

Policy Directive: compliance is mandatory

Minimising Restrictive Practices in Health Care Policy Directive

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Summary This policy directive outlines the requirements for SA Health services to act on minimising, or eliminating where possible, the use of restrictive practices, and meeting requirements to practice safely and lawfully if restraint or seclusion are applied during a period of health care. There is an extensive toolkit to support implementation.

Keywords restrictive practice policy directive, restrictive practice policy, restraint policy, Safety, restrictive care, minimising restrictive practice, least restrictive practice, restraint, seclusion, physical, chemical, mechanical, pharmacological, responding, challenging behaviour, violence, aggression, prevention, psychological harm, physical, violence, unsafe, threaten, withdrawal, avoid harm, work health safety, WHS, behaviours of concern, OH&S

Policy history Is this a new policy? *N*
Does this policy amend or update an existing policy? *Y*
Does this policy replace an existing policy? *Y*

Applies to *All Health Networks*

Staff impacted *All Staff, Management, Admin, Students; Volunteers*

EPAS compatible *Yes*

Registered with Divisional Policy *Yes*

Contact Officer

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1.1	02/11/2015	current	Minor amendments to increase clarity



Minimising restrictive
practices in health care
Policy Directive



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Minimising restrictive practices in health care Policy Directive

1. Objective

This policy directive outlines the requirements for SA Health services to act on:

- minimising, or eliminating where possible, the use of restrictive practices
- meeting requirements to practice safely and lawfully if restraint or seclusion are applied during a period of health care.

This policy directive is to be read / administered in conjunction with the following:

- [Prevention and responding to challenging behaviour](#) policy directive, and toolkit
- [Prevention and responding to workplace violence, aggression and challenging behaviour](#) policy guideline, and tools
- [Providing Medical Assessment and/or Treatment Where Patient Consent Cannot be Obtained Policy](#)
- [Restraint and seclusion in mental health services](#) policy guideline, and fact sheets
- [Dealing with intoxicated patients policy](#)

2. Scope

This policy directive applies to all SA Health employees or persons who provide health services or residential care services on behalf of SA Health and who may be required to provide care for a consumer who is experiencing distress or exhibiting challenging behaviours. These may:

- result in actions or behaviours that may, or have the potential to, physically or psychologically harm another person or self, or property, or
- limit the ability to safely provide treatment, and
- lead to consideration of the use of restrictive practices.

This includes medical practitioners, nurses, allied health professionals and other health practitioners, SA Ambulance Service paramedics and ambulance officers, Authorised Officers and authorised health professionals (under the *Mental Health Act 2009*) and security officers (as defined under the *Health Care Act 2008*) who may assist in the application of restraint and seclusion.

This policy directive and the accompanying tools do not:

- apply to mental health patients who are being treated in a designated mental health service. These are covered by the [Restraint and seclusion in mental health services](#) policy guideline
- apply to people who are not patients or consumers of the health service, that is not receiving treatment, for example visitors, relatives, friends, and other members of the public (hospital by-laws provide for this situation)
- provide legal advice
- provide advice on clinical issues or replace clinical judgement in all situations, but will refer to such guidelines where relevant
- apply where these are in conflict with another statutory requirement for the use of occupant restraints &/or seatbelts to facilitate safe patient transport under the *SA Road Traffic Act*, Australian Road Rules (Sect 265 & 266) and Civil Aviation Safety Regulations 1998 (refer section 4.13).
- apply where a patient is under arrest or a prisoner of SA Police or Department of Correctional Services where statutory requirements exist, and obligation to public safety and maintaining custody override medical need

3. Principles

- 3.1 Assessment and treatment should be provided in the least restrictive way and in the least restrictive environment that is consistent with the consumer's proper care and protection, treatment efficacy and public safety.
- 3.2 Health services and SA Health residential care facilities will respond to challenging behaviour, including behaviour that limits the ability to safely provide care, in ways that engage with the consumer and carer, and respect the individual's rights, dignity, autonomy and decision-making capacity, while effectively managing risk to the consumer, workers and others.
- 3.3 Restrictive practices are potentially harmful non-therapeutic interventions.
- 3.4 Restrictive practices should not be used:
 - as an alternative to adequate staffing, equipment or facilities to safely carry out the practice
 - as a punishment or for the convenience of others, or as a substitute for adequate surveillance, workers, resources or facilities to provide safe care.
- 3.5 The use of restrictive practices should be a last resort, and only occurs where:
 - alternative strategies have failed to achieve or maintain safety for the consumer experiencing distress, workers or others
 - alternative strategies have failed to enable safe provision of treatment, for example medications required by an Inpatient Treatment Order
 - behaviours and actions are assessed to be imminently or actually harmful to a consumer or others, or
 - the health practitioner believes a failure to do so could put the consumer, workers or public at a significant health or safety risk.
- 3.6 If restrictive practices are used as the last resort, the wellbeing and safety of the consumer and workers is supported by:
 - assessment and processes that ensure that there is proper authority to do so, and take into consideration the consumer's decision-making capacity, mental and physical state, the level of risk and the ability of the service to apply restrictive practices safely
 - using restrictive practices that are in accord with current evidence and clinical guidelines, applicable law, and also applied in the safest, least restrictive and most respectful, humane way and for the least possible time
 - implementing strategies such as de-escalation and de-briefing for all people present during and after the application of restrictive practices, in order to minimise the duration of the restrictive practice, the harm and trauma, and optimise recovery.
- 3.7 Disclosure of the use of restrictive practice in relation to a person should be made to a substitute decision-maker, person responsible, guardian, relative, carer or friend of the person as soon as it is practicable, and where it is safe and appropriate to do so.
- 3.8 Organisational leadership, clinical governance and training and education underpin improvements to care in response to systematic review of incidents and to implementation of evidence-based best practice.

