

Principles for Safe Management of Disturbed and /or Aggressive Behaviour and the Use of Restraint

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Clinical/ Patient Services - Incident management
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Summary The policy focuses on dealing with disturbed and / or aggressive patients or other individuals who pose a risk of harm to themselves or others. The policy outlines the principles underpinning the prevention strategies and the management of disturbed and / or aggressive behaviour, and the use of manual / mechanical restraint (as an option of the last resort) for NSW public health facilities. This policy does not cover the use of pharmacological restraint and the management of mental health patient in declared mental health services and mental health facilities (refer - PD2012_035).

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Applies to Local Health Districts, Specialty Network Governed Statutory Health Corporations, Affiliated Health Organisations, Public Hospitals

Audience All staff Including Clinical, Medical, Nursing, Security Officers, Emergency Departments

Distributed to Public Health System, NSW Ambulance Service, Ministry of Health, Private Hospitals and Day Procedure Centres

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Policy Manual Patient Matters

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Director-General

This Policy Directive may be varied, withdrawn or replaced at any time. Compliance with this directive is **mandatory** for NSW Health and is a condition of subsidy for public health organisations.

PRINCIPLES FOR SAFE MANAGEMENT OF DISTURBED AND / OR AGGRESSIVE BEHAVIOUR AND THE USE OF RESTRAINT

PURPOSE

This document outlines the principles for safe management of disturbed and / or aggressive behaviour in NSW public health facilities with the view to promoting:

- The reduction and, where possible, elimination of the use of manual / mechanical restraint in NSW public health facilities
- The safety of staff, patients and members of the public in a situation where disturbed and / or aggressive behaviour occurs in inpatient clinical areas.

This policy does not cover:

- The use of pharmacological restraint
- The management of mental health patients and the use of seclusion in declared mental health services and mental health facilities, which is covered by *PD2012_035 Aggression, Seclusion & Restraint in Mental Health Facilities in NSW*.

MANDATORY REQUIREMENTS

This document applies to staff who work in NSW public health facilities and may be exposed to disturbed and / or aggressive behaviour.

Public health organisations must ensure that:

- Local processes and procedures are in place for the prevention and management of disturbed and / or aggressive behaviour, including the appropriate use of manual / mechanical restraint consistent with the principles outlined in this document
- Staff have appropriate skills to apply manual / mechanical restraint appropriately and, where necessary, access to appropriate training as specified in the *Policy Directive: Violence Prevention and Management Training Framework for the NSW Public Health System (PD2012_008)*.

IMPLEMENTATION

Chief Executives of Local Health Districts and Specialty Health Networks are required to:

- Provide the overall direction for the implementation of the principles, early identification of disturbed and / or aggressive behaviour, the use of de-escalation strategies and the minimisation of the use of manual and mechanical restraint
- Ensure the implementation of risk management practices to identify, assess and manage risks associated with a) the use of manual / mechanical restraint and b) hospital clinical care areas that are at high risk of the occurrence of disturbed and / or aggressive behaviour
- Ensure local processes and procedures are in place for the management of disturbed and / or aggressive behaviour, consistent with the principles outlined in the policy

- Ensure staff working in high-risk clinical care areas have the appropriate skills and supervision to facilitate prevention, early identification and management of disturbed or aggressive behaviour.

Directors of Clinical Governance are required to:

- Review local restraint practices to ensure the compliance of the principles outlined in this policy
- Ensure processes and procedures are in place for adequate monitoring of the patient in manual / mechanical restraint including accurate documentation and incident notification (of aggressive episode) and management
- Monitor and evaluate the strategies utilised to prevent escalation of disturbed and / or aggressive behaviour
- Provide regular evaluation reports to the respective committees summarising the number of incidents of aggressive episode; the effective of the prevention strategies; and recommendations for training, environment and strategy to promote ongoing reduction in incidence.

