, following restrictive practices processes for NDIS participants. Refer to NDIS Commission Understanding Behaviour Support and Restrictive Practices – for providers
- Where conflict exists with another statutory requirement under the *Road Traffic Act (SA), Australian Road Rules* (Sect 265 & 266) and *Civil Aviation Safety Regulations 1998*
- A patient who is under arrest or a prisoner of SA Police or Department for Correctional Services where statutory requirements exist, and obligation to public safety and maintaining custody override medical need. For more information refer to Prisoners - Care and Treatment in SA health Services Policy

# 3. Definitions

- **Restrictive Practice:** means the use of any form of restraint as defined within this clinical guideline.
- **Chemical Restraint**: means the use of medication or chemical substance for the primary purpose of influencing a person's behaviour. It does not include the use of medication prescribed by a medical practitioner for the treatment of, or to enable treatment of, a diagnosed mental disorder, a physical illness, or a physical condition.
- **Community Treatment Order**: means a legal order which requires a person with a mental illness to receive treatment without their consent at a specific place at regular intervals.
- **Environmental Restraint:** means a practice or intervention that restricts or involves restricting a person's free access to all parts of their environment, including items or activities, for the purpose of influencing their behaviour.
- **Guardian**: means a person who has been appointed under the *Guardianship and Administration Act 1993* or is a legal guardian of a minor.

- **Inpatient Treatment Order**: means a legal order which requires a person with a mental illness to receive treatment in a designated mental health service without their consent.
- **Mechanical Restraint:** means the use of a device to prevent, restrict, or subdue a person's movement for the primary purpose of influencing a person's behaviour but does not include the use of devices for therapeutic or non-behavioural purposes.
- **Person Responsible:** means the person responsible for a patient in accordance with the *Consent to Medical Treatment and Palliative Care Act 1995 SA* Part 2A ss14
- **Physical Restraint:** means the use or action of physical force to prevent, restrict or subdue movement of a person's body, or part of their body, for the primary purpose of influencing their behaviour. Physical restraint does not include the use of a hands-on technique in a reflexive way to guide or redirect a person away from potential harm/injury, consistent with what could reasonably be considered the exercise of care towards a person.
- **Prone/Supine Restraint Position**: means forcing the person into a face up or face down position.
- **Risk of harm to others:** means the use of force against another person, or an express or implied threat that force will be used against another person, or behaviour that substantially increases the likelihood that physical or mental harm will be caused to any other person (whether intentionally or unintentionally)
- **Risk of harm to self:** means self-harm, or an express or implied threat of self-harm, or behaviour that substantially increases the likelihood that physical or mental harm will be caused to the person (whether intentionally or unintentionally)
- **Seclusion:** means the confinement of the consumer/patient at any time of the day or night alone in a room or area from which free exit is prevented.
- **State-wide services**: includes State-wide Clinical Support Services, Prison Health, SA Dental Service, BreastScreen SA and any other state-wide services that fall under the governance of the Local Health Networks.
- **Substitute Decision Maker:** means a person who has been appointed as such under the *Advance Care Directives Act 2013*

## 4. Prinicples of the standard

The following National Safety and Quality Health Service Standards (NSQHSS) apply:

