Guideline

Aggression, Seclusion & Restraint in Mental Health Facilities - Guideline Focused Upon Older People

Summary This guideline supports the implementation of PD2012_035 Aggression, Seclusion and Restraint: Preventing, Minimising and Managing Disturbed Behaviour in Mental Health Facilities in NSW within mental health settings focused upon older people.

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Secretary, NSW Health

Guideline

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GUIDELINE SUMMARY

AGGRESSION, SECLUSION AND RESTRAINT: PREVENTING, MINIMISING AND MANAGING DISTURBED BEHAVIOUR IN MENTAL HEALTH FACILITIES IN NSW

Guideline for implementation in mental health settings focussed upon older people

PURPOSE

This document provides guidance about caring for older people whose behaviour can potentially cause harm.

KEY PRINCIPLES

The key principles outlined in the Australian National Seclusion and Restraint Project (2009) *National Suite of Documentation* guide this document. These principles are summarised below and detailed in PD2012_035 Appendix 3.

Principle 1: Protection of fundamental human rights
Principle 2: Protection against inhumane or degrading treatment
Principle 3: Right to highest attainable standards of care
Principle 4: Right to medical examination
Principle 5: Documentation and notification
Principle 6: Right to appropriate review mechanisms
Principle 7: Compliance with legislation and regulations

USE OF THE GUIDELINE

This guideline may be used in mental health facilities in NSW focussed upon older consumers. It can be applied to the care of older people in all mental health units.

It is designed to be read in conjunction with PD2012_035 Aggression, seclusion and restraint: Preventing, minimising and managing disturbed behaviour in mental health facilities in NSW.

REVISION HISTORY

Version	Approved by	Amendment notes
June 2012 (GL2012_005)	Director-General	New Guideline

ATTACHMENTS

1. Aggression, seclusion and restraint: Preventing, minimising and managing disturbed behaviour in mental health facilities in NSW: Guideline for implementation in mental health settings focussed upon older people.

Aggression, seclusion and restraint: Preventing, minimising and managing disturbed behaviour in mental health facilities in NSW

Guideline for implementation in mental health settings focussed upon older people

NSW GOVERNMENT Health

GUIDELINE

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CONTENTS

1 BACKGROUND

1.1 About this document

This guideline supports the implementation of PD2012_035 *Aggression, seclusion and restraint: Preventing, minimising and managing disturbed behaviour in mental health facilities in NSW* within mental health settings focussed upon older people. PD2012_035 discusses interventions to be undertaken in NSW mental health facilities to minimise and manage disturbed behaviour. Its major focus is on the prevention of aggressive behaviour. It also includes information about seclusion and restraint practices.

Reducing the use of seclusion and restraint has been identified as a major practice change initiative for Australian mental health services. The National Mental Health Seclusion and Restraint Project (NMHSRP) involved collaboration between State and Territory Governments and the Commonwealth to reduce and, where possible, eliminate the use of seclusion and restraint in public mental health services.

PD2012_035 is based on the national documentation, principles and six core strategies of the NMHSRP and supports the reduction of seclusion and restraint in NSW Mental Health Services.

This guideline has been developed as older people may experience disturbed behaviour resulting from medical and other reversible factors as well as from psychiatric symptomatology. Restrictive interventions pose particular risks to older people, including falls, serious injury, increased duration of hospitalisation and death.

Balancing care and safety

Health workers, particularly those who work in mental health units and emergency departments, carry a greater risk of work-related aggression than workers in many other occupations. Some of this aggression is caused by a small minority of mental health consumers, though most mental health consumers pose no risk at all (Finfgeld-Connett, 2009: Victorian Government, 2004; Workcover, 2001).

In mental health there is a delicate balance between the need to prevent and manage aggressive behaviour so that staff, consumers and visitors are safeguarded, and the need to promote the health and welfare of consumers in the least restrictive manner (Livingston et al, 2010; Victorian Government, 2004; NSW Mental Health Act, 2007).

Promoting a safe workplace requires a complex equation of appropriate environmental, policy, staffing, training, emergency response and review and support mechanisms (Victorian Government, 2004; Workcover, 2001). Managing aggressive behaviour is one part of this equation; however, there is no universally agreed method of doing so (Finfgeld-Connett, 2009; Happell & Harrow, 2010; Laker et al, 2010; Livingston et al, 2010; Stubbs et al, 2009).

Seclusion and physical/manual restraint are used in some mental health inpatient units as a means of managing aggressive behaviour, though paradoxically their use carries some risk of

physical and mental harm to health workers and consumers alike (Happell & Harrow, 2010; Stubbs et al, 2009).

A broad approach to aggression management that focuses on prevention strategies and considers individual, environmental, and clinical variables is likely to yield the most effective results (Biancosino et al, 2009; Davison, 2005; Finfgeld-Connett, 2009; Livingston et al, 2010).

Many mental health consumers have experienced trauma at some point in their lives and this trauma impacts on their interactions with people and services (Jennings, 2004; SAMHSA).

> *"Traumatic experiences can be dehumanizing, shocking or terrifying, singular or multiple compounding events over time, and often include betrayal of a trusted person or institution and a loss of safety...Trauma includes physical, sexual and institutional abuse, neglect, intergenerational trauma, and disasters that induce powerlessness, fear, recurrent hopelessness, and a constant state of alert."* (National Centre for Trauma Informed Care, SAMHSA, accessed March 2011).

Some interactions, like seclusion or restraint, can trigger vulnerabilities from past trauma. Mental health services can avoid unintentionally retraumatising vulnerable consumers by avoiding coercive practices and through respectful collaboration between the consumer and the people close to them. During any incident involving seclusion or restraint, this principle can be supported by remaining as calm as possible, explaining the process, why it is being initiated and what is required for the process to cease.

