



Mental Health Restraint Policy

1. Background

In accordance with the [WA Chief Psychiatrist's Standards for Clinical Care 2015](#), WA Country Health Service (WACHS) is committed to working with consumers and carers to prevent, reduce and eliminate the use of restrictive practices. Early intervention, assessment, crisis management, de-escalation and other alternatives to restraint are preferred interventions of choice in managing patient care and safety. WACHS recognises however that there are circumstances where restraint may be necessary to minimise imminent risk to the patient, visitors and/or staff.

2. Policy Statement

WACHS upholds that the dignity and rights of people accessing mental health services must be respected and supported at all times. As such, restraint is only to be used as a last resort, with the least amount of physical force required and for the shortest period of time, when all other less restrictive interventions have been exhausted. The purpose of this policy is to describe safe clinical and documentation requirements should restraint be required to ensure the safety of the patient, staff or others within WACHS acute psychiatric units.

2.1 Legislative requirements

All staff must be aware of statutory requirements, best practice guidelines and reporting requirements in relation to restraint interventions.

- The use of restraint must be compliant with National and State policy, procedure and legislation. Restraint of patients with a mental illness at an authorised place must be conducted in accordance with the Mental Health Act (MHA) 2014
- Although non authorised areas fall out of the scope of the MHA 2014, and therefore the scope of this policy, it is recommended that all clinical staff refer to the Chief Psychiatrists Clinical Practice Standard: 'Seclusion and Bodily Restraint Reduction' for guidance around the restraint process.

2.2 Key Principles

- The use of restraint is not considered a therapeutic intervention and should be avoided wherever possible
- WACHS MH does not support the use of mechanical restraint
- Restraint must be used in the most respectful way and can only be considered when;

- There is an imminent risk of danger to the individual or others and no other safer intervention is identified at the time
- There is a need for the administration of a prescribed treatment and all attempts of all other least restrictive alternative interventions have been unsuccessful
- The use of restraint potentially creates significant risks for people with mental illness, their carers and staff. These risks may include physical harm and /or psychological trauma, loss of dignity, cultural harm, breakdown in therapeutic relationships and injury
- Staff must be aware of patient risk factors which may result in complications during and following the use of physical restraint (e.g. respiratory problems, cardiac conditions, pregnancy, etc.)
- The patient must be continually assessed to monitor for signs of physical deterioration. The restraint will be ceased immediately if the patient becomes physically compromised (e.g. vomiting, any indication of breathing difficulties and/or any changes to level of consciousness)
- Prone restraint should be avoided wherever possible. If required to safely manage the patient, prone restraint must not exceed three minutes due to an increased risk of hypoxia to the patient
- If there are concerns that a situation is escalating, or if consideration is being given to the use of restraint, the most senior registered nurse on the ward (after hours the most Senior Registered Nurse on duty) must be called to attend the clinical area as a matter of urgency. The purpose of this clinician attending is to assess and ensure all de-escalation and/or alternative interventions have been attempted
- If staff are concerned about escalation of a potentially dangerous situation, a Code Black should be called early to ensure prompt attendance by nominated staff and security personnel
- Patients, and with consent, their family/carer or nominated Personal Support Person (PSP), will be actively involved in the assessment process and their ongoing care planning and treatment choices.

2.3 Compliance with best practice standards

Compliance with best practice standards will be met by:

- Early identification and risk assessment of individuals who may require restraint as a safety intervention of last resort
- Implementing a comprehensive management plan, developed in a multi-disciplinary framework and in consultation with the person, their carers or nominated PSP, which identify relevant life experiences, risk factors and strategies to deal with episodes of violence and aggression
- High quality, active treatment interventions conducted by trained and competent staff who effectively employ individualised alternative strategies to prevent and defuse escalating situations
- Close monitoring and reporting of restraint as defined by the MHA 2014 legislation and regulations.

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- For Aboriginal people, taking into account traditional beliefs and practices and when practicable and appropriate, involving collaboration with health workers, traditional healers and language interpreters from their communities.

