Policy

Policy Directive: compliance is mandatory

Preventing and Responding to Challenging Behaviour Policy Directive

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Summary

The Preventing and Responding to Challenging Behaviour Policy Directive sets out an overarching rationale for the prevention and response to challenging behaviour across SA Health and represents a shared vision for action. It outlines the expectation that health services will implement and support actions to prevent and then safely respond to challenging behaviour using consumer-centred, evidence-based care and treatment as a key strategies. There is an accompanying toolkit to support its implementation.

Keywords

challenging behaviour policy directive, challenging behaviour, violence and aggression, preventing, responding, violence, aggression, prevention, response, physical, psychological harm, physical violence, threatened, harm, abuse, work health safety, WHS, worker safety, WH&S, safe workplace, hazards, risk assessment, worker health, risk control measures, mental health, restraint, seclusion, safety and quality, S&Q, mental illness, drug and alcohol

Policy history

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

Applies to

All Health Networks

Staff impacted

All Staff, Management, Admin, Students; Volunteers

EPAS compatible

Yes

Registered with Divisional Policy Contact Officer

Yes

Policy doc reference no.

D0379

Version control and change history

Version	Date from	Date to	Amendment
1.0	07/05/2015	current	Original version

Government of South Australia
SA Health

SA Health

Preventing and Responding to Challenging Behaviour

Policy Directive

Government of South Australia

SA Health

Preventing and Responding to Challenging Behaviour Policy Directive

1. Objective

Challenging behaviour is any behaviour with the potential to physically or psychologically harm another person, or self or property. It can be deliberate or unintentional and ranges from verbal abuse, through to acts of physical violence. Ultimately, regardless of its level of extremity, challenging behaviour is a barrier to the delivery of care in a way that is safe for the consumer and worker.

This document sets out an overarching rationale for the prevention and response to challenging behaviours across SA Health and represents a shared vision for action. In particular it:

- is a visible commitment to the prevention of the harm that can result to consumers, workers, and others in South Australian public health services
- outlines the expectation that health services will be committed to the implementation and support of actions primarily to prevent and then safely respond to challenging behaviour using consumer-centred, evidence-based care and treatment as a key strategy
- recognises SA Health's duty of care to all its workers in reducing exposure to challenging behaviour, including aggression and violence, and the responsibility to provide safe, lawful, high quality care and uphold the rights and dignity of consumers.

The Policy Directive is accompanied by a series of resources to support implementation (Challenging Behaviour Toolkit) and a policy guideline entitled Preventing and Responding to Workplace Challenging Behaviour, Violence and Aggression.

2. Scope

All SA Health workers or persons who provide health services on behalf of SA Health must adhere to the standards and principles described in this Policy Directive.

This Policy Directive extends to the working relationships that SA Health services have with partners including but not limited to South Australia Police; emergency services such as Royal Flying Doctor Service and MedStar; Non-Government Organisations(NGO) and aged care providers; Department of Communities and Social Inclusion - Disability and Domiciliary Care; Department of Correctional Services; and local government.

Interactions or conflicts that do not involve a consumer or carer but occur between two or more workers are not in scope. These are dealt with through Workforce policies, policy guidelines and procedures.

3. Principles

Effective prevention and response to challenging behaviour in the provision of health services requires an integrated systems approach. The key principles underpinning this Policy are listed below.

3.1 Providing health care in a way that minimises risk of physical or psychological harm to consumers and to health workers.

3.2 Providing consumer-centred care and respecting all rights of consumers, including health care rights.

3.3 Identifying best practice clinical care as a major focus in improving the safety and quality of healthcare.

3.4 Consumers and workers being treated with equality and respect, their rights and responsibilities are central to promoting safety.

3.5 Supporting the rights of the consumer to be treated in the least restrictive environment to the extent that it does not impose serious risk to the consumer, worker and others.

3.6 Providing a health service environment that is safe for workers, consumers, carers and families.

3.7 Delivering workforce and training strategies that result in skilled, high performance teams with expertise tailored to the clinical context and health service in which they work.

3.8 Implementing processes for ongoing monitoring, evaluation and reporting on trends and targeted improvements.

4. Detail

4.1 Standards

SA Health organisations and services will ensure that:

4.1.1 a governance structure and systems are in place, with responsibility for developing, implementing and monitoring improvements including prevention strategies, workers response during an incident, follow-up care and service and facility design. This will be enabled by:

- inclusion of expertise from Work Health and Safety (WHS), Safety and Quality, risk management, clinical, management, security, non-clinical worker and consumers
- review of data, measures and information including but not limited to incidents, worker numbers and skill mix, case mix, training schedules, worker surveys and consumer feedback and experience
- best practice guidelines and local procedures being available and accessible.

4.1.2 there is screening, assessment and care provided in accord with legislative and policy requirements, and best practice

4.1.3 there are systems of care to enable and facilitate prevention; to enable safe, effective and timely response and protection of consumer and worker, and to enable resolution of incidents and promote recovery

4.1.4 consumers, carers and family participate in the planning, design and evaluation of services, with their health care team in the development of their health care plans and this is documented

4.1.5 consumers report that their health care rights are upheld

4.1.6 any application of force, restraint, seclusion and containment is authorised, used only as the last resort and is lawful, used with minimal frequency and duration, and is least restrictive for maintenance of safety

4.1.7 incidents where there is potential or actual harm to workers and/or consumers arising from challenging behaviour are reported in the Safety Learning System (SLS), investigated, reviewed and action taken. This includes all incidents when restrictive practices are used, and incidents where security services are involved (such as Code Black)

4.1.8 workers participate in relevant education and training, and have access to policies, procedures and other relevant resources, including equipment to support their role and responsibilities.

4.2 Prevention and response

All health services should consider prevention strategies that can be implemented in their health settings. The diversity in care and treatment settings may impact on what is relevant within each environment. Therefore it is important to understand the context and contributing factors that influence where and how challenging behaviour may occur and the most appropriate response.

4.2.1 Understanding the context in which challenging behaviours occur

There are situations where a person may exhibit behaviour that is challenging for others to experience. For example if the situation is very stressful and they are in pain or fearful or they have the perception that their care is unsafe and/or disrespectful.

The person displaying the behaviour may be attempting to have their needs met, concerns heard, or fears for their family member recognised. Behaviour is a form of communication, and the person may or may not intend to threaten or to interrupt the care being provided.

Challenging behaviour may also indicate the presence of a cognitive, emotional or mental health problem, including substance abuse. A number of diagnoses or conditions can predispose consumers to exhibiting challenging behaviour.

People who have experienced previous trauma in their lives are more likely to have increased emotional responses in situations where they feel unsafe, unsure or challenged.