Seclusion and restraint represent one end of a spectrum of responses to aggressive behaviour and the risk of imminent harm but are not considered forms of therapeutic treatment in NSW. The position of NSW Health is that a range of therapeutic interventions and broad risk management approaches for managing aggression will be utilised in place of seclusion and restraint whenever this is safely possible.

At all times, the clinician's primary goals will be to safely:

1. **engage** with the consumer
2. **identify** the causes of any behavioural disturbance
3. **treat** those causes appropriately.

This practice, along with environmental, resource, educational and skill support, can prevent many episodes of seclusion and restraint and result in a safer workplace (Biancosino et al, 2009; Davison, 2005; Finfgeld-Connett, 2009; Livingston et al, 2010).

The Zero Tolerance approach to violence in the workplace emphasises effective clinical management and compassionate care of consumers. It requires people to consider their behaviour and its effect on others. Because mental illness and mental disorder can sometimes lead to diminished control, impulsivity and lack of ability to self regulate behaviour, the Zero Tolerance policy requires special consideration in mental health services.

Physical contact and restraint

It is important to be respectful of the personal space of all mental health consumers and mindful of any physical contact or touch. When giving care of any kind, prior negotiation of physical contact with the consumer is preferable.

Involuntary confinement and a feeling of lack of control can be distressing for mental health consumers and can preface an aggressive incident (Finfgeld-Connett, 2009). In situations when a consumer demonstrates signs of escalating aggression, all reasonable steps will be taken to seek resolution without physical contact. When this is not possible, short term physical/manual restraint may occasionally be required.

Training in Local Health Districts (LHDs) will address the principles of physical/manual restraint to ensure these interventions are respectfully and safely applied.

Restraint position

There have been instances both in Australia and internationally in which young apparently healthy people have died suddenly while being held in a physical/manual restraint. The face down position in restraint has been implicated in these deaths.

In NSW, in those rare circumstances when physical/manual restraint is required, face up restraint may be safer in some situations.

When face down restraint is used, it will be time limited. The maximum time a person will be held on the ground in face down restraint is approximately 2-3 minutes, the minimum amount of time necessary to administer medication and/or remove the person to a safer environment.

Mechanical restraint

Mechanical restraint devices include belts, harnesses, manacles, sheets, straps, mittens and other items used to restrict a consumer's movement.

NOTE: handcuffs are not an acceptable form of restraint in NSW Health facilities.

Mechanical restraint devices are not routinely used in NSW mental health facilities and their inclusion in this document is not a recommendation for increased usage. In facilities that use mechanical restraint, the equipment must be reviewed and approved for use by the relevant LHD governance committee(s) and specific policies and procedures must guide their use.

Staff within mental health settings focussed upon older people must be provided with specific training and refresher training in the procedures for use of the equipment, in a manner relevant to older consumers. All restraints must be kept clean, working and safe (including no hard/abrasive/ sharp edges). The use of any such device must be carefully monitored and recorded in a Register.

Any consumer in a mechanical restraint device involving the restriction of all limbs will be given 1:1 nursing care.

At no time will a consumer in mechanical restraint be held in a locked room.

Care will be taken to protect the privacy and dignity of any person in a mechanical restraint device who is in a public area.

Chemical restraint

"Chemical restraint" is a term used to describe a pharmacological method used solely to restrict the movement or freedom of a consumer. Chemical restraint through the overuse of sedation is not an acceptable form of restraint and is not used in NSW.

Medications used as part of a treatment plan to manage a mental disorder or mental illness are not considered chemical restraint. Emergency sedation or rapid tranquillisation that is used to manage disturbed behaviour resulting from a mental disorder or mental illness is not considered chemical restraint in NSW.

Sedative medication can be appropriately used for the management of disturbed behaviour. It is important that this practice is safely managed by adherence to evidence based guidelines.

1.2 Applicability

This guideline may be used in mental health facilities in NSW focussed upon older consumers.

If there is a need for local supporting documents, they should include an electronic reference or hard copy of this guideline. If it is necessary for local variation from this guideline, that reason should be noted in local documents

It is recognised that there may be rare occasions when it is necessary to deviate from this procedure. In these instances, reasons for the deviation must be noted in the consumer's health care record and included in a post-incident review.

1.3 Target audience

This document applies to members of multidisciplinary teams in all public mental health facilities in NSW focussed upon older consumers.

It also applies to non-clinical staff involved in managing aggressive behaviour in such settings.

More specific responsibilities are outlined in the related Policy Directive.

1.4 Other relevant information

A full reference list is provided in PD2012_035 **Appendix 7.**

This document has been designed to be read in conjunction with:

NSW Health GL2008_017 Health Facility Guidelines – Australasian Health Facility Guidelines in NSW

NSW Health (2009) Mental Health for Emergency Departments: A Reference Guide

NSW Health PD2007_061 Incident Management

NSW Health PD2011_077 Recognition and Management of Patient who is Clinically Deteriorating

NSW Health PD2009_027 Physical Health Care within Mental Health Services

NSW Health GL2009_007 Physical Health Care of Mental Health Consumers

NSW Health PD2005_593 Privacy Manual (Version 2) – NSW Health

NSW Health PD2007_040 Open Disclosure

NSW Health PD2005_315 Zero Tolerance Response to Violence in the NSW Health Workplace (under revision

Department of Health and Ageing (2004) Decision-Making Tool: Responding to Issues of Restraint in Aged Care

1.5 Key definitions

Key Definitions used in this document can be found in **Appendix 2 of** PD2012_035.

Key Principles that shape this document can be found in **Appendix 3 of** PD2012_035

2 PREVENTING DISTURBED BEHAVIOUR IN OLDER PEOPLE

Disturbed behaviour in all mental health units can sometimes be linked to external factors such as clinical symptomatology, interpersonal interactions, the environment and other causes. Some of these causes can be prevented (Davison, 2005; Finfgeld-Connett, 2009). Disturbed behaviour in older people can also be linked to medical illness, physical discomfort, sensory impairment, or having significant unmet needs that they cannot communicate to staff. People with dementia are more vulnerable to these influences.