2.4 Prior to Restraint:

- On admission, clinical staff will ensure a risk assessment is undertaken to ascertain the potential for aggression or violence
- A Psychiatric Services Online Information System (PSOLIS) Management Plan will be completed with the patient and carer/family member as soon as practical on admission, identifying, wherever possible, precipitating and exacerbating factors which may result in restraint and outline a graded series of responses. Patients and their carer/family members must be given sufficient time to read through the Management Plan, offered an opportunity to ask questions, or seek clarification, before being asked to sign the document.
- Wherever possible restraint should be planned, and a nominated Lead Clinician, Team Leader and Scribe identified. In an emergency situation, when a restraint is unable to be planned, a Lead Clinician will be nominated immediately prior to the restraint commencing, or as soon as practically possible.
- Before undertaking a restraint, consideration should be given as to whether:
 - The patient is medically fit to be restrained
 - It is safe to do so based on assessing the number and appropriateness of staff available (including competency, size, physical health etc.)
 - It is safer to wait for more staff to become available, or to call police or other outside assistance
 - Evacuation is the safest option.
- Medical Practitioners, mental health practitioners or the person in charge of the ward must explore all least restrictive interventions prior to restraint being considered. Prevention and early interventions to consider include, but are not limited to:
 - Implementation of the patient's and/or family/carer's documented advice regarding the appropriate strategy to reduce distress and agitation
 - Defusing and de-escalation techniques
 - Peer support involvement, dependent upon consent of the patient and availability of the Peer Support Worker
 - Ensuring a culturally secure environment. This may include, if safe and appropriate, consultation with Aboriginal Mental Health Workers to communicate patient options
 - Diversional activities and sensory modulation
 - Low stimulus environment (e.g. comfort room, outdoor area, dedicated low stimulus zone)
 - Pro re nata (PRN) medication, used in conjunction with other strategies, for the purpose of calming, not sedating.

2.5 Exclusion Criteria:

- Restraint may not be used where the patient has been assessed as medically unfit
- Restraint may not be used for the purposes of discipline, coercion or staff convenience such as managing inadequate staffing levels.

2.6 Procedure to undertake restraint

Medium Risk Restraint	
Description	The situation or the patient's concerns cannot be easily de-escalated, posing an imminent risk of danger to the individual or others and no other safer intervention can be identified
Aim	To carry out the restraint using the minimum amount of force, for the minimum amount of time to address the risk posed
Method	Intervention by a minimum of two staff members. Restraint may be used in standing or sitting position. De-escalation and safe disengagement are utilised. MHA 2014 Forms are required for this level of restraint.

High Risk Restraint	
Description	There is imminent risk of danger to the individual or others and no other safer intervention can be identified
Aim	To carry out the restraint using the minimum amount of force, for the minimum amount of time to address the risk posed.
Method	Intervention by a minimum of 3 staff members. A full physical 3 point restraint managed by a Team Leader. The team consists of two staff members who are responsible for the patient's arms and one staff member (the Team Leader) who is responsible for co-ordination of the restraint intervention and communication throughout the interaction. The Team Leader continues to utilise de-escalation and crisis communication throughout the restraint process. On engagement with the patient, the staff responsible for the patient's arms step forward securing the arms in alignment with the patient's torso and the Team Leader takes a step back. The third member of staff can secure the patient's legs if the risks deem this is required. Crossing the patient's legs and positioning them near the buttocks will not be used during the restraint unless staff are exiting a seclusion room, and for no longer than 30 seconds. The restraint can be managed in a standing, kneeling or fully prone position. If

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prone restraint is required to safely contain the situation, it should not exceed 3 minutes due to an increased risk of hypoxia to the patient. If risk prevents cessation of prone restraint following 3 minutes, further prone restraint must be authorised by the most senior clinician in attendance. The Clinical Nurse Specialist (CNS)/Nurse in Charge of the Ward (after hours the most Senior Registered Nurse on duty) and the Medical Practitioner will be required to take an active and urgent role in identifying strategies to cease prone restraint at the earliest opportunity.