4. Detail

4.1 Definitions

Restrictive practice means all the types of restraint, care and control, reasonable force, and seclusion. It is not always clear in a clinical setting what actions constitute restrictive practices. Definitions and examples are included in Tool 1 - What are restrictive practices, and what types are there?

Types of challenging behaviour that may precede the use of restrictive practices include verbal and/or physical abuse, potential or actual harm to the worker and other people, property damage and disruption to the service.

Health workers may also encounter challenging behaviour if they:

- intervene to avoid or stop harm from occurring to themselves, other person(s), or damage to property
- act to protect the person from deliberate or unintentional self-harm (eg wandering or absconding, falling, self-harm and suicide attempts)
- act to prevent a person from leaving, or absconding without leave of absence
- are transporting the person to or between treatment centres
- are providing treatment under legal orders
- are providing routine care such as showering, wound care
- intervene to enforce hospital by-laws.

Where the challenging behaviour is not compatible with safe delivery of care, and alternative strategies have failed, the clinical team might consider the least restrictive practice to bring about safe resolution for all.

4.2 Prevention and minimisation of restrictive practices

A safe approach to managing the care of patients who exhibit disturbed and/or aggressive behaviour is one that focusses on prevention strategies and positive changes to the provision of assessment, treatment, care and support. All health services will implement evidence-based strategies for the prevention, early recognition and response to challenging behaviour. This should be relevant to their health setting and the consumers accessing the service eg strategies for adolescents differ from those for older people with dementia or delirium.

These are summarised in Tool 3 – Clinical strategies to minimise the use of restrictive practices and a list of current references is provided.

These include, but are not limited to, proactive assessment and management of the causes, triggers or contributing factors such as health conditions like delirium or psychosis, symptoms such as pain, drug withdrawal, personal stressors, interpersonal interactions and environmental stressors.

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

Good communication and consumer-centred care underpin the development and preservation of positive relationships between workers and consumers and their carers. This includes cultural awareness, cultural competency and trauma informed care.

Adequate levels of care, surveillance, facilities and resources support minimisation of restrictive practices.

Staff should be familiar with the options for retreat, withdrawal and/or calling for assistance from other staff using mechanisms such as duress alarms, Code Black or Code 51 (SAAS) calls in emergencies.

4.3 Education and training

Training and education is required to ensure that workers have the skills and knowledge required for their role and responsibilities (see also 5 - Roles and Responsibilities).

Training should include identification of individuals and groups that may be more vulnerable to harm from restrictive practices. This may be additional physical vulnerability to 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.

For further information:

- Tool 4 - Safe application of restrictive practices, and recovery.
- [Preventing and Responding to Challenging Behaviour](#) e-learning module

- [Prevention and responding to challenging behaviour](#) Policy Directive resource toolkit Tool 5 - Education and Training Framework
- [Cultural Respect Framework for Aboriginal and Torres Strait Islander Health, 2004 – 2009](#), Australian Health Ministers' Advisory Council.

4.4 Documentation

The use of any restrictive practice should be documented. The documentation in the medical/clinical record or EPAS about any of the care provided before, during and after an incident involving restrictive practices should include:

- the results of clinical assessment, assessment of decision-making capacity, clinical rationale and alternative strategies attempted
- the names, signatures and designation of those health workers initiating or confirming the care plan describing the use restrictive practices, and names of any witnesses to any discussion with the consumer and /or Substitute Decision-Maker or Person Responsible about use of restrictive practices
- the duration of the plan, and
- the consent, or relevant legal authority (see also 4.6).

For further information:

- [Providing Medical Assessment and or Treatment](#) where consent cannot be obtained policy directive.

4.5 Handover

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
- any restrictive practices that are in place, the care and review required to minimise harm and duration.

Handover includes transfer into a service, such as an emergency department, for example where ambulance paramedic's handover the care of a restrained consumer to the emergency department workers, handover between shifts, or handover back to the person's residential care facility.

For further information:

- [SA Health Clinical Handover policy directive](#)

4.6 Confirming and reviewing the plan of care for use of any restrictive practice

A plan to use restrictive practices should be initiated and documented by at least two health practitioners, ambulance officers or paramedics.

- Where practicable, it is recommended that a plan is made by the treating medical practitioner and one other, such as a registered nurse.
- Two nurses can initiate the use of restrictive practices if there is 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.
- In an emergency, after a duress call or Code Black call made, the medical officer in the attending Emergency Response Team (ERT) can confirm the plan made by the team.

As well as confirming that the ongoing care plan for restrictive practice is required and appropriate, medical officers verify the appropriate legal authority and investigate and document the consumer's decision-making capacity.

Plans for the use of restrictive practice apply for a maximum of 24 hours. If the restraint is removed for periods of 30 minutes or less, it is considered to be a continuous incident.

Reviews of the consumer by a medical officer with others involved such as nurses, ambulance officers or paramedics should be conducted at least every 4 hours, where practicable. Reasons for continuation or plans for cessation should be documented.

After 8 hours a senior doctor (registrar or consultant) should attend, review the consumer with nurses, and document or revoke the ongoing care plan.

For further information:

- [Restraint and seclusion in mental health services Policy Guideline](#)

4.7 Legal considerations

Further detail is provided in [Tool 5](#) – Legal information about restrictive practices, and in SA Health Providing Medical Assessment and/or Treatment Where Patient Consent Cannot be Obtained [Policy Directive](#).