To prevent disturbed behaviour, it is important for managers and staff to incorporate risk identification and management into routine and ongoing team communications. A variety of means may assist this process including (but not limited to):

- Interacting with consumers, visitors and colleagues in a respectful, calm, professional manner
- Explaining procedures and providing clear information about mutual expectations of reasonable behaviour to consumers and visitors
- Supporting individual recovery goals
- Practising patient centred care that responds to the individual clinical needs of each consumer and is not focussed on the convenience of the health service
- Genuinely engaging with and including consumers, families and carers in all aspects of care, including incident review processes (Finfgeld-Connett, 2009)
- Identifying particular stressors for each consumer as well as their current drug and alcohol use, previous trauma and history of aggression
- Using individually tailored, holistic care plans for each consumer that identify a range of strategies for preventing and dealing with stress, substance withdrawal (including nicotine) and disturbed behaviour
- Employing appropriate risk identification, assessment and management practices that apply to individual consumers, the unit environment and potentially stressful situations (such as Mental Health Review Tribunal hearings)
- Promoting good communication between all members of the multidisciplinary team about the risks that have been identified and strategies to manage that risk
- Implementing a predictable routine with a range of meaningful activities (Davison, 2005; Finfgeld-Connett, 2009)
- Promoting high levels of interaction between staff and consumers (Davison, 2005)

- Ensuring staff have access to training consistent with the core education and training priorities of the National Mental Health Seclusion and Restraint Project (**Appendix 4 of** PD2012_035)

- Building well designed units that provide lots of space and privacy for the consumer and encourage high levels of contact between staff and consumers (Biancosino, 2009).

As the risk of falls is often considered in decisions to use restraint, all mental health inpatient units with a role focussed upon older people should ensure they are complying with PD2011_029 *Prevention of Falls and Harm from Falls among Older People: 2011-2015*. They should also be aware of the NSW Falls Prevention Strategy and consider implementing relevant strategies.

All mental health inpatient units with a role focussed upon older people should also ensure staff have access to appropriate guidelines on the assessment and management of delirium, such as *Clinical Practice Guidelines for the Management of Delirium in Older People*.

All mental health inpatient units with a specialised function in managing older people should have an approved format for recording and communicating a behaviour management plan that is consistent with person centred care. Two approaches to such planning are shown in Appendix 1. They should also consider having specific tool(s) for behavioural assessment such as a behavioural monitoring log (example can be found in GL2006_014 *Guidelines for working with people with challenging behaviours in residential aged care facilities*).

3 MINIMISING DISTURBED BEHAVIOUR

When a consumer shows signs of distress, anger or aggression, mental health clinicians are supported to intervene promptly and take a problem solving, flexible and therapeutic approach (Finfgeld-Connett, 2009).

When clinicians recognise that a consumer is becoming distressed or aggressive, ward procedures must support them to employ a range of therapeutic interventions including (but not limited to):

- Spending 1:1 time with the consumer and actively engaging with them
- Employing active listening skills to hear what the consumer is trying to convey
- Using short, clear sentences in a lower tone of voice
- Promoting opportunities for contact with a friend or family member (as long as this is agreeable to the consumer)
- Using strategies negotiated with the consumer that help them manage stress
- Engaging the consumer in a physical activity
- Using sensory modulation equipment
- Offering an opportunity for time out in an unlocked area where the consumer can be on their own to calm down (e.g. bedroom, quiet room)
- Employing a range of de-escalation techniques
- Offering PRN medication
- Offering nicotine replacement therapy (for smokers) to reduce symptoms of agitation or other strategies in line with GL2009_014 *Smoke-Free Mental Health Facilities in NSW – Guidance for Implementing*.

Section 5.1 provides further information regarding communicating with older people.

Staff safety must be considered when deciding on the most appropriate interventions.

Mental Health services will ensure all members of the mental health team are competent in a range of interventions to minimise disturbed behaviour consistent with the core education & training priorities in Appendix 4 of PD2012_035.

3.1 Considering possible causes

In addition to the strategies above, the possibility of delirium must be considered in the assessment of any older consumer who is becoming agitated, distressed or 'confused'; or for whom restraint, seclusion or sedation is being considered. Assessment must also consider if other reversible factors of agitation or ataxia are present.

A list regarding relevant factors is available in Table 1.

Table 1: Factors to consider in the assessment and management of a patient potentially requiring the use of restraint, sedation or seclusion

(adapted from *Clinical Practice Guidelines For The Management Of Delirium In Older People* and Sydney's St Vincent's Hospital guidelines and DoHA's *Decision Making Tool: Responding to issues of restraint in Aged Care*)

Start with critical management issues that may be associated with delirium:

- Has hypoxia been ruled out?
- Has hypotension been ruled out?
- Has hypoglycaemia been ruled out?
- Has major electrolyte disturbance been ruled out?
- Has an infection been ruled out?
- Has urinary retention been ruled out?
- Has constipation and faecal impaction been ruled out?
- Has a history regarding all the medications currently taken been obtained?
- If a person is agitated/distressed: has pain, thirst and hunger been ruled out?
- Is alcohol withdrawal syndrome possible?