Standard 1 – Clinical Governance

Standard 2 – Partnering with Consumers

Standard 5 – Comprehensive Care

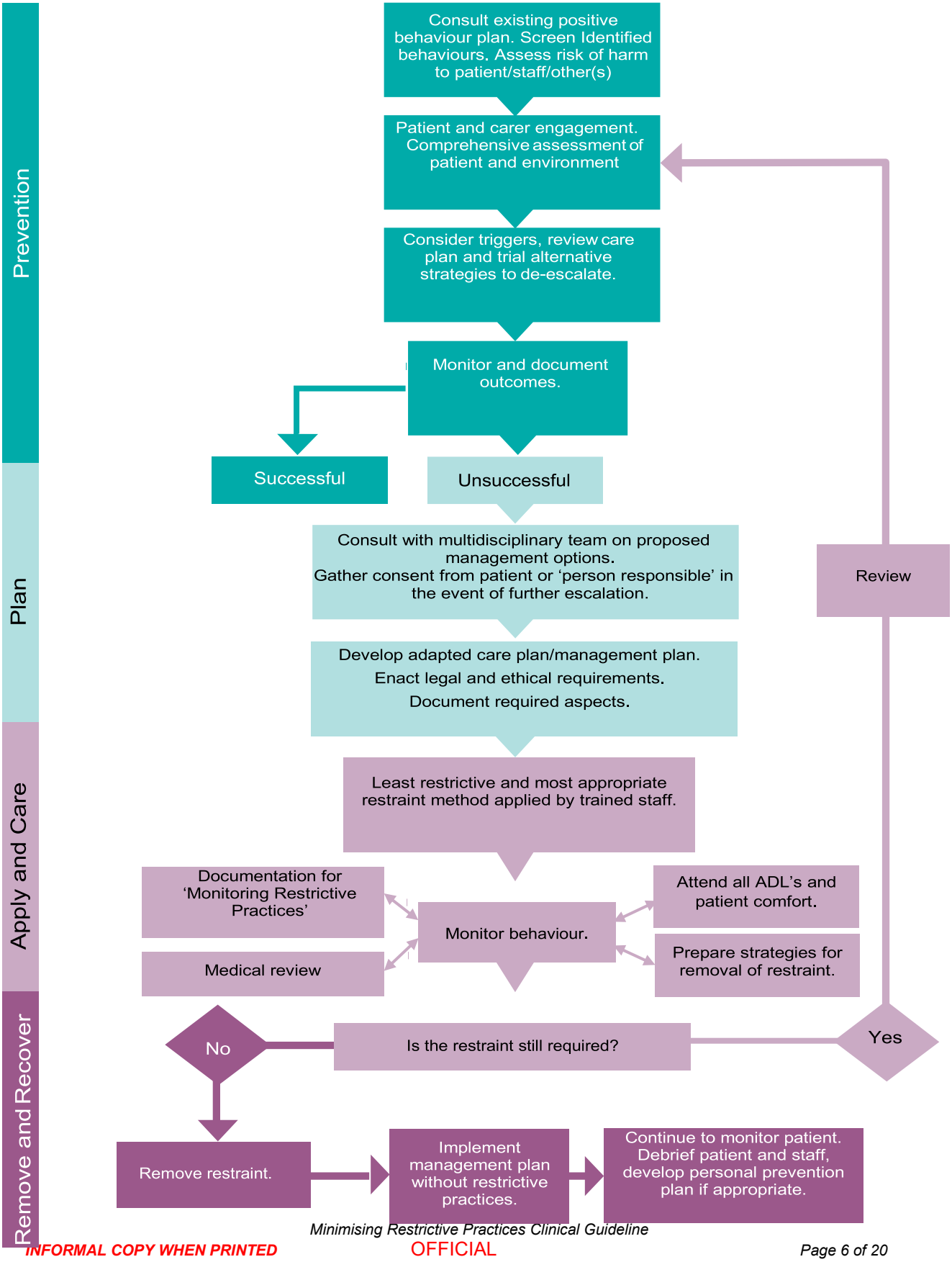
Standard 6 – Communicating for Safety

Standard 8 – Recognising and Responding to Deterioration

## 5. General

### Figure 1 – Restraint Minimisation – Flowchart

Refer to the RESTRICT Reflective Practice tool to understand what needs to be considered before applying Restrictive Practices to any patient.



# 6. Pathway / protocol

## 1.1 Early Planning to Minimise Restrictive Practices

A safe approach to managing the care of patients who exhibit behaviours of concern is one that focusses on prevention strategies and positive changes based on assessment, treatment, care, and support. All health care services should implement evidence-based strategies and trauma-informed principles for the prevention, early recognition, and response to challenging behaviour. This should be relevant to their health setting and the patients accessing the service e.g., strategies for young people differ from those for older people with dementia or delirium.

### 1.1.1 Consumer Engagement

Early care planning including the identification of triggers for distress and implementation of methods to calm and relax are vital in preventing the need for and use of restrictive practices. Ensure general patient considerations are kept high including regular access to food and drink, toileting provisions, entertainment, meaningful activities, and offering assistance when needed.

### 1.1.2 Communication

Good communication and patient-centred care underpin the development and preservation of positive relationships between workers and patients and their carers. This includes cultural awareness, cultural competency, and trauma informed care. Special consideration is to be taken for the non-English speaking community as communication and consent will be more challenging to obtain. Ensure all available resources such as interpreters and communication tools are utilised to support dialogue between the clinician and patient and their family or carer.

If a consumer has communication challenges, consider consulting with a speech pathologist to develop strategies for the consumer.

It is important for prevention, harm minimisation and least restrictive care that all occasions of clinical handover include information about any behaviours that have the potential to escalate and could lead to the use of restrictive practices.

### 1.1.3 Pain Assessment

Pain and discomfort can be a significant contributing factor to distress, agitation, combative behaviour, and disorientation. This is particularly prevalent in people with non-verbal communication such as children, people with disability and the cognitively impaired as these patient cohorts are often under medicated for pain in the context of barriers in expressing their experiences of pain verbally. It is highly recommended to engage families and carers in preparing a suitable pain assessment for the individual's needs, an example of a tool is The Disability Distress Assessment Tool (DisDAT), this can be stored in the medical record for ongoing reference.

Ensure patients have adequate pain relief and are assessed regularly for new pain. Tools such as visual pain charts should be used where appropriate. Most importantly, the interpretation of the patient's pain by familiar carers or family members must be considered. Pain assessment tools that are particularly useful for non-verbal patients and are available within Sunrise EMR are:

- FLACC (Face, Legs, Activity, Cry, Consolablity)
- PAIN AD (Pain Assessment in Advanced Dementia)
- FACES Pain scale

### 1.1.4 Considerations for the Vulnerable

It is essential that healthcare workers identify individuals and groups that may be more vulnerable to harm from restrictive practices. This may be additional vulnerability to physical harm, for example older people, or vulnerability to emotional harm, for example young people, Aboriginal and Torres Strait Islander people or people who have a history of trauma such as veterans. Additional care and planning, particularly focusing on early engagement with the patient, family and carer is essential.