Any use of restrictive practices should satisfy one of the following three conditions (4.7.1, 4.7.2 or 4.7.3).

4.7.1 Consent has been provided.

Consent for the restraint has been provided by either the consumer or if they are unable to do so, by a third party who has authority to do so. Third parties, such as Substitute Decision-Maker, Person Responsible or parent of a young person may have the authority to consent to medical treatment, but do not necessarily have the authority to consent to restrictive practices, for example guardians may need to apply to SA Civil and Administrative Tribunal (SACAT) for an order under section 32(1) (c) of the *Guardianship and Administration Act 1993*.

4.7.2 There is legal authority to restrain a consumer to provide treatment, maintain safety or carry an order into effect.

- Under the *Guardianship and Administration Act 1993* (section 32) a guardian can seek extra powers from SACAT to authorise the use of restrictive practices to enforce accommodation and/or treatment.
- Under the *Mental Health Act 2009* (section 56 or section 57), or
- Detention under the *South Australian Public Health Act 2011* (section 73, 74, 75, 77)
- The person is a prisoner (under Department of Corrections) or in the custody of the SA Police

4.7.3 There is an immediate need and duty to protect people and property from harm.

Where a consumer in a public health facility is exhibiting challenging behaviour and is posing an immediate and serious risk of harm to themselves or another person, it will be lawful to restrain the consumer or other individual to prevent the harm, or further harm, eventuating. The intent of the restraint is as a means of self-defence or defence of others.

However, 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.

There may be emergency situations where, because of extreme resistive, combative or aggressive behaviour, it is not possible to assess decision-making capacity, obtain consent or safely physically assess the consumer without the interim or temporary application of restraint.

In these cases the restraint is used to ensure safety of all people during the assessment and initial treatment. As with all use of restraint, efforts are made to

ensure minimal force and least restriction, including sedation are used, and for the shortest duration.

Immediately after the consumer is safely restrained a clinical assessment should be undertaken by a medical practitioner, or staff acting at the direction of the practitioner, or ambulance officer/paramedic in the case of SAAS, to identify and treat the underlying conditions that may have caused this behaviour, and other illness or injury that present an imminent risk to life or health (as defined by the *Consent to Medical Treatment and Palliative Care Act 1995 SA*).

Once the physical assessment is complete, the restraint should be removed unless the consumer continues to be a danger to them self or others, there remains an overriding necessity to protect the consumer and other people from harm, or the assessment indicates that emergency treatment is required. The next steps should be pursued without delay. These may be, for example:

- applying for an order from South Australian Civil and Administrative Tribunal (SACAT) or
- obtaining third party consent for treatment, or
- taking the person into care and control or placing them under a mental health treatment order.

If emergency treatment is required and the patient cannot consent, Section 13 of the *Consent to Medical Treatment and Palliative Care Act 1995 SA* sets out circumstances in which medical practitioner can lawfully administer medical treatment. Impaired decision-making capacity, and ability to consent can arise in situations where, for example the person's consciousness is impaired, they are intoxicated or in later stages of dementia (SA Health Providing Medical Assessment and/or Treatment Where Patient Consent Cannot be Obtained [Policy Directive](#)).

Under common law the defence of necessity could possibly be raised in circumstances when hospital staff prevent an incompetent patient from leaving a health service if;

- there was a serious threat or imminent danger to the health or life of the patient
- there were no other means of avoiding the threat of danger to the patient other than by restraining and detaining them, and
- the restraint was proportionate to the threat.

4.7.4 Potentially unlawful use of restrictive practices.

Where a consumer has decision-making capacity and he or she refuses a medical assessment and/or treatment, it is unlawful for a health practitioner to proceed with treatment, authorise any restrictive practices in order to provide that treatment, or prevent the consumer from leaving.

The use of restraint is potentially an assault or unlawful imprisonment (at both criminal and civil law) if it occurs without justification.

If the consumer makes a complaint to South Australian Police, a health practitioner who has used force and/or restrained someone without consent, or legal authority or without a compelling need and duty to protect people and property from harm, may be charged with assault or unlawful imprisonment.

Deliberate infliction of pain or other harm while applying restrictive practices are unacceptable and illegal.

Clear and comprehensive documentation of the consumer's behaviours, the level and type(s) of threat, circumstances, unsuccessful alternative strategies, clinical rationale and attempts to minimise restriction, harm and pain are therefore important.

Under the *Mental Health Act 2009*, a voluntary person cannot be secluded.

For further information:

- SA Health Providing Medical Assessment and/or Treatment Where Patient Consent Cannot be Obtained [Policy Directive](#)
- [Prevention and responding to challenging behaviour Policy Directive](#) Toolkit - Tool 1 Quick guide to policy and legal information relating to challenging behaviour

4.8 Safe application of restrictive practices

There are physical and psychological risks associated with use of restrictive practices. In addition, any use of physical force can significantly increase the chances of injury, harm or trauma to consumers and / or workers.

A public health service owes a duty of care and should take all reasonable steps to minimise any harm occurring to a consumer who has restrictive practices applied.

To reduce risk of harm to consumers and workers there are considerations and actions required before, during and after, and these are described in Tool 4 - Safe application of restrictive practices, and recovery. Tool 4 highlights consumers who are more vulnerable to trauma or harm arising from restrictive practices.

Seclusion should only be used for consumers who are being treated under an order of the *Mental Health Act 2009* in a mental health treatment centre where there are facilities and appropriate expertise.