A staff member appointed as the Scribe records information as per the Scribe's role and liaises with the Team Leader and the Lead Clinician.

[MHA 2014 Forms](#) are required for this level of restraint.

2.7 Authorising Restraint:

- All forms related to restraint must be completed as per the [Reporting Restraint to the Chief Psychiatrist Flowchart](#)
- If the patient needs to be restrained urgently;
 - a medical practitioner, mental health practitioner or the person in charge of the ward can make an oral authorisation (Form 10A) or written authorisation (Form 10B) which allows the person to be restrained for 30 minutes
 - As soon as possible, and within 30 minutes, the person who authorised the restraint (if not a medical practitioner) must inform a medical practitioner that restraint is being or has been used.
 - The most senior registered nurse on the ward (after hours the most senior registered nurse on duty) will be informed of, and is required to attend the restraint as soon as possible.
 - The person who authorised the restraint must inform the Treating/Duty Psychiatrist within 30 minutes of the restraint and record the treating psychiatrist's name and qualifications and the date and time they were informed on the restraint form (Form 10C).
 - As soon as practicable after the restraint has been applied (or the patient has been released if the restraint is for a short time), the person who authorised the restraint must complete a restraint form (Form 10B).
- If a restraint is a planned event because a patient will not comply with treatment and needs to be restrained for treatment to be given, a medical practitioner, mental health practitioner or person in charge of a ward will complete a written authorisation for restraint (Form 10B).

2.8 Restraint to Administer Prescribed Treatment:

In the event a restraint is ordered by the Medical Practitioner to enable the administration of a prescribed treatment which is deemed necessary, the Medical Practitioner will:

- Discuss and explain the need for the treatment with the patient and their

- carer, nominated PSP and/or peer support worker
- Determine reasons why the patient may not be compliant with the treatment and offer a second opinion where no agreement can be reached
- Ensure all least restrictive alternatives are attempted, right up to the last moment, and documented in the patient's medical record
- Authorise the restraint; and
- Be present during the restraint.

Restraint is only to be authorised when there is documented evidence of the above steps being undertaken.

2.9 Patient Management during Restraint

- The Team Leader is responsible for ensuring the patient's wellbeing is continually assessed and their breathing is not compromised.
- Observations of the patient during restraint must be recorded on the Form 10D and must ensure that:
 - The patient has a clear airway
 - The patient's limbs are not being injured and
 - The restraint is not causing pain
- A mental health practitioner, registered or enrolled nurse must provide ongoing care, utilise verbal de-escalation techniques and ensure patient needs and dignity are met
- A Scribe will be nominated by the Lead Clinician and is responsible for recording in real time details of the restraint on the Physical Restraint form (Form 10D).
- The most senior registered nurse on the ward (after hours the most Senior Registered Nurse on duty) will be informed of, and is required to attend the restraint as soon as possible.
- In accordance with the patient's wishes and care plan, the family/carer, or PSP should be informed as soon as practical regarding the use of restraint and when it has been terminated. This contact is to be documented in the patient's medical record, identifying the family/carer or PSP and the time of the contact. If the patient does not wish to have the responsible person informed this is to be documented in the patient's clinical records.
- Only mental health practitioners or security staff working within WACHS MH services, who have successfully completed regionally endorsed training in the recognition and management of challenging and aggressive behaviour within the last 12 months, may be involved in the management of a patient in restraint.

2.10 Confirmation, Extension, Variation, Revocation or Expiry of Bodily Restraint

- If the restraint is prolonged, a Medical Practitioner will need to examine the patient and confirm if the restraint can continue beyond the first 30 minutes (Form 10E). Restraint can only be ordered for periods of 30

minutes at a time and the patient must be examined by a Medical Practitioner before any extension.

