Newsletter: 218/2018
Date: 8 April 2019
Distribution: ALL PUBLIC HEALTH MEMBERS
Contact: Your HSU Organiser

Your feedback required:
Draft Seclusion and Restraint policy

Dear Member,

The HSU has received from NSW Health a draft policy on **Seclusion and Restraint in NSW Health Facilities** which has been attached to this newsletter. The HSU is seeking feedback from members on this draft policy.

Please provide any comments or feedback to Donna Austin via email donna.austin@hsu.asn.au by close of business 29 April 2019.

Not a member of the HSU? Now is time to join and have your say! You can join online at www.hsu.asn.au/join or call 1300 HSU NSW and join over the phone.

A union's effectiveness and negotiation power depends upon the strength and density of its membership base. Join your work colleagues today by becoming a member of the Health Services Union and help us continue to protect and improve your working life.

In unity,

Gerard Hayes
Secretary, HSU NSW/ACT/QLD

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Mr Gerard Hayes
Secretary
Health Services Union
gerard.hayes@hsu.asn.au

Our ref H19/11510

Dear Mr Hayes

Consultation: Draft Seclusion and Restraint in NSW Health Facilities Policy Directive and Guideline

I am pleased to provide you with a draft of the *Seclusion and Restraint in NSW Health Facilities Policy Directive* and *Guideline* for your information and review.

Please find attached:

- Draft *Seclusion and Restraint in NSW Health Facilities Policy Directive*
- Draft *Seclusion and Restraint in NSW Health Facilities Guideline*
- Feedback Form.

The scope of this new simplified, principles-based policy is intended to be broader than just mental health patients and facilities. It will apply to the care of any patient in all NSW hospital settings, not only to mental health consumers and mental health facilities or declared emergency departments.

Please provide your comments and suggestions about the *Policy Directive* and *Guideline* by completing the feedback form provided. Please email your feedback form to MOH-SeclusionPrevention@health.nsw.gov.au by 3 May 2019.

Following review and incorporation of feedback, the *Policy Directive* and *Guideline* will be formatted for publication. Telephone enquiries can be directed to Nikki Maloney, A/Director, Planning, Performance and Regulation, Mental Health Branch, Ministry of Health on 02 9424 5974.

Yours sincerely

2.4.19

Dr Nigel Lyons
Deputy Secretary, Strategy and Resources

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Policy Directive

Seclusion and Restraint in NSW Health Facilities

Document Number	
Publication Date	
Functional Sub group	
Summary	This document outlines the principles and values to reduce, and where possible, eliminate the use of seclusion and restraint in NSW Health facilities. It outlines ways to prevent and safely manage acute behavioural disturbance and to support distressed patients.
Author Branch	
Branch Contact	
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, Ambulance
Distributed to	
Review date	
Policy Manual	
File No.	
Status	

POLICY STATEMENT

SECLUSION AND RESTRAINT IN NSW HEALTH FACILITIES

PURPOSE

This policy replaces PD2012_035 Aggression, seclusion and restraint in mental health facilities in NSW and PD2015_004 Principles for safe management of disturbed and/or aggressive behaviour and the use of restraint. It applies to all NSW Health staff working in NSW public health facilities. It outlines the principles and values to reduce, and where possible, eliminate the use of seclusion and restraint in NSW Health facilities. It outlines ways to prevent and safely manage acute behavioural disturbance and to support distressed patients. Safety must be paramount when using seclusion and restraint.