4.8.1 Initial application

Initial application of restraint or seclusion will be carried out in a safe manner and with expertise that meets relevant professional standards, duty of care, codes of conduct, work health and safety and other legislative requirements, and the values of SA Health. This means that:

- restraint or seclusion will only be applied to a consumer by a 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 knowledge and skills including:
 - de-escalating and managing disturbed and/ or aggressive behaviour
 - team-based methods of safe application, and withdrawal or retreat
 - avoidance of physical restraint in prone position, or any other method that impacts on airway, breathing or circulation, or includes deliberate or unintentional application of pain
 - identification of consumers who may be more at risk of harm from physical restraint, and where special precautions are required
 - selection and use of equipment that, by its design, optimises safety for consumer and workers during application
 - relevant policy and legislation.

4.8.2 Care during the period when a restrictive practice is applied

All health workers who provide care to the consumer during the time that restrictive practices are in place will have training and education to ensure they have knowledge and skills, including:

- physical and behavioural monitoring, observation that commence immediately restraint is applied
- strategies to minimise physical harm, such as skin care and position changes, and treatment for any injury sustained
- ongoing de-escalation, including reassurance and calming strategies to minimise duration
- care and respect of the consumer's dignity
- frequent review of the ongoing need for the restrictive practice

Further detail regarding recommended schedules of care such as release of restraint and physiological and behavioural monitoring is included in Tool 4 – Safe application of restrictive practices, and recovery, section 5.

Specialised care and equipment is required for the care of the sedated consumer when there is administration of sedative agents that can depress respiratory function. Evidence-based protocols and procedures are used for prescribing and administering sedation, and the Glasgow Coma Scale (or equivalent) is used to monitor sedation levels.

4.9 Cessation of restraint

Any restrictive practices will be applied only to the extent that is reasonably necessary, that is for the shortest possible time and with least restriction. As described in Tool 4 - Safe application of restrictive practices, and recovery, the decision to cease restrictive practices will be based clinical judgement informed by:

- the ongoing monitoring and review of the consumer's mental and physical state and the consumer's ability to control their behaviour
- the risk of harm
- the continued need to provide lawful treatment or transport.

Immediate cessation will be required if the risk of harm from the restrictive practice outweighs other risks, or if there is injury or deterioration of the consumer's health condition(s) and Medical Emergency Response (MER) call or similar are initiated as required by the Recognition and responding to the deteriorating patient policy directive.

For further information:

- [Restraint and seclusion in mental health services](#) Policy Guideline Fact Sheet 5 - Guide to review of restraint and seclusion
- [Prevention and Responding to Challenging Behaviour](#) Toolkit - Tool 5 Education and Training Framework.

4.10 Recovery

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

To promote short and long term recovery after an incident, appropriate care and support for all people involved or witnessing the incident should be available. Managers and supervisors play a key initial role in ensuring that these take place. This is further described in Tool 4 - Safe application of restrictive practices, and recovery.

4.10.1 Workers

For workers, recovery means restoring confidence, feeling safe, and with the ability to provide high quality care.

A formal or informal de-briefing with each worker may be required to establish 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 Management of Work Injured Employees (WHS) Policy Directive.

Workers who wish to pursue grievance procedures or charges against the aggressor of assault or other offence will require advice and support to do this, as described in Work Health and Safety Fact sheet – Worker Support (FS 022).

4.10.2 Consumers and witnesses

For consumers and witnesses, recovery includes restoring a positive relationship with the health service.

For inpatient and other settings, managers or health practitioners should discuss the incident as soon as practicable with the consumer and / or their family / carer using open disclosure principles and practices.

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. Handover to the receiving service should therefore include information about any involvement of family / carer in the incident, to better inform the subsequent discussion with consumer, family / carer that takes place in the receiving service.

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.

Attempts should be made to resolve any issues or concerns. The consumer 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 complaint should be given to the consumer / family / carer.

In the same way that it is important to identify individuals who may be more vulnerable to harm from restrictive practices (4.3 and Tool 4 - Safe application of restrictive practices, and recovery), the tailoring of intervention to support recovery requires consideration of cultural, linguistic, gender and health literacy requirements of the individual, and the meaning of their experience to them. For example a female interpreter, written materials or an Indigenous Liaison Officer may be needed to ensure that the process occurs appropriately and effectively. Longer term counselling, advocacy or support may be required and advice about access should be provided.

For further information:

- [Preventing and Responding to Challenging behaviour](#) Resource toolkit Tool 6 - Guide to incident reporting and review.
- [Restraint and Seclusion in Mental Health services](#) Policy Guideline Fact Sheet 7 - Debriefing following restraint or seclusion incident.
- [SA Health Policies](#) including Open Disclosure Policy, Consumer Feedback Policy and the Community Visitor Scheme (for Mental Health), cover complaint handling and feedback.

4.11 Incident reporting and review, learning and quality improvement

Incident reporting requirements are described in Section 14.

Actions to support shared learning and practice improvement include team review of the reported incident, team de-briefs and monitoring of data trends, and undertaking a Root Cause Analysis (RCA) for serious patient incidents.

For further information:

- [SA Health Incident Management](#) Policy Directive.
- [Prevention and Responding to Challenging Behaviour](#) toolkit Tool 6 - Guide to reporting and review of challenging behaviour incidents.

4.12 Clinical governance

All health services will have an executive led organisation-wide system of clinical governance with responsibility for programs to minimise use of restrictive practices, aligned with systems for preventing and responding to challenging behaviour.

Activities will include, but not be limited to:

- development and implementation of a plan for quality improvement, based on clinical risk and annual gap analysis. This can be informed by results of the [Preventing and responding to Challenging behaviour](#) Resource Tool 2 - Hazard identification and Risk Assessment tool (WHS FOR020)
- development and review of procedures and protocols
- review of clinical audit and monitoring other data, including notifications
- seeking consumer experience and feedback, and consumer engagement
- incident management
- oversight of professional development, undertake gap analysis
- implementation of best practice prevention, approval, authorisation, application and recovery.