- Variations to the bodily restraint order are to be recorded (Form 10F).
- If the restraint is to be revoked, the Medical Practitioner will complete the required Form (Form 10G) and ensure an examination is carried out (Form 10i).
- If the restraint continues for more than 6 hours, a Psychiatrist must review the authorisation for restraint and make a record of that review (Form 10H).
- Following all restraints, the Medical Practitioner will, within 6 hours of release, conduct an examination to ensure the patient has not suffered any complication or deterioration of their mental or physical state (Form 10i).

2.11 Patient Management Post Restraint

- Following restraint, all patients must be offered support and counselling preferably from a person of their choice. Support may also include access to the Mental Health Advocacy Service.
- Aboriginal MH staff should ensure the cultural welfare and safety of the patient following restraint wherever possible
- A Post Restraint Interview must be offered to the patient and is to be conducted as soon as practicable by a member of staff chosen by the patient. With the consent of the patient, Peer Support involvement and the patient's family/carer and/or PSP should be included in the review process.
- The information gathered by the Post Restraint Interview is to be recorded as 'Post Restraint Interview' in the patient's medical record.
- The most senior registered nurse on the ward (after hours the most Senior Registered Nurse on duty) is responsible for ensuring the patient's risk assessment and management plan is reviewed and updated as part of the clinical review process in collaboration with the patient and/or their family/carer or PSP as soon as practicable post restraint.
- Patients have a right to refuse to engage in a Post Restraint Interview but every attempt should be made to engage them in the process. If a patient chooses not to engage in a Post Restraint Interview, this should be documented in the medical record.

2.12 Staff Debriefing

Line Managers must organise post restraint debriefing for staff in accordance with local service policies and procedures.

2.13 Documentation

- The relevant [MHA 2014 Forms](#) must be completed for every occasion of

bodily restraint

- All forms must be checked to ensure they are comprehensively and accurately completed and comply with the MHA 2014 legislative requirements prior to submitting to the Office of the Chief Psychiatrist (OCP)
- A copy of all restraint forms are to be forwarded to the Nurse Manager or delegate once all of the forms are checked and completed in full
- A copy of all the forms used in the restraint process must be given to the patient unless it is determined by the medical officer that to do so may not be in the best interest of the patient or others. If the forms are not provided to the patient, the medical officer will document the reasons for this decision in the patient's clinical record.
- Datix CIMS online notification form must be completed whenever the restraint has resulted, or may have resulted, in harm to the patient.
- The patient's management plan will be reviewed and updated after every incident of restraint.
- PSOLIS alerts and incidents will be reviewed and updated.
- Transfer and discharge documentation should include triggers that resulted in restraint and known individual de-escalation and preventative strategies

2.14 Executive Review of Restraint

An Executive Review of Restraint by the Clinical Director, Regional Manager (or delegate) and the Nurse Unit Manager must occur within seven days of the event occurring (see Appendix A). Outcomes of each review will be recorded on the relevant WACHS (Region Specific) Seclusion and Restraint database and in the patient's medical record.

Where required, a formal case conference can be coordinated for complex cases, which may include:

- Patients who have three or more restraint events within one week
- Any restraint longer than six hours
- Any event which results in an injury to the patient, staff or others
- If required, the Clinical Director can further escalate complex cases to the Director of Psychiatry and the Coordinator of Nursing Mental Health for an independent review.
- The Clinical Director will ensure evidence of local interventions and reviews are available during the independent review.