Consider other clinical factors that may require management:

- Distress
- Pain
- Post-operative complications
- Alcohol/drug withdrawal/intoxication
- Other metabolic abnormalities
- Hydration
- Hunger
- New/increased psychosis
- Depression or anxiety
- New neurological deficit

Comfort factors that may be able to be addressed:

- Positioning
- Temperature
- Immobility
- Communication issues – e.g. need for interpreter, hearing aid, glasses etc
- Boredom
- Toileting needs
- Thirst
- Loneliness
- Lack of activity
- Constipation

Environmental factors that may be modifiable:

- Noise
- Odours
- Lighting
- Temperature
- Over/under-stimulation
- Hazards
- Staff gender/cultural taboo for personal care

Factors that may need be known to impact on ability to cooperate with interventions and require further assessment or influence interventions:

- Acquired cognitive impairment (dementia, delirium, head injury)
- Developmental disability
- Psychosis
- Severe depression or anxiety
- Cultural beliefs

The following investigations are used to screen for common causes of delirium:

- Urinalysis and MSU (if urinalysis abnormal)
- Full blood examination
- Urea and electrolytes
- Glucose
- Calcium
- Liver function tests
- Chest x-ray
- Cardiac enzymes
- ECG

Further investigations will be dependent upon clinical features and expert consultant advice, and may include:

- Specific cultures, eg blood and sputum (if fever present, cough and/or abnormal chest radiograph)
- Arterial blood gases (if short of breath, cough and/or abnormal chest radiograph)
- CT brain (if history of falls, patient/client on anticoagulant therapy or focal neurological signs present)
- Lumbar puncture (if headache and fever and meningism present)
- EEG (may assist in determining aetiology eg non-convulsive status epilepticus)
- Thyroid function tests
- B12 and folate

3.2 Strategies specific to older people

The following tables provides strategies specific to older people that may prevent the need for restraint. It is a compilation of Joanna Briggs Evidence Based Practice Information Sheets for Health Professionals and the NCAHS Restraint Alternatives and Behaviour Management Strategies Checklist.

It is recommended that all mental health units with a specialised function in managing older people review this list in light of their role, clinical population and resources to determine which strategies will be available and supported locally. A proforma should then be developed that allows staff to indicate what strategies have been used with an individual patient, based upon a prioritised form of this list.

Table 2: Management strategies for specific older populations

Table 2: **Management of Specific Populations**

Cognitively Impaired Person

- wall-mounted white board marker to record day of week & the names of staff
- continuous orientation to environment
- provide familiar objects from person's home
- reality orientation
- involving patient in conversation
- a confusion box containing such things as laundry to fold, stuffed animals, purses and wallets
- small hand held objects
- changing resident's seating arrangements throughout the day
- television or radio
- listening to music
- bed, chair or wrist alarms
- remove or treat cause of delirium
- identify bathroom with picture
- confused patients near nurses station

Person at Risk of Falling

- coloured armbands to identify people at risk of falling
- fall precautions and risk factors identified for each person
- fall prevention program

Person who Wanders

- picture taken and kept in nurses station to aid in finding them
- identify those who are mobile and confused on admission
- a unique house coat designed and used for wandering patients to aid in easy recognition by staff
- implemented a "code yellow" that required all staff to immediately look in their area for the missing patient
- visual barriers for doors
- cloth barriers across doorways, attached with velcro
- locked door or closed unit
- alarm devices and exit door alarms
- sheltered courts and gardens and easy access to safe outdoor areas
- circular corridors, activity areas at the end of each corridor
- provide activities, walking and recreation
- night-time activities for those who wander at night

Person who Tampers with Medical Devices

- IM instead of IV therapy
- abdominal binder placed over padded gastrostomy tube
- mittens or socks on hands instead of wrist restraints
- soft football shaped foam in person's hand covered with stockingette to protect medical devices

Agitated or Violent Person

- rocking chair and recliners
- soothing music
- offer diversions such as TV or radio

Person with Impaired Mobility

- physical and occupational therapy
- rehabilitation and exercise programs
- teach safe transfer techniques
- development of an ambulation program
- create path clear of furniture
- non-slip floor treatment
- body padding
- mobility aids
- use of transfer rails
- appropriate shoes and treaded slippers
- encouraging consistent use of assistive devices

Table 3: General strategies suitable for older people in hospital

PHYSIOLOGICAL STRATEGIES

- Regular mobilisation
- Bowel management
- Toileting program
- Offer diet and fluids
- Facilitated safe wandering
- Warm milk
- Change of seating arrangement
- Resite IV
- Rest period
- Try different staff members
- Regular physical review
- Leave for 5 minutes and try again
- Medication review
- Treatment of infections
- Hip protectors
- Pain management
- Schedule analgesia to help overcome insomnia
- Remove any physiological causes of mental state impairment

SEATING POSITION AND SUPPORT

- Chairs with deep seats
- Pillows on seats
- Large pillows (like bean bags) on floor
- Rockers or recliners
- High back or supportive chairs
- Removal of wheels
- Customised seating (wedge cushions, D placement cushions or with hole in centre)
- Bean bag cushions for chair to reduce risk of slipping or for person with continuous 'jerky' movements to stop them moving out of chair
- Wheelchair arm cushion to prevent sideways slumping/leaning of person with CVA

SAFETY IN BED

- Concave mattress
- Water mattress to reduce movement to edge of bed
- Use of body length pillows to aid positioning
- Individualise bed height
- Person at risk to sleep on a mattress on floor
- Removal of wheels
- Bed height adjusted to lower leg length
- No bedrails, or half bedrails with low beds
- Non-slip strips on floor by bed
- Trapeze to enhance mobility in bed
- Chair or table at bedside to help with transfer
- Positioning cushions to prevent movement to edge of bed
- Soft floor mat or mattress by bed to cushion any falls
- Visual reminders to encourage patient or resident to use call bell

- Bed boundary markers to mark edges of bed, such as mattress bumpers, rolled blanket or 'swimming noodles'
- Under sheets

TOILETING AND CONTINENCE

- Frequent assistance with toileting
- Toileting schedule
- Cleaning promptly after soiling
- Individual elimination rounds
- Incontinence evaluation
- Identify bathroom with picture/appropriate language
- Bedside commode

ENVIRONMENTAL

- Modify lighting, easy to turn on lights
- Non-slip strips on floor/non-slip floors
- Clear pathways
- Easy access to safe outdoor areas
- Lowered bed height
- Locked exit doors
- Increased staffing (special)
- Cloth barriers across doorways attached with velcro
- Remove wheels from bed
- Activity areas at the end of each corridor
- Ensure mobility aids are easily reached
- Reduce environmental noise
- Soothing music
- Structural design of units modified to enhance visibility of residents
- Signage