For further information:

- [Prevention and Responding to Challenging Behaviour](#) Resource toolkit Tool 3 - Example terms of reference for a health service Challenging behaviour prevention and response committee.

4.13 Special considerations for patient transport

- This policy directive does not apply where it is in conflict with a statutory requirement for the use of occupant restraints &/or seatbelts to facilitate safe patient transport under the SA Road Traffic Act, Australian Road Rules (Sect 265 & 266) and Civil Aviation Safety Regulations 1998. This applies to the period of time whilst a patient is situated on an ambulance stretcher or in an ambulance vehicle/aircraft. It includes the periods preparing for transport, during the transport and following the transport before the patient is transferred off the ambulance stretcher or equivalent. These circumstances are outside the scope of this policy directive.
- Sect 267(6) of the Australian Road Rules should not be interpreted to apply in this circumstance. These allow for non-use of occupant restraint in limited medical circumstances.
- The Civil Aviation Safety Regulations provide discretion to a pilot in relation to the application of restraint to ensure the safety of an aircraft – especially during flight. This may apply to transfers via Royal Flying Doctor Service, Australian Helicopter or other contracted aeromedical service provider aircraft.

5. Roles and Responsibilities

5.1 SA Health Chief Executive (CE) will:

- ensure that, across SA Health use of restrictive practices is minimised, health professionals and managers are aware of legal considerations and potential consequences, and any use is in accordance with this policy, and legislative and other relevant policy requirements
- ensure appropriate training and support is provided to workers across SA Health to implement this policy directive.

5.2 Deputy Chief Executive, System Performance and Service Delivery, in conjunction with relevant departmental executive directors, and divisions such as Mental Health, Workforce Health and Safety and Quality will:

- establish, maintain and review systems and associated processes for best practice minimisation of restraint and seclusion at a state level, including reporting systems
- provide advice to SA Health in response to specific queries about policy and legislative requirements

- coordinate timely reporting of relevant information to external bodies, including the community
- provide advice to the CE and Minister for Health and Ageing on issues of public concern / media or public attention
- ensure that other government agencies including but not limited to SA Police, Department of Corrections, aged care providers, Royal Flying Doctor Service and MedStar are aware of this policy and the implications for the minimisation of restraint and seclusion by SA Health services.

5.3 The Office of the Chief Psychiatrist will:

- ensure that additional specific reporting and monitoring responsibilities related to the *Mental Health Act 2009* are met
- develops, monitors and reviews the Restraint and Seclusion in Mental Health Services Policy Guideline and associated standards related to the *Mental Health Act 2009*.

5.4 CEs or Chief Operating Officers (COO) of Local Health Networks (LHNs) or South Australian Ambulance Service (SAAS) will:

- ensure that obligations under this policy, legislation and other relevant SA Health policy, including incident reporting and review, complaints management, open disclosure, informed consent, recovery strategies and education and training are met
- ensure that there is a system for clinical governance with responsibility for monitoring and improving performance, and for conducting relevant quality improvement activities, review of protocols or procedures, advising on training requirements, work health and safety requirements, and support for teams to practice practical responses to incidents
- allocate sufficient human and material resources, and delegate day-to-day responsibility to enable effective activities to minimise use of restraint and seclusion, support consumer engagement and workforce training to occur
- provide advice to the CE and Minister for Health and Ageing on issues of public concern / media or public attention
- ensure that the design of new services and facilities, changes to work practices and purchase of new equipment are in accord with best evidence for minimisation of restraint and seclusion.

5.5 Managers - Safety and Quality, Risk and Workforce Health will:

- promote this policy, guidelines, accompanying tools and relevant policies, procedures and safe work procedures
- assist others to meet their obligations under this policy, legislation and other relevant SA Health policy, including incident reporting and review, complaints management, open disclosure, informed consent and education and training
- ensure that an evaluation strategy is in place to monitor practice and outcomes, and design appropriate quality improvement activities.

5.6 Clinical educators will:

- ensure that workers, and teams (including Emergency Response teams) have access to education and training appropriate to their roles.

5.7 Directors / Managers of health services or divisions / business units will, where relevant:

- support the implementation of this policy and accompanying guidelines and tools
- establish governance and accountability; awareness among workers, consumers and the community

- develop, implement and monitor local systems and procedures, including data collection, analysis and improvement planning; worker training, including local emergency drills / team responses and mechanisms for clinicians and consumers to raise concerns about abuse of restraint; and engagement with consumers and the community
- review all incidents of restraint and seclusion in their area. Ensure that appropriate follow-up takes place including discussion with consumer and families in accord with Open Disclosure Policy
- initiate and lead team reviews of incidents when appropriate in accord with SA Health Incident Management Policy
- support workers, consumers and others to participate in activities to promote their personal recovery.

5.8 All SA Health employees should:

- adhere to the principles, recommended practice and intent of this policy, its guidelines and tools
- undertake relevant training to ensure that they have relevant skills and knowledge to provide care in accordance with the guidelines and best practice recommended in the tools
- report all incidents where restraint or seclusion are used to Safety Learning System
- participate in quality improvement activities to minimise restraint and seclusion and the harm that may arise, improve multidisciplinary teamwork and consumer-centred care
- participate in planning and training and/or practice of team responses to a situation requiring the use of restrictive practices
- participate in activities to promote their personal recovery from incidents, if relevant
- participate in activities that promote the recovery process for consumers and carers.