*Children:*

While restraint should be avoided for all individuals whenever possible, it is especially concerning when applied to children, as it can have profound and lasting effects on their well-being and development.

- Vulnerability and Trauma: Children are inherently more vulnerable and less equipped to understand the reasons behind restraint. Being physically restrained can lead to feelings of fear, helplessness, and trauma, potentially causing lasting emotional distress. These negative experiences can impact a child's trust in caregivers and healthcare providers, influencing their future interactions with medical professionals.
- Developmental Stage: Children's brains and bodies are still developing, and they have limited coping skills to manage stressful situations. The use of restraint can disrupt their sense of safety and security, hindering healthy emotional and cognitive development.
- Communication Difficulties: Children, especially young ones, may have difficulty expressing their needs or emotions verbally. Restraint may escalate their frustration, leading to more challenging behaviours and potentially exacerbating the situation.
- Potential for Physical Harm: Children's bodies are smaller and more delicate than adults', making them more susceptible to injuries during restraint. The risk of physical harm, such as bruises or fractures, is higher in children.

*Aboriginal and Torres Strait Islander peoples:*

The use of restraint on Aboriginal and Torres Strait Islander peoples should be approached with cultural sensitivity, respect, and an understanding of historical trauma and social context. Inclusion of Aboriginal Liaison Officers or equivalent should be incorporated into care planning. Healthcare providers must strive to create culturally safe environments that prioritise Indigenous peoples' well-being and agency while employing alternative approaches to address challenging behaviours.

- Cultural Sensitivity: Restraint can be deeply traumatic for Aboriginal and Torres Strait Islander peoples, as it may invoke historical and intergenerational trauma related to colonial experiences and loss of autonomy. Healthcare providers need to understand and respect the cultural backgrounds and beliefs of Indigenous peoples. The use of restraint may exacerbate the existing mistrust and apprehension towards mainstream healthcare systems.
- Connection to Land and Community: Aboriginal and Torres Strait Islander peoples often have strong connections to their land and community. Restraining an Indigenous person can disrupt their cultural and spiritual connection, leading to feelings of alienation and loss of identity.
- Communication and Understanding: Language barriers and cultural differences can hinder effective communication during restraint situations. The lack of cultural understanding may lead to misinterpretations of behaviours, further complicating the use of restraint.
- Health Disparities: Aboriginal and Torres Strait Islander peoples already face significant health disparities and lower life expectancy compared to non-Indigenous Australians. The use of restraint may compound existing health inequalities and further contribute to their negative experiences within the healthcare system.

*Older people, veterans and those with cognitive impairment*:

There are evidence-based alternatives, such as person-centred care, fall prevention strategies, and environmental modifications, that can be more effective and less restrictive in managing the needs of older patients. Refer to Aged Care Quality and Safety Commission Restrictive Practices for Providers website on strategies and information on providing care to older people.

- Communication Difficulties: Many people with cognitive impairment may have difficulty expressing their needs or emotions verbally. Restraint can escalate their frustration and agitation, hindering effective communication and potentially causing an increase in challenging behaviours.
- Age-Related Vulnerabilities: Older people may have physical frailty or cognitive decline, making them more susceptible to injuries during restraint. The risk of harm, such as pressure ulcers or disorientation, is higher in this population.
- Trauma and Confusion: Restraint can cause trauma and confusion in people, particularly those with cognitive impairment. It may evoke feelings of fear and confinement, leading to heightened agitation and distress. This is particularly applicable in veterans.

*People with Disability (Intellectual, Physical, and Invisible)*

Addressing the needs of individuals with disabilities requires a compassionate, informed approach that prioritises their safety, well-being, and rights. Their heightened vulnerability and diverse needs require careful, individualised approaches to ensure safety, dignity, and well-being.

- Physical Vulnerabilities: People with disabilities may have physical conditions that make them more susceptible to injury during restraint. Conditions such as brittle bone disease, muscular dystrophy, or other mobility impairments increase the risk of physical harm, including fractures, dislocations, or muscle damage.
- Communication Challenges: Individuals with disabilities may have varied communication abilities, including non-verbal communication and use of augmentative and alternative communication systems (AAC). Restrictive practices can impede their ability to express discomfort, pain, or needs, potentially escalating distress and leading to further behavioural issues.
- Sensory Sensitivities: Many people with disabilities have heightened or atypical sensory processing. The physical and emotional stress of restraint can be overwhelming, causing sensory overload, panic, or extreme discomfort, exacerbating the individual's condition.
- Trauma: People with disabilities are more likely to have had negative or harmful experiences with healthcare and restrictive practices in the past, increasing the likelihood that the use of restraint will trigger or exacerbate trauma. Individuals with disabilities are often less likely to receive timely and appropriate psychological support following restrictive practices incidents.

The unique vulnerabilities within these populations necessitate a greater focus on non-restrictive approaches and alternative strategies that prioritise their emotional well-being and long-term development. Healthcare providers must strive to create a safe and supportive environment for each of these vulnerable population groups, emphasising compassionate care and communication to ensure positive health outcomes without resorting to restrictive practices.