Workers may also encounter challenging behaviour if they:

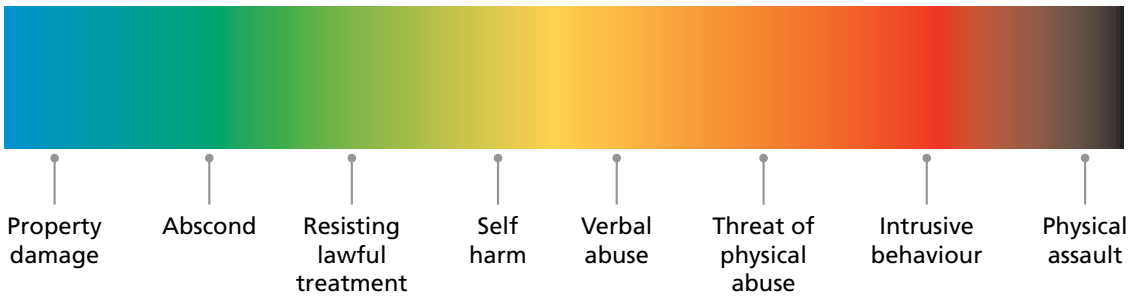
- intervene to avoid or stop harm from occurring to themselves, other person(s), or damage to property
- act to protect the person from deliberate or unintentional self-harm (for example wandering, falling, self-harm and suicide attempts)
- act to prevent a person from leaving, or absconding without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

The person exhibiting challenging behaviour may be the consumer, carer, family, friends, or even bystanders.

The challenging behaviour may be displayed by someone who has decision-making capacity and their actions are deliberate. The verbal and or physical abuse, potential or actual harm to the worker and other people, property damage and disruption to the service are not compatible with safe delivery of care, and may be considered an offence or a criminal act.

Further information is available: Challenging Behaviour Toolkit: Tool 1 Quick guide to policy and legal information relating to challenging behaviour

Challenging Behaviour Spectrum



4.2.2 High risk settings

All health care settings have the potential for challenging behaviours to occur, and health workers require a minimum level of knowledge and skills to deal with these situations safely. As Diagram 1 illustrates, a health care setting can be considered to be 'high risk' if challenging behaviour is more commonly encountered because care is frequently provided:

- to people with clinical conditions that may predispose to challenging behaviour
- in emergency, traumatic, stressful or emotional situations (these can be termed high risk times)
- in situations where there is limited access to assistance for workers from team members, security services or emergency response teams. For example home visits, services operating outside business hours, rural or remote services, services that are small, minimally staffed or standalone (these can be termed high risk locations).

High risk settings therefore include, but are not limited to, ambulance services, drug and alcohol services, emergency departments (including waiting areas), medical and surgical wards, rehabilitation, geriatric, mental health, residential care, primary and home care (community), transport and parts of maternity and children's services.

Diagram 1

The health service provides care for people with high risk conditions	The health service provides care at high risk times	The health service provides care at high risk locations
> Frequent (daily) > Occasionally (weekly/monthly) > Rarely (once/twice a year)	> Emergency > Pre-operative urgent non elective > Post-operative major surgery > Life-changing events > Mental health crises	> Emergency department > Acute > Long stay-rehabilitation, residential care > Community-based settings

4.2.3 High risk clinical conditions

Challenging behaviour may indicate that a consumer has a cognitive, emotional, mental health or drug misuse problem. Early recognition and appropriate care and treatment are essential.

Guidelines exist for screening, assessment, diagnosis and treatment of many relevant conditions such as alcohol withdrawl and these guidelines should underpin care.

4.2.3.1 Mental illness

For people experiencing a mental illness, being admitted to hospital can be a confronting and frightening experience, particularly when this occurs in the context of a mental health crisis, and is done under a mental health treatment order and their liberty is being removed.

Even in a less acute stage of illness, such as in community-based services, challenging behaviour including self-harm, intrusive or sexualised behaviour, wandering (where this places the person at risk), offensive language or physical abuse can occur. These behaviours can be difficult for workers to manage. A mental illness can limit some people's capacity to engage and to communicate their needs.

4.2.3.2 Alcohol and other drug misuse

People who misuse alcohol and other drugs may exhibit challenging behaviour when they present at acute or community based treatment health services or are treated by ambulance services. Individuals may exhibit the short term effects of extreme intoxication or drug use, including:

- physical reactions, for example, deteriorating or loss of consciousness, overheating, dehydration, trauma, seizure or head injury
- psychological reactions, for example panic attacks, psychosis, suicidal thoughts and behaviours, and aggression.

Drug misuse problems are often associated with a host of social, behavioural, psychological and physical problems. These include increased symptom severity and suicidal behaviour, poor adherence to treatment, more hostile and aggressive behaviours and drug-seeking behaviour. Substance withdrawal and co-occurring conditions can exacerbate these.

4.2.3.3 Dementia

Confusion or cognitive impairment is a common condition for older people in hospital. More than 30% of older people present with or develop confusion during their admission, most commonly as a result of dementia and delirium [1]. Behavioural changes can accompany acute illness such as sepsis or urinary retention.

Dementia can limit the capacity of consumers to engage and to communicate their needs. Language, hearing and other communication issues can also arise with advanced age and increased disorientation. For people with dementia, being admitted to hospital can be a confusing and frightening experience. If there are unmet needs this may lead to an escalation of behaviour that is difficult for workers to manage. This includes wandering (where this places the person at risk), disruption or intrusion, physical and verbal aggression, resistance to personal care and refusal to accept services, socially or sexually inappropriate behaviour [2].

4.2.3.4 Delirium

Delirium is an acute disturbance of consciousness, attention, cognition and perception, and can result in individuals demonstrating challenging behaviour. It is most common among older people, and is often overlooked or misdiagnosed. It is both predictable and preventable, if early clinical assessment and clinical management are provided [3].

Pre-existing dementia is one of the most common predisposing risk factors for the development of delirium. Other risk factors include severe medical illness, alcohol withdrawal, depression, abnormal sodium, visual impairment and undergoing orthopaedic or neurosurgery. Older people with limited English proficiency may be at higher risk because of the difficulty communicating their needs and understanding information[4].

4.2.3.5 Intellectual disability, acquired brain injury and neurodegenerative conditions

Between 4 and 17 per cent of people with an intellectual disability display behaviour that can result in injury to self and/or others, or property damage[5,6].

People who have acquired brain injury, long term or degenerative neurological disorders may also display challenging behaviour as a result of their condition, and find hospitalisation and treatment distressing experiences.

4.2.3.6 History of trauma

Children and adults who have experienced severe and/or complex trauma may have increased likelihood of behaviours that impede the provision of safe care. Examples include people with post-traumatic stress disorder, survivors of torture and trauma and children or youth with developmental trauma disorder.

Further information is available: Challenging Behaviour Toolkit: Tool 4 Clinical guidelines and additional resources

4.2.4 Stages of an incident involving challenging behaviour

For the purpose of describing strategies or interventions, it is useful to consider an event or incident in stages-before, during or after.

These stages can overlap, not all stages are present in any single incident, and an intervention can be applicable over more than one stage. For example de-escalation processes can and should be used as an early intervention and right through post event de-briefing.