MANDATORY REQUIREMENTS

1. Local health districts/specialty health networks must adhere to legal, privacy and consent requirements, particularly in relation to: NSW Mental Health Act 2007; Mental Health (Forensic Provisions) Act 1990 (NSW); Guardianship Act 1987; Children and Young Persons (Care and Protection) Act 1998; Work Health and Safety Act 2011 (NSW); and; the clinician's duty of care to the patient.
2. All NSW Health districts and networks must develop local procedures to prevent the use of seclusion and restraint that are consistent with a human rights approach and least restrictive care principles.
3. If restraint or seclusion is used, the patient must be assessed by a Medical Officer as soon as possible before, during or after the event to ratify or cease the intervention and to review the patient's status under the Mental Health Act.
4. A nominated clinical staff member must visually supervise and verbally communicate with the patient for the duration of seclusion or throughout any restrictive practice.
5. Staff must cease restrictive interventions as soon as the risk of imminent harm has passed.
6. Staff must offer debriefing with the patient following any restrictive intervention.
7. A patient's carer(s) identified under the Mental Health Act 2007 must be informed of any incident involving restrictive interventions after an incident has occurred.
8. Staff must record all restrictive interventions in the patient's health care record and in a dedicated Register (preferably electronic records) for restrictive interventions.
9. Official Visitors must have access to the Register and monthly summary of seclusion and restraint data for declared emergency departments and mental health facilities.
10. All NSW Health districts and networks must submit seclusion and restraint data from declared emergency departments and mental health facilities to the Ministry of Health.
11. All instances of seclusion and/or restraint should also be reported in Incident Information Management System (IIMS) in accordance with the PD2014_004 Incident Management Policy.

IMPLEMENTATION

Chief Executives must:

- Ensure that the principles, values and requirements of this policy are applied to support the reduction and elimination of seclusion and restraint use in NSW Health.
- Review the use of seclusion and restraint on a monthly basis.
- Ensure that there are documented procedures in place to effectively respond to and investigate alleged breaches of this policy.

Managers must:

- Promote a human rights, recovery oriented, trauma informed and person-centred culture within the health service.
- Review all documentation, videos or other reports related to the use of restrictive interventions within a 48-hour timeframe.
- Ensure that all clinical and non-clinical health staff understand this policy in practice.
- Ensure staff receive training on how to prevent, recognise and respond to signs of distress and behavioural disturbance and maintain awareness of patient safety, their safety and the safety of other staff.
- Implement review mechanisms, that include patient (and where relevant family/carer) input, to understand causality, revise practices and improve quality and safety.
- Ensure audits of compliance with the policy are conducted at least once each year.

Clinical staff must:

- Provide leadership in using non-restrictive interventions to manage distress and acute behavioural disturbance.
- Develop skills in how to prevent, recognise and respond to signs of distress.
- Read and comply with the principles and requirements of this policy.
- Record and review relevant data associated with seclusion and restraint episodes.
- Support the involvement of the patient and their family/carer in clinical decisions affecting their treatment.
- Maintain awareness of their safety and the safety of other staff.

Non-clinical staff must:

- Comply with the requirements of this policy and procedure.
- Follow the direction of clinical staff.
- Maintain awareness of their safety and the safety of other staff.

REVISION HISTORY

Version	Approved by	Amendment notes

Seclusion and Restraint in NSW Health Facilities

NSW GOVERNMENT Health

GUIDELINE

Issue date: Month-1234

GL1234_123

CONTENTS

1 BACKGROUND

1.1 About this document

This guideline supports implementation of the Seclusion and Restraint in NSW Health Facilities policy XXX. NSW Health staff must follow the principles of the policy to reduce, and where possible, eliminate the use of seclusion and restraint in NSW Health facilities. This guideline describes ways to prevent and safely manage acute behavioural disturbance.

This guideline applies to all NSW Health staff working in NSW public health facilities. It applies to all individuals who access public health services. While the principles and values outlined in this guideline apply to all settings and population groups, implementation of specific prevention and de-escalation strategies may apply differently to different settings and groups. Age, gender, cultural, religious, language and other significant individual factors or vulnerabilities (e.g. people with a disability, pregnant women) or specific settings (e.g. Forensic hospital) should be recognised and accommodated appropriately, wherever possible.

The guideline is informed by international conventions on human rights and several key documents including (but not limited to): Australian Mental Health Statement of Rights and Responsibilities 2012; Australian National Mental Health Commission Seclusion and Restraint Project; National Principles to Support the Goal of Eliminating Mechanical and Physical Restraint in Mental Health Services; National Safety and Quality Health Service (NSQHS) Standards User Guide for Health Services Providing Care for People with Mental Health Issues; and, the Australian Commission on Safety and Quality in Health Care's Recognising Signs of Deterioration in a Person's Mental State and Delirium Clinical Care Standards.