3. Definitions

Appropriately Trained Mental Health Clinician	This refers to a Mental Health Clinician, working within WACHS MH services, who has within the last 12 months, successfully completed regionally endorsed training in the recognition and management of challenging and aggressive behaviour. Staff who have not attained competency within the last 12 months, can assist during a restraint incident by:
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	<ul style="list-style-type: none"> • Raising the emergency response if required • Providing ongoing care for other patients • Offering support to others as required • Ensuring a safe environment for the restraint team • Notifying the Clinical Nurse Specialist (CNS), Medical team and next of kin of the incident • Checking, preparing and administering prescribed medications (within scope of practice) and/or • Other tasks as directed by the Team Leader
Bodily Restraint	<p>The physical or mechanical restraint of a person who is being provided with treatment or care at an authorised hospital. Bodily restraint does not include:</p> <ol style="list-style-type: none"> a) physical or mechanical restraint by a police officer acting in the course of duty; or b) physical restraint by a person exercising a power under section 172(2) MHA 2014.
Mental Health Practitioner	<p>A person who is accredited as one of the following, and has at least three years' experience in the management of people who have a mental illness:</p> <ul style="list-style-type: none"> • a psychologist • a nurse whose name is entered on Division 1 of the Register of Nurses kept under the Health Practitioner Regulation National Law (Western Australia) as a registered nurse • an occupational therapist • a social worker.
Physical restraint	<p>Restraint of a person by the application of bodily force to the person's body to restrict the person's movement.</p> <p>A person is not being physically restrained when being provided with the physical support or assistance reasonably necessary to:</p> <ol style="list-style-type: none"> a) enable the person to carry out daily living activities b) redirect the person because the person is disoriented

4. Roles and Responsibilities

All levels of leadership and management, both within Mental Health Services and at regional executive level, are to lead the monitoring and reduction of restrictive practices, as per the Chief Psychiatrist's Standards for Clinical Care 2015.

Clinical Leads

Provide strategic leadership, workforce and organisational development to ensure local health systems use least restrictive practice and reduce the use of seclusion and restraint

Managers and Clinicians

- Ensure clinical staff are provided with continuing education and support in least restrictive practice and the use of restraint and seclusion
- Ensure reduction in the use of restraint and seclusion and engage in monitoring of quality care and patient and population health outcomes to inform quality improvement
- Ensure documentation and reporting requirements of the MHA 2014 and associated regulations are met.
- Provide support, debriefing and opportunities to learn
- Aboriginal Mental Health Workers are to be involved following episodes of restraint when it is appropriate to follow up the cultural welfare and safety of the patient

Medical Staff

Medical staff must take a proactive role in minimising restrictive practices.

- The treating or on-call Psychiatrist must take an active leadership role in facilitating strategies which reduce restrictive practices
- Comply with the requirements of the MHA 2014 as they pertain to seclusion & restraint
- Medical staff must attend an Acute Psychiatric Unit, at the earliest possible time, when there is evidence of escalating risk not settling with remote support
- Medical staff must take an active decision making role early in the restraint process to limit duration and maximise safety

Lead Clinician

For the purpose of this policy the Lead Clinician is an appropriately trained Mental Health Clinician who coordinates the emergency situation and environment during the restraint intervention e.g. delegation of specific staff roles such as scribe and team leader, crowd control, medication and contacting the Medical Officer.

Team Leader

The Team Leader is an appropriately trained Mental Health Clinician who is selected on the basis of their rapport with the patient and their skills and competencies in the management of violence and/or aggression. The Team Leader is situated at the head of the patient and is responsible for the monitoring of the patient's safety during the restraint process.

The Team Leader's primary role is to:

- Communicate and support the patient
- Direct the restraint team to ensure safe physical restraint techniques are applied
- Monitor the patient's physical wellbeing
- Reduce the intensity of the restraint
- Increase the space available to the patient
- Gradually decrease the number of staff involved
- Consider the use of alternatives to restraint, and/or terminate the restraint if they assess it is safe to do so.

The Team Leader is also responsible for regularly communicating with the Lead Clinician and Scribe prior, during and after the emergency situation.

Scribe

The scribe is an appropriately trained Mental Health Clinician who is responsible for:

- Documenting the events as they occur in real time on the Physical Restraint form (Form 10D)
- Ensuring the recording of times are consistent across all documentation
- Advising the Team Leader of any concerns about the patient's safety and/or any imminent or ongoing threat to the safety of staff/others and
- Alerting the Team Leader of each minute that has elapsed and the length of time that has elapsed since the commencement of the restraint until the cessation of the restraint.