There are common strategies and best practice guidance for the de-escalation and safe clinical treatment and management of challenging behaviour, regardless of the setting or clinical scenario.

The aims of care are summarised in Table 1. At each stage there are strategies that will promote the care and safety of both consumers and workers.

1 The care of Confused Hospitalised Older Persons Program (CHOPS) 2014 NSW Agency for Clinical Innovation (ACI)
2 Australian Institute of Health and Welfare 2013 'Dementia in care in hospitals: costs and strategies. Cat. No. AGE 72 Canberra: AIHW
3 Australian and New Zealand Society for Geriatric Medicine Position Statement 13 Delirium in Older People Revised 2012
4 Clinical Practice Guidelines for the Management of Delirium in Older People Published by the Victorian Government Department of Human Services, Melbourne, Victoria, Australia on behalf of AHMAC
5 Emerson E, Kiernan C, Alborz A, Reeves D, Mason H, Swarbrick R, Hatton C. The prevalence of challenging behaviours: a total population study. Research in developmental disabilities 2001 22(1):77-93
6 Holden B, Gittlesen, JP. A total population study of challenging behaviour in the country of Hedmark, Norway: prevalence, and risk markers. Res Dev Disabil. 2006 Jul-Aug: 27(4):456-465. Epub 2005 August 30.

Table 1 Stages of an incident

Stage		Aims of care
BEFORE	Screen	Predict and prepare for prevention
	Recognise risk	Reduce the likelihood of challenging situation or behaviour developing at all
EARLY INTERVENTION	Early intervention	Reduce the risk that challenging behaviour will escalate. Prevention of emergency situations
DURING	Challenging behaviour commenced	Reduce the risk that harm to consumer or worker will result Reduce the use of/need for restraint and seclusion
	Application of restraint or seclusion	Minimise harm/adverse outcomes to consumer and/or worker if this occurs
AFTER	Recovery	Optimise recovery of consumer and workers
	Evaluation	Reduce the risk that there will be recurrence

4.2.4.1 Before an event-prevention and preparation

The three main action areas aimed at preventing challenging behaviour are:

- health system design, including the physical space and sequential movement of people within it. A security threat analysis is a key activity, as are risk assessment and risk control
- building workers skills and teamwork. This includes the clinical teams, non-clinical workers, security officers and others as applicable
- provision of effective treatment and care for consumers and their health care rights.

Before an event, plan for the treatment of high risk service users by:

- using a flagging system to note consumers with a history of disruptive or repeated behaviours
- reviewing documentation of treatment orders, plans and agreements such as Advance Care Directives, guardianship, mental health or other orders, Ulysses agreements, or personal prevention plans (these latter examples are used in mental health settings)
- engaging with the consumer, family, carer to develop a personal prevention plan- working with the person to identify what increases or reduces their stress, and planning care around what they would like to happen to prevent and optimise self-control, pre-emptive and proactive strategies.

In some situations, for example emergency services or community-based services, workers have limited or no opportunity to establish these plans.

The Challenging Behaviour Toolkit: Tool 2 Hazard Identification and Risk Assessment, includes, but is not limited to, the consideration of workplace design and clinical settings that may have the potential risk of challenging behaviour, aggression and violence.

4.2.4.2 Early intervention

The escalation of behaviour to the point of imminent or actual aggression is not a linear process, and in many instances de-escalation strategies will prevent or reduce the chances of challenging behaviour occurring.

Early intervention to reduce escalation of behaviour includes three main strategies, observation and assessment; de-escalation and the provision of best care. They are outlined in more detail in Table 2.

Table 2 – Key strategies during early intervention

Key Strategy	Aims to reduce the risk that challenging behaviour will escalate.	How
Observation and assessment	Family/carers observation, insights and advice can be valuable	> Engage these people in care, if applicable.
	Observation and assessment	> Risk screening and assessment to identify level of risk, possible triggers and contributing factors. > Identify signs that a person is becoming anxious, agitated or aggressive, or developing delirium or physical deterioration (in which cases rapid medical intervention is required).
De-escalation	De-escalation through good communication skills	> Use a safe approach, open body language, calm and clear communication. > Address the consumer's immediate needs. > Identify what the person would like to happen to avoid stress etc. > Interventions to address social stressors.
	De-escalation techniques - skills that can be taught and learned with practice	> Negotiation, reassurance and behavioural strategies, or diversional and sensory modulation techniques. > Nursing, allied health, psychological and medical interventions. > Strategies that provide alternatives to restraint and/or seclusion.
	De-escalation approaches relevant to specific groups	> For example, AGRO+ for paediatric consumers and DBMAS for older adults with dementia. > Use of personal safety tools with the consumer.
Providing best care	Manage the environment (triggers and contributing factors)	> Planning care with the consumer and their family, and the clinical team around prevention and control, pre-emptive and proactive strategies.
	Tailor the treatment of a consumer exhibiting challenging behaviour to their symptoms and health conditions.	> For example, there is considerable difference between the clinical treatment and management of delirium and the management of brain injury or alcohol withdrawal.

The skills and knowledge required to de-escalate a situation are included in a variety of training programs, from improving customer service to those aimed at negotiation in critical incident situations. Some key components include:

- acting on identified needs, for example pain control
- use of positive behaviour strategies, limit setting strategies
- preventative/distraction/diversionary strategies
- communication – verbal and non-verbal, considering
  - personal space and body language
  - encouragement of reasoning, calming strategies
  - listening carefully with empathy and respect
- monitoring own personal response and professional detachment.

4.2.4.3 During an event

SA Health workers have the duty of care and responsibility to take reasonable care for their own health and safety, and to not place others at risk through their actions. (*Work Health and Safety Act* 2012(SA) and its regulations)

Continuous assessment and observation will provide information to judge the risk of harm, and treatment or action that may be required. It is also important to know the consumer's decision-making capacity and therefore their ability to provide informed consent, because this affects the legality of possible actions.

The stepped response for workers to get additional support or assistance should be used. Depending on the rate of escalation and the situation, the worker caring for the consumer can initiate:

- a senior staff member to jointly review the consumer for early signs of challenging behaviour, and the care plan
- a team huddle to develop a shared plan
- an urgent medical review and/or multidisciplinary review of the consumer and care plan
- a call for assistance for security services, to stand-by, assist the staff member or remove the person from the health service (if not a patient and not needing medical attention)
- a call for additional assistance from the Emergency Response Team to provide either or both of expert de-escalation or physical intervention to ensure safety (Code Black). The equivalent for the SA Ambulance Service is Code 51 for an emergency police attendance
- a call for SA Police attendance
- other options including retreat, dis-engagement or withdrawal of self and others from the area.

Inappropriate behaviour exhibited by workers when responding to a consumer's challenging behaviour may result in initiation of an investigation and disciplinary process.