### 1.1.5 Environmental Considerations

It is the responsibility of all healthcare workers to consider environmental adjustments that can be beneficial to the care and wellbeing of their patients. Occupational Therapists (OTs) can be engaged to support environmental modifications. Services can employ strategies such as adjustments to room

layout and lighting, sensory modulation, and structured meaningful activity programs, that address triggers such as boredom, frustration, restlessness and over- or under-stimulation, that can lead to challenging behaviours.

Some suggestions include:

- Single room, ideally in a low stimulus area, away from nursing station
- Large enough room, to accommodate additional bed if family member/carer staying overnight.
- A room preferably with window/natural light
- Access to an outdoor space such as a courtyard
- Unnecessary and potentially dangerous items (e.g. things that can be thrown) to be removed from the room.
- Use of colours, drawings, signs to decorate the room.
- Availability of items and access to activities which can keep individual entertained and occupied. Examples include sensory items, drawing and painting material, play dough/ magic sand, music playing device, video playing device, games, and outside activities.

Hospital inpatient wards should employ early consideration into modifying patient rooms according to the patients' needs to provide a culturally appropriate and safe space that encourages calming behaviours. An example being, an older confused person assessed as a high falls risk being admitted, preparing the room by obtaining a low bed, placing falls mats, and removing unnecessary clutter such as chairs or over-ways. This may minimise the likelihood for the use of restrictive practices during the admission to protect the patient from harm.

Whenever they can, staff should maintain the patient's usual routine as much as possible, particularly medication management, rather than altering the patient's routine to fit a hospital schedule.

Where possible and within safe hospital systems, encouraging family members to stay with patients is likely to lead to a reduction in the use of restrictive practices.

### 1.1.6 Documentation of minimising restrictive practices

Clear and comprehensive documentation is mandatory to the human rights of the patient, and it is the responsibility of the clinician to ensure this is completed to a high standard. Full list of documentation requirements in Appendix 1.

- Objective description of the patient's behaviours
- Assessment of decision-making capacity
- Strategies utilised to minimise restriction.
- Level of consent obtained from patient and/or Substitute Decision-Maker/Person Responsible
- Clinical assessment including pain, medication management, bowel/toileting.
- Cleary identifiable names, signatures and designation of those healthcare workers completing the above minimising restrictive practice strategies.

## 2.1 Initiating Restrictive Practices

### 2.1.1 What not to do with restraint

Restrictive practices must not be used:

- To address inadequate levels of staffing, equipment, or facilities.
- As a punishment or for the convenience of others.

**The following forms of restraint (or acts during restraint) are prohibited:**

- Prone/Supine position restraint (i.e., holding someone face down or face up on the floor)
- Psycho-social restraint (i.e., staff withhold basic human rights such as drinks, social interaction, communication, or staff use verbal coercion or threats to control patients' behaviour)
- Exclusion (i.e., excluding the patient from their own healthcare discussions)
- Restrictions to any part of the respiratory or digestive function.
- Inflicting pain.

### 2.1.2 Restrictive Practices vs Necessary Care/Treatment

Practitioners are required to consider each scenario on a case-by-case basis and to seek the advice of the Clinical Risk Manager or equivalent. Specific legal authority (under the *Mental Health Act 2009* or the *Guardian and Administration Act 1993*) is required to use any restrictive practices that involve the use of force.

In general, physical contact that doesn't involve any use of force and is part of 'medical treatment' is not considered a restrictive practice. Medical treatment is where the primary purpose is therapeutic, that is, employed for the person's health, wellbeing, and quality of life, rather than behavioural change. The types of interventions that may fall within the scope of 'medical treatment' include:

- Administration of drugs (with sedative effect) for the health, wellbeing, and quality of life of the patient.
- Activities of daily living (ADLs) where no force is required, the patient does not resist and their movement is not impeded by other means (Refer to Clinical Scenarios: When is it restraint? Tool).

Restrictive Practices that are not classified as medical treatment require comprehensive documentation as highlighted in Appendix 1. However, they may not be classed as an incident. Some examples include:

- Legal authority to restraint is present and minimal force is needed to prevent the person from going to places that no usual person can attend (such as staff rooms or other patient rooms)
- Completing ADLs on a patient with a Section 32 and special powers for restrictive practices.

A restrictive practice that is also an incident and therefore is reportable on SLS can include any of the following situations:

- There is no legal authority for the restrictive practice.
- The restrictive practice is a result of a challenging behaviour.
- Injury to the patient or staff has occurred throughout the restrictive practice process.

### 2.1.3 Roles and Responsibilities

Restraint or seclusion will only be applied to a patient by a senior clinician or clinically led team, with support provided by trained security officers, or SA Police officers where required and available. Members of a team that applies restrictive practices will have training and education to ensure they have appropriate knowledge and skills in the relevant patient cohort (i.e., restraint of a child or elderly person).

