Minimising Restrictive Practices In Health Care Toolkit

TOOL 4
Safe application of restrictive practices, and recovery

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**Purpose**

The purpose of this tool is to outline actions, strategies and considerations to achieve the least restrictive care and the safest possible outcome for all people, if restraint or seclusion is applied.

When restrictive practices are used, the wellbeing and safety of the consumer and staff is supported by actions before, during and after the use of restrictive practices.

1. Before - Actions include assessment and approval processes that ensure that there is proper authority, and takes into consideration the consumer’s decision-making capacity, mental and physical state, the level of risk and the ability of the service to apply restrictive practices safely.

2. During - Actions while a restrictive practice is in place will ensure that restrictive practices are in accord with current evidence, applicable law, policies and guidelines, and also applied in the safest, least restrictive and most respectful, humane way and for the least possible time.

3. After - Actions to optimise recovery, through implementing strategies such as de-escalation and de-briefing for all people present during and after the application of restrictive practices.

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**Restraint minimisation - Decision making flow chart**

Flowchart adapted from “Minimising restraint use in adults toolkit”, NSW Agency for Clinical Innovation, 2013.
Introduction

Restrictive practices result in the intentional restriction of an individual's voluntary movement or purposeful behaviour:

- to stop a person doing something they appear to want to do (where the consumer's actions are putting themselves or others at risk of harm, intentionally or unintentionally), or
- so that something can be done to them (most commonly to enable safe provision of necessary health care or transport to a health care facility).

There are physical and psychological risks associated with use of restraint and seclusion. Restrictive practices are potentially harmful, non-therapeutic interventions. Any use of physical force can significantly increase the chances of injury, harm or trauma to consumers and/or workers.

Restrictive practices should not be used as a punishment or for the convenience of others, or as an alternative to adequate surveillance, staffing or resources to provide safe care, or in an unsuitable environment for the individuals’ appropriate care.

Restrictive practices should never include deliberate infliction of pain or verbal threat of pain or other harm.

The use of restrictive practices can be minimised by positive changes to the provision of care and support, and using alternative strategies. This tool should be read in conjunction with Tool 3 Clinical strategies to minimise the use of restrictive practices.

Before - assessment and care-planning processes

Comprehensive documentation in the medical record or EPAS is important.

There are some key questions to ask when making the decision to apply a restrictive practice. If the answer to all these questions is no, re-consider using any restrictive practices.

1. Is there a current assessment? Is there a plan (personal prevention plan) already in place to guide action in such situations? Is the medical practitioner aware of the change in mental/physical state and these behaviours? If not a review is required.

2. Is the person physically or emotionally more vulnerable to harm from the restraint application procedure? Additional precautions may be required. Examples include:
   - people who have a history of trauma/detention who may be re-traumatised by the episode of restraint (e.g., refugees, prisoners of war, people who have been abused previously)
   - people who have intellectual disability and those with cognitive impairment such as dementia or delirium
   - people who have physical health issues, for example obesity or cardio-respiratory disease, osteoporosis
   - people who have a current injury, or have indwelling tubes or devices such as catheters, wound drains
   - 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 and Aboriginal and Torres Strait Islander people
   - children and young people, older people and pregnant women.

3. Have alternative strategies, such as changes to care and how it is delivered, been explored and attempted, as far as practicable?
   - Have alternative strategies failed to achieve or maintain safety for the consumer experiencing distress, staff or others?

4. Is there a clear understanding of the legal authority that applies in this situation (and underpins the clinical approval/order)?
   - Is it an emergency?
   - Is there immediate or imminent danger to a person, or people? Are the behaviours and actions assessed to be imminently or actually harmful to a consumer or others?
   - Does the health practitioner believe a failure to apply restrictive practices could put the patient, workers or public at a significant health or safety risk?
   - Does the person require immediate treatment to preserve their life or health?
   - Does the person have decision-making capacity? If yes, is there consent?
Is the person under a mental health Inpatient Treatment Order, or has the person been taken into Care and Control, because there is a likelihood that they are suffering a mental illness?

- For people subject to mental health treatment orders, the Restraint and Seclusion in Mental Health Services Policy Directive and Restraint and Seclusion – Application and Observation Requirements Chief Psychiatrist Standard outline the processes for initiating, reviewing and ceasing restraint and seclusion, as well as prevention, de-escalation, observation, debriefing, and cultural and age considerations.