ALARMS

- Bed, chair or wrist alarms for cognitively impaired
- Alarms to manage wandering
- Exit door alarm
- Electronic sensor system

PSYCHOSOCIAL INTERVENTIONS

- Active listening
- Individualised activity
- Family /friends/volunteers companionship, increased visiting
- Familiar staff /encourage and or increase interaction
- Therapeutic touch
- Massage, relaxation techniques
- Behaviour modification
- Reality orientation
- White noise for insomnia
- Sensory aids, sensory stimulation or decreased sensory stimulation
- Quiet room, reduced environmental noise

ALTERATIONS TO NURSING CARE

- Additional supervision and observation
- Evaluate and monitor conditions that can alter behaviour
- Increase staffing levels
- Individualised daily routines, such as toileting and napping
- Structured daily routines
- Individual needs of person known to staff
- Nursing assistants learning to anticipate and be present during transfers
- Call bell within reach
- At risk patients near nurses station
- Change bothersome treatments, such as initiate oral feeding instead of IV or NG and removal of catheters and drains as soon as possible
- Individualised person centred care
- Facilitated napping
- Limit time spent in bed to sleep time

ACTIVITIES AND PROGRAMS

- Developing rehabilitation and exercise programs that involve teaching safe transfer techniques
- Development of an ambulation program
- Physical, occupational and recreational therapies
- Exercise incorporated into the daily plan of care
- Night time activities for those who wander at night
- Individual and group activities
- Recreational and social activities
- Appropriate outlets for industrious or anxious behaviour
- Structured daily routines
- Wandering should be permitted

4 RESTRAINT AND SECLUSION PROCESSES

4.1 Restrictions on the use of restraint & seclusion

NSW SMHSOP benchmarking activities in 2010 demonstrated minimal access to a seclusion room within SMHSOP specific inpatient units, but significant variation in restraint practice. This variation appeared, at least in part, related to variation in consumer populations.

Mechanical restraint use is still not a common event in SMHSOP inpatient units. Inclusion of advice regarding mechanical restraint devices and seclusion in older people in this document is not a recommendation for increased usage. In facilities that use mechanical restraint, the equipment must be reviewed and approved for use by the relevant governance committee(s) and specific policies and procedures must guide their use.

Physical/manual restraint by a team, mechanical restraint and seclusion should only be used for people detained in a mental health facility under the NSW Mental Health Act 2007. If one of these interventions is applied to a voluntary patient, they must be assessed by a Medical Officer (M.O.) as soon as possible after the event to review their status under the Mental Health Act.

Non-declared mental health facilities should have appropriate policies and procedures to ensure that if restraint is required within non-declared mental health units, such as Transitional Behavioural Assessment and Intervention Service (T-BASIS) units, then any necessary consent is obtained consistent with the NSW Guardianship Act 1987). In exceptional circumstances where emergency restraint may be needed, immediate consent would not be required; however, the Guardianship Tribunal must be notified to consider a guardianship order at the earliest opportunity thereafter.

Physical/manual restraint by a team of trained staff, mechanical restraint or seclusion can be used to manage the risk of serious imminent harm only when appropriate, safe **alternative options** have been considered and trialled and only for **the briefest period** required to allow the consumer to regain control of their behaviour and maintain their safety.

The use of restraint and seclusion is guided by the following principles:

- The safety and wellbeing of the person is vital
- The safety and wellbeing of staff is vital
- Seclusion or restraint is used for the minimum period of time
- All actions undertaken by staff are justifiable and proportional to the consumer's behaviour
- Any restraint used must be the least restrictive to ensure safety
- The consumer is regularly reviewed and monitored so that any deterioration in their physical condition is noted and managed promptly and appropriately.

4.2 Seclusion of older people

As seclusion within an inside area is rarely required for older people, inpatient units with a role focussed upon older people will rarely require a seclusion room. Such units should have clear policies regarding when the use of a courtyard or other larger area may be considered seclusion and ensure that such use is consistent with this policy. They should also have clear guidance regarding indications for transfer to an alternate unit of a consumer due to need for seclusion to ensure that such transfers are appropriate and safe.

Interpretation of the definition of restraint in consumers who are immobile, or whose mobility is significantly impaired, can be difficult. The national definition of seclusion (in full in Appendix 2 of PD2012_035) states that seclusion is "The confinement of the consumer at any time of the day or night alone in a room or area from which free exit is prevented. Key elements….. (4) The consumer cannot leave of their own accord."

An older consumer who is immobile, or whose mobility is significantly impaired, should not be considered to be in seclusion simply because they are alone in a bedroom when this is appropriate for sleep, their usual (non-mental health related) care, or the consumer's express wish. However, if such a consumer is alone in any area for other reasons, they should be considered to be in seclusion.

The care plan for any immobile or poorly mobile consumer should include clear direction regarding appropriate socialisation whilst an inpatient, and appropriate circumstances for the consumer to be in their bedroom.

Seclusion will not be used:

- When the consumer is actively self harming
- As a routine procedure when a consumer is abusive, threatening or destructive of property
- As a routine procedure following physical restraint
- Simply as a low stimulus environment – other options will be trialled first
- To prevent a consumer from absconding from a mental health unit
- As a punishment or threat.

A consumer can request voluntary isolation or quiet time alone if this is part of their care plan. This is not deemed seclusion because the door is not locked and exit is not restricted.

4.3 Restraint of older people

Restraint of any form in older people has particular risks. Observational studies suggest that physical restraint may increase the risk of death, falls, serious injury and increased duration of hospitalisation. However, there is little information to enable the magnitude of the problem to be determined (Evans, 2003). Older people also have a higher risk of medical and other reversible factors precipitating disturbed behaviour; or exacerbating existing problems with behaviour.