All workers who provide care to the patient during the time that restrictive practices are in place will have training and education to ensure they have the knowledge and skills to care for that specific patient cohort.

Two registered nurses can initiate the use of restrictive practices (excluding chemical restraint and seclusion) if there is an immediate need to do so. In this case, an interim plan is made, requiring review and confirmation by a medical officer within one hour. This review can be done by telephone where physical review is not practicable, for example during lengthy transport or in rural or remote settings.

### 2.1.4 Person with capacity to provide or deny consent.

For information on assessment of decision making capacity, refer to Providing Medical Treatment where patient consent cannot be obtained, guideline and Impaired Decision-Making Factsheet.

Consent can only be provided by the patient or the parent or guardian of a minor, or a guardian appointed under the *Guardianship and Administration Act* 1993 (section 32) who has received extra powers from the South Australian Civil and Administrative Tribunal (SACAT) to authorise the use of restrictive practices. Any recommended restrictive practices can be applied that are consented to by a patient with decision making capacity, so long as they remain within the principles as outlined within the policy.

For patients who speak English as a second language an interpreter should always be utilised when obtaining consent.

If initiating a restrictive practice under a section 32 (*Guardianship and Administration Act 1993 SA*), the legal order and Special Powers Orders pertaining to restrictive practices must be documented to be sighted, by the authorised practitioner initiating the restrictive practice.

**Consent not provided** (but does not qualify for legal authority orders under the *Mental Health Act 2009 (SA)* or *Guardianship and Administration Act* 1993. (Refer to Refer to the Chief Psychiatrist Restraint and Seclusion Standards and Advance Care Directives policy):

Any person who has decision-making capacity under the *Consent to Medical Treatment and Palliative Care Act* 1995, has the right to refuse a medical assessment and/or treatment. In these circumstances, the health practitioner must not proceed with treatment, authorise any restrictive practices to provide that treatment, or prevent the patient from leaving. This includes situations wherein the medical practitioner feels the patient may be at risk of harm to themselves or others if they were to leave the premises against medical advice, this is inclusive of child under the age of 16 years, in this circumstance the Department of Child Protection should be notified. Refer to SA Health policy, Providing Medical Treatment where patient consent cannot be obtained and guideline for further guidance.

### 2.1.5 Person without capacity to provide or deny consent.

For information on assessment of decision making capacity, refer to Providing Medical Treatment where patient consent cannot be obtained, guideline and Impaired Decision-Making Factsheet.

Applying any form of restraint (as per the definition of restrictive practices), seclusion or detaining a patient within a locked ward must have legal authority under Section 32 of the *Guardianship and Administration Act 1993*, unless restrictive practices are required to provide treatment that will prevent

death or serious permanent harm to the patient. If there is no legal authority currently in place, refer to section 3.1. Use of Restrictive Practices without direct legal authority.

### 2.1.6 Use of restrictive practices where the patient does not have decision making capacity and restrictive practices are required to provide treatment that will prevent death or serious permanent harm to the patient.

Emergency medical care is classified as medical treatment that will prevent death or serious permanent harm to the patient. Section 13 of the *Consent to Medical Treatment and Palliative Care Act 1995 SA* only authorises the restraint and force to the extent that is reasonably necessary to provide the lifesaving/serious risk-averting treatment. It does not give the medical practitioner a licence to provide any other treatment, even treatment that is related to the life-saving treatment.

### 2.1.7 Restrictive Practices where a substitute decision-maker or guardian with additional powers to authorise the use of restrictive practices (under Section 32 of the Guardianship and Administration Act 1993) consents to restrictive practices to facilitate the treatment or care of the patient.

Under the *Guardianship and Administration Act 1993* (section 32) a guardian can seek extra powers from the SACAT to authorise the use of restrictive practices, to enforce treatment and/or accommodation, that is to prevent the person from leaving. (See Restrictive Practices and Special Powers from the Office of the Public Advocate and Providing Medical Assessment Treatment where Patient consent cannot be obtained Policy)

Prior to initiating any restrictive practice directed by a nominated substitute decision-maker or guardian, the section 32 legal order and Special Powers Orders pertaining to restrictive practices must be sighted, and documented to be sighted, by the medical practitioner initiating the restrictive practice.

### 2.1.8 Restrictive Practices in the case of an authorised officer under the Health Care Act 2008

An authorised officer as per the *Health Care Act 2008* Section 43, may restrain a consumer who is:

- considered to be acting in a manner that constitutes disorderly or offensive behaviour.
- considered on reasonable grounds to be a threat to another person.
- suspected on reasonable grounds of being unlawfully in possession of an article or substance, or
- is suspected on reasonable grounds to have committed or to be likely to commit an offence against any Act or law.

In order to:

- provide the consumers name, address or to answer questions relating to the above.
- submit to a search of clothes or anything in their possession.
- seize possessions that on reasonable grounds could be used to harm a person on site or constitutes an article or substance the possession of which is unlawful in the circumstances, or
- remove the consumer from the site (when not in need of medical assistance).