6. Reporting

- There are requirements for documentation in the medical / clinical record.
- All use of restraint and/or seclusion will be reported into the 'patient incident' module of Safety Learning System (SLS), and if a worker or other person is harmed a report is required in the 'worker incident' section of SLS.
- If security officers participate in application of restrictive practices, their involvement is recorded in the 'Security Incident' section of SLS.
- There are additional requirements under the *Mental Health Act 2009*, and the *Work Health and Safety Act 2012* (SA).
- After 8 hours a report is made through Safety Learning System to the Office of the Chief Psychiatrist for patients under an Inpatient Treatment Order (under the *Mental Health Act 2009*, or to the appropriate designated executive for non-mental health matters, for example, the Director of Medical or Nursing services. ([Restraint and seclusion in mental health services](#) Policy Guideline - Fact Sheet 8 Restraint and seclusion reporting))
- There are requirements for reporting health service data to the relevant committee and clinical governance system.

For further information:

- Tool 2 - Reporting and review of incidents – restraint and seclusion
- [Preventing and Responding to Challenging Behaviour](#) Policy Directive Resource Toolkit.
 - Tool 6 - A guide to the reporting and review of challenging behaviour
 - Tool 7 - Evaluation and metrics for challenging behaviours and restrictive practices

7. EPAS

The documentation of the use of restraint and seclusion, and the clinical management of the person before, during and after will be recorded as part of the medical record in EPAS. This will include the use of alerts, recording of relevant treatment or other orders.

Section 4.3 outlines requirements for documentation in the medical record or EPAS.

8. Exemption

N/A

9. Associated Policy Directives / Policy Guidelines

- [Advance Care Directives policy directive](#)
- [A Framework for active partnership with consumers and the community](#)
- [By-laws for incorporated hospitals policy directive](#)
- [Charter of health and community services rights policy directive](#)
- [Child safe environments policy directive](#)
- [Clinical handover policy](#)
- [Consent to medical treatment and health care policy guideline](#)
- [Consumer feedback management policy directive and guideline](#)
- [Dealing with Intoxicated Patients Policy](#)
- [Employee Assistance Program policy directive](#)
- [Incident management policy directive](#)
- [Open disclosure policy directive](#)
- [Providing medical assessment and or treatment where patient consent cannot be obtained policy directive](#)
- [Restraint and seclusion in mental health services policy guideline](#)
- [SA Health Respectful behaviour policy](#)
- [Work Health and Safety Duty of care to all persons policy directive](#)
- [Work Health and Safety Reporting and investigation policy](#)

10. References, Resources and Related Documents

[Prevention and responding to challenging behaviour](#) policy directive Resource Toolkit - Tool 1 Quick guide to policy and legal information relating to challenging behaviour

Legislation

Relevant legislation can be accessed at www.legislation.sa.gov.au.

Advance Care Directives Act 2013 (SA)

Aged Care Act 1997 (Commonwealth)

Australian Human Rights Commission Act 1986

Children's Protection Act 1993 (SA)

Civil Liability Act 1936 (SA)
Consent to Medical Treatment and Palliative Care Act 1995 (SA)
Controlled Substances Act 1984
Criminal Law Consolidation Act 1935 (SA)
Guardianship and Administration Act 1993 (SA)
Health and Community Services Complaints Act 2004 (SA)
Health Care Act 2008 (SA)
Health Practitioners Regulation National Law Act 2009
Independent Commissioner against Corruption Act 2012 (SA)
Mental Health Act 2009 (SA)
Public Intoxication Act 1984
Return to Work Act 2014 (SA)
Road Traffic Act (SA)
South Australian Public Health Act 2011 (SA)
Work Health and Safety Act 2012 (SA)

Other resources and related documents

Aged Care Accreditation Standards
 Aged Care Charter of Resident’s Rights and Responsibilities
[Australian Open Disclosure Framework 2013](#) Australian Commission for Safety and Quality in Health Care
 Australian Road Rules (Sect 265 & 266)
 Civil Aviation Safety Regulations 1998
[Code of Ethics for the South Australian Public Sector](#)
[Code for the Case Management of Behaviours that present a risk for HIV transmission](#)
 DO151 SA Chief Public Health Officer protocol 2013-2018
[Guardian Consent for Restrictive Practices in Disability Settings 2014](#) The Office of the Public Advocate, South Australia
[SA Charter of Health and Community Services Rights](#) Health and Community Services Complaints Commission, South Australia
[Safety and Wellbeing in the Public Sector 2010-2015 \(SA\)](#)
[SA Strategy to safeguard the rights of older South Australians 2014-2021](#)
[South Australia’s Strategic Plan](#) (Target 86 to improve psychological wellbeing in South Australia).
[South Australia’s Health Care Plan 2007 –2016](#)
[South Australia’s Mental Health and Wellbeing Policy 2010-15](#)
 South Australian Public Sector Values
 United Nations Convention for the Rights of People with a Disability 2006 (ratified by Australia in 2008)
 United Nations. Principles for the Protection of Persons with a Mental Illness 1991.
 United Nations. The Universal Declaration of Human Rights

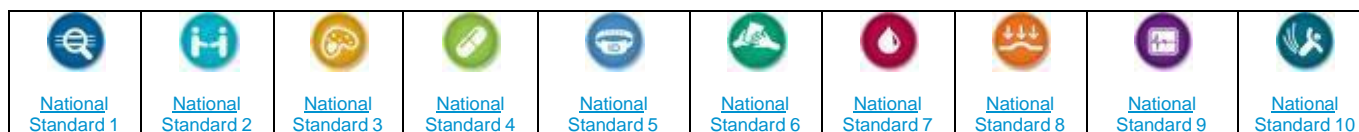
References

Australian and international clinical guidelines and evidence summaries are listed in Tool 3 – Clinical strategies to minimise the use of restrictive practices.