- Is the person under a Guardianship order, and if so what is specified?

Further information is available:

- Tool 5 – Legal information about restrictive practices
- Providing Medical Assessment and or Treatment where consent cannot be obtained policy directive.
- MH Fact sheet Fact Sheet 8 Restraint and seclusion reporting
- Restraint and seclusion in mental health services policy guideline
- Minimising restrictive practices in health care Policy Directive
- Tool 1 - Quick guide to policy and legal information relating to challenging behaviour

5. Which clinicians will verify or sign off the care plan that includes the use of restrictive practice? What is the duration of this care plan (maximum 24 hours)?

6. Has the consumer and their carer or Substitute Decision Maker been involved in decision-making as far as practicable?

- Prior to application, decisions about restraint and seclusion should be made in consultation between the multi-disciplinary team and the consumer and their carer(s), or parent or guardian (if consumer is a child), or substitute decision-maker (SDM), as far as practicable.

- This consultation includes the provision of information about any legal orders, their rights and alternatives, in a format that matches their information needs.

7. What additional help is needed to be able to safely apply restrictive practices to this consumer with this team of workers?

- What skills, equipment and expertise is required, how quickly, and how many people?
- What are the options for retreat or withdrawal if required?
- Should there be a Code Black call made to request the immediate presence of an Emergency Response Team?
- Is additional assistance required from SA Police?

Before - team work and equipment

Team work

Restraint or seclusion of a patient will be applied by a clinically-led team. A suitably qualified and trained health professional leads the process of restraint. In some situations, the team should have leadership or extensive input from a clinician who has rapport or detailed knowledge of the consumer.

The team should have a clear plan for the application of restraint/seclusion, so that all members of the team:

- know their roles
- know when/if withdrawal is required, how that will be done
- know who is coordinating

Where vigorous resistance is anticipated and the intention is full restraint, a team should consist of at least five people.

A dedicated team should train together to develop knowledge and skills about teamwork and methods of application, withdrawal and equipment that optimise safety for staff and consumer.

Equipment

A range of appropriate equipment is available for restraint, and appropriate physical space for seclusion. Workers require training in the safe use of the available equipment.
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Services must only use mechanical restraint devices approved by the CEO or delegate for use within that health service, LHN.

Appropriate mechanical restraints must be:

- professionally manufactured and designed for purpose
- easy to apply and adjust to size, and have wide cuffs
- have no sharp edges and not be made from rough or abrasive material
- allow the patient to be placed in a sitting or lying position
- able to be cleaned.

During - minimising harm and trauma while applying restrictive practice

Any forcefully maintained position that hinders both chest, neck and abdomen movement can potentially cause asphyxiation, particularly if the consumer is intoxicated or already physiologically compromised (see vulnerable groups).

- Physical restraint when the person is in a prone position should be avoided to reduce the risk of positional asphyxia. If in the course of a restraint a person is in a prone position then this must cease as soon as practical and is not to exceed two minute duration. During this time one member of the team is responsible for monitoring respiration and for signs of physiological compromise.

- Prolonged physical (manual) restraint should be avoided, particularly if the person is bent over.

During – care of the restrained or secluded person

Any restrictive practices will be applied only to the extent that is reasonably necessary, that is for the shortest possible time and with least restriction. To minimise harm and duration:

- continue attempts to de-escalate and maintain communication with the consumer, provide information, reassurance and calming strategies, provide care and respect the person’s dignity
- constantly review the need for the restrictive practice to determine when restriction can be reduced or ceased
- where practicable, protect other consumers, visitors and staff not involved from becoming involved, witnessing or hearing the events, where these may be distressing.

Staff responsible for caring for a restrained or secluded consumer will have relevant knowledge and skills to carry out routine care including de-escalation and review as above. Care includes:

- monitoring physical status – the person should be able to be observed continuously. Observations including vital signs and pulse oximetry, skin integrity, are required 15 minutes after application and at least every 30 minutes after that. Monitoring includes that relevant for existing medical condition(s) or injury(s) and any additional monitoring indicated by the agents used (eg ECG monitoring, Glasgow Coma Scale)
- monitoring mental status - communication and continuous observation of behaviour and level of consciousness
- providing access to food, fluids, personal comfort and toilet facilities
- scheduled release of any mechanical restraint to protect circulation, joints and soft tissue, and to inspect skin, as follows:
  - no limb should be restrained longer than 50 minutes, and released for no less than 10 minutes in total per hour. If necessary release one limb at a time.
  - inspect the skin at every release
  - a person held in a restraint device that is attached to all four limbs will be allowed to change position, eg to stand, roll or walk at least every four hours.

