<table>
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<tr>
<th>NAME OF DOCUMENT</th>
<th>Restraint use with adult patients</th>
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<tr>
<td>TYPE OF DOCUMENT</td>
<td>Procedure</td>
</tr>
<tr>
<td>DOCUMENT NUMBER</td>
<td>SESLHDP483</td>
</tr>
<tr>
<td>DATE OF PUBLICATION</td>
<td>November 2015</td>
</tr>
<tr>
<td>RISK RATING</td>
<td>Medium</td>
</tr>
<tr>
<td>LEVEL OF EVIDENCE</td>
<td>NSQHS Standards 1.1, 1.2, 1.5, 2.2, 4.3, 8.2, 9.2, 10</td>
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<tr>
<td>REVIEW DATE</td>
<td>November 2018</td>
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<tr>
<td>FORMER REFERENCE(S)</td>
<td>PD 111</td>
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<tr>
<td>EXECUTIVE SPONSOR or</td>
<td>A/Prof Peter Gonski</td>
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<td>Nurse Manager Aged Care and Rehabilitation Stream</td>
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<td>DOCUMENT</td>
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<tr>
<td>KEY TERMS</td>
<td>Restraint, delirium, confusion, chemical restraint, mechanical restraint</td>
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<td>SUMMARY</td>
<td>SESLHD is committed to the principle of restraint minimisation. This policy provides the parameters under which restraint may be used in situations of patient safety or critical need and provides details of strict conditions and monitoring requirements.</td>
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1. POLICY STATEMENT

South Eastern Sydney Local Health District (SESLHD) is committed to principles of restraint minimisation. SESLHD considers the use of restraint must be reserved for circumstances of patient safety or critical need and only to be implemented when all other options have been explored. Health services must support people’s rights to balance safety from harm and freedom of choice.

Use of restraint can increase the risk of injury to a patient in hospital. Risks include injury or death through strangulation or asphyxia resulting from the use of mechanical restraints. Immobilisation through mechanical restraint can result in chronic constipation, incontinence, pressure injuries, loss of bone and muscle mass, walking difficulties, increased feelings of panic and fear, boredom and loss of dignity. Restraints can have a dehumanising effect on the patient and restrict individualised treatment (Commonwealth of Australia 2012).

Except in a critical need situation a person must not be restrained without their consent or the consent of their person responsible.

In general the law protects an individual’s right not to be restrained including:

- The right to freedom of movement.
- The right to immunity from unwarranted interference from bodily contact by others; and
- The right of immunity from conduct by others that would subject the person to unreasonable risk of injury.

Restraint should only be used as a measure of last resort and is applied in the following circumstances:

- To permit administration of life saving treatment or care that otherwise could not be administered.
- To protect patients or clients from self injury or injury to others when no other means of protection is practical.

**Key principles for the use of restraint**

<table>
<thead>
<tr>
<th>Principle</th>
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<tr>
<td>Principle 1</td>
<td>Protection of fundamental human rights</td>
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<td>Principle 2</td>
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<td>Principle 7</td>
<td>Compliance with legislation and regulation</td>
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Table reference: 3.2.1 NSW Health PD2015_004 p. 7
2. BACKGROUND

The aim of this document is to describe the circumstances under which a restraint may be used and to provide clinical guidance to ensure patients are managed safely and optimally within the acute, sub-acute and aged care facility environments.

Specific groups of patients require may be more vulnerable to risk of physical and psychological harm from the use of restraints:

- Young people
- Older people
- Pregnant women
- Patients with physical health issues (e.g. obesity, diabetes, cardiac disease and metabolic disorders)
- Patients with a history of trauma / detention who may be re-traumatised by the episode of restraint (e.g. refugees, people who have been abused at any stage of their life)
- Patients with an intellectual disability and those with cognitive impairment such as dementia or delirium
- People who are under influence of drugs or other substances
- People who have engaged in a physically exhausting combative struggle for longer than two minutes.
- People from culturally and linguistically diverse background
- Aboriginal and Torres Strait Islander people.

For these groups of patients, it is important to adopt non-restrictive means of managing disturbed and / or aggressive behaviour whenever it is possible.