### 2.1.9 Clinical Holding in Children

At times there is a need to ‘hold’ a child for the safe and efficient delivery of a clinical procedure or medical treatment. This is referred to as Clinical Holding, which is described as brief immobilisation of a child with the child’s parent’/guardian’s consent. There is legal authority to use this restrictive practice under the common law power of a guardian if:

- the child does not reasonably understand the procedure/treatment that will occur or the consequences if the procedure/treatment does not occur, and a parent/guardian gives their consent, or
- a child gives their consent.

If a parent does not give consent, holding should not be used unless the medical practitioner understands it to be in the best interests of the child's health and well-being (as per *Consent to Medication Treatment and Palliative Care Act 1995* Division 4)

Clinical holding is not always in the best interest of the child as it can create traumatic experiences which can also negatively impact on the child's and parents' relationship to the health service. Clinicians are to have the skills in assessing the situation and determining the least traumatising pathway for a child to receive their treatment.

Clinical holding should be limited to a brief duration during the procedure or treatment, and it should only be considered by the clinician when non-physical techniques are deemed ineffective in accomplishing the procedure or treatment effectively.

## 3.1 Use of Restrictive Practices without direct legal authority

Circumstances may arise where practitioners need to use restrictive practices without express legal authority. In these cases, restrictive practices must only be in the situations outlined within the policy and sections 3.1.1, of this clinical guideline.

In these circumstances practitioners will have to rely on common law and/or statutory defences including the self-defence, defence of property, and sudden or extraordinary emergency defences to potential criminal charges in the *Criminal Law Consolidation Act* 1935 at sections 15, 15A, and 15E.

Practitioners should ensure they are adhering to the principles as outlined in the Minimising Restrictive Practices Policy when considering use of restrictive practices. These principles reflect the components of the defences to any claims that may be made in relation to the use of restrictive practices and will assist in ensuring that the use of restrictive practice is acceptable under scrutiny.

It is recommended that practitioners liaise with a patient's Substitute Decision-Maker or Person Responsible in these circumstances to ensure they endorse the proposed use of the restrictive practice.

All use of restraint or seclusion while awaiting a legal authority or as a result from challenging behaviour is to be recorded within the Safety Learning System (SLS) in accordance with the *Minimising Restrictive Practices Policy*.

### 3.1.1 Restrictive practices where there is a risk of significant or serious harm to the patient, self or others, which cannot be effectively managed in a less restrictive way.

*Risk of Harm to the Patient*

Consent is to be obtained where decision making capacity is present (under the *Consent to Medical Treatment and Palliative Care Act 1995*, the patient has the right to refuse a medical assessment and/or treatment). If consent is denied and expressed or implied harm to self is ongoing, and clinicians have determined high likelihood of harm may occur, a mental health legal authority may be needed - follow the processes as outlined in the Restraint and Seclusion Policy and Guideline.

For patients who have cognitive impairment or disabilities, self-harm through actions such as hitting, scratching, biting may occur, either in moments of distress or as part of their usual behaviour. In these situations, it is crucial to apply restrictive practices only when there is a risk of significant or serious harm to the patient. The restrictive practices and processes followed must abide by the principles as outlined in the *Minimising Restrictive Practices Policy* and, wherever practical, should always be supported by the involvement of family or carers.

*Risk of Harm to Self or Others*

If restrictive practices are required to protect oneself (the worker) or others from harm, it will be lawful to restrain the patient with the intent of the restraint as a means of self-defence or defence of others (as per Division 2 section 15 *Criminal Law Consolidation Act* 1935.). This would not include scenarios in which disengaging from the situation was possible and could have de-escalated the situation. However, any use of restraint should be reasonable in the circumstances and use the minimum amount of force or sedation for the shortest period of time.

*Code Black team or security assistance*

If medical attention is not required by the consumer, security assistance may be called who may restrain a consumer to remove them from the premises as per 2.1.8 Restrictive Practices in the case of an authorised officer under the Health Care Act 2008.

If the consumer may require medical treatment (inpatient, triaged within emergency department) a clinical team is required to assist in the response of expressed or implied harm to others, such as a Code Black team or local organisation equivalent. The emergency response team attending must include an expert clinician who can assess the patient's decision-making capacity, employ a range of de-escalation techniques, and holds appropriate authority to approve the initiation of restrictive practices.

*Community services and out of hospital facilities*

Within community services, or out of hospital facilities, local processes involving personal duress pendants, security services or SA police are to be followed. Security services may restrain a consumer as per 2.1.8 Restrictive Practices in the case of an authorised officer under the Health Care Act 2008 and other relevant sections of the *Health Care Act 2008*.

## 4.1 Least Restrictive

Any use of restraint should be reasonable in the circumstances and use the minimum amount of force or sedation for the shortest duration required in response to the threat or risk of harm. Refer to the *Clinical Scenarios Tool: When is it Restraint?* for examples of least restrictive practice.