If restraint cannot be avoided then it must only be used:

- After clinical review
- For the briefest period required to allow the consumer to regain control of their behaviour and maintain their safety
- In the form that is considered to have the least risk to the individual consumer.

Special considerations in managing the behaviour of older patients include:

- Special care must be taken in any 'hands on' or mechanical restraint to adapt this for the degree of frailty of the individual Particular priority should be given for examination and review for potential acute physical health problems
- Any form of restraint has the potential to reduce the subsequent mobility of an older person
- The relative risks of falls if not restrained versus the risks of needs to be considered and discussed with the consumer's Primary Carer or Guardian
- The mobility status of an older person receiving restraint must be assessed and documented prior to initiation of restraint, or as soon as practicable after this if consumer resistance prevents prior assessment
- Mobility should be reassessed at intervals noted in the consumer care plan
- Services should consider any benefit in including a mobility assessment as a standard part of admission and pre-discharge assessments. The Timed Get Up and Go (TUG) (available at **Appendix 2**) is an example of one such assessment. Mobility assessment should occur after appropriate admission falls risk assessments have occurred.
- If there is recurrent or prolonged use of restraint in a consumer who is older, frail, or physically disabled, it is important to arrange physiotherapy and/or appropriate specialist medical review (e.g. geriatric or rehabilitation physicians) regarding the potential to improve the person's mobility, and implement feasible recommendations.

4.4 Legal implications

All staff will adhere to the principles of care outlined in the NSW Mental Health Act 2007 Section 68. The principles with particular relevance to this document include the need to:

- Provide the best possible care in the least restrictive environment
- Provide high quality treatment and care in accordance with professionally accepted standards
- Provide information to consumers about treatment, alternatives to treatment and treatment effects
- Ensure any medicine given to a consumer is prescribed for a therapeutic purpose and not as a punishment or for the convenience of others
- Ensure that any restrictions to a consumer's liberty and interference with their rights, dignity and self-respect is kept to a minimum
- Ensure consumers develop their own treatment plans
- Ensure carers' rights are respected and that they are informed about changes to the consumer's care at the earliest opportunity.

There may be exceptional circumstances when duty of care is the primary justification to restrain a person in order to provide that person with medical care or treatment. In the use of restraint staff must be satisfied that the treatment provided is reasonable and accepted as safe, competent

professional practice i.e. the most minimal amount of restraint/force necessary to respond to the situation. Staff must also exercise reasonable care and skill to ensure the safety, comfort and humane treatment of consumers in restraint/seclusion.

The safety of staff, patients and other members of the public are of paramount importance and s190 of the Mental Health Act recognises that the authorised medical officer, and other staff, may have to take appropriate action to protect safety of staff, patients and other members of the public during an aggressive incident that involves a risk of serious physical harm. Section 190 also by implication recognises the need, for example under Occupational Health and Safety legislation, for workplaces to ensure the safety of staff and other members of the public.

As such, it is important to consider the safety of employees at all times when deciding how to manage an aggressive incident.

Physical/manual restraint by a team, mechanical restraint and seclusion should only be used for people detained in a mental health facility under the NSW Mental Health Act 2007. If one of these interventions is applied to a voluntary patient, they must be assessed by a Medical Officer (M.O.) as soon as possible after the event to review their status under the Mental Health Act.

4.5 Decision making regarding the initiation, duration and type of restraint in older people

The decision regarding initiation of restraint or seclusion in an older consumer may be guided by the *Restrictive Interventions Decision Making Tool for Older People in Mental Health Facilities.* However, the decisions regarding type, duration and initiation of restraint are always clinical decisions and must also take into account the relative potential risks and benefits of types of restraints and alternatives to restraints

See **Appendix 4** for a Flowchart for Decision Making About Restrictive Interventions for Older People.

Initial Action
Whilst the remainder of the flowchart must be considered in deciding whether to initiate restraint, it is essential to ensure the immediate safety of all concerned. Follow the emergency procedures, policies and protocols of your facility, and ensure that assessments and decisions are made in timeframes appropriate to the risk posed by the patient's behaviour and condition.

4.6 Types of restrictive practices

Restraint and seclusion, as defined in this Guideline (see Appendix 2 of PD2012_035), are at the most severe restriction of an individual's freedom of movement that occur within mental health care. However, due to the risk of falls and/or ongoing mobility impairment in older people, it is important to minimise any restriction of movement. Whilst not comprehensive, restrictive practices (i.e. that restrict mobility) can be considered in the following categories (adapted from Appendix 2 of PD2012_035: *Decision-making tool: Responding to issues of restraint in Aged Care* DoHA).

Perimeter restriction:

- Locked exit doors
- Fenced areas with locked gates

Person to person restriction:

- Hands on redirection
- Psychological measures to restrict movement
- Verbal measures to restrict movement

Devices that may be used for patient safety or restraint:

- Concave mattresses
- Restrictive seating other than table tray restraint
- Soft bed boundary markers

High risk indirect restriction:

- Removing mobility aids
- Bed rails
- Table tray restraint
- Oral medication with a significant likelihood of causing sedation

High level direct restriction

- Parenteral psychotropic medication Physical/ manual restraint as defined in Appendix 2 of PD2012_035
- Mechanical restraint as defined in Appendix 2 of PD2012_035, including belts, harnesses, manacles, sheets, straps and the use of furniture (including beds with cot sides and chairs with tables fitted on their arms) used solely for the purpose of restraining a consumer's freedom of movement
- Mittens that cannot be removed by the consumer
- Seclusion

Prohibited forms of restriction:

- Vest restraints MUST NOT be used in older people as they can result in injury or death

4.7 Authorisation of an episode of mechanical restraint or seclusion

Seclusion and restraint are interventions that require consideration at a senior clinical level. Physical/manual restraint by a team is often conducted at short notice and time constraints prevent immediate authorisation. To ensure good oversight, all physical/manual restraints must be coordinated by a senior clinician and be reviewed afterwards (see PD2012_035 Section 6: Incident Review).