Unless the treating doctor participated in the restraint or seclusion and /or approved the use of restrictive practices, he/she should be informed within one hour.

Restrictive practices are a team decision and must have a medical review within the first hour and every 4 hours thereafter, as well as review by a senior doctor before 8 hours.
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During - special precautions

- Any deterioration of the consumer’s physical condition triggers an escalation in care (multidisciplinary team review (MDT) or Medical emergency response (MER) as appropriate) and cessation of restraint / seclusion. Access to emergency resuscitation equipment is required.
- A person held in a restraint device that is attached to all four limbs, or a net, should be cared for in an area where their privacy can be protected, and efforts made to protect dignity at all times.
- Specialised care is required with the administration of sedative agents that can depress respiratory function, and for the care of the sedated consumer. This:
  - must only be performed by trained and experienced health professionals who have immediate access to a range of appropriate equipment and monitoring, as well as trained assistants
  - must follow evidence-based protocols, that include medications, dosage, additional monitoring required, least restrictive and least intrusive route of administration, and consider age, body size and co-morbidity
  - requires use of the Glasgow Coma Scale (GCS) or similar to monitor the level of sedation of the person.

During - review and cessation of restrictive practices

This is a clinical decision that should be informed by the observation and monitoring of the person, and the success of the ongoing de-escalation and calming strategies.

Physical or mechanical restraint, or seclusion, must be ceased when the person has:

- regained control of their behaviour
- the immediate risk of serious harm has passed
- the person's safety, and that of others, can be maintained
- the person can reliably assure staff that they or others are not at risk.

Similar to the approval for commencement of the use of restrictive practices, there should be two staff who approve cessation, and the treating doctor (if not one of the two) should be informed within an hour, and review as soon as practicable.

After - optimising recovery

The experience of forcibly applying restrictive practices, or of being restrained, or of witnessing a loved one being restrained can be difficult. Immediate and later strategies to promote short and long term recovery of staff, consumers and others involved should be readily available.

Any use of restrictive practices will be followed by appropriate care and support to all people involved or witnessing, including de-briefing to promote recovery and development of strategies to prevent recurrence.

These include, but are not limited to:

- access to medical treatment if physical injury has occurred
- de-briefing and on-going support to workers and other people involved in or witnessing an incident, as required
- de briefing using open disclosure principles and practices, and discharge planning, with consumer, carer, family
- team review of the incident
- access to treatment and supportive counselling through manager or Employee Assistance Program (EAP)
- modification to the consumer’s care plan to include care of any injury, supportive counselling, strategies to avoid future need for restraint (such as personal prevention plans or Ulysses agreements), discharge planning
- access to supportive counselling for the family, carers, witnesses and others affected
- the person and carer(s) are be given the opportunity to make complaints if they feel that inappropriate care was provided, and/or be involved in system improvement strategies aimed at reducing restraint and seclusion.

After an incident there are requirements for reporting into Safety Learning System and other reporting systems.
Managers’ roles

These include, but are not limited to:

> oversight of immediate actions to ensure safety and to gather information and preserve evidence if required
> promotion of team learning and quality improvement through reporting and review of incidents with team and individuals
> promotion of recovery of consumers and carers to re-establish a relationship with consumer and carers
> promotion of recovery of workers to ensure they feel safe, and have confidence in their ability to provide quality care
> participation in organisation-wide clinical governance system with responsibility for minimising use of restraint and seclusion, and that is aligned with systems for prevention and responding to challenging behaviour activities, such as:
  - clinical audit and data monitoring, including patient and consumer experience and feedback
  - incident management
  - oversight of professional development and implementation of best practice prevention
  - procedures and processes for approval, authorisation, application and recovery.

Further information is available:

> Restraint and Seclusion in Mental Health services Policy Guideline - Fact Sheet 7 Debriefing following restraint or seclusion incident
> Prevention and responding to challenging behaviour Policy directive and toolkit
> Tool 6 - A guide to the reporting and review of challenging behaviour incidents
> Tool 3 - Example terms of reference for a health service Challenging behaviour prevention and response committee