This policy does not include:

- Children
- Situations where violence or imminent risk of violence relating to Code Black when acting in accordance with the Self defence sections 418 of the Crimes Act 1900 or the Mental Health Act 2007 see Aggression, Seclusion & Restraint in Mental Health Facilities in NSW Document Number PD2012_035
- When affecting an arrest under Section 100 of the Law enforcement Act 2002 (refer to Protecting People and Property - NSW Health Policy and Standards for Security Risk Management in NSW Health Agencies)
- Minimal restrictive environmental strategies, such as secure gates or doors with keypad entry, are used in some ward areas and specialised units. These strategies are used to keep patients with cognitive impairment safe from harm while still allowing freedom of movement around the ward.
3. DEFINITIONS

| Capacity | Generally, when a person has capacity to make a particular decision they can:  
|          | • understand the facts and choices involved  
|          | • weigh up the consequences, and  
|          | • communicate the decision  
|          | (NSW Attorney General's Dept. 2008) |
| Code black | The colour code allocated by the Australian Standards AS4083-1997 Planning for emergencies – health care facilities for personal threat (armed or unarmed persons) threatening injury to others or to themselves. |
| Critical need situation | A situation in which actions are enforced to provide lifesaving treatment, in self-defense, to protect the patient, others, and/or property, or where statutory powers exist under Guardianship or Mental Health Legislation. |
| Restraint | The interference with, or the restriction of, an individual's freedom of movement and/or behaviour through the use of a device or removal of a mobility aid. |
| Chemical restraint | The intentional use of medication to control a person's behaviour when:  
|          | • no medically identified condition is being treated  
|          | • the treatment is not necessary for a condition  
|          | Chemical restraint includes the use of medicines when:  
|          | • the behaviour to be affected by the active ingredient does not appear to have a medical cause  
|          | • part of the intended pharmacological effect of the medicine is to sedate the person  
|          | • for convenience or for disciplinary purposes.  
|          | Examples of pharmacological agents used as chemical restraint are antipsychotic, antidepressant, anxiolytic and hypnotic drugs.  
|          | Chemical restraint – must not be implemented until alternatives are explored extensively through assessment. |
### Mechanical restraint

Mechanical restraint refers to the use of mechanical device to restrict a person’s movement in an emergency situation of aggressive behaviour, where the person is at an immediate risk of harm to self or others.

Examples of manufactured mechanical restraint devices include (but are not limited to) belts, harnesses, manacles, straps and mittens.

### Manual restraint

Manual restraint refers to the use of a minimal amount of manual force (human to human) to restrict a person’s movement in an emergency situation of aggressive behaviour, where the person is at an immediate risk of harm to self or others.

### Person responsible

In NSW the Person Responsible is –

1. An appointed guardian (including an Enduring Guardian) who has the function of consenting to medical, dental and health care treatments or, if there is no guardian,
2. The most recent spouse or de facto spouse (including same sex partner) with whom the person has a close, continuing relationship or, if there is no spouse or de facto spouse,
3. An unpaid carer who is now providing care to the person or arranged/provided this support before the person entered residential care or, if there is no carer
4. A relative or friend who has a close personal relationship with the person.

### Extreme restraints

- seclusion
- posey crisscross vest
- leg or ankle restraint
- manacles/shackles (hard)
- soft wrist/hand restraints

Extreme restraints should never be used in residential aged care facilities.

### Stressors and triggers

Factors that may contribute to a person change in behaviour such as:

- Undesired interpersonal interactions
- Personally interpreted stress
- Environmental disturbances (e.g. noise, confined space)
- Clinical conditions (e.g. mental illness, brain disorder, intellectual disability, delirium, dementia)
4. RESPONSIBILITIES

4.1 Nurses will:
- Familiarise themselves with this procedure
- Implement this procedure consistently throughout their practice
- Identify potential risk of aggression through assessment in association with the multi-disciplinary team
- Develop a management plan to reduce the risk of aggression.
- Maintain communication with the treating team.
- Raise any concerns with their Supervisors or Nurse Unit Managers

4.2 Medical staff will:
- Familiarise themselves with this procedure
- Implement it consistently throughout their practice
- Identify the risk of aggression in association with the multi-disciplinary team
- Contribute to development of a management plan to reduce the risk of aggression.
- Maintain communication with the treating team

4.3 Line Managers/Supervisors will:
- Ensure that medical and nursing staff are provided with training in this procedure and its implementation
- Monitor compliance with this procedure
- Provide ongoing training and support to nursing and medical staff in implementing this procedure

4.4 District Managers/Service Managers will:
- Ensure that compliance with the procedure is monitored and support the implementation of education programs related to this procedure.
- Investigate any concerns that are raised by staff regarding compliance with this procedure.