Staff are required to:

- Follow local clinical processes and procedures for dealing with disturbed and / or aggressive behaviour
- Undertake relevant training relating to the management of disturbed and / or aggressive behaviour and restraint procedure
- Discuss identified risk(s) and develop management plan with patients, families and carers
- Take notice of early signs of disturbed and / or aggressive behaviour and take any threat seriously
- Seek assistance as early as possible and preferably before the situation escalates
- Implement de-escalation strategies as part of the process of engaging with the patient, family/ carer to reduce the likelihood of disturbed and / or aggressive behaviour
- Closely monitor the patient's physical and mental condition when he/ she is restrained (manual / mechanical restraint is to be used as an option of the last resort)
- Clearly document the reason and the type of restraint use, the start and end time of restraint, and patient's physical condition and clinical assessment in patient record
- Follow local processes and procedures to manage, report and record the incident.

REVISION HISTORY

Version	Approved by	Amendment notes
January 2015 (PD2015_004)	Deputy Secretary, Governance, Workforce and Corporate	New policy

ATTACHMENTS

1. Principles for Safe Management of Disturbed and / or Aggressive Behaviour and the Use of Restraint: Procedures.

**Principles for Safe Management of Disturbed and / or
Aggressive Behaviour and the Use of Restraint**



Issue date: January-2015

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CONTENTS

1	BACKGROUND	1
1.1	About this document	1
1.2	Introduction	1
1.3	Key definitions	2
1.4	Legal and legislative framework	3
2	PREVENTION OF DISTURBED AND / OR AGGRESSIVE BEHAVIOUR	3
2.1	Assessment of stressors or triggers	4
2.2	Guiding principles for prevention strategies	4
2.3	De-escalation of verbal aggression	5
3	MANAGEMENT OF AGGRESSIVE BEHAVIOUR	6
3.1	Retreat and back-up options	6
3.2	Use of restraint	6
3.2.1	Key principles for the use of restraint	7
3.2.2	Specific groups of patients	7
3.2.3	Team approach for restraint	8
3.2.4	Specific considerations for manual / mechanical restraint	8
3.2.5	Assessment and monitoring a patient / individual who is placed in restraint	9
3.2.6	Documentation	10
4	POST-INCIDENT MANAGEMENT	10
4.1	Post-incident review	10
4.2	Post-incident support	10
4.3	Complaints	10
4.4	Data and review	11
4.5	Audit	11
5	RELATED POLICIES AND RESOURCES	11
5.1	Related policies	11
5.2	Related resources	12
5.3	Other resources	13

1 BACKGROUND

1.1 About this document

This policy provides the principles underpinning the prevention strategies and the management of disturbed and / or aggressive behaviour, and the use of manual / mechanical restraint (as the last resort) for NSW public health facilities.

This policy does not cover:

- The use of pharmacological restraint
- The management of mental health patients in declared mental health services and mental health facilities, which is covered by [PD2012_035 Aggression, Seclusion & Restraint in Mental Health Facilities in NSW](#).

In a health context, in limited circumstances, it may be necessary to use restraint (as the last resort) in a public health facility, when:

1. Dealing with disturbed and / or aggressive patients or other individuals who pose a risk of harm to themselves or others
2. As an incidental part of treatment to a patient.

This policy mainly focuses on the issue relating to dealing with disturbed and / or aggressive patients or other individuals who pose a risk of harm to themselves or others in NSW public health facilities.

1.2 Introduction

Staff working in NSW public health facilities may be involved in managing patients or other individuals who may exhibit disturbed and / or aggressive behaviour.

Some hospital clinical care areas are at high risk of the occurrence of disturbed and / or aggressive behaviour. These areas are to be identified through risk assessment and local processes and procedures are to be developed for these areas.

There may be other clinical areas where patients with specific medical conditions also pose a high risk. These patients should be identified through a clinical risk assessment.

For the purpose of this policy, restraint refers to manual or mechanical restraint only. Restraint is only to be used as the last resort in managing a disturbed and / or aggressive patient or other individual who poses a risk of harm to themselves or others.

There is an international shift towards the reduction and, where possible, elimination of the use of restraint in health facilities. NSW Health supports this approach. A safer approach to managing the care of patients who exhibit disturbed and / or aggressive behaviour is one that focuses on prevention strategies especially communication, engagement, situation awareness and appropriate case management. This approach is likely to have a better outcome for staff, patients and members of the public.

These prevention strategies include:

- Risk assessment and management of triggers or stimuli

- Ongoing communication and engagement with the patient and their family / carer as a part of the patient's care
- Case management involving the patient and their family / carer
- Situation awareness
- Assessment of situation, self capacity, engagement and de-escalation

A summary of strategies for prevention, management of behavioural escalation and aggressive behaviour is provided in Section [5.3 \(a\)](#).