The use of mechanical restraint or seclusion must be authorised in the Register by a Medical Officer (M.O.) *within one hour* of the event.

In rural/remote regions where an M.O. is not on duty or on call, the senior nurse on duty in the mental health unit can authorise the intervention. In these circumstances, an M.O. must provide authorisation at the next available opportunity within 24 hours.

NOTE: A patient cannot be confined in a mechanical restraint device inside a locked room at any time.

A person held in a four limb restraint device will not be cared for in a public area.

Care will be taken to protect the privacy and dignity of any person in any other kind of mechanical restraint device who is in a public area.

Regardless of the authorising officer, whenever a consumer is placed in mechanical restraint or seclusion, a senior clinician who has not been involved in the incident/authorisation must be notified immediately.

The senior clinician contacted may vary depending on the time of day of the incident or other local needs. In order of preference, the senior clinician will be:

1. The consultant psychiatrist on duty
2. The M.O. on duty
3. The senior mental health clinician on duty (NUM or nursing supervisor)
4. On call medical staff (consultant psychiatrist or M.O.)
5. On call senior mental health service clinician (such as nursing supervisor)
6. Senior health service clinician on duty
7. Senior health service clinician on call.

The authorisation for seclusion is valid from the time the seclusion room door is locked until it is unconditionally unlocked. The seclusion period is not broken when the consumer leaves the seclusion room to attend to personal hygiene or receive medication, food or fluids.

The authorisation for mechanical restraint is valid from the time each limb is restrained until all limbs are unconditionally released, or other restraint device is unconditionally removed for a purpose other than a required brief release to meet care requirements.

The removal of mobility aids must only be considered after completion of an appropriate falls assessment by the senior nurse on duty; discussion with the relevant psychiatrist (or Senior Clinician as outlined above) ; and inclusion of appropriate falls prevention strategies in the patient's care plan.

All forms of *high level direct restriction* require recording in a register, and compliance with record keeping, practice and reporting responsibilities as outlined in PD2012_035.

High risk indirect restriction should only be initiated after an initial assessment of the need for this by a senior clinician, and appropriate documentation of this assessment and decision.

The removal of mobility aids should only be considered after completion of an appropriate falls assessment by the senior nurse on duty; discussion with the relevant psychiatrist (or Senior Clinician as outlined in Section 4.3) ; and inclusion of appropriate falls prevention strategies in the

patient's care plan. The decision to remove mobility aids must be documented by the senior nurse on duty and reviewed daily.

The need for medication with a significant likelihood of causing sedation should be initially approved by a psychiatrist (or medical officer from Senior Clinician logic as outlined in Section 4.3). The impact of the use of sedating medication should be considered in all clinical reviews, and the need for ongoing PRN sedating medication reviewed intervals of no longer than 1 week.

Bed rails, other than for patient transport, should only be used where there is a specific indication, and the potential benefits of using bed rails are considered to outweigh the potential risks of entrapment, falls from an increased height, or deliberate self harm. Note that cognitive impairment increases the risks of accidental harm in this setting (NHS, 2007). The decision to use bed rails must be documented by the senior nurse on duty; and reviewed at intervals no longer than 1 week.

4.8 Prolonged or multiple episodes of restraint

There may be infrequent and specific situations that require prolonged or repeated episodes of restraint, such a combination of very high falls risk with an inability to recognise this risk, leading to repeated failed attempts to walk and often combined with physical aggression. If this occurs services must comply with Section 4.13 'Exceptional circumstances' of PD2012_035.

Additionally if these circumstances arise in older people:

- Ensure alternative options to restraint have been identified and actively implemented whenever possible (as per Table/Figure below)
- Assess and document the mobility prior to initiation of restraint, or as soon as practicable after this if consumer resistance prevents prior assessment. Mobility should be reassessed at intervals noted in the consumer care plan
- Consider the relative risks of falls if not restrained versus the risks of restraint – this also needs to be discussed with the consumer's Primary Carer, Guardian or Person Responsible
- Arrange physiotherapy and/or appropriate specialist medical review (e.g. geriatric or, rehabilitation physicians) regarding the potential to improve the person's mobility, and implement feasible recommendations
- Ensure care planning includes actions to maintain or improve the consumer's mobility
- Collaborative assessments including the medical superintendent, consumer and their primary carer must occur at least once every 2 working days unless there is collaborative agreement to set alternative review periods. However, these review periods must not be greater than 1 week.

5 All other aspects of PD2012_035

All other aspects of PD2012_035 must be complied with within mental health facilities focussed upon older people.

5.1 Communication with older people

Older people may have impairment of cognition, sight or hearing; or no impairment in any of these areas. Older carers may have their own health issues that impact upon the amount, timing and type of communication they are involved with. In meeting requirements of PD2012_035 it is essential that staff adapt their communication strategies to meet the needs of each older person.

Key issues to consider in communicating with older people include:

- Ensuring the person is using hearing aids or glasses if these are required. It is also possible to obtain external hearing amplifiers for people who have hearing impairment but no personalised hearing aid
- Body language conveys over half of communication, and the tone and pitch of voice over 30%. Words themselves convey less than 10%. Negative body language, facial expression or voice tone will be easily detected by an older person; including one with dementia.
- Try to keep sentences short and simple; focussed on one idea at a time.
- Always ensure you are allowing enough time to be understood and are not talking too quickly
- Avoiding competing sounds or visual distractions will assist communication. This may include avoiding having excessive staff present.
- Do NOT
    - Argue
    - Sound condescending or bossy
    - Focus on what someone cannot do—try to tell them what they can do
    - Talk about people in front of them as if they are not there

(adapted from Alzheimers's Australia Helpsheet 2.1)