5. PROCEDURE

5.1 Situations when a restraint may be used:
- When there is a critical care need where actions are enforced to provide life saving treatment, in self-defence, to protect the patient, others, and/or property, or where statutory powers exist under Guardianship or Mental Health Legislation.
- A person must not be restrained without their consent or the consent of the person responsible, except in a critical need situation.
- Restraint should only be applied or administered after all other options have been considered and have been unsuccessful.
- Restraint must only be used for the minimum amount of time and in the least restrictive
manner and the need for restraint should be reviewed regularly by the treating medical team and nursing staff

- If security staff are required to manually restrain a patient it must occur under the direction and supervision of a senior medical or nursing clinician.

- Restraint must be reviewed every 24 hours in a hospital environment and every 42 days in the Aged Care Facility.

5.2 Consent

If the application of mechanical and/or chemical restraint is urgently required in a critical need situation it may be applied without consent initially but consent must be obtained as soon as possible from the Person Responsible.

When a patient has capacity, informed consent must be obtained prior to mechanical and/or chemical restraint use.

If the patient is unable to give consent and mechanical and/or chemical restraint is deemed necessary as an adjunct to medical treatment, then consent should be given by the Person Responsible.

When a patient has no Person Responsible and if restraint is considered necessary as part of an ongoing Behavioural Management Plan, an urgent application to the NSW Guardianship Tribunal must be made. The Tribunal can appoint either a Guardian or the Public Guardian with the function of providing consent for the use of restraint. In the interim see 5.1

If the Guardianship Tribunal appoints a Guardian with the function of consenting to mechanical and/or chemical restraint, this Guardian becomes the Person Responsible overriding all others.

Documentation of consent procedure and signed consent from the patient, person responsible or Guardian is required on the Patient Restraint Chart.

In a case where consent is sought through the Guardianship Tribunal, the Person Responsible, where one exits, must still be notified of the proposed mechanical and/or chemical restraint use and their name, relationship, date and time documented in the patient's medical record.

If the patient and/or their Person Responsible are objecting to the proposed use of mechanical and/or chemical restraint, this must be documented in the medical record and an application to the Guardianship Tribunal must be made.

If in doubt about who should consent to the use of mechanical and/or chemical restraint the NSW Civil and Administrative Tribunal (Guardianship Division) can be contacted for independent advice Telephone number: 9556 7694 - 24 hours 7 days per week.
5.2.1 Patient Assessment
Comprehensive individualised medical and nursing assessment of the patient must be performed and documented prior to considering the use of a restraint. The assessment should include the following:

5.2.2 Physical assessment
A full physical assessment should be undertaken to detect underlying causes of behaviour and/or delirium such as presence of infection or pain.

5.2.3 Mental/Cognitive State
Assess the patient for intrinsic or extrinsic (environmental) triggers for behaviour. Where the patient is alert and not confused, the reasons for the patient’s behaviour and the issue of physical restraint should be discussed with the patient prior to application of restraint.

Where a patient is confused, his or her behaviour should be carefully observed to determine any treatable causes of agitation or combative behaviour. Reversible causes may include delirium, sensory overload, sensory deprivation, hallucinations and delusions.

5.2.4 Medication review – should be carried out to identify any possible adverse effects of medications that may be affecting the person’s behaviour.

5.2.5 Environmental assessment:
A common cause of aggression in older people is their misinterpretation of the environment and miscommunication, where aggressive behaviour is often triggered by fear. On-going engagement with the patient and their family / carer through clear, respectful and open communication allows early detection, identification and appropriate management of triggers that may lead to aggressive behaviour.

When a disturbed behaviour occurs, do not enter the patient’s / individual’s personal space without their permission (unless there is an immediate risk of self-harm or harm to others) as this could escalate their distress, anger and / or behavioural disturbance.

5.3 Management Plan
Refer to local guidelines for the non-pharmacological strategies for the patient who is experiencing confusion.