1.3 Key definitions

Restraint In this policy, restraint refers to the use of manual force and / or a mechanical device to restrict a person's movement in an emergency situation of aggressive behaviour, where that person is deemed to be at an immediate risk of harm to self or others.

The two types of restraint covered by this policy are:

A) **Manual Restraint**

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

B) **Mechanical Restraint**

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

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

Note: Handcuffs are not an acceptable form of restraint used in NSW Health facilities. Patients (with handcuffs) brought in by Police or Corrective Services are to be transferred to clinicians for assessment. Handcuffs should be removed unless the patient remains under custody of an accompanying Police or Corrective Services officer.

Appropriate mechanical restraints must¹:

- Be adjustable to reflect the physical frailty of the patient
- Allow the patient to be placed in a sitting or lying position
- Have a wide cuff to prevent tightening and reduced circulation
- Have no sharp edges or not be made from material that is sharp or abrasive
- Be made of a material that is easy to clean
- Be easy to apply, i.e. when the patient is moving
- Be difficult for the patient to remove
- Be able to be secured to furniture i.e. a bed or chair. It is appropriate to pre-prepare a bed with restraints.

¹ [Protecting People and Property-NSW Health Policy and Standards for Security Risk Management in Health Agencies: Protecting People and Property Manual Chapter 14: Role of Security Personnel in NSW Health](#)

- Human rights** Human rights are often defined in different ways. Simple definitions that are often given (*Australian Human Rights Commission*) include²:
- The recognition and respect of people's dignity
 - A set of moral and legal guidelines that promote and protect recognition of our values, our identity and ability to ensure an adequate standard of living
 - The basic standards by which we can identify and measure inequality and fairness
 - Those rights associated with the Universal Declaration of Human Rights.

1.4 Legal and legislative framework

The use of restraint is potentially an assault (at both criminal and civil law) if it occurs without legal justification.

Where a patient or other individual in a public health facility is behaving in a violent or aggressive manner and is posing an immediate risk of harm to themselves or another person, it will be lawful to restrain the patient or other individual to prevent the risk of harm eventuating. However, any use of restraint must be reasonable in the circumstances and the minimum amount of force required to respond to the threat. That is, the legal justification of the restraint is self-defence, or defence of others.

A lawful restraint is a restraint that is used to respond to an immediate risk of harm with no more force used than is reasonable and necessary to deal with the risk of harm.

Restraint should only ever be used as the last resort to deal with a risk of harm. A public health facility owes a duty of care to any patient or individual they restrain and should take all reasonable steps to minimise any harm occurring to the patient / individual under restraint.

2 PREVENTION OF DISTURBED AND / OR AGGRESSIVE BEHAVIOUR

Successful prevention of an escalation of a disturbed behaviour can minimise or eliminate the use of restraints in health care facilities. Prevention strategies include:

- Embedding risk identification and management education routinely for relevant health care team
- Maintaining ongoing team communications between staff and the patient and their family/ carer
- Building staff capacity to recognise and identify triggers / stressors, and to apply appropriate responses including de-escalation strategies, through education and training
- Discussing the identified risk(s) and developing the management plan with the patient, family/ carer.

² Australian Human Rights Commission. [Human Rights Explained: Fact Sheet 1 Defining Human Rights](#).

2.1 Assessment of stressors or triggers

Aggression is often an escalation of a disturbed behaviour triggered by a range of contributing factors, including:

- Clinical conditions (e.g. mental health illness, brain disorder, intellectual disability and cognitive impairment)
- Undesired interpersonal interactions
- Personally interpreted stress
- Environmental disturbances (e.g. noise, confined space).

The most important role in regards to assessment is to identify the contributing factors, to understand why aggression is occurring and to treat the underlying cause(s) or condition(s). A common cause of aggression in older people is their misinterpretation of the environment and miscommunication, where aggressive behaviour is often triggered by fear.

On-going engagement with the patient and their family / carer through clear, respectful and open communication allows early detection, identification and appropriate management of triggers that may lead to aggressive behaviour.

Where necessary, input should be sought from staff who have expertise and knowledge in identifying precursors to aggressive behaviour during the clinical risk assessment, as part of a multidisciplinary approach to the care of the patient.