It is recognised that language is a powerful tool and certain terms have been used in this guideline based on current practice and consultation.

In contemporary recovery oriented mental health services, the term 'patient' is no longer used. However, given the breadth of this guideline, the word 'patient' has been used to refer to any person accessing or using a health service. In practice, however, it is best to enquire how a person would like to be addressed (e.g. patient, consumer, client, person with a mental health issue).

'Acute behavioural disturbance' refers to a range of behaviours that place the patient and/or others at high risk of harm. Indicators of acute behavioural disturbance may include: aggression, hostility, physical and verbal intimidation, hitting, cutting, kicking, throwing objects, using weapons or objects (such as scissors or needles) as weapons, loud and threatening speech and gestures and highly disinhibited behaviours. In practice, it is critical to understand the function, and where possible the cause, of the behaviour and signs of mental state deterioration. For example, acute behavioural disturbance may arise from or be associated with drug use/misuse, present and/or past experiences of trauma or significant distress and organic causes (acute neurological or exacerbation of existing conditions, e.g. spectrum disorders) or clinical symptoms of physical health conditions such as delirium.

1.2 Introduction

NSW Health is committed to reducing, and where possible eliminating the use of seclusion and restraint. Recognition of human rights is a significant factor in shaping this commitment.

The safety of patients, staff and other individuals must be paramount. Seclusion and restraint are significant interventions which must only be used to support patient and staff safety. Therefore, it is important to consider the adverse safety impact of restrictive practices in anticipating and planning how to manage acute behavioural disturbance.

Restrictive practices, such as seclusion and restraint, are not therapeutic but may be needed to support care. Restrictive practices are used only as a safety intervention of last resort, if preventive strategies, de-escalation and alternative least restrictive methods have not worked and/or there is immediate risk for serious harm to the patient, staff, or other people, if no action is taken. In such instances, seclusion and restraint must be carried out by suitably trained staff in a respectful way, with appropriate review and monitoring.

1.3 Key definitions

Restrictive practices involve the use of interventions and practices that have the effect of restricting the rights or freedom of movement of a person. These primarily include restraint (chemical, mechanical or physical) and seclusion.

Least restrictive practices refer to practices that maximise the autonomy, wellbeing and safe care of the patient and reduce or prevent practices that restrict personal freedoms, dignity and rights.

Restraint[1]

Restraint is defined as the restriction of an individual's freedom of movement by physical or mechanical means.

Physical Restraint: The application by health care staff of 'hands-on' immobilisation or the physical restriction of a person to prevent the person from harming himself/herself or endangering others or to ensure the provision of essential medical treatment.

Mechanical Restraint: The application of devices (including belts, harnesses, manacles, sheets and straps) on a person's body to restrict his or her movement. This is to prevent the person from harming himself/herself or endangering others or to ensure the provision of essential medical treatment. The use of furniture (including beds with cot sides and chairs with tables or trays fitted on their arms) that are used solely for the purpose of restraining a person's freedom of movement is considered mechanical restraint. It does not include the use of furniture that restricts the person's capacity to get off the furniture where it is used for a therapeutic purpose.

The use of a medical or surgical appliance for the proper treatment of physical disorder or injury is not considered mechanical restraint.

Handcuffs (i.e. metal handcuffs) are not an acceptable form of restraint in NSW Health facilities. Handcuffs should be removed unless the person remains under custody of an accompanying Police or Corrective Services officer.

Chemical restraint: Chemical restraint describes a pharmacological method used solely to restrict the movement or freedom of a patient. Chemical restraint (as defined here) through the overuse of sedation is not an acceptable form of restraint and is not to be used in NSW Health. *Rapid tranquillisation*[2] (also called emergency sedation) is the use

[1] Based on the Australian Institute of Health and Welfare (2018). *Mental Health Services in Australia: Restrictive practices*.
[2] Taken from the National Institute for Clinical Evidence (NICE) Guidelines for England and Wales (2005). *Violence and aggression: short-term management in mental health, health and community settings.* NICE guidelines [NG10]. Published date: May 2015.

issues'.[5] Recovery-oriented practice and attitudes:

- encapsulate care that maximises self-management of mental health and wellbeing, i.e. individuality and personal autonomy
- are person-centred, empowering, collaborative and promote a safe and respectful environment
- assist families to understand the challenges and opportunities arising from their family member's experiences.