Further information is available: Preventing and Responding to Workplace Challenging Behaviour, Violence and Aggression Policy Guideline

4.2.4.4 Safe practice in application of restraint, seclusion and other restrictive practices

There are physical and psychological risks associated with use of restraint and seclusion. Any use of physical force can significantly increase the chances of injury occurring to both workers and/or consumers.

In some situations the use of restrictive practices such as restraint or seclusion, or force, may be required in order to protect a person (worker, consumer, other) from imminent harm.

Restraint, seclusion or the use of force are a last resort and only used when the risk of not using them outweighs the risk of using them. The Policy Directive Minimising Restrictive Practices in health care and toolkit; and Policy Guideline Restraint and Seclusion in Mental Health Services and Fact Sheets provide detailed guidance on the current best available evidence on the prevention of restraint and seclusion, including early intervention measures, and promotion of the principles of least restrictive practice.

4.2.4.5 After an event- immediate actions

Directly following the event, depending on the result of the incident, there are immediate actions including ensuring safety and attending to any physical injuries, providing practical and emotional support to those involved, notifying management and/or security services as required and preserving evidence if applicable.

Workers may need to be relieved of duty, and monitoring of the consumer's physical and emotional status must continue.

De-briefing allows recovery for:

- consumers and witnesses, by restoring a positive relationship with the health service
- workers by restoring confidence, feeling safe, and the ability to continue to provide high quality care in a safe work environment.

4.2.4.6 Promoting recovery, review and quality improvement

A single serious incident or a series of lesser incidents can have a significant effect on the people involved. Workers may experience a range of emotions including loss of confidence in their own abilities and symptoms of post-traumatic stress disorder.

The Management of Work Injured Employees (WHS) Policy Directive supports a planned approach to providing an effective injury management service to SA Health workers, aiming to achieve a successful early and safe return to work, while promoting best practice for physical and psychological recovery.

Consumers report long-term issues such as insomnia, nightmares, lack of trust in the system and fear of confined spaces after restraint and seclusion.

There are strategies to promote recovery from the incident and health services should include:

- de-briefing with consumer and carer or family, especially if they have witnessed the use of restraint or seclusion
- on-going support to consumer and workers, especially de-briefing with a senior team member from management and employee assistance program (EAP) as required
- de-briefing with witnesses to a serious incident
- open disclosure principles guide de-briefing and discussion with consumers and carers post event (Open Disclosure Policy) and there are avenues for complaints to be addressed
- discharge planning and preparing for the service user's possible return to the service
- team review of incidents.

The ability to participate in recovery strategies, especially for consumers may be limited in some settings such as ambulance service, but it should be pursued where practicable, including at a later stage in the person's health care.

Workers who wish to pursue charging the aggressor with assault or other offence will require advice and support to do this (Fact Sheet 022 Worker Support (WHS).

Further information is available: Challenging Behaviour Toolkit: Tool 6 A guide to reporting and review of challenging behaviour incidents.

5. Roles and Responsibilities

5.1 Executives

The Chief Executive (CE) of the Department for Health and Ageing will take reasonable and practicable steps to:

- ensure that challenging behaviour is prevented and responded to appropriately across SA Health in accordance with this Policy Directive, and legislative requirements.

Deputy Chief Executive and Service Delivery System Performance and relevant Departmental Executive Directors will:

- establish, maintain and review systems and associated processes for best practice prevention and response to challenging behaviour at a state level
- provide advice to SA Health, Local Health Networks (LHNS) and Chief Executive Officers (CEOs) 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 on issues of public concern/media or public attention
- provide support to LHNs where legal opinion, advice or representation is required
- ensure that other government agencies including but not limited to South Australia Police, Department of Correctional Services , Commonwealth Department of Social services and aged care providers, are aware of this Directive and the implications for the management of challenging behaviours by SA Health services.

CEOs or Chief Operating Officers (COO) of Local Health Networks (LHNs) or SA Ambulance Service (SAAS) will take reasonable and practicable steps to:

- support consumer participation in their own care and in the design, planning and evaluation of relevant parts of the service
- allocate sufficient human and material resources, and delegate day-to-day responsibility to enable effective prevention and response to challenging behaviour programs to operate, appropriate data to be analysed to inform planning and evaluation, consumer engagement and workforce training to occur
- provide advice to the CE and Minister for Health on issues of public concern / media or public attention
- ensure that the design of new services, facilities and redevelopments, changes to work practices and purchase of new equipment are in accord with best evidence for prevention and safe response to challenging behaviour
- ensure that there is a governance structure for Work Health Safety and quality improvement activities to address challenging behaviour; to meet the requirements of standards, policy and legislation; and to evaluate outcomes of strategies
- ensure that there are procedures protocols and instructions to support the prevention and response to challenging behaviour
- ensure that workers have access to relevant training and equipment.

The Chief Psychiatrist will:

- monitor and report as required on the treatment of mental health consumers, including the use of restraint and seclusion, and consumer and care feedback
- develop, monitor and review standards and best practice guidance for mental health services and health services providing care for mental health consumers
- provide advice to the CE and Minister for Health on issues of public concern/media or public attention
- monitor the *Mental Health and Emergency Services Memorandum of Understanding - SA Health, SA Ambulance Service, Royal Flying Doctor Service and South Australia Police 2010* and raise issues regarding challenging behaviour (Part 9, Section 59).

5.2 Managers and clinicians

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

- assist the LHN CEOs and COOs to fulfil their responsibilities, accountability and duty of care
- promote this Policy Directive and accompanying guidelines and tools, and relevant local procedures
- assist others to meet their obligations under this Framework, including incident reporting and education and training
- assist with evaluation strategies to monitor practice and outcomes, and participate in the design of appropriate quality improvement activities.

Clinical educators will:

- ensure that workers have access to education and training appropriate to their roles, to enable them to have skills, knowledge, attitudes and understanding required to prevent, assess risk, de-escalate and manage challenging behaviour
- ensure workers understand relevant legislative, policy and reporting requirements required by their role and the location/setting and the clientele serviced.

Directors/Managers of health services or divisions / business units will:

- lead or participate in mechanisms for governance and accountability; engaging workers, consumers and the community; and supporting the implementation of this Directive and accompanying guidelines and tools
- develop, implement and monitor local systems and procedures, including incident data collection analysis and improvement planning, worker training and engagement with consumers and the community.

Directors/Managers of Security Services will:

- develop procedures around the activities/roles of authorised officers (security officers) including emergency and evacuation plans and regular drills, testing and maintenance of communication and duress equipment
- lead analysis of threat and security planning
- ensure that Security Officers have skills and expertise to:
  - maintain public order
  - assist clinical teams to provide care with minimal risk to all people present.
- ensure that records are kept of Security Officer's activities in relation to challenging behaviour and maintenance of public order and that this data is reviewed and used to inform planning in collaboration with the clinical governance and risk management.