There should be consultation with carers/family members to identify a baseline of usual behaviour and information sought as to the patient’s personal preferences and routines. If the patient has a known history of intellectual disability or dementia, consult with regular carers to ascertain current strategies that may be in place to support their management in their home. Consider the use of TOP5 or Person Centred Profile forms.
Key points to note:
1. Engage with the patient, their family / carer and other health professionals (using a team approach) to identify stressors/ triggers for disturbed behaviour as part of the initial and ongoing patient care.

2. Undertake appropriate clinical assessment to obtain information on the patient’s condition. For example, cognitive screening tools for older persons, medical assessment of mental health patients and Drug and Alcohol assessment tools.

3. Develop ways to manage stressors / triggers of disturbed behaviour and document a management plan for health care teams to follow.

Following assessment, a management plan aimed at identifying and reducing the cause of the behaviour should be devised and implemented in consultation with family/carer and documented in the patient’s medical record.

Only when all possible management strategies have been trialled and deemed unsuccessful, may the need for the use of restraint be considered, this decision should be made collaboratively by the treating multidisciplinary team. See SESLHDPR/345 - Prevention, Diagnosis and Management of Delirium in Older Persons.

Patients should be nursed in a quiet area where they can be easily observed and staff must be aware of the safety issues surrounding a patient who is restrained.

5.4 Authorisation

The use of mechanical or chemical restraint must be authorised in writing by a Medical Officer on the Patient Restraint Chart.

5.5 Mechanical Restraint

Injuries and death have occurred as a direct complication of mechanical restraint use.

Within SESLHD only approved, purpose designed manufactured restraints may be used. Improvised restraint arrangements such as bandages, sheets, meal trolleys must never be used as a restraint.

Only the following restraints may be used:
- Padded limb restraint
- Padded mitten restraint
- A chair that is used to inhibit the patient’s movement eg water chair, air chair.

Any restraint used must meet the requirements of the NSW Health Principles for safe management of disturbed and /or aggressive behaviour and the use of restraint PD2015_004.
5.5.1 Mandatory Procedures for using a mechanical restraint

- Except in a critical need situation a medical officer must document authorisation for restraint following consent from the patient/person responsible and consultation with the multi-disciplinary team.
- Following application of restraints in a critical need situation the need for restraint must be reviewed as soon as possible after the period of critical need has passed.
- If restraint continues to be necessary then appropriate assessments must be conducted and the restraint must be authorised and documented by a medical officer. If authorisation is by a junior medical officer, he/she should consult with a senior medical officer prior to authorisation.
- Medical Authorisation must be documented on a Patient Restraint Chart.

5.6 Chemical Restraint

Chemical restraint is the intentional use of medication to control a person’s behaviour when:

- no medically identified condition is being treated
- the treatment is not necessary for a condition

Chemical restraint – must not be implemented until a thorough assessment has been completed and non-pharmacological management strategies trialled and deemed unsuccessful.

It is recommended that a senior medical officer prescribe medications for chemical restraint. If a junior medical officer prescribes the medication for chemical restraint it must be in consultation with a senior medical officer (minimum of registrar level). In the Aged Care Facility the resident’s general practitioner will prescribe.

Drugs commonly used for chemical restraint include sedatives and anti-psychotics. The risks of these drugs include over-sedation, increased falls risk and extra-pyramidal side effects from anti-psychotics.

5.6.1 Extra-pyramidal side effects:
Extra-pyramidal symptoms are caused by dopamine blockade or depletion in the basal ganglia; this lack of dopamine often mimics idiopathic pathologies of the extra-pyramidal system.

Extrapyramidal physical symptoms may include:
- tremor
- slurred speech
- akathisia (restlessness)
- dystonia (involuntary muscle contractions)
- anxiety
- distress
- paranoia
- bradyphrenia (slowed thinking)
5.6.2 Mandatory Procedures for Using Chemical Restraint

- The medication and dosage must be the most appropriate for the situation and prescribed within usual clinical practice guidelines. Therapeutic Guidelines: Psychotropic – delirium management (revised February 2013).

- A record of medications given should be kept and **must accompany the patient** if they are moved to another location.

- Medical Authorisation must be documented on a [Patient Restraint Chart](#).

5.6.3 Nursing management of the person with a mechanical or chemical restraint

All patients who are being restrained require close monitoring. Nursing care and observations are required and must include but are not limited to:

- **Patient Restraint Chart** should be implemented and maintained for the duration of the restraint period.