Collaborative relationships and communicating effectively across the health service and all levels of staff and with patients and their family/carers, as well as key stakeholders such as staff in other agencies (e.g. police), support safe and quality care.

Health services also should demonstrate authentic co-production and co-leadership (i.e. working collaboratively in an equal partnership) with patient leaders and advocates across seclusion and restraint reduction initiatives.

2.5 Trauma informed care principles

Many people have experienced trauma in their lives affecting their psychological and physical health and wellbeing, however, these experiences may not have been identified or known. Universal trauma precautions must be taken and care and interventions must be **trauma informed**.

In parallel with the core tenets of a recovery-oriented approach, the core principles of trauma informed care are:

- safety
- trustworthiness
- choice
- collaboration
- empowerment.

Staff need to understand how trauma affects the life of a patient. Restrictive procedures such as searching, restraint, sedation and seclusion may increase distress and trigger vulnerabilities from past trauma. Interactions with health services and health staff may be re-traumatising for some people and exacerbate their distress and behaviour. Staff should make every effort to minimise potential distress through clear communication and respectful, sensitive interactions.

Many Aboriginal people have experienced significant intergenerational trauma and may also present with distress and or display acute behavioural disturbance due to multiple experiences of past and/or recent grief and loss. Considering and responding to this trauma, as well as the cultural and social needs of Aboriginal patients, are essential for providing appropriate care.

Staff may experience vicarious trauma through exposure (single, repeated and/or prolonged) to incidences of acute behavioural disturbance and application of seclusion and restraint procedures. Executive leaders and line managers should ensure their staff

[5] Defined by the Department of Health and Ageing (2013). *National Framework for Recovery-oriented Mental Health Services*.

are supported and appropriately trained in relation to vicarious trauma and have access to assessment tools and measures to mitigate risks of vicarious trauma.

3 ESSENTIAL ELEMENTS

This section aligns with the *National Principles to Support the Goal of Eliminating Mechanical and Physical Restraint in Mental Health Services* and the *National Principles for Communicating about Restrictive Practices with Consumers and Carers*[6]. It applies equally to all health services and to all patient groups (e.g. children, older persons, people with an intellectual disability). It demonstrates how the above principles and values may be applied to prevent and reduce the use of seclusion and restraint.

Primary goals of intervention for acute behavioural disturbance are to safely: engage with the patient; identify causes and/or antecedents of behavioural issues; and, treat those causes and the behavioural issues appropriately. These practices along with environmental resources, education and skilled support, as well as planning ahead, identifying and managing potential risks, can limit the use of seclusion and restraint and result in a safer workplace and a better experience for patients and staff.

3.1 Prevention strategies

All local policies, guidelines and procedures should be based on human rights and person-centred. They should use trauma informed language and be written and reviewed collaboratively with patients and families/carers.

Services should adopt evidence-based practice approaches, as these continue to develop, to reduce and where possible eliminate the use of seclusion and restraint.

In addition, the following strategies should be applied to limit the need for the use of seclusion and restraint:

- Provide convenient and early access to health services, including access to 24-hour assessment and mental health services.
- Provide welcoming, culturally safe environments. Consider the physical, emotional and relational aspects of environments. These environments help make people feel safe, comfortable, accepted, and confident that they will be respected, listened to and will receive high-quality care.
- Maximise the availability of quiet, soothing and calming spaces or rooms, especially in Emergency Departments, and sensory options. The use of sensory tools and strategies promotes patient self-regulation, behaviour, participation in daily activities and coping with stressful situations.
- Engage patient advocates, interpreters, peer workers, Aboriginal health liaison and mental health staff and clinical liaison staff, where available, to support patients.
- Develop respectful relationships and interact with patients, visitors and colleagues in a calm and professional manner; treat patients with empathy and kindness (e.g. spend time chatting, provide a cup of tea).
- Take time with the patient – time spent early on in respectful and genuine engagement and assessment with a patient can save time later, helping to better understand and appropriately address the patient's needs, triggers, causes of distress, behavioural issues and other concerns.
- Engage with family/carers and obtain information that helps to better understand the patient and their needs and concerns (e.g. identify triggers or stressors and

[6] Australian Health Ministers' Advisory Council, Mental Health, Drug and Alcohol Principal Committee, Safety and Quality Partnership Standing Committee.

supportive ways to intervene, strengths, interests, likes/dislikes, recent events), as well as the needs of the family/carer.