All SA Health workers will:

- adhere to the principles and intent of this Policy Directive
- ensure that they have relevant skills and knowledge to then provide care in accordance with the guidelines and best practice recommended in the tools
- ensure that all incidents where challenging behaviour results in restraint or seclusion, or worker or consumer are harmed, are reported as required
- participate in review of worker and consumer incidents and Work Health Safety quality improvement activities.

6. Reporting

SA Health services have a responsibility to collect and analyse relevant data to inform planning and improvement to the safety and quality of services and work environment. There are a variety of systems available to monitor and report aspects of the response to challenging behaviour to the responsible executive.

Tool 2 Hazard identification and risk assessment for challenging behaviour should be used annually to examine all of the risk factors in consultation with appropriate workers and consumers, and a Risk Treatment Plan developed.

All incidents should be reported into the Safety Learning System (SLS) (Incident Management Policy Directive). If:

- a worker or other person (such as a visitor) has been harmed, log an 'incident affecting staff'
- a consumer has been harmed, log an 'incident affecting patient'
- both have been harmed (or more people) multiple reports are required
- a consumer has exhibited challenging behaviour or has been restrained or placed in seclusion, log an 'incident affecting patient'.

Security services are required to report all incidents when security staff are involved, including Code Black, in security incident section of SLS. The designated clinical manager, and security manager when appropriate, will review these incidents.

Documentation of all incidents should occur in the consumer's medical record (or EPAS) outlining:

- the clinical treatment and management during an incident, for example medications given
- the participation of the consumer, family and/or carer in care planning.

Investigation principles include:

- investigate and collect information as soon as possible after the incident
- look for causes and/or contributing factors
- review the effectiveness of the risk control measures, and identify new control measures
- document outcomes and involve the team and consumer, carer.

Further information is available: Challenging Behaviour Toolkit: Tool 6 Guide to incident reporting and review of challenging behaviour incidents. WHS Reporting and Investigation policy directive.

7. EPAS

- Restraint and seclusion is recorded as part of the electronic medical record which is built in to EPAS.
- Any incidents of challenging behaviour affecting patients and worker are to be entered in to the Safety Learning System as a matter of process.
- Any incidents where restraint and seclusion are used are also entered into the Safety Learning System.

8. Exemption

NA

9. Policy Directives / Policy Guidelines

Appointment and Administration of Authorised Officers under legislation committed to the Minister for Health; Minister for Ageing and the Minister for Mental Health and Substance Abuse Policy Directive

By-laws for Incorporated Hospitals Policy

Carer Participation Position Statement

Charter of Health and Community Services Rights Policy

Clinical Handover Policy

Clinical Handover Guidelines

Consent to Medical Treatment and Health Care Policy Guideline

Consumer Feedback Management Policy

Consumer Feedback Management Guideline

Dealing with Intoxicated Patients Policy Directive

Employee Assistance Program Policy Directive

Framework for Active Partnership with Consumers and the Community

Guide for Engaging with Consumers and the Community Policy Guideline

Incident Management Guideline Incorporating Open Disclosure Response Policy

Incident Management Policy Directive

Management of Work Injured Employees (WHS) Policy Directive

Mental Health Services Pathways to Care Policy Directive

Mental Health Services Pathways to Care Policy Guideline

Minimising restrictive practices in health care Policy Directive

Open Disclosure Policy

Preventing and Responding to Challenging Behaviour Policy Directive

Providing Medical Assessment and or Treatment where consent cannot be obtained Policy Directive

Remote or Isolated Work Health and Safety (WHS) Policy Guideline

Remote or Isolated Work Safety (WHS) Policy Directive

Respectful Behaviour Policy

Restraint and Seclusion in Mental Health Services Policy Guideline

Roles, Responsibilities & Governance (OHSW&IM) Policy

Safety and wellbeing in the Public Sector 2010-2015 (Dept Premier and Cabinet)

Smoke-free Policy

South Australia's Mental Health and Wellbeing Policy 2010 – 2015

Work Health and Safety Duty of Care to all Persons Policy Directive

Work Health, Safety and Injury Management (WHSIM) Policy Directive

Work Health and Safety Reporting and Investigation Policy

10. References, Resources and Related Documents

South Australian legislation

Advance Care Directives Act 2013

Carers Recognition Act 2005

Children's Protection Act 1993

Civil Liability Act 1936

Consent to Medical Treatment and Palliative Care Act 1995

Criminal Law Consolidation Act 1935

Disability Services Act 1993

Guardianship and Administration Act 1993

Health and Community Services Complaints Act 2004

Health Care Act 2008

Mental Health Act 2009

Public Intoxication Act 1984

Return to Work Act 2014

South Australian Public Health Act 2011

Work Health and Safety Act 2012 (SA)

Workers Rehabilitation and Compensation Act 1986

Australian legislation

Aged Care Act 1997

Australian Human Rights Commission Act 1986

Disability Discrimination Act 1992

Health Practitioners Regulation National Law Act 2010

Racial Discrimination Act 1975

Regulations and codes and other resources

Australian Open Disclosure Framework 2013

Code of Ethics for the South Australian Public Sector

Good Medical Practice: A Code of Conduct for Doctors in Australia

Guard and patrol security services AS/NZS 4421:2011

Health Care Regulations for the Health Care Act 2008 (SA)

Planning for emergencies in emergency facilities AS 3745-2010

United Nations: The Universal Declaration of Human Rights

Safework Australia Codes of practice

Work-Related Violence: Preventing and responding to work-related violence

Work Health and Safety Consultation, Cooperation and Coordination

Managing the Work Environment and Facilities

How to Manage Work Health and Safety Risks

Guide for Handling and Transporting Cash

Prevention and management of customer aggression: A guide for employers

Prevention and management of aggression in health services: A handbook for workplaces

Work Health and Safety Regulations 2012 (SA)

References

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2. Australian Institute of Health and Welfare 2013. Dementia care in hospitals: costs and strategies. Cat.no. AGE 72. Canberra: AIHW.) http://www.reboc.com.au/
3. Australian and New Zealand Society for Geriatric Medicine Position Statement 13 Delirium in Older People Revised 2012
4. Clinical Practice Guidelines for the Management of Delirium in Older People Published by the Victorian Government Department of Human Services, Melbourne, Victoria, Australia on behalf of AHMAC.
5. Emerson E, Kiernan C, Alborz A, Reeves D, Mason H, Swarbrick R, Hatton C. The prevalence of challenging behaviours: a total population study. Research In developmental disabilities 2001 22(1):77-93
6. Holden B, Gitlesen JP. A total population study of challenging behaviour in the county of Hedmark, Norway: prevalence, and risk markers. Res Dev Disabil. 2006 Jul-Aug; 27(4):456-65. Epub 2005 Aug 30.
7. "Let's talk about restraint" Rights, risks and responsibility, 2008, Royal College of Nursing, UK.
8. Restrictive physical intervention and therapeutic holding for children and young people – guidance for nursing staff, 2010 Royal College of Nursing UK.
9. Fallot, R & Harris, M 2009, 'Creating Cultures of Trauma-Informed Care (CCTIC): A Self-Assessment and Planning Protocol', Washington, DC. Community Connections.
10. National Mental Health Seclusion and Restraint Project, National Mental Health Commission.

