Mental Health Act 2016

Chief Psychiatrist Policy

Physical restraint

Contents

General

The *Mental Health Act 2016* (the Act) makes provision for a range of safeguards and restrictions in relation to the use of physical restraint in an authorised mental health service (AMHS) that promote the national and state priority of reducing, and where possible, eliminating physical restraint.

Physical restraint generally refers to the use by a person of his or her body to restrict the patient's movement. However, physical restraint does not include the giving of physical support or assistance reasonably necessary to enable the patient to carry out daily living activities, or to redirect the patient because the patient is disoriented.

Physical restraint is to be used as a last resort where less restrictive interventions are insufficient to protect a patient, or others, from physical harm, provide necessary treatment and care to a patient, prevent serious damage to property, or prevent a patient detained in an AMHS from leaving the service without approval.

It is an offence to use physical restraint on a person in an AMHS other than in accordance with the Act, except where the restraint is authorised under another law.

The following principles **must** be applied in the use of physical restraint:

- maintaining the safety, wellbeing and dignity of the patient is essential
- protecting the safety and wellbeing of staff is essential
- physical restraint should only be used for the minimum period of time necessary, and
- all staff actions should be justifiable and in proportion to the patient's behaviour and broader clinical context.

Scope

This policy is mandatory for all authorised mental health services (AMHSs). An authorised doctor, authorised mental health practitioner, AMHS administrator or other person performing a function or exercising a power under the Act **must** comply with this policy.

Clinicians should work collaboratively with and in partnership with patients to ensure their unique age-related, cultural and spiritual, gender-related, religious and communication needs are recognised, respected and followed to the greatest extent practicable. Clinicians should consider the timely involvement of appropriate local supports and provide treatment and care with a recovery-oriented focus.

This policy **must** be implemented in a way that is consistent with the objects and principles of the Act.

Policy

1 Application of the physical restraint provisions

Key points

Physical restraint of a patient is the use, by a person, of his or her body to restrict the patient's movement.

Physical restraint under the Act does not include:

- the giving of physical support or assistance reasonably necessary to enable a patient to carry out daily living activities or to redirect a disorientated patient, or
- physical restraint authorised under another law, or
- physical restraint required in urgent circumstances.

The physical restraint provisions of the Act and this policy apply to any person who is a patient.

- A patient is defined as:
  - an involuntary patient (see definitions), or
  - a person receiving treatment and care for a mental illness in an AMHS, other than as an involuntary patient (including under an AHD or with the consent of an attorney or guardian)

Physical restraint may be used in any unit within an AMHS, including an emergency department, provided that sufficient resources are available to safely meet the needs of the patient and staff.

Any use of physical restraint on a patient in an AMHS, including restraint used in urgent circumstances, **must** be recorded on the physical restraint clinical note template in CIMHA. This applies to:

- physical restraint in a mental health inpatient or other specialist mental health unit within a hospital or in an AMHS community facility, or
- physical restraint in another area of an AMHS (for example, Emergency Department) where mental health service staff are involved in the decision or process of the person's physical restraint.

This includes, for example, where physical restraint is applied in order to move a patient to a seclusion room, or to administer medication.

The administrator of the AMHS must ensure that procedures are in place within their service to ensure these records are maintained.

Where physical restraint is planned, prior authorisation **must** be sought from an authorised doctor or health practitioner in charge (for example to transfer a patient to, or from, a seclusion room).

Authorisation may be given for the use of physical restraint on a patient for one or more of the following purposes:

- to provide treatment and care to the patient,
- to protect the patient or others from physical harm,
- to prevent the patient from causing serious damage to property, or

- for a patient detained in an AMHS, to prevent the patient from leaving the service without permission.

The authorising doctor or health practitioner in charge **must** be satisfied that there is no other reasonably practicable way to achieve the purpose of the physical restraint.

Authorisation of physical restraint may be provided verbally.

Physical restraint must not be used:

- as a substitute for other less restrictive interventions,
- as a form of discipline or punishment,
- as a substitute for adequate staffing levels, or
- as a substitute for staff training in crisis prevention and intervention to manage aggressive, harmful behaviours.

As far as is practicable and safe, verbal strategies, de-escalation techniques and other evidence-based strategies such as sensory modulation **must** be used to help the patient safely gain control of their behaviour.