11. Other

N/A

12. National Safety and Quality Health Service Standards



Governance for Safety and Quality in Health Care	Partnering with Consumers	Preventing & Controlling Healthcare associated infections	Medication Safety	Patient Identification & Procedure Matching	Clinical Handover	Blood and Blood Products	Preventing & Managing Pressure Injuries	Recognising & Responding to Clinical Deterioration	Preventing Falls & Harm from Falls
☑	☑		☑		☑				☑

- Standard 1 Governance and Standard 2 Partnering with consumers can support, and be supported by this policy directive.
- Clinicians caring for consumers with elevated risk of falling may consider use of restraint, contrary to both Standard 10 and the [SA Health Policy Directive on Prevention and management of falls and harm from falls](#).
- Standard 6 Clinical handover supports communication within and between teams, and minimisation of restrictive practices and safety.
- Standard 4 Medication safety is essential for use of medications as chemical restraint.

This Policy Directive supports health services to meet requirements of the National Mental Health Standards 2010, namely:

- Standard 1 (Rights and Responsibilities - The rights and responsibilities of people affected by mental health problems and / or mental illness), and
- Standard 2 (Safety - The activities and environment of the MHS are safe for consumers, carers, families, visitors, workers and its community).

13. Risk Management

Risks relevant to the use of restrictive practices include:

- harm or injury to consumers
- harm or injury to workers and other people present
- poor consumer experience, complaints, failure of open disclosure requirements
- failure to meet National Safety and Quality Health Service Standards, and/or National Mental Health Standards
- adverse media and public perceptions regarding allegations of assault, or unlawful imprisonment, negligence, malpractice or misconduct
- potential risk to health practitioners, and others assisting health practitioners, in regards to legal proceedings related to alleged assault, or unlawful imprisonment if an employee acts outside of the framework explained in this policy.
- inappropriate or unlawful restraint
- unreported events
- inconsistent clinical management.

Activities for SA Health services to reduce organisational risk include:

- ensuring adequate training of workers in relation to this policy and related policies
- ensuring adequate training of workers in principles and practice of least restrictive care
- complying with relevant legislation and being able to provide evidence that supports this
- ensuring adequate training of managers in the actions required to support recovery of consumers and workers, complaint and grievance handling, learning and practice improvement
- documentation of assessment of consumer's capacity, obtaining informed consent, and the care plan and authority to apply restrictive techniques, as applicable
- meeting the requirements of relevant standards (NSQHSS and National Mental Health Standards) and being able to provide evidence that supports this
- responding to complaints, coronial requests, medico-legal, requests under the Freedom of Information legislation and malpractice investigations.

14. Evaluation

Demonstration of compliance with this policy directive by Local Health Networks and health services will include:

- evidence of clinical governance, quality improvement projects and clinical audit of practice against this policy
- evidence of change in clinical practice, for example assessment of risk of challenging behaviour, and participation in training and education relevant to roles
- monitoring and action in response to consumer experience and consumer feedback relevant to restrictive practices
- evidence of consumer participation in service design, planning and evaluation relevant to restrictive practices
- incident reporting, review and management (SLS).

Rates of restraint and seclusion in mental health services will be documented annually in the Office of the Chief Psychiatrist Annual Report and provided quarterly to the Local Health Networks.

The SA Health Safety and Quality Unit monitors consumer experience (SACESS) and complaints, feedback (SLS).

The SA Health Safety and Quality Unit will report data and trends of restraint and seclusion through the annual Patient Safety Report; through reports to the Portfolio Performance Review committee; and displayed in Local Health Network Analytics and Reporting System (LARS).

Metrics include rates of seclusion and restraint, and rates of complications / harm from restraint or seclusion.

For further information:

- [Prevention and Responding to Challenging behaviour](#) Toolkit - Tool 7 Evaluation and metrics for challenging behaviour and restrictive practices.

15. Attachments

Minimising restrictive practices in health care toolkit

Tool 1 - What are restrictive practices, and what types are there?

Tool 2 – Reporting and review of incidents – restrictive practices

Tool 3 - Clinical strategies to minimise the use of restrictive practices

Tool 4 - Safe application of restrictive practices, and recovery

Tool 5 - Legal information about restrictive practices

16. Definitions

In the context of this document:

- **Authorised officer** means a person appointed under an Act. The purpose, powers and roles varies between Acts.

In the context of the *Mental Health Act 2009* an authorised officer is:

- a mental health clinician (see the separate definition of 'mental health clinician'), or
- an employee or volunteer ambulance officer authorised by the CEO of SAAS, or
- a person employed as a medical officer or flight nurse by the Royal Flying Doctor Service of Australia (Central Operations) Incorporated or the Royal Flying Doctor Service of Australia (South Eastern Section), or
- a person of a class prescribed by the regulations (none currently)

An authorised officer has powers under section 56 of the *Mental Health Act 2009* to: use care and control, transport, restrain, use medication (if authorised to do so under the *Controlled Substances Act 1984*), enter and remain in a place, and search a person and remove items. These powers can only be used if a person appears to have a mental illness and be at risk of harm, or is subject to a community treatment order, inpatient treatment order or patient transport request.

Under the *Health Care Act 2008* authorised officers act to prohibit disorderly or offensive behaviours within a health service or its grounds, and are able to use reasonable force or restraint for this purpose. These include some security officers.