11. Other

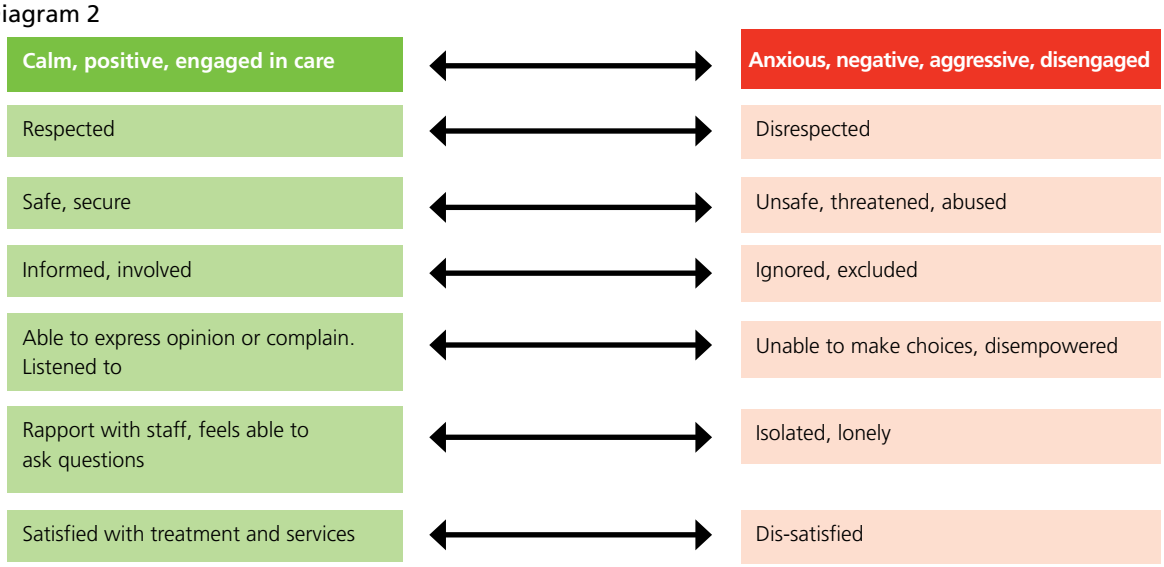
The following approaches support and enable effective prevention and appropriate responses to challenging behaviour.

11.1 Consumer-centred care

Consumer centred care is healthcare that is respectful of, and responsive to the preferences, needs and values of consumers, their carers and the community. Effective systems for prevention and response to challenging behaviours are supported by implementation of these principles and practice. Approaches promoting partnerships in health care, empowering consumers and self-management can facilitate a collaborative and beneficial relationship.

Diagram 2 illustrates examples of the negative emotions that can arise when health care rights (Health and Community Services Commission Charter of Rights) are not upheld, there is poor communication and when consumer-centred care is not in practice.

Diagram 2



Consumers of health care services and their carers have expectations of a level of customer service and kindness. Consumer and carer perceptions that care is unsafe or not meeting the individual's needs can also be triggers for escalation in behaviour. Factors such as long waiting times, lack of privacy and information can be triggers for anxiety, agitation or aggression.

11.2 Communication and diversity

Engaging with people and the development of a therapeutic relationship are the basic fundamentals of health care.

Health worker's compassion, voice, body language and consideration of personal space are all important in conveying respect.

This includes the health workers' own body language and how they physically touch and handle the consumer's body, possessions, and enter the consumer's bed area. Use of interpreters or Aboriginal health workers are examples of respect for language and cultural needs.

Being welcoming, polite, respectful, using empathic listening in all interactions with consumer and family or carer, addressing concerns and meeting immediate needs are important. Failing to achieve respectful communication can be early triggers for the escalation of challenging behaviour.

Consumers of health services, families and carers, and the health workforce itself, reflect the variation in culture, language, values, needs and health literacy that is found across Australian society. People from different cultural groups may have a different understanding, interpretation and expectations of health care, including their role.

11.3 Teamwork, clinical communication and culture

Effective inter-professional teamwork is strongly correlated with the delivery of safe, quality consumer care. Methods of team training, including simulation can improve safety and optimise the contribution from each team member and the consumer. TeamSTEPPS® is an effective, evidenced based tool for improving teamwork, communication and patient safety.

Further information about TeamSTEPPS® is available on the Safety and Quality section of the SA Health website: www.sahealth.sa.gov.au/safetyandquality

Safe care requires that clear, concise, timely communication occurs in a manner that ensures the consumer and those involved in the planning and delivery of care, know the plan and assess the plan for risk. (Clinical Handover Policy)

A safety culture comprises the attitudes held within a workplace from executive leaders to frontline workers. Where safety culture is strong, there are better outcomes for workers and consumers because:

- there is collaboration to seek solutions to consumer safety issues, including learning from analysis of incidents (Incident Management Policy)
- there is an organisational commitment and appropriate governance structure to respond to behaviours that undermine a culture of safety and provide resources to address safety concerns (Challenging Behaviour Toolkit: Tool 3 Example Terms of reference for a health service challenging behaviour prevention and response committee)
- there is support for workers who have been involved in harmful incidents for example through an Employee Assistance Program (Work Health Safety and Injury Management Policy Directive).

11.4 Health system design and security

A health service facility is required to be both a safe and efficient workplace, and a place of healing and care. It is important to establish a balance where both needs are satisfied.

Environment design can therefore be considered as part of the early preparation and prevention of challenging behaviour. A risk identification and risk control or mitigation approach is imperative in reducing environmental risks, and this requires participation by workers, security services, consumers, carers, and facility managers.

There are a number of factors that interplay, including the worker skill mix, the workload, the physical environment, equipment, the sequence and scheduling of tasks and activities.

Design features that can increase both consumer and worker stress include crowding and lack of privacy; poor access to drinks, telephones, equipment and workstations; ambient or sensory features such as lighting and noise levels; temperature and ventilation; and untidiness and uncleanliness.

The Challenging Behaviour Toolkit: Tool 2 Hazard identification and risk assessment can be used to analyse elements of the service design.

The security service and use of volunteers and assistants in nursing can also be considered as part of the early preparation and prevention of challenging behaviours.

Security service expertise should be included in the facility's risk assessment process and security threat analysis, as well as responding to challenging behaviour. The need for security officers and their roles in a health service will depend on a range of factors. These include the size of the facility, other locally implemented safe environment strategies and the health conditions treated.

Further information is available: Preventing and Responding to Workplace Challenging Behaviour, Violence and Aggression policy guideline.