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

Key points to note:

1. Engage with the patient, their family / carer and other health professionals (using a team approach) to identify stressors/ triggers for disturbed behaviour as part of the initial and ongoing patient care
2. Undertake appropriate clinical assessment to obtain information on the patient's condition. For example, *cognitive screening tools for older persons*, *medical assessment of mental health patients* and *Drug and Alcohol assessment tools*
3. Develop ways to manage stressors / triggers of disturbed behaviour and document a management plan for health care teams to follow.

Examples of assessment tool hyperlinks:

- [Cognitive screening tools for older persons](#)
- [Medical assessment for mental health patients in](#)

2.2 Guiding principles for prevention strategies

Key principles to guide prevention strategies are as follows:

- Positive and proactive care is the main approach to patient care
- Reduce excessive reliance upon restrictive interventions
- Restrictive interventions are to be used as the last resort

- People must be treated with compassion, respect, dignity and kindness. Staff are to comply with the NSW CORE (Collaboration, Openness, Respect and Empowerment) values
- Health services must support people’s rights to balance safety from harm and freedom of choice
- Positive relationships between the people who deliver services and the people they support must be protected, preserved and promoted at all times.

These key points are summarised as PANEL (**P**articipation, **A**ccountability, **N**on-discriminatory, **E**mpowerment and **L**egality) principles, which underpin the prevention strategies and the management of disturbed and aggressive behaviour.

The **PANEL** principles³ provide a human rights-based approach for prevention strategies to avoid restrictive care practices.

Key Principle	What it means	What it looks like in practice
PARTICIPATION	Enabling participation of all key people and stakeholders	Consulting with the person, staff and other stakeholders; involving the person, carers and support staff in developing risk assessments and management plans where possible; identifying and reducing barriers to the person accessing services.
ACCOUNTABILITY	Ensuring clear accountability, identifying who has legal duties and practical responsibility	Clearly outlining responsibilities under relevant legislative Acts and ensuring staff are aware of their obligations to respect human rights.
NON-DISCRIMINATORY	Avoiding discrimination and ensuring attention is paid to groups who are vulnerable	Using person centred care planning approaches that are non-discriminatory and ensuring all staff are sensitive to cultural diversity and the stigma associated with mental illness.
EMPOWERMENT	Empowering staff and people who use services with the knowledge and skills to understand their rights	Raising awareness of the rights of persons who use services and empowering people through appropriate and timely interventions.
LEGALITY	Complying with all relevant legislation	Identifying the human rights implications in restrictive management and continually considering the principles of fairness, respect, equality, dignity and autonomy.

2.3 De-escalation of verbal aggression

In situations when a patient or an individual demonstrates signs of escalating verbal aggression, all reasonable steps are to be taken to seek resolution without physical contact.

In dealing with a patient or an individual who is verbally aggressive, staff should remain calm and use effective communication skills to de-escalate the situation through:

³ United Kingdom Department of Health (2014) “Positive and Proactive care: reducing the need for restrictive interventions.”(Online.) [Cited on: 11 November 2014, from: <https://www.gov.uk/government/publications/positive-and-proactive-care-reducing-restrictive-interventions>]

- Respecting personal space
- Appropriate body language using a non-confronting manner
- Establishing appropriate verbal contact to engage with the person
- Communicating in a clear and concise manner, avoiding repetition
- Listening and acknowledging the person's concerns
- Identifying the person's needs and feelings
- Setting clear limits and boundaries
- Being respectful
- Expressing an intention to help the person
- Offering choices that are realistic
- Working with their family / carer / relatives to calm the person if safe and appropriate to do so
- Providing the person time and space to settle / calm down.

3 MANAGEMENT OF AGGRESSIVE BEHAVIOUR

3.1 Retreat and back-up options

If all reasonable steps have failed to resolve or de-escalate the situation and the situation continues to escalate (with immediate risk of self-harm or harm to others), staff should seek help and back-up support to ensure the appropriate clinical management of the aggressive behaviour and the safety of those involved. Staff may decide to retreat to a safe place if necessary, but must ensure that back-up support is arranged to control the situation and to protect others. The back-up support staff should also be advised that the staff member is retreating.