6 LIST OF ATTACHMENTS

1. Person Centred Behaviour Plans
2. Timed Get Up and Go (TGUG)
3. Consent for Restraint of Older People in Non-Declared Mental Health Facilities
4. Restrictive Interventions Decision Making Tool for Older People

APPENDIX 1: PERSON CENTRED BEHAVIOUR PLANS

Example 1: *Person Centred Behavioural Management Plan (from Braeside SMHSOP Inpatient Unit Plan)*

Tips to help _____ and you have a better day
(Insert preferred name)

Commenced: _____ **Ceased:** _____ _____
(Date) (Date) (Signature)

	I like (or need)	**I do not like (avoid)**
Communicating with me		
Approaching me		
Topics to talk about (consider major life events, Usual recreational activities, important people in patient's life)		
When I am quiet (consider how avoid		
When I am becoming agitated or distressed (de-escalation strategies)		
When I am agitated, distressed or exhibiting a challenging behaviour (can describe below)		

Prepared by: **Signature:** **Date:**
(name)

	I like (or need)	I do not like (avoid)
Activities		
When I don't sleep at night		
Environment		
Other important things		
Prepared by (name)	Signature	Date

Example 2: *Person Centred Behavioural Management Plan (from North Coast Area Health Service Plan)*

Patient ID Label	**IMPORTANT INFORMATION** The purpose of this form is to consult with family or carers about how challenging behaviours can best be managed. The signature of both the nurse and the person responsible indicate that both parties have agreed to this care

Known challenging behaviour(s): *[please describe in detail]*
Current management strategies: *[things that work]*
Triggers for challenging behaviours: *[things that create behaviour]*
Likes: Dislikes:
Important family members:
Major life events:
Routines:

Issue	**Strategy**

Problems to be aware of:

Nurse and designation:

Name: _____

Signature:_____

Date:_____

Person Responsible (i.e. Primary Carer, guardian, spouse, defacto, carer or allocated person)

Name: _____

Signature:_____

Date:_____

APPENDIX 2: TIMED GET UP AND GO (TGUG)

(Adapted from PD2008_015 Amputee Care Standards in New South Wales)

The TGUG is a measurement of mobility. It includes a number of tasks including standing from a seating position, walking, turning, stopping, and sitting down which are all important tasks needed for a person to be independently mobile. The person can use any assistive walking device they normally use.

Test:

1. Ask the person to sit with their back to a standard ward chair, their arms resting on the arm rests
2. Ask the person to stand up from a standard chair and walk a distance of approximately 3 metres, turn around and walk back to the chair and sit down again
3. Record in an agreed part of the clinical record the time taken to complete the test

The timing:

1. May be recorded using either a wristwatch with a second hand or a stopwatch
2. Begins when the individual starts to rise from the chair and ends when they are again seated in the chair

Prior to commencing the test ensure:

1. Any walking aid they may use is in hand
2. The person has their usual footwear on (or note their footwear if normal footwear is not available)

APPENDIX 3: CONSENT FOR RESTRAINT OF OLDER PEOPLE WITHIN NON-DECLARED MENTAL HEALTH FACILITIES

Non-declared mental health facilities should have appropriate policies and procedures to ensure that if restraint is required within non-declared mental health units, such as Transitional Behavioural Assessment and Intervention Service (T-BASIS) units, then any necessary consent is obtained consistent with the NSW Guardianship Act 1987.

Such units must be aware of:

- The principles of who may provide medical and dental consent in different situations as described by the Guardianship Tribunal
- *Determining whether to consent to proposed medical or dental treatment* (Position Statement 10 of the Office of the Public Guardian)
- *Determining whether to consent to the use of restraint on an elderly person in a care facility* (Position Statement 11, Office of the Public Guardian)

The following material is adapted from the above references.

Whilst exercising duty of care, a Person Responsible or Guardian may provide a basis for consent for restraint in limited circumstances. Restraint in a non-declared Mental Health Unit will usually require one of the following:

- Consent from a Guardian who has been specifically given relevant restrictive powers by the Guardianship Tribunal
- Urgent application to the Guardianship Tribunal (Applications, Guardianship Tribunal) for any of the following:
    - Medical consent to allow use of restraint
    - Appointment of a Guardian with restrictive powers including the ability to consent to restraint
    - An order to provide relevant restrictive powers to an existing Guardian
- Assessment of the ability to and clinical appropriateness of completing a Schedule 1 and transfer of the individual to a declared Mental Health Facility.

Local procedures must provide guidance to clinicians regarding the impact of local service configurations and accessibility upon use of these options. Expectations regarding documentation of actions to enact either of these options MUST be clearly documented.

Physical restraint for medical purposes

A Person Responsible or Guardian with a medical and dental consent or health care decision making authority can consent to forms of restraint that are part of the medical treatment prescribed for the person, for example, a short term physical restraint following a surgical operation.

The proposed restraint must be documented in the care plan where medical and other treatment is recorded.

The restraint should be used solely for the purpose of promoting the health and well being of the person and its use should be regularly reviewed. Any objection by the person, either verbally or through their behaviour, means the Guardian or Person Responsible can no longer consent to the use of the restraint.

An application to the Guardianship Tribunal should be made to request the authorisation necessary to consent to the use of the restraint, or to give a Guardian authority to consent to the continued use of the restraint.

Chemical restraint for non-medical purposes

Consent to the use of medication to control a person's behaviour is regulated by Part 5 of the Guardianship Act 1987. If the person objects to the treatment only the Guardianship Tribunal can authorise the treatment or give a Guardian authority to provide consent to the treatment against the person's wishes.

The position statements and Guardianship Tribunal Medical and Dental Consent Application form provide clear expectations regarding the information required to apply for consent for restraint. Compliance with this policy should be consistent with these expectations.

APPENDIX 4: RESTRICTIVE INTERVENTIONS DECISION MAKING TOOL FOR OLDER PEOPLE

*(*adapted from *Decision Making Tool: Responding to issues of restraint in Aged Care,* DoHA*)*