- Engage in intentional patient rounding[7], i.e. purposeful hourly communication by staff with each patient and/or their carer or family) during usual scheduled activities.
- Communicate clearly, honestly and regularly with patients about what is happening (or not happening if patients have to wait to be seen) and what is likely to happen.
- Explain procedures and provide clear information about mutual expectations of reasonable behaviour to patients and visitors.
- Jointly develop goals and plans, including recovery workbooks, advance directives and early warning sign/relapse safety plans.
- Make joint or supported decisions with patients about risk management and safety, including consideration of sensory modulation strategies to manage distress/arousal.
- Include family and carers in opportunities for positive risk taking and learning, including reviews of incidents.
- Promote good communication between all members of the multidisciplinary team about the patient and staff safety risks that have been identified and strategies to manage those risks.
- Use safety huddles[8], at the beginning of the day and at every shift changeover, to support teams and staff across all levels of the health service to increase awareness and focus on patient and staff safety.
- Implement appropriate handover protocols[9] to support patient care and safety.
- Implement a predictable routine in inpatient settings with a range of meaningful activities.
- Ensure all patients have had their nicotine addiction assessed and treated if necessary.
- Understand mental state deterioration in all patients. Intervene early and use tools to track triggers and monitor deterioration (i.e. reported change, distress, loss of touch with reality or consequence of behaviour, loss of function and elevated risk of harm to self, others or property).
- Have safe medication administration guidelines.
- Employ appropriate risk identification, assessment and management plan practices that apply to individual patients, the environment and potentially stressful situations (e.g. Mental Health Review Tribunal hearings).

[7] See Clinical Excellence Commission, Intentional Patient Rounding: Information for Clinicians and Health Professionals
[8] See Clinical Excellence Commission, Safety Huddles Implementation Guide and
[9] See Agency for Clinical Innovation Implementation Toolkit: Standard Key Principles for Clinical Handover.

3.2 Managing escalating behaviours[10]

- Recognise individual signs of distress/arousal, from jointly developed wellness or personal safety plans.
- Communicate clearly and respectfully with the patient at all times, focussing on assisting the patient to return to a calmer state.
- Use calming de-escalation strategies, especially those identified by the patient and their family/carer as being helpful.
- Choose the least restrictive treatment intervention possible by considering whether an intervention:
    - increases or decreases the patient's ability to self-regulate and self-manage their emotions and behaviour
    - respects the patient's choice, values and preferences
    - enables the patient to perform as many life skills as possible and connect with their regular life
    - maximises the patient's connection with close relationships, support networks and community
    - augments the patient's positive sense of self and draws on their strengths
    - offers opportunities for a patient to learn new skills, maximise their potential or connect with their inherent strengths.
- When a patient shows signs of distress, agitation, anger or aggression or reports feeling this way, staff should be supported to intervene promptly for patient and staff safety and take a problem solving, flexible and therapeutic approach. They should ensure they maintain awareness of their own and other staff members' safety when employing a range of therapeutic interventions including (but not limited to):
    - encouraging self-reflection
    - encouraging the patient (and their family/carer) to let staff know when they are feeling distressed or agitated
    - engaging designated trained staff to support the patient
    - intervening early when a patient displays signs of agitation or notifies staff they are feeling agitated
    - spending 1:1 time with the patient and actively engaging with them
    - employing active listening skills to hear what the patient 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 and helpful to the patient and safe for all concerned)
    - activating the safety plan and using strategies negotiated with the patient