Staff are to be familiar with the following back-up options, such as:

- Calling for support from senior staff or clinician
- Use of a duress alarm (where such system is available) or initiation of the duress response
- Activation of the local emergency response (i.e. Code Black).

3.2 Use of restraint

Where possible, the patient or the individual is to be assessed for any underlying causes or conditions that trigger the aggressive behaviour and activate an appropriate treatment plan or management strategies.

The use of manual / mechanical restraint should only be considered (and used only as the last resort) when the patient or the individual is at immediate risk of self-harm or harm to others and all reasonable steps have failed to seek resolution without physical contact.

Restraint carries risks of physical and mental harm to staff, patients and other members of public. If the use of restraint (manual / mechanical) is considered, it must be undertaken by staff who have the necessary skills to apply manual / mechanical restraint, in accordance with the minimum training standards set out in PD2012_008 *Violence Prevention and Management Training Framework for the NSW Public Health System*.

Local Health Districts (LHD) / Specialty Health Networks (SHN) must ensure staff have appropriate training and skills in de-escalating and managing disturbed and/ or aggressive behaviour (e.g. the Violence Prevention and Management suite of courses developed by the Health Education and Training Institute or other appropriate courses in use within Local Health Districts).

If restraint is used (as the last resort when all other strategies have failed), it must take into account the specific considerations outlined in [Section 3.2.4](#).

Restraint must be discontinued as soon as the patient / individual has regained behavioural control, the immediate risk of harm has passed or police assistance has arrived.

3.2.1 Key principles for the use of restraint⁴

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 mechanism
Principle 7	Compliance with legislation and regulation

3.2.2 Specific groups of patients

Specific population groups of patients⁵ may be more vulnerable to physical or psychological harm by the restraint procedure. This includes:

- Children and young people
- Older people
- Pregnant women
- Patients with physical health issues (e.g. obesity, diabetes, cardiac disease and metabolic disorders)
- Patients with a history of trauma / detention who may be re-traumatised by the episode of restraint (e.g. refugees, people who have been abused at any stage of their life)
- Patients with an intellectual disability and those with cognitive impairment such as dementia or delirium

⁴ Details of the key principles are provided in Appendix 3 of [PD2012_035: Aggression, seclusion and restraint: Preventing, minimising and managing disturbed behaviour in mental health facilities in NSW](#).

⁵ Specific groups of patients are provided in Appendix 6 of [PD2012_035: Aggression, seclusion and restraint: Preventing, minimising and managing disturbed behaviour in mental health facilities in NSW](#).

- People who are under influence of drugs or other substances
- People who have engaged in a physically exhausting combative struggle for longer than two minutes
- People from culturally and linguistically diverse background
- Aboriginal and Torres Strait Islander people.

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

3.2.3 Team approach for restraint

The restraint of a patient or an individual in clinical care areas is the role of the clinical team, with supplementary support provided by security staff at the direction of clinical staff if necessary and available.

Applying manual restraint is a team approach and a lead clinician must be identified to lead the supporting staff to undertake the restraint procedure. An appropriate team leader is someone who:

- Has completed training in the safe use of restraint
- Is confident and competent to lead a restraint procedure, or has the best rapport with the patient
- Assigns roles for each staff member (one to support or hold each limb) participating in the restraint procedure
- Positions close to the head of the patient and continues to engage with the patient during the restraint in an effort to reassure and calm the patient
- Monitors the patient's airway and physical condition during the restraint procedure.

3.2.4 Specific considerations for manual / mechanical restraint

Restraint should be avoided where possible, as there are serious dangers with continuous restraint in any position. Specific considerations if manual/ mechanical restraint is undertaken are listed below.

A) Mechanical restraint equipment

In clinical areas where mechanical restraint is used, the equipment must be reviewed and approved by the relevant local health district (LHD) or specialty health network (SHN) governance committee (s). A specific procedure must be in place to guide the use of mechanical restraint equipment and staff must be trained in the use of the equipment.

The restrictions on the use of mechanical restraint are:

- Restraint devices must be professionally manufactured, not hand-made
- Restraint devices must meet the requirements set out in Section [1.2 Key definition](#)
- A person cannot be confined in a mechanical restraint device inside a locked room at any time
- A person held in a four limb restraint device should be cared for in a designated clinical space / area to protect the patient's privacy

- Care must be undertaken to protect the privacy and dignity of any person in any kind of mechanical restraint device.