Medication may assist to prevent the need for the use of physical restraint.

- Additionally, if other strategies have been ineffective or are not appropriate, acute sedation may also need to be considered as part of a treatment strategy to prevent harm to the patient and others (refer to Chief Psychiatrist Policy – Clinical need for medication).

Authorisation under the Act is not required where physical restraint is:

- required in urgent circumstances (e.g. to restrain a patient who is physically aggressive), or
- authorised under another law, or
- for the giving of physical support or assistance reasonably necessary to enable the patient to carry out daily living activities or redirect a disorientated patient.

1.1 Requirements for the use of physical restraint

1.1.1 Procedures

Key points

Administrators must ensure that all units that may use physical restraint have procedures clearly outlining a standard approach to the use of physical restraint within the unit.

- This will include a team-based approach to be used for planned (i.e. non-urgent) and unplanned physical restraint.

The following should be outlined for a team-based approach:

- the individual tasks required, including overall leadership of the physical restraint, responsibility for physical monitoring of the patient and for specific tasks associated with physical restraint, and
- the intended staffing and allocation of roles, with consideration for situations in which intended staffing may not be available or where staff may have a different skillset, including clinicians with different levels of training, health security staff and other operational staff.

If health security officers, staff from other clinical areas within the HHS or other service providers such as first responders use different approaches to physical restraint, local procedures should clarify which takes priority in case of any areas of overlap.

The approach taken to physical restraint must be supported by a structured occupational violence prevention and management training package for staff, approved by the Hospital and Health Service (HHS). Where possible this should include scenario-based training to improve live responses.

Staff carrying out a restraint under the Act **must** be appropriately trained to protect the welfare and dignity of the patient. This training must include de-escalation strategies, physical restraint techniques, trauma-informed care, recovery-oriented practice and de-briefing strategies.

Administrators should ensure appropriate mechanisms are in place to enable review of all physical restraint events within the unit, as part of established quality and safety processes.

1.1.2 Preparation and planning

Emergency situations can and will arise unexpectedly, and not every physical restraint event can be prevented or planned. However, practice which is consistent with clear, specific procedures and aligns with associated training may protect patients and staff and may reduce the likelihood of prolonged physical restraint.

In situations where an intervention with an individual patient includes a need for physical restraint as a possible contingency, the treating team and relevant team members trained in the use of restraint should develop a specific plan for the intervention, including any possible physical restraint.

To the greatest extent possible, preparation and planning should be undertaken collaboratively with the patient and family/carers and should lead to an agreed plan for the prevention of physical restraint (wherever possible) and for the safe management of any necessary physical restraint, including minimising the duration of the restraint.

1.1.2.1 Prevention of physical restraint

Situations that may trigger distress, anger and aggression should be identified, such as:

- refusing a patient's request (e.g. for leave or for a personal item),
- administration of treatment not wanted by the patient at that time (e.g. medication, electroconvulsive therapy (ECT)), or
- a planned transfer to a more restrictive environment (e.g. a high dependency unit).

Individualised strategies and less restrictive alternatives to prevent the need for physical restraint should be identified, for example:

- verbal strategies, de-escalation techniques, and the use of sensory items and/or a quiet room or sensory room, in addition to use of medication, to reduce distress.

1.1.2.2 Factors to consider for the safe management of physical restraint

- Identification of the risks associated with the behaviour/s of concern, along with the objectives of physical restraint and the risks associated with the restraint and associated care.
- The management of specific risks associated with the restraint plan.
- The most appropriate timing of any required physical restraint.
- Individual patient risk factors, including degree of cooperation, possible intoxication, any medications given, age, obesity, and the presence of respiratory, neurological or musculoskeletal disorders.
- Any heightened vulnerability to significant psychological trauma, especially for minors, patients with a history of trauma, abuse and/or detention.
- The identification of persons from Aboriginal and Torres Strait Islander backgrounds and strategies to address cultural needs.
- Mechanical and postural factors which may increase the risk of harm to the patient during physical restraint, including restraint positions likely to restrict breathing or venous return.

To meet the goal of minimising duration of physical restraint, staff should make any necessary preparations for subsequent management of behaviour prior to initiating the intervention.

- This may include preparation of medications, seclusion rooms, oxygen and any other necessary requirements.