- Mechanical restraint must be removed at least hourly.

- **Every 15 minutes** - the person being restrained must be observed by a nurse and if a mechanical restraint is used this must be sighted by a nurse because of the potential for injury.

- **Hourly observations** - should be documented in the [Patient Restraint Chart](#) with the addition of:
  - airway patency
  - skin colour
  - oxygen saturation
  - level of alertness
  - evidence of ongoing behavioural disturbance or agitation
  - response to medication.

Care provided during the period of restraint should include:

- provision of adequate hydration and nutrition
- regular toileting
- active or passive exercises
- emotional needs of the patient must be addressed with reassurance and constant, clear explanation.

**Monitoring of the following:**

- physical safety
- skin integrity of the restrained body area and other areas at risk of pressure damage due to positioning
- regular pain assessment
- continuing assessment to detect any changes to physical condition eg. Signs of infection or alteration in biochemistry
- an environmental assessment eg. noise, light, temperature
If antipsychotic drugs have been used, monitor for decreased level of consciousness, extra pyramidal adverse effects such as: tremor, slurred speech, restless or agitation, involuntary muscle movements, anxiety, distress, paranoia or slowed thinking processes for 48 hours and notify the medical officer immediately of any side effects observed.

Some flexibility in observations is accepted so as not to unnecessarily wake/irritate the patient further, reason should be documented.

Ongoing restraint in the hospital environment must be reviewed at least every 24 hours and every 42 days in the Aged Care Facility.

5.7 BEDRAILS
SESLHDPR/421 - Bedrails adult inpatient use

5.8 FOLLOWING THE IMPLEMENTATION OF RESTRAINT:
Completion of an IIM report is required following any episode of aggression or if any injury has been sustained.

Notify the Nurse Unit Manager or Senior Nurse Manager if:
- there are implications for the nursing workload
- there is potential for patient self harm or harm to others
- if a critical incident has occurred

6. DOCUMENTATION
- SESIAHS Patient Restraint Chart (SEI110040_280114)
- TOP 5 Toolkit - Clinical Excellence Commission NSW Health
- Person-centred Profile - order no. SES060.159
- Results of the medical officers physical examination, conclusions and management plan must be documented in the patient medical record

7. AUDIT
Annual point prevalence ward audits.

8. REFERENCES
Legislation:
- Guardianship Act NSW 1987
- Guardianship Regulation 2010
- Mental Health Act 2007

References:
Restraint use with adult patients

- NSW Health, 2000 ‘Best Practice Model for the use of Psychotropic Medications in Residential Aged Care Facilities and Guidelines on the Management of Challenging Behaviour in Residential Aged Care Facilities in NSW’
- Therapeutic Guidelines Ltd, 2013 (etg 42 March 2014) viewed via CIAP 02.10.2014

Associated policies:
- SESLHDPR/421 - Bedrails adult inpatient use
- SESLHDPR/345 - Prevention, Diagnosis and Management of Delirium in Older Persons
- SESLHDPR/380 - Falls prevention and management for people admitted to acute and sub-acute care
- PD2015_004 - NSW Health – Principles for safe management of disturbed and /or aggressive behaviour and the use of restraint.
- GL2015_007 - NSW Health - Management of patients with Acute Severe Behavioural Disturbance in Emergency Departments
- PD2014_004 NSW Health - Incident Management Policy
- NSW Health - Protecting People and Property - NSW Health Policy and Standards for Security Risk Management in NSW Health Agencies
- PD2012_035 - NSW Health - Aggression, Seclusion & Restraint in Mental Health Facilities in NSW

9. EDUCATION

NSW Health Module 2 – Minimisation of Aggression
Non-Violent Crisis Intervention – Risk Managing Aggression

10. REVISION AND APPROVAL HISTORY

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<th>Revision No.</th>
<th>Author and Approval</th>
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<td>April 2015</td>
<td>1</td>
<td>Author: Janine Masso CNC Dementia/Delirium, the following Aged Care CNCs: Gemma Price, Olivia Paulik and Bronwyn Arthur, Simmi Grover, Melissa Buchanan</td>
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<td>October 2015</td>
<td>2</td>
<td>Reviewed by Aged Care &amp; Rehabilitation Services Stream. Minor changes recommended by DQUMC at August 2015 meeting. Changes made and endorsed by Executive Sponsor</td>
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