[10] See also NSQHS Standards User Guide for Health Services Providing Care for People with Mental Health Issues and PD2013_049 Recognition and Management of Patients who are Clinically Deteriorating for other details on detecting and recognising acute deterioration, and escalating care and responding to acute deterioration.

and/or family/carer that help them manage stress or curb disturbed behaviour

- engaging the patient in a physical activity
- using sensory modulation equipment
- providing feedback about the patient's behaviour and how it impacts on other people
- offering an opportunity for time out in an unlocked area where the patient can be on their own to calm down (e.g. bedroom, quiet room)
- offering PRN (i.e. as needed) medication
- offering appropriate/adequate nicotine replacement therapy (for smokers) to reduce symptoms of agitation or other strategies in line with PD2015_033 NSW Health Smoke-Free Health Care Policy.

- Consider and act on the need for staff to withdraw to a safe place if faced with unsafe levels of acute behavioural disturbance.
- As a last resort, consider and act on the need to secure spaces where other staff or patients are located if faced with unsafe levels of acute behavioural disturbance.

3.3 During restraint [11]

- The clinical decision to use restraint must only be taken when all other less restrictive options have been tried, or considered and excluded. Such procedures should be followed for the least restrictive, shortest possible time necessary.
- There should be continuing attention to the patient's dignity, privacy and self-respect and self-regulation.
- Care will be taken to protect the privacy and dignity of any patient in any type of restraint who is in a public area.
- Restraint should only be carried out by appropriately trained/competent staff using the safest techniques. Patients who are restrained must, at all times, be under the care and close and regular supervision of appropriately qualified medical or nursing staff.
- Prior authorisation of the use of physical restraint should be obtained from an authorised doctor or health practitioner in charge unless:
  - the circumstances are urgent, or
  - the physical restraint is authorised under law.
- A team approach should be taken with supplementary support provided by security staff at the direction of clinical staff if necessary and available.
- Ensure that any work requirements involving restrictive interventions do not compromise the clinical responsibilities for staff and any significant personal cultural obligations, in particular Aboriginal staff.

[11] See also Safety Notice 003/16 Use of Prone Restraint and Parenteral Medication in Healthcare Settings and PD2017_043 Violence Prevention and Management Training Framework for NSW Health Organisations for more details.

- One staff member should be identified as the lead for assisting the patient to return to a calmer state.
- Acknowledge and validate the individual's distress and provide ongoing reassurance.
- In line with NSW Safety Notice 003/16 Use of Prone Restraint and Parenteral Medication in Healthcare Settings, avoid the prone restraint (face down) position wherever possible.
    - If there is no alternative (e.g. due to the type of behaviour), then it must only be used for the shortest period necessary to safely change position.
    - Prone restraint needs to be exercised with a high level of vigilance and ceased as soon as possible.
- The bending of the head or trunk towards the knees should be avoided wherever possible, and where it occurs, it should be for the minimum necessary time.
- There should be no direct pressure on the neck, thorax, back or pelvic area.
- Monitor airways, breathing, consciousness and body alignment at all times.
- Monitor patients where intramuscular or intravenous medication was administered within one hour prior to the use of physical restraint or during the physical restraint, and seek immediate medical treatment if there is a concern.
- Cease physical restraint as soon as it is no longer required, and ensure that, wherever possible, the physical restraint does not exceed 10 minutes.
- In facilities that use mechanical restraint devices, the equipment must be reviewed and approved for use by the relevant local health district/speciality health network governance committee(s) and specific policies and procedures must guide their use.
- Staff must be provided with specific training and refresher training in the procedures for use of the equipment. 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 patient in a mechanical restraint device involving the restriction of all limbs will be given 1:1 nursing care (see additional considerations in section 3.4).
- At no time will a patient in mechanical restraint be held in a locked room.
- Any deterioration in a patient's physical condition is noted and managed promptly and appropriately.

3.4 Seclusion and Observation

- Seclusion must occur in a room or area:
    - with adequate space and lighting
    - where staff have clear visibility of the patient
    - which is free from hazards (e.g. hanging points, objects that may be used to cause harm, wet floors)
    - where staff can have easy access to the room.
- The patient must be provided with sufficient bedding and clothing, sufficient food and

drink, and access to toilet facilities.