B) Manual restraint

In the rare circumstance when manual restraint is required, the restraint techniques should be carefully considered and risk assessed to ensure the least restrictive strategy is being utilised.

All restraint techniques pose a risk to the physical health of the patient / individual. Manual restraint that requires holding the patient / individual in a bent over, seated, prone or supine position for a prolonged period of time increases this risk. Manual restraint should be limited to the amount of time necessary to:

- Allow the patient / individual to safely regain control of their behaviour
- Allow the application of mechanical restraint
- Administer medication, and / or remove the patient / individual to a safer environment.

C) Restraint position

The restraint position options include standing, sitting, kneeling, supine and prone.

- Prone restraint has been identified as being high risk due to the increased risk of respiratory restriction. There have been instances in which young apparently healthy people have died suddenly while being held in a physical restraint. The prone position has been implicated in these deaths.
- Prone restraint must only be used as the last resort when all other reasonable steps and other restraint positions have failed to appropriately respond to the threat of self harm or harm to others.

3.2.5 Assessment and monitoring a patient / individual who is placed in restraint

It may not be possible to assess the patient / individual before the restraint procedure is being applied. Immediately after the patient/ individual is being restrained, a clinical assessment must be undertaken by a medical officer to identify and treat any underlying clinical condition that may have caused the aggressive behaviour.

The team leader is to provide guidance to the staff members who apply the restraint; monitor the patient and ensure that the restraint is maintained for the shortest period possible.

At all times during the restraint, a clinical member must be identified to be responsible to monitor and document the patient's physical condition while the patient is in restraint. Close clinical monitoring of the patient's physical condition includes airway, breathing, circulation, level of consciousness and skin integrity where the manual force or device is applied. An example of an assessment checklist is provided in Section [5.3 \(b\)](#).

Any changes or deterioration of the patient's condition should trigger urgent action(s) such as reduction of pressure, repositioning the patient and/ or mechanical restraint and activation of emergency medical assistance.

The restraint must be used for the shortest period possible to allow the person to safely regain control of their behaviour. Restraint must be ceased when the person has regained behavioural control or the immediate risk of serious harm has passed. Next of kin or primary carer must be notified of aggressive episode and the use of restraint where possible.

3.2.6 Documentation

- Each episode of the use of restraint must be recorded in the patient's health care record including the reason for restraint, the type of restraint use, the patient's physical condition, the duration of the restraint and if medication was administered.
- Each incident of aggressive behaviour is to be reported in Incident Information Management System (IIMS) in accordance with the [PD2014_004 Incident Management Policy](#).
- If an episode of restraint use has resulted in injury, this must also be recorded in IIMS.

4 POST-INCIDENT MANAGEMENT

4.1 Post-incident review

The occurrence of an incident of aggressive behaviour is to be reported and reviewed within the required timelines in accordance with the [PD2014_004 Incident Management Policy](#) and local procedures. The outcomes of the reviews are to be communicated to the team in the health care unit and through the organisation so that learning from each incident can be shared among health care units.

The Individual patient care plan is to be reviewed by the treating medical team (with the patient and their family / carer) to include / amend prevention strategies for managing identified stressors or stimuli that trigger behavioural escalation.

4.2 Post-incident support

The experience of the use of restraint could be difficult for the patient and staff who are involved in the incident. To minimise the impact, the following strategies should be considered:

- The patient's ongoing care plan should include supportive counselling as required
- The family / carer who is distressed about the situation should be offered supportive counselling which can occur within the inpatient setting or on an outpatient basis
- Other patients in the clinical area, who may have seen and are distressed about the incident, should also be offered supportive counselling
- Staff who experience distress may be offered support from their team manager, their clinical supervisor or the Employee Assistance Program (EAP).

4.3 Complaints

In some instances, the patient and / or their family / carer may feel that inappropriate care was provided during the management of the incident. Clinicians should attempt to discuss the incident and resolve the issues at the time using open disclosure (as necessary). The collaborative review process also provides an opportunity to address any concerns through open and honest discussion.

If this is not acceptable to the patient and / or their family / carer, information on how to lodge a formal complaint with the facility must be given to the patient / family / carer.