11.5 Education and training requirements

Further information is available: Challenging Behaviour Toolkit: Tool 5 Education and Training Framework

11.5.1 Orientation and ongoing training and education programs:

- are provided regularly to the clinical and nonclinical workforce to enable them to have skills and knowledge to support prevention and response systems
- consider the individual's place of work and are tailored to individual roles and responsibilities
- are multidisciplinary and include a team approach.

11.5.2 Learning and teaching activities in prevention and response to challenging behaviour will include:

- teamwork and structured clinical communication
- partnering with consumers and consumer centred care
- de-escalation in critical situations
- stepped response to getting help
- applying restraint or other restrictive practices as last resort options only.

11.5.3 Delivery and attendance at education programs is supported by allocated time and resources and is reported within organisational structures.

The following ELearning modules for online education are available:

- What is Safety and Quality?
- Clinical Handover
- Communication and Teamwork – TeamSTEPPS® – Why do we have training about teamwork
- Communication and Teamwork – TeamSTEPPS® – skills to improve teamwork
- Introduction to Preventing and Responding to Challenging Behaviour
- Minimising Restrictive Practice.

11.6 Legislation and policy guiding the response to challenging behaviour

A number of Acts, policies, guidelines, regulations and codes define and detail how health services manage the safe provision of health care services while ensuring the health, safety and welfare of all those involved in the provision of care and those receiving care. These include:

- consumers health care and human rights to safe and least restrictive care
- the conduct, powers and authority of health professionals and other workers for example treating doctors, nurses and other health professionals, ambulance and security officers who provide care in situations where:
  - the consumers capacity to consent and/or the consumer's ability to cooperate with treatment is limited, particularly where there are no legal orders in place
  - the health and or safety of the workers, consumer and/or people in the immediate vicinity is of immediate or long term concern
  - where force, restraint or seclusion are used during care or transport, to restore public order, or protect public health.

Further information is available: Challenging Behaviour Toolkit: Tool 1 Quick guide to policy and legal information relating to challenging behaviour.

12. National Safety and Quality Health Service Standards

✓		National Standard 1 – Governance for Safety and Quality in health service organisations
✓		National Standard 2 – Partnering with Consumers
		National Standard 3 – Preventing and controlling healthcare associated infections
		National Standard 4 – Medication safety
		National Standard 5 – Patient Identification and Procedure Matching
		National Standard 6 – Clinical Handover
		National Standard 7 – Blood and Blood products
		National Standard 8 – Preventing and Managing Pressure Injuries
✓		National Standard 9 – Recognising and Responding to Clinical Deterioration in Acute Health Care
		National Standard 10 – Preventing Falls and Harm from Falls

13. Risk Management

A risk management approach to all areas of the prevention and recognition of challenging behaviours across SA Health is required, and should be part of the day to day business of health services.

Services are required to undertake hazard identification and risk assessment using Challenging Behaviour Toolkit: Tool 2 WHS Hazard Identification and Risk Assessment on an annual basis. Where areas of high risk are identified a treatment plan must be completed and actioned.

14. Evaluation

A health service may require a number of measures to monitor performance in prevention and response to challenging behaviour.

Health services should undertake an annual review using Tool 2 – Hazard identification and risk assessment.

Further information is available: Challenging Behaviour Toolkit: Tool 7: Evaluation and metrics for challenging behaviour.

Measures		Data Source
Clinical management of challenging behaviour	Rate of appropriate preventative interventions, including screening, care planning, successful de-escalation, personal protection plans Rate of documentation of the clinical monitoring of any application of force, restraint and/or seclusion	EPAS, medical record audit or patient report from (SAAS) CCME and CBIS non-inpatient charts, records – community and mental health.
Worker safety	Rate/number of harm to workers Rate/number of notifiable incidents and claims resulting from challenging behaviour incident. Number of closed cases.	> SLS Work Health and Safety section. > SAAS (IRQA Incident Report and Quick Assessment).
Consumer centred care	Rate of Consumer feedback indicating that their rights are supported and they are treated with dignity and respect, and other relevant feedback Consumer and family/carer involvement in care planning	> SLS consumer feedback SA Consumer Experience Surveillance System. > Lived experience register (Mental Health). > EPAS, medical record audit.
	Number/rate of harm to consumers	SLS patient incident section.
	Rates of de-briefing with consumers, and the use of Open Disclosure after incidents	SLS patient incident section and medical record audit.
Restraint and seclusion	Number and rates (per 1000 OBD) of: > restraint or seclusion > restraint less than 4 hours, over 8 hours, over 12 hours for adults in mental health or general inpatient > restraint and/or seclusion applied for over 30 minutes to a child 17 years and younger > Mental Health Critical incidents (reportable to Office for the Chief Psychiatrist) > repeated restraint and seclusion to individuals.	SLS patient incident section.
Security services and Emergency Response Teams	> Rates/numbers of Code Black, duress calls > Number/rates of incidents where SA Police attendance required. > Proportion of Security 'attend only' with successful de-escalation. > Number of occasions where Security officers applied physical force, escorted a person from the premises, searched a person or their possessions. > Proportion of Code Black calls where restraint/seclusion was an outcome.	SLS Security incident section.
Clinical Governance	Rates of incident with management review and action. Risk assessment and action plan.	> SLS all relevant sections > Risk register
	Strong safety culture throughout the organisation.	Staff patient safety culture survey
Education and training programs	Completion of training program– numbers, types, proportion of relevant staff completed, frequency training offered.	Clinical educators records/other

15. Attachments

Attachment 1: Challenging Behaviour Toolkit

Tool 1: Quick Guide - Policy and Legal Information relating to Challenging Behaviour

Tool 2: Hazard Identification and Risk Assessment Tool

Tool 3: Example Terms of Reference for a Health Service Challenging Behaviour Prevention and Response Committee

Tool 4: Clinical Guidelines and additional resources

Tool 5: Education and Training Framework

Tool 6: Guide to reporting and review of challenging behaviour incidents

Tool 7: Evaluation and metrics for challenging behaviour and restrictive practices

Attachment 2: Preventing and Responding to Workplace Challenging Behaviour, Violence and Aggression Policy Guideline

Fact Sheet: Worker Support

16. Definitions

Advance Care Directives: Under the *Advance Care Directives Act 2014*, these are legal documents in which competent adults can:

- record their instructions, wishes and preferences for future health care, residential, accommodation and personal matters and/or
- appoint one or more adult Substitute Decision-Makers to make decisions on their behalf, if they are unable to do so.

Adverse event: See Harmful incident.

Assault: An unlawful physical attack and/or attempt to do violence to another. (*Criminal Law Consolidation Act 1935*)

Authorised officers: There are several Acts which provide for the appointment of authorised officers, and the purpose, powers and role of an authorised officer varies between the Acts.