1.1.3 Use of physical restraint in an AMHS

Staff carrying out the restraint **must** complete the following.

Prior to physical restraint (or as soon as possible during emergency restraint):

- adhere to any plan in place to prevent and/or safely manage the use of physical restraint on the patient, to the extent possible.
- Wherever possible, avoid or mitigate mechanical and postural factors which may increase the risk of harm to the patient during physical restraint.
    - This includes restraint positions that restrict breathing or venous return, for example prone restraint, and any position in which the patient's head or trunk is bent towards their knees.

During restraint:

- Use no more physical force than is necessary and reasonable in the circumstances.
- Ensure that the patient's airway, breathing, consciousness and body alignment are monitored by a clinician at all times.
    - This should include continuous consideration by all involved staff of the physical risks associated with extended duration of restraint, in particular by the clinician responsible for monitoring and the clinician leading the restraint.
- There should be no direct pressure on the neck, thorax, back or pelvic area.
- Observe for indications of physical or mental distress, and ensure that clinical concerns are appropriately escalated, and that appropriate treatment and care is provided.
- Monitor patients where intramuscular or intravenous medication was administered within **one (1) hour** prior to the use of physical restraint or during the restraint and seek immediate medical treatment if there is a concern.
- If necessary, change physical restraint positions where it is safe to do so.
- Cease physical restraint as soon as it is no longer required.
    - The assessment of risks of continuing the restraint needs to be continuously balanced against the risks associated with ceasing it.

1.1.4 Medical review of the patient

A medical review of the patient, including a physical examination if clinically appropriate and safe to do so, must be undertaken by an authorised doctor as soon as practicable after the use of physical restraint. The patient must be closely monitored for as long as clinically necessary.

Consideration should be given to the person's ongoing clinical management, including whether involuntary treatment under the Act is required.

Relevant information **must** be recorded in the patient's clinical record on CIMHA regarding the use of physical restraint (refer to section 2).

1.1.5 Post-event debriefing

A review (or debrief) with the patient involved in the physical restraint (with the patient's consent), and with other patients involved in any event that led to the physical restraint, must be undertaken as soon as is clinically appropriate after the physical restraint ends, in order to:

- enable open discussion about the physical restraint, the events leading to it and the patient's experience of it,
- allow the patient to ask questions, and
- provide an opportunity to identify strategies that may assist in preventing the need for physical restraint in the future. This may include a written plan or list of strategies that can be shared with and utilised by the patient, their support person/s and staff.

The review (or debrief) should include support persons such as a family member or peer worker where possible and appropriate.

A review (or debrief) for all staff involved in the physical restraint of the patient **must** also be undertaken as soon as practicable after the physical restraint ends, to:

- enable open discussion about the physical restraint, the events leading to it and the staff's experience of it,
- identify the triggers which resulted in the need to use physical restraint,
- evaluate the methods used to respond to the need for physical restraint, and
- identify measures to reduce, and where possible, prevent future use of physical restraint.

2 Notifications and recording

The health practitioner in charge of the unit must ensure that each time a patient is physically restrained, the information listed in section 2.1 is recorded on the Physical restraint clinical note template in CIMHA.

- The Physical restraint clinical note template includes sections for all items listed, with the exception of post-event review.

Key points

The Clinical Director (or appropriately delegated person) must notify the Chief Psychiatrist **immediately** where physical restraint results in, or is associated with:

- the death of a patient during or within **24-hours** following physical restraint of the patient, or
- significant harm to a patient or other person during physical restraint or within **24-hours** following physical restraint of the patient.

Notification must be made via phone or email to the Chief Psychiatrist.

This notification process is in addition to the requirements contained in the Chief Psychiatrist Policy – Notification of critical incidents and non-compliance with the *Mental Health Act 2016*.

2.1 Recording physical restraint events

The following information **must** be recorded in the patient's clinical record on CIMHA:

- the actual times and duration of physical restraint by AMHS staff, the type of physical restraint used, and the number of staff involved in the physical restraint event,
- the reasons for the physical restraint, including the events that led to the physical restraint,
- why there was no other reasonably practicable way to protect the patient, others or property, to provide treatment or to prevent the patient from leaving the service,
- clinically relevant details regarding the patient's health at the time of the physical restraint, including signs of alcohol or other drug intoxication or withdrawal,
- the patient's behaviour during the physical restraint,
- whether seclusion or mechanical restraint directly preceded or followed the physical restraint,
- medications administered up to one hour prior to, during or immediately after the physical restraint (including medication name, dosage, frequency and route of administration),
- any adverse events relating to the physical restraint, including injury to patients or staff,
- the results of the clinical review of the patient that took place immediately after the physical restraint, and
- post-event review with the patient, staff and any other relevant persons.

