Overview

- These Practice Guidelines:
  - set out key information and procedures for authorised mental health services (AMHS) regarding physical restraint of a patient
  - are to be read in conjunction with the relevant provisions of the Mental Health Act 2016 (MHA 2016) (Chapter 8) and the Chief Psychiatrist Policy: Physical Restraint, and
  - are mandatory for all AMHS staff exercising a power or function under the MHA 2016.

Key information

- The MHA 2016 makes provision for a range of safeguards and restrictions in relation to the use of physical restraint in an AMHS that promote the national and state priority of reducing and where possible eliminating physical restraint.
- 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 MHA 2016.

Definitions

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.

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).

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.
Guidelines

1 Application of the physical restraint provisions

- The physical restraint provisions of the MHA 2016 apply to any person, whether voluntary or involuntary, who is receiving treatment and care for a mental illness in an AMHS.

- 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 under the MHA 2016 must be recorded as a physical restraint event in CIMHA including, 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.

- The use of physical restraint under the MHA 2016 must comply with the requirements under the Chief Psychiatrist Policy: Physical Restraint.

- The Chief Psychiatrist Policy: Physical Restraint does not apply where:
  - a person uses physical contact in a momentary way, such as to deflect a blow from a temporarily distressed patient
  - physical restraint is used as part of treatment and care with the agreement of the patient, such as to steady an arm for an injection, or
  - 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.

2 Requirements for the use of physical restraint

- Under the MHA 2016, the physical restraint of a patient must be authorised by an authorised doctor or a health practitioner in charge of an inpatient or other unit.

- Authorisation may be given for the use of physical restraint on a patient for one or more of the following purposes:
  - to protect the patient or others from physical harm
  - to provide treatment and care to the patient
  - 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. As far as is practicable and safe, strategies such as de-escalation techniques should be used to help the patient safely gain control of their behaviour.
• Prior authorisation of the use of physical restraint should be sought from an authorised doctor or health practitioner in charge (for example to transfer a patient to, or from, a seclusion room), unless the physical restraint is urgently required, for example to restrain a patient who is physically aggressive.

• Authorisation of physical restraint may be provided verbally.

• Authorisation is not required where physical restraint is for any of the following:
  – 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
  – where physical restraint of the patient that is authorised under another law, or
  – where physical restraint of the patient that is required in urgent circumstances, for example to restrain a patient who is physically aggressive.

• If physical restraint is authorised under the MHA 2016, staff carrying out the restraint must ensure that:
  – no more physical force is used than necessary and reasonable in the circumstances
  – the patient’s airways, breathing, consciousness and body alignment are monitored at all times during the restraint
  – prone (face down) restraint is avoided wherever possible, and where it occurs it must not exceed 2 minutes
  – physical restraint is ceased as soon as it is no longer required
  – the patient is clinically reviewed as soon as practicable after the use of physical restraint and closely monitored for as long as clinically necessary
  – relevant information regarding the use of physical restraint is recorded in the patient’s clinical record on CIMHA (refer to section 3 Notifications and recording).

• A review (or debrief) with the patient, and where appropriate their support person/s, must be undertaken as soon as is clinically appropriate after the physical restraint, in order to:
  – enable open discussion about the physical restraint and the events leading to it
  – allow the patient to ask questions
  – provide an opportunity to identify strategies that may assist in preventing the need for physical restraint in the future.

• 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 evaluate:
  – the triggers which resulted in the need to use physical restraint, and
  – the methods used to respond to the need for physical restraint.
3 Notifications and recording

- 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
  - 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.
- The health practitioner in charge of the unit must ensure that each time a patient is physically restrained, the information listed below is recorded in the patient’s clinical record on CIMHA. The Physical Restraint clinical note template in CIMHA includes sections for all items listed with the exception of post-event debriefing.
- 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 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.
- In addition, the following information must be recorded in the patient’s clinical record. Wherever possible, this should be on CIMHA:
  - post-event debriefing of the patient, staff and any other relevant persons.
Glossary of Terms

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<tr>
<td>AMHS</td>
<td>Authorised Mental Health Service</td>
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<td>CIMHA</td>
<td>Consumer Integrated Mental Health Application</td>
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<td>MHA 2016</td>
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Referenced Forms, Clinical Notes and Templates

- Physical Restraint clinical note

Referenced Documents & Sources

- Chief Psychiatrist Policy: Physical Restraint
- Guardianship and Administration Act 2000
- Health Practitioner Regulation National Law
- Mental Health Act 2016

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