- Under the *Mental Health Act 2009* an authorised officer is a person who has power to take the person into care and control to facilitate an assessment (see also Care and Control)
- Under the *Health Care Act 2008* authorised officers act to prohibit disorderly or offensive behaviours within the hospital or its grounds. These include some security offices

Other Acts include *South Australian Public Health Act 2011, Tobacco Product Regulation Act 1997*, *Public Intoxication Act 1984* and *Controlled Substances Act 1984*. Refer to the Acts themselves or to the Policy Directive '*Appointment and Administration of Authorised Officers under legislation committed to the Minister for Health; Minister for Ageing and the Minister for Mental Health and Substance Abuse*'.

Capacity: See Decision-making capacity.

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

Challenging Behaviour: 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.

Clinical handover: The transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another person or professional group on a temporary or permanent basis. (Australian Commission on Safety and Quality in Health Care).

Code Black: Code Black is defined by Standards Australia as being used 'For personal threat (armed or unarmed persons threatening injury to others or themselves, or illegal occupancy).

The Code Black signal can be triggered through a duress alarm, emergency phone number, or other local mechanism. The equivalent code for SA Ambulance Service is Code 51. In practice, it is initiated by a health worker(s) when they feel that their safety is threatened, and it is a request for urgent assistance from a team that includes clinical and security expertise, where possible.

Competent: (see also Decision-making capacity) Competence is a legal term used to describe the mental ability required for an adult to complete a legal document. An adult is deemed to be either competent or not competent to complete the document. Competence is assumed unless there is evidence to suggest otherwise. Competence is a requirement for completing a legal document that prescribes future actions and decisions, such as an Advance Care Directive. A competent adult must understand what the document is, what it will be used for and when it will apply.

Consent: See Informed consent.

Consumer Centred Care: Healthcare that is respectful of, and responsive to the preferences, needs and values of patients, consumers and the community, and includes the dimensions of respect, emotional support, physical comfort, information and communication, continuity and transition, coordination of care, involvement of family and carers, and access to care.

De-briefing: These can be formal or informal discussions after an incident intended to exchange information, provide support and plan actions. Consumers, managers and workers can participate. Mental Health Fact Sheet 7 De-briefing following an incident of restraint and/or seclusion

Decision-making capacity: A person's decision-making capacity relates 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.

(Consent to Medical Treatment and Palliative Care Act 1995, Consent to medical treatment and Health Care Policy guideline and Providing Medical Assessment and / or Treatment where Consent cannot be obtained Policy Directive).

De-escalate: 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: 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.

Emergency medical treatment: Treatment that is necessary to meet an imminent risk to life or health (*Consent to Medical Treatment and Palliative Care Act 1995*).

Emergency response team: The team of medical, nursing, security and other health professionals with high level skills and knowledge of management in situations of challenging behaviour. This team responds to Code Black calls and similar with the primary aim of de-escalation and use of least restrictive practices to maintain safety and provide care, or further escalate to police or other agencies as indicated.

Escalation: With reference to challenging behaviour, this term can be used in either of the following ways:

- An increase in the intensity or seriousness of something; for example, intensification or an escalation of aggression.
- An increase in the response sought to a situation, where a low level response has failed to resolve the situation.

Harmful incident: An incident that led to patient harm. This term is used interchangeably with 'adverse event'. Such incidents can either be part of the healthcare process, or occur in the healthcare setting (ie while the patient is admitted to, or in the care of, a health service organisation). *(*Australian Commission on Safety and Quality in Health Care*)*

Incident: Any event or circumstance which could have (near miss) or did lead to unintended and/or unnecessary psychological or physical harm to a person and/or to a complaint, loss or damage *(*Incident Management Policy*)*

Informed consent: A process of communication between a patient who has decision-making capacity and their medical officer that results in the patient's authorisation or agreement to undergo a specific medical intervention. Consent obtained freely, without coercion, threats or improper inducements, after:

- appropriate description to the consumer of the nature of treatment involved, the range of other options, including not having any treatment, and the possible outcomes and implications such as the success rates and/or side effects for the consumer and others
- questions asked by the consumer have been answered
- provision of adequate and understandable information in a form and language demonstrably understood by the patient or substitute decision-maker.

(Consent to medical treatment and Health Care Policy guideline)

Intoxication: Means a temporary disorder, abnormality or impairment of the mind that results from the consumption or administration of intoxicants and will pass on metabolism or elimination of intoxicants from the body. (*Criminal Law Consolidation Act 1935*)

Least restrictive: 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*)

Mental impairment: Includes a mental illness; or an intellectual disability; or a disability or impairment of the mind resulting from senility, but does not include intoxication (*Criminal Law Consolidation Act 1935*).

Restraint: Means the intentional restriction of an individual's voluntary movement or purposeful behaviour by physical, chemical, mechanical or other means. A plain English definition for restraint 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
- to restrict a person's movement, so that something can be done to them. This is most commonly to enable safe provision of lawful and necessary health care or transport to a health care facility (where there is consent or a legal order)[7].

Restrictive practices: This term encompasses a range of methods, including seclusion, to either restrict movement or disengage from harmful behaviour. The term includes all the types of restraint and also the use of voice or language (sometimes called emotional restraint) and physical or mechanical barriers (sometimes called containment) to restrict a person's liberty or to contain a person in a designated space[8].

Seclusion: The confinement of a consumer at any time of the day or night alone in a room or area from which free exit is prevented[10]. Seclusion is not the deliberate isolation for the purpose of infection prevention and/or control, or during radio/chemotherapy.

Trauma informed care: A reconceptualisation of traditional approaches to health and human service delivery. Trauma-informed services are alert to the possibility of the existence of trauma in the lives of all clients/patients/consumers, irrespective of whether it is known to exist in individual cases. Child and adult trauma survivors are sensitised to stimuli that may trigger the fright fight or flight response. In order to minimise challenging behaviours, practice needs to be aimed at preventing this fear response. Key principles of trauma informed care include safety, trustworthiness, choice, collaboration and empowerment.

7 "Let's talk about restraint" Rights, risks and responsibility, 2008, Royal College of Nursing, UK
8 Restrictive physical intervention and therapeutic holding for children and young people – guidance for nursing staff, 2010 Royal College of Nursing UK.
10 National Mental Health Seclusion and Restraint Project, National Mental Health Commission.

Ulysses agreement: A consumer's documented plan for aspects of their care. These are used in Mental Health to provide services with an understanding of the person's wishes in relation to treatment and management during periods where their mental state may preclude them from making informed decisions. They are not legally binding and do not replace, rescind or over-ride an Advanced Care Directive.

Wandering: Ambulation or mobility that appears to be lacking in purpose or intent.

Worker(s): For the purposes of this document workers are generally referred to as staff or health care workers, including, but not limited to, employees, contractors, subcontractors, employees of contractors/subcontractors, employees of labour hire companies that have been assigned to work in the business, an apprentice or trainee, security officers, students (including dental, medical, nursing students contributing to health service provision and students gaining work experience) and volunteers.

For more information

SA Health
Safety and Quality Unit,
Telephone: (08) 8226 6971
www.sahealth.sa.gov.au/challengingbehaviourstrategy

Public: I1-A1

Interpreter

Government of South Australia

SA Health