### 4.1.1 Documentation upon application of restrictive practices

- Description of the restrictive practices and reasoning for application
- If applicable, the section 32 legal order and Special Powers Orders pertaining to restrictive practices must be documented to be sighted, by the medical practitioner initiating the restrictive practice.
- The plan for removal of restraint
- Names of witnesses and/or participants to any discussion with the patient and /or Substitute Decision-Maker or Person Responsible about application of restrictive practices
- All use of restraint or seclusion while awaiting a legal authority or as a result from challenging behaviour must be reported into SLS. Refer to Challenging Behaviour/Restraint SLS Topic Guide

## 5.1 Reviewing and Ceasing Restrictive Practices

### 5.1.1 Parameters for Maintaining Restrictive practices.

The regular review of patients with restrictive practices in place is essential to maintaining the safe application, recovery and informing the decision to cease restrictive practices. This review will be based on clinical judgement informed by:

- The ongoing monitoring and review of the patient's mental and physical state and the patient's ability to control/modify their behaviour.
- The reduced risk of harm to self or others.

Plans for the use of restrictive practice are to be time limited and when this point is reached, restrictive practices cessation strategies are to be enacted. To authorise the ongoing use of a restrictive practice, a senior doctor (registrar, consultant, or GP) is to review the patient and determine strategies for ceasing the restrictive practice.

Regular multidisciplinary reviews of the patient, led by a medical officer, are to occur throughout the use of restrictive practices.

### 5.1.2 Documentation for monitoring restrictive practices.

- Physical and mental state, including decision making capacity assessment by medical practitioner.
- Clinical assessment (vital signs, pain, mental state, sedation score if applicable) and assessment of risk (relating to the reason for initiating restrictive practice).
- Skin and injury assessment (if injury is sustained, the restrictive practice is to be ceased immediately unless the risk of harm to others or the patient outweighs that of the injury).
- If chemical restraint used – oxygen saturation level and respiratory rate in addition to the clinical assessment criteria is to be documented.
- Verification by a medical practitioner that current legal authority for restrictive practice is still applicable.
- Reasons for continuation of restrictive practice.
- Strategies to encourage removal of restrictive practices.

### 5.1.3 Ceasing Restraint

Restraint must be removed where there is:

- A risk of harm from the restrictive practice which outweighs other risks.
- Deterioration to the patient's health condition or injury caused, resulting in a medical emergency response call or similar.
- No longer an imminent risk of death or serious harm to the patient or others
- A change in the patient's decision-making capacity resulting in the ability to provide or deny consent.

### 5.1.4 Documentation upon ceasing restrictive practices.

- Reason for cessation
- Total length of time of patient in restrictive practice
- Plan to prevent re application of restrictive practice.
- Documented debrief and recovery practices to patient and family or guardians.

### 5.1.5 Recovery

The experience of forcibly applying restrictive practices, or of being restrained, or of witnessing a loved one being restrained can be difficult. Strategies to promote short and long-term recovery of staff, patients and others involved should be readily accessible and available.

All people involved in an incident where there may be physical or psychological trauma, and strong emotions such as aggression or fear, can recover better if there is debriefing and follow-up.

Promotion of recovery includes immediate strategies such as:

- first aid and treatment for physical harm
- de-briefing or counselling for emotional harm
- review of care plan, and discharge planning

### 5.1.6 Consumer and Families/Carers

For inpatient and other settings, managers or healthcare practitioners should discuss the incident through a debrief as soon as practicable with the patient/family/carer using open disclosure principles and practices. A visit from a social worker to support the debrief prior to the patients discharged is to be offered.

Discussion provides opportunity to develop strategies to prevent recurrence, and these should be added to the care plan, discharge plans and documented in the medical record.

Ambulance services and other services where the duration of that episode of care is very brief may not be the appropriate service to do this. Ambulance Services handover to the receiving service should therefore include information about any involvement of family/carer in the restrictive practice, to better inform the subsequent discussion with patient, family/carer that takes place in the receiving service.

Attempts should be made to resolve any issues or concerns. The patient and/or their family/carer may feel that inappropriate care was provided, and if their concerns are not resolved through this discussion, information about avenues for making and resolving a patient complaint should be given to the patient/family/carer.

- Fact Sheet – Trauma-informed post-incident conversation guide
- Tool 8 – Challenging Behaviour, Violence and Aggression – Post-Incident Support Toolkit

### 5.1.7 Workers

For workers, recovery means restoring confidence and feeling safe. A formal or informal de-briefing with each worker may be required to establish the need for referral to Employee Assistance Program (EAP) for counselling, additional training or support, or other action as required to promote recovery.

A planned approach to providing effective injury management, with the aim of achieving effective, early and safe return to work, and promote best practice for physical and mental recovery, is described in the SA Health Injury Management Policy .

If workers felt threatened or were injured during restraint of a patient and wish to pursue grievance procedures or charges against the aggressor, they will require advice and support to do this by contacting their local work health and safety team or human resources.

## 7. Governance and Monitoring

Reporting on incidents of challenging behaviour resulting in restrictive practices through SLS should be reported locally through governance systems.

Training and education are required to ensure that workers have the skills and knowledge required for their role and responsibilities as determined locally.

Training should include identification of individuals and groups that may be more vulnerable to harm from restrictive practices and additional strategies to support these populations.

Refer to the Consent to Medical Treatment Policy Guideline for information on civil claims regarding alleged unlawful health or medical treatment, detainment, or other restrictive practices.