Community visitors under the *Public Guardian Act 2014* may request information about the use of physical restraint on minors in an AMHS.

AMHS staff **must** provide information as recorded under section 2 of this policy when requested by a community visitor (whether or not it is during or connected with a visit).

3 Monitoring and reporting

Monitoring physical restraint rates, the types of events that result in physical restraint, the types of physical restraint used, and any adverse events is a necessary part of minimising the use of physical restraint.

Data will be publicly reported in the Chief Psychiatrist Annual Report in accordance with national standards.

Issued under section 305 of the *Mental Health Act 2016*.

Dr John Reilly

Chief Psychiatrist, Queensland Health

22 May 2020

Definitions and abbreviations

Term	Definition
AMHS	Authorised Mental Health Service - a health service, or part of a health service, declared by the Chief Psychiatrist to be an authorised mental health service. AMHSs include both public and private sector health services. While treatment and care is provided to both voluntary and involuntary patients, additional regulation applies under the Act for persons subject to involuntary treatment and care.
CIMHA	Consumer Integrated Mental Health Application – the statewide mental health database which is the designated patient record for the purposes of the Act.
Clinical Director	means a senior authorised psychiatrist who has been nominated by the administrator of the AMHS to fulfil the Clinical Director functions and responsibilities outlined in this Practice Guideline.
HHS	Hospital and Health Service
Health Practitioner	Means a person registered under the Health Practitioner Regulation National Law, or another person who provides health services, including, for example a social worker.
Health Practitioner in Charge of a Unit	Means the health practitioner who has clinical responsibility for the unit where the patient will be physically restrained (e.g. the nurse unit manager, or senior registered nurse in charge).

Involuntary Patient	Means:
	• A person subject to any of the following:
	  ○ An examination authority,
	  ○ A recommendation for assessment,
	  ○ A treatment authority,
	  ○ A forensic order,
	  ○ A treatment support order,
	  ○ A judicial order, or
	• A person detained in an AMHS or PSHSF under section 36, or
	• A person from another state detained in an AMHS under section 368(4).

NSP	Nominated support person - a family member, carer or other support person formally appointed by a patient to be their nominated support person. NSP rights include: • must be given all notices about the patient that are required under the Act • may discuss confidential information about the patient's treatment and care • may represent, or support the person, in any hearings of the Mental Health Review Tribunal, and • may request a psychiatrist report if the person is charged with a serious offence.

Term	Definition
Patient	• An involuntary patient, or • A person receiving treatment and care for a mental illness in an AMHS, other than as an involuntary patient, including a person receiving treatment and care under and Advance Health Directive or with the consent of a personal guardian or attorney.
Physical restraint	Generally, refers to the use by a person of his or her body to restrict the patient's movement. However, physical restraint does not include the giving of physical support or assistance reasonably necessary to enable the patient to carry out daily living activities or to redirect the patient because the patient is disoriented.
Relevant AMHS administrator	The relevant AMHS administrator is: • the administrator of the AMHS currently providing clinical services to the person, or • if the person is not currently receiving mental health services (i.e. no open service episode), the administrator of the AMHS for the location where the person resides.
Support person/s	Includes, an appointed Nominated Support Person or, if the person does not have a Nominated Support Person, a family member, carer or other support person.

Referenced documents and sources
Physical Restraint clinical note template (in CIMHA)
Chief Psychiatrist Policy – Clinical need for medication
Chief Psychiatrist Policy – Notification of Critical Incidents and Non-compliance under the Mental Health Act 2016
Public Guardian Act 2014

Document status summary	
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Attachment 1 – Key contacts

Key contacts	
Office of the Chief Psychiatrist	Phone: 07 3328 9899 / 1800 989 451 Email: MHA2016@health.qld.gov.au
Local Independent Patient Rights Adviser	Phone: Email:
Community visitor	Phone: Email:
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	Phone: Email:
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