- **Care and control** means (under the *Mental Health Act 2009* section 56) the use of your vocal, social and physical presence to influence and manage a person, to facilitate their assessment and/or treatment. A person you have made subject to section 56 powers is legally obliged to follow your instructions.

Control is defined as influence and authority over a person. Care is defined as the responsibility for and treatment of a person with an illness. (Section 56 – Care and Control, Fact Sheet – *Mental Health Act 2009* SA Health Office of the Chief Psychiatrist and Mental Health Policy)

- **Challenging behaviour** means actions and/or behaviours that may or have potential to physically or psychologically harm another person, self or property. Challenging behaviours and/or actions can be deliberate/intentional or unintentional and can take different forms, any of which can:
 - potentially or actually stop, interrupt or limit the ability for health service or care to be provided in a way that is safe for both consumer and workers
 - result in a person or people feeling unsafe or threatened or feeling that intervention, or retreat /withdrawal, is warranted to avoid, or limit, physical or psychological harm to someone, or property.
- **Chemical restraint** – see pharmacological restraint
- **Code black** means an emergency call for assistance 'For personal threat (armed or unarmed persons threatening injury to others or themselves, or illegal occupancy) (Standards Australia)
- **Containment** means a form of restraint that is not applied directly to a person's body, but limits freedom of movement beyond a specified area. Examples include a secure ward for care of people with dementia, or the presence of a security guard. (Also termed perimeter restraints, environmental restraint or detention – see Tool 1)
- **De-briefing** means formal or informal discussions after an incident intended to exchange information, provide support and plan actions. Consumers, managers and workers can participate.
- **Decision-making capacity** means a person's decision-making capacity related to their ability to make a particular decision, and this can fluctuate over time. Decision-making capacity is required in order to provide informed consent to medical treatment. A person has decision-making capacity, in relation to a specific decision, if they can:
 - understand information about the decision
 - understand and appreciate the risks and benefits of the choices
 - remember the information for a short time
 - tell someone what the decision is and why they have made the decision.

In some circumstances children aged under 16 are able to provide consent without parents or guardians ([Providing medical assessment and or treatment where patient consent cannot be obtained policy directive](#))

- **De-escalate** means to reduce the level or intensity of a conflict, threatening or dangerous situation, primarily using verbal and non-verbal communication skills and

techniques.

- **Duty of care** means the extent to which a healthcare provider must reasonably ensure that no harm comes to a patient, themselves or other persons under the provider's care or in their acts or omissions.
- **Least restrictive** means an environment or intervention which places the least amount of restriction on freedom of movement while maintaining the safety of the person and others (*Mental Health Act, 2009*).
- **Mechanical restraint** is the application of equipment, devices (including belts, harnesses, sheets and straps) on, or around a consumer's body to restrict the person's movement.

As well as purpose-designed devices, furniture such as bed rails and tray tables can be considered a restraint when they are used solely for the purpose of restraining a consumer's freedom of movement.

- **Medical practitioner** in line with the *Consent to Medical Treatment and Palliative Care Act 1995* means a person registered under the Health Practitioner Regulation National Law to practise in the medical profession (other than as a student) and includes a dentist.
- **Mental health clinician** (*Mental Health Act 2009*) means a person of a class of persons determined by the Chief Psychiatrist to be a mental health clinician for the purposes of the Act, including: people with tertiary mental health qualifications employed by a public mental health service, some public emergency department medical practitioners and registered nurses, some country hospital medical practitioners and registered nurses, some medical practitioners and registered nurses of the SA Prison Health Service, and some medical practitioners, flight nurses and paramedics of MedSTAR.
- **Open disclosure** means an open discussion with a consumer or patient about an incident(s) that resulted in harm to that patient while receiving health care ([Open Disclosure policy directive](#)).
- **Pharmacological (or chemical) restraint** has no agreed national definition. A proposed definition is the administration of medication where the primary purpose is to manage behaviour that has not arisen from mental illness (SA Mental Health Strategy). The Office of the Public Advocate (2012) proposes that 'the administration of medication where the primary purpose is to subdue or control the behaviour of a person, then the use of that medication is a chemical restraint'.

The use of medication is deemed therapeutic if the primary purpose of the administration of the medication is the treatment of symptoms of mental illness and/or psychological distress, irrespective of any concomitant sedative effect.

Medication can only be administered by persons authorised under the *Controlled Substances Act 1984* s18 1d or regulations.

- **Physical restraint (or manual or bodily restraint)** is the hands-on immobilisation, or the physical restriction, of a consumer by one or more workers holding, moving or blocking the person or one or more limbs.
- **Person responsible** is a person close to the consumer who is available and willing to consent to or refuse consent to health care (including life-sustaining measures) when the consumer has impaired decision-making capacity.
- **Reasonable force** means the use of such force as may be necessary in the circumstances for the purpose of ensuring the proper medical or dental treatment, day to day care and well-being of the person, or protection of themselves or others from harm.
- **Restraint** means the intentional restriction of an individual's voluntary movement or

purposeful behaviour by physical, chemical, mechanical or other means. It is action that:

- uses, or threatens to use force; to stop a person doing something they appear to want to do (whether or not the consumer resists), where the consumer's actions are putting themselves or others at risk of harm, intentionally or unintentionally, or
 - restricts a person's movement, so that something can be done to them. This is most commonly to enable safe provision of necessary health care or transport to a health care facility (with third party consent or under a legal order).
- **Restrictive practices** mean all the types of restraint, care and control, reasonable force, and seclusion.
 - **Seclusion** means the confinement of a person alone in an area from which the person cannot leave of their own volition.

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