## 8. Associated policies / guidelines / clinical guidelines / resources

- Minimising Restrictive Practices Policy
- ACSQHC User Guide for Health Services with Intellectual Disability
- Preventing and Responding to Challenging Behaviour Toolkit
- Clinical Incident Management Policy
- Providing Medical Assessment Treatment Where Patient consent cannot be obtained Policy
- Advance Care Directives policy
- Impaired Decision-Making Factsheet
- Prisoners - Care and Treatment in SA health Services Policy
- Chief Psychiatrist Restraint and Seclusion Standards
- Challenging Behaviour/Restraint SLS Topic Guide
- Local Health Network specific procedures
- Voluntary Assisted Dying Clinical Guideline
- Special powers | South Australian Civil and Administrative Tribunal

## 9. Reference


- Advance Care Directives Act 2013
- Aged Care Quality and Safety Commission Restrictive Practices Provider website
- Aging and Adult safeguarding (Restrictive Practices) Amendment Bill 2021
- Civil Aviation Safety Regulations 1998
- Consent to Medical Treatment and Palliative Care Act 1995 SA
- Criminal Law Consolidation Act 1935
- Disability Inclusion (Restrictive Practices - NDIS) Regulations 2021
- Guardianship and Administration Act 1993
- Health Care Act 2008
- Behaviour Management: A Guide to Good Practice – Dementia Support Australia
- Seclusion and Restraint in NSW Health Settings Policy Directive
- Northern Devon Healthcare (NHS) Restrictive Practices Policy
- Acute Behavioural Disturbance Paediatric National Guideline
- Acute behavioural disturbance: Acute management
- Autism and developmental disability: Management of distress/agitation
- Understanding Restrictive Practices Practice Paper - Department for Child Protection
- NDIS Commission Understanding Behaviour Support and Restrictive Practices – for providers
- SA Road Traffic Act, Australian Road Rules
- Restrictive Practices Guidelines – Department of Human Services
- *Mental Health Act 2009*

## 10. Appendices

Appendix 1 - Documentation outline

## 11. Document Ownership and History

**Developed by:** Safety and Quality Unit, DHW
**Contact:** Health.DHWclinicalgovernanceenquires@sa.gov.au
**Endorsed by:** SA Intellectual Disability Health Service
**Date endorsed:** 17/03/2025
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**CG number:** CG008
**CG history:** Is this a new clinical guideline (V1)? **N**
Does this clinical guideline amend or update and existing clinical guideline? **Y**
If so, which version? **V1.0**
Does this clinical guideline replace another clinical guideline with a different

| Approval Date | Version | Who approved New/Revised Version | Reason for Change |
|---|---|---|---|
| 17/03/2025 | V1.1 | Clinical Guideline Domain Custodian | Inclusion of disability specific content and appendix 1. |
| 28/03/2024 | V1 | Domain Custodian, Clinical Governance, Safety and Quality | Original |

# Appendix 1 – Documentation Outline

Clear and comprehensive documentation is mandatory to the human rights of the patient, and it is the responsibility of the clinician to ensure this is completed to a high standard.

**Documentation of minimising restrictive practices**

- Description of the patient's behaviours
- Assessment of decision-making capacity
- Strategies utilised to minimise restriction.
- Level of consent obtained from patient and/or Substitute Decision-Maker/Person Responsible
- Clinical assessment including pain, medication management, bowel/toileting.
- Cleary identifiable names, signatures and designation of those healthcare workers completing the above minimising restrictive practice strategies.

**Documentation upon application of restrictive practices**

- Description of the restrictive practices and reasoning for application
- If applicable, the section 32 legal order and Special Powers Orders pertaining to restrictive practices must be documented to be sighted, by the medical practitioner initiating the restrictive practice.
- The plan for removal of restraint
- Names of witnesses and/or participants to any discussion with the patient and /or Substitute Decision-Maker or Person Responsible about application of restrictive practices
- All use of restraint or seclusion while awaiting a legal authority, as a result from challenging behaviour or that cause injury to the patient or staff, must be reported into SLS. Refer to Challenging Behaviour/Restraint SLS Topic Guide

**Documentation for monitoring restrictive practices.**

- Physical and mental state, including decision making capacity assessment by medical practitioner.
- Clinical assessment (vital signs, pain, mental state, sedation score if applicable) and assessment of risk (relating to the reason for initiating restrictive practice).
- Skin and injury assessment (if injury is sustained, the restrictive practice is to be ceased immediately unless the risk of harm to others or the patient outweighs that of the injury).
- If chemical restraint used – oxygen saturation level and respiratory rate in addition to the clinical assessment criteria is to be documented.
- Verification by a medical practitioner that current legal authority for restrictive practice is still applicable.
- Reasons for continuation of restrictive practice.
- Strategies to encourage removal of restrictive practices.

**Documentation upon ceasing restrictive practices.**

- Reason for cessation
- Total length of time of patient in restrictive practice
- Plan to prevent re application of restrictive practice.
- Documented debrief and recovery practices to patient and family or guardians.