4.4 Data and review

Each health care unit that uses restraint must have local processes in place to collate data; monitor the use of restraint; report findings from review and audit; and develop / amend strategies to minimise the use of manual / mechanical restraint and to support less restrictive practices.

4.5 Audit

Each health care unit is to undertake an annual audit to identify, detect and monitor the trend of the use of manual and / or mechanical restraint. The recommended measures are:

- Reason for restraint: Dealing with disturbed and / or aggressive patient or other individual who pose a risk of harm to themselves or others
- Type of restraint: a) Manual, and b) Mechanical (and the type of devices)
- Duration of each restraint.

5 RELATED POLICIES AND RESOURCES

5.1 Related policies

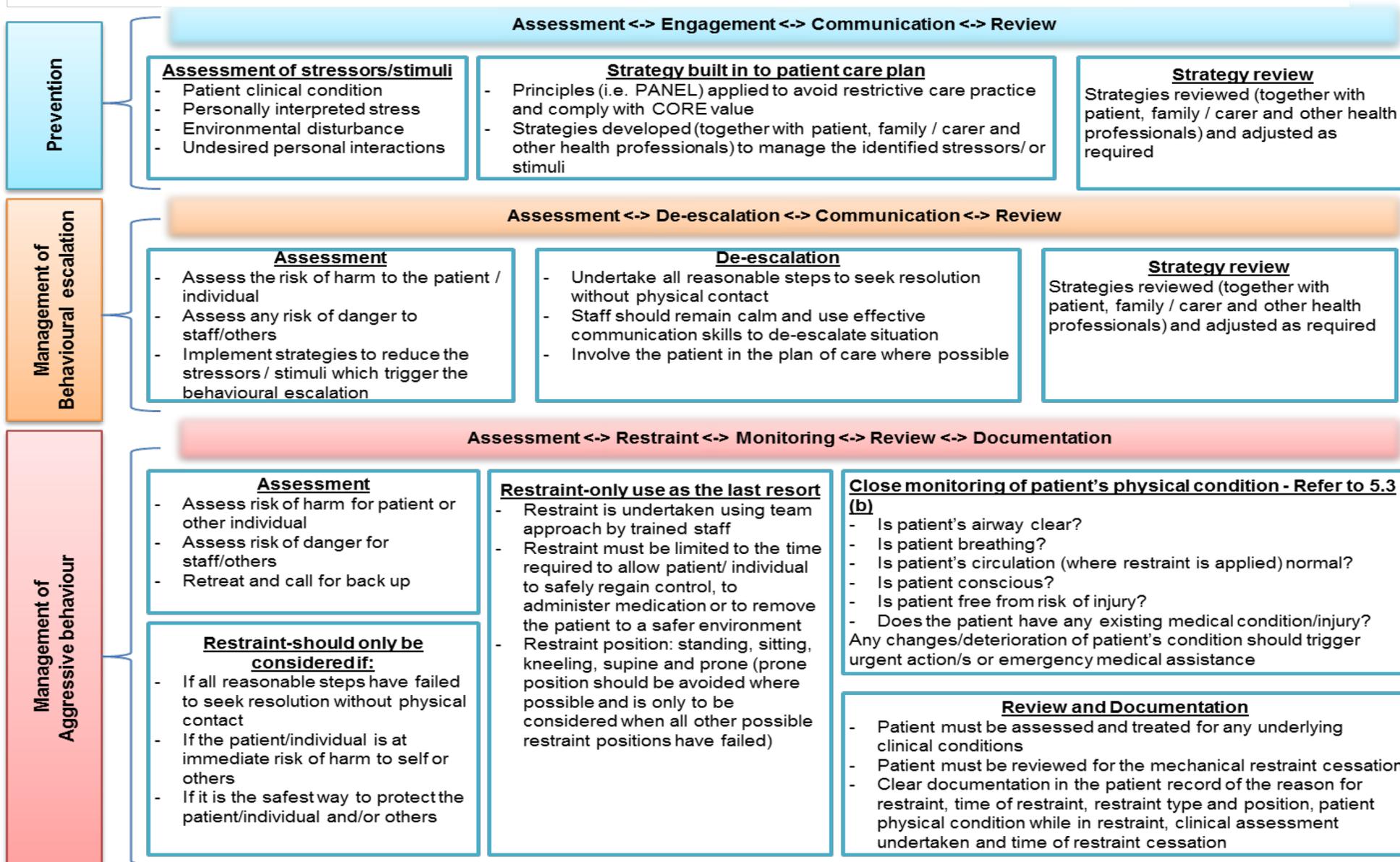
Reference	Description	Focus Area
PD2015_xxx	Minimising Restraint Use in Adults	- Mechanical restraint - Older adults in acute and subacute hospital setting including multipurpose services
PD2015_001	Preventing and Managing Violence in the NSW Health Workplace - A Zero Tolerance Approach	Requirements for identifying, assessing and eliminating or controlling violence related risks, and for providing an appropriate response when violence occurs
PD2012_035	Aggression, Seclusion & Restraint in Mental Health Facilities in NSW	Mental health facilities
PD2012_008	Violence Prevention & Management Training Framework for NSW Public Health System	Minimum standards for training
PD2010_033	Children and Adolescents - Safety and Security in NSW Acute Health Facilities	- Protection of children and adolescents from risk of harm to self or others in public health facilities - Patient groups i.e. mental health patients or those affected by drugs and alcohol
GL2012_005	Aggression, Seclusion & Restraint in Mental Health Facilities – Guidelines Focused Upon Older People	Mental health facilities – older people
Policy Manual	Protecting People and Property - NSW Health Policy and Standards for Security Risk Management in NSW Health Agencies	Chapter 14: Role of security personnel in NSW Health and the management of all security related risks, including those related to violence and in the clinical environment Chapter 29: Duress response arrangement