Security Personnel

Should Security Personnel attend a potential or actual restraint event, their role is to assist the clinical team under the direction of the Lead Clinician.

5. Compliance

Failure to comply with this policy may constitute a breach of the WA Health Code of Conduct (Code). The Code is part of the [Integrity Policy Framework](#) issued pursuant to section 26 of the [Health Services Act 2016](#) (WA) and is binding on all WACHS staff which for this purpose includes trainees, students, volunteers, researchers, contractors for service (including all visiting health professionals and agency staff) and persons delivering training or education within WACHS.

WACHS staff are reminded that compliance with all policies is mandatory.

Seclusion and Restraint data is monitored and reviewed at the WACHS Mental Health Safety, Quality and Risk Steering Committee and by the WACHS Board. All seclusion and restraint forms are provided to the Office of the Psychiatrist for review and monitoring.

6. Records Management

[MHA Forms 2014](#)

7. Evaluation

Evaluation of this policy is to be carried out by the Director of Psychiatry Adult / Older Adult every three years at minimum.

8. Standards

[National Safety and Quality Health Service Standards](#) – 5.31, 5.32, 5.33, 5.34, 5.35, 5.36, 6.7, 6.8, 6.9, 6.10, 6.11

[National Standards for Mental Health Services](#) - 1, 2, 6, 8, 10

9. Legislation

[Health Practitioner Regulation National Law \(WA\) Act 2010](#)
[Mental Health Act 2014](#)

10. References

Chief Psychiatrist's Standards for Clinical Care: Seclusion and Bodily Restraint Reduction [Mental Health Act 2014, Division 6](#)
[Strategies to end the use of seclusion, restraint and other coercive practices; World Health Organisation, 2017](#)
[Restraint reporting to the Chief Psychiatrist \(Authorised Hospitals\) WA](#)

11. Related Forms

[Mental Health Act 2014 Forms](#)

12. Related Policy Documents

WACHS [Mental Health Seclusion Policy](#)

13. Related WA Health System Policies

[WA Health Code of Conduct](#)
[WA Health Consent to Treatment Policy](#)

14. Policy Framework

[Mental Health Policy Framework](#)

**This document can be made available in alternative formats
on request for a person with a disability**

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Appendix A: Executive Review of Restraint

An Executive Review of Restraint by the Clinical Director, Regional Manager (or delegate) and the Nurse Unit Manager must occur within seven days of the event occurring.

The purpose of the Executive Review of Restraint is to consider the following questions:

- 1 Could the restraint have been anticipated?
 - a If so, could any management strategies have been put in place sooner?
 - b Was the patient's risk assessment accurate and contemporaneous?
- 2
 - a Which staff were involved in the restraint?
 - b Were all staff involved in the restraint appropriately trained mental health clinicians*? **This refers to WACHS mental health clinicians, who have within the last 12 months, successfully completed regionally endorsed training in the recognition and management of challenging and aggressive behaviour.*
- 3 Was the restraint performed safely and in accordance with overarching legislation, policy and standards?
- 4 Did the restraint result, or have the potential to result, in harm to the patient?
 - a If so, were any immediate health care needs of the patient identified and met?
 - b Was a Datix CIMS online notification completed at the time?
 - c Following this Executive Review of Restraint, does a CIMS online notification form and subsequent investigation need to be initiated?
- 5 Did the restraint result in harm to staff or others?
 - a If so, were their immediate health care needs identified and met?
 - b Were the required Occupational Health and Safety forms completed?
- 6 Were cultural considerations taken into account prior to, during and following the seclusion?
- 7 Was all required documentation completed in line with MHA 2014 requirements?
- 8 Was a Post Restraint Interview offered to the patient?
 - a With consent of the patient, was their family/carer/PSP and Peer Support included in the review process?
- 9 Was debriefing organised for staff following the restraint?
- 10 What worked well for this patient?
- 11 What could be done differently in the future?
- 12 How will the results of this review be shared with ward/local staff and others?