5.2 Related resources

Reference	Description	Focus Area
Agency of Clinical Innovation (ACI) Tools	Cognitive Screening for Older Adults	Assessment tool for Older Adults (combined AMTS, DRAT and CAM),
	Toolkit-Minimising Restraint Use in Adults	Adults in acute and subacute hospital setting including multipurpose services
	Physical Assessment for Mental Health Patients Form	Assessment tool for emergency department
Health Education Training Institute (HETI) training	Violence Prevention and Management in the workplace training	Training modules include personal safety and team restraint techniques

5.3 Other resources

(a) Strategies for minimisation of the use of manual/mechanical restraint in the clinical area



(b) Assessing and monitoring patients' condition and risk while they are in restraint (adopted and modified from the dynamic risk assessment process⁶)

Airway?	<p>Can they get air in?</p> <ul style="list-style-type: none"> • Is there any pressure to their neck? • Is there anything covering their face? • Is there any other item blocking their airway? • Is their mouth or throat free from vomit? • Are there any signs of airway obstruction? i.e. Gurgling/ gasping sounds; verbal complaints or difficulty speaking.
Breathing?	<p>Are they able to breathe?</p> <ul style="list-style-type: none"> • Is their chest free to move? • Is their thoracic area free from pressure? • Are there signs they are having difficulty breathing? i.e. An increased effort to struggle; or heightened distress/ anxiety.
Circulation?	<p>Can blood be circulated efficiently?</p> <ul style="list-style-type: none"> • Are their limbs free from pressure? • Are there any signs of tissue hypoxia? i.e. pale/ grey/ blue skin colouring to the lips nail beds or earlobes? • Are there reported symptoms of compartment syndrome? Pain, pins and needles, unable to feel the pulse and/ or paralysis?
Level of consciousness?	<p>Are they alert?</p> <ul style="list-style-type: none"> • Are their eyes open? • Are they talking? • Are they interacting with you?
Deformity?	<p>Is there a risk of injuring any joints, limbs, or other skeletal/ muscular structures?</p> <ul style="list-style-type: none"> • Is the spine in correct alignment? • Are the joints of the upper and lower limbs free from end-of-range stress? • Is the patient complaining of discomfort or pain to any part of their body?
Existing medical condition or injury?	<p>Is there anything known about the patient's medical history and/ or complication that could influence the risk?</p> <ul style="list-style-type: none"> • Any known respiratory disease? • Any known cardiac or vascular disease? • Any other relevant pathology or injury?

⁶ Hollins L. Managing the risks of physical intervention: developing a more inclusion approach. *Journal of Psychiatric and Mental Health Nursing*, 2010;17:369-376