- Observation requires staff to be person-centred and focuses on meaningful and therapeutic engagement with a patient, not just visual monitoring. Staff must talk with patients during episodes of seclusion and also ask about their physical and psychological needs.
- Observation through engagement is for safety, protection from harm and maintenance of wellbeing. It provides an opportunity to develop rapport and contribute to ongoing assessment and recovery.
- Ongoing engagement with the patient, family and carers supports shared decision making around continued observation and care planning.
- The gender mix of staff during the intervention and during any exit/entrance to the seclusion room should be considered. If the patient is female, it is best if a female staff member is present.
- The senior nurse on duty is responsible for ensuring that staff observing the patient in seclusion are relieved regularly, preferably with no more than an hour at a time without a break.
- When handing over responsibility for observation, both clinicians will counter-sign an entry in the patient's health care record detailing the patient's condition at the time.
- At shift handover, if a patient is in seclusion or a mechanical restraint involving restriction of all limbs, a senior nurse or Medical Officer from each shift will conduct a comprehensive review of the patient (including mental state, physical state and risk assessment) to determine whether the episode of restraint or seclusion can cease.
- Each new staff member responsible for observations will be introduced to the patient in seclusion and the reason for the change will be explained.

3.5 Post seclusion and restraint events

- A medical review should be conducted following restraint or seclusion and close monitoring of the patient for as long as clinically necessary, especially where acute sedation has been administered, the restraint involved a period of intense struggle, or the patient complains of, or appears to have, an injury or be in discomfort.
- Family/carers should be advised of episodes of seclusion and restraint, where possible.
- Episodes and any adverse events should be documented in clinical records and on a register.
- A timely and open review process should be conducted with the staff and the patient following any restraint or seclusion event. Triggers and the methods used to respond to the event should be evaluated with family, support persons or others who witnesses the event, where appropriate. This should include a debrief meeting immediately following the event and a more formal or structured review later.

- Debriefing and review should provide the opportunity for shared learning and ways to support patient care in the future (e.g. advance care planning) and staff professional development.
- Debrief staff following a restraint or seclusion event in accordance with local policy and procedures.
- Support strategies should be available for the patient, staff, patients, family/carers and/or others who witnessed the event, and any others as appropriate. This may include providing clear written information explaining seclusion and restraint and complaint processes. This is especially appropriate where a verbal or follow up meeting is not practical.
- Peer workers or carer consultants or patient advocates should be engaged in debriefing and review processes.

3.6 Staff training

- The principles underpinning training should be standardised, competency-based, provided at induction and at regular intervals thereafter.
- Training should be developed, delivered and evaluated in partnership with patients, family/carers, peer workers and Aboriginal communities.
- Training should enable staff to understand human rights and their application in practice. This foundation should enable staff to develop a person-centred, values-based approach to care, in which personal relationships, continuity of care and a positive approach to promoting health underpin the therapeutic relationship.
- Training should provide staff with skills to assess acute behavioural disturbance and precipitating and predisposing factors.
- As a minimum, clinical staff should be trained in:
    - human rights
    - prevention and early intervention strategies with a strong emphasis on communication and other non-physical strategies (e.g. environmental changes)
    - trauma-informed care
    - sensory modulation
    - mindfulness
    - cultural competence
    - non-coercive therapeutic crisis intervention
    - harm-minimising, standardised physical restraint and seclusion practices (used as a last resort)
    - reflection skills and how to continue to learn from situations, to further develop skills over time, particularly to avoid situations reoccurring
    - debriefing.
- All staff required to use restraint must be trained in line with NSW Health policy PD2017_043 Violence Prevention and Management Training Framework for NSW Health Organisations.

3.7 Monitoring and reporting

Safety, high quality of health care and practice are dependent on the right information being available.

Given the significance of using seclusion or restraint, it is essential that these events and the patient's and staff's experiences are recorded, reported and monitored.

A reporting system should be seen as an 'information, analysis, learning, feedback and action' system. They are key elements of improvement and integration and help to build the evidence on best practice. Health services need to balance the focus of collecting and integrating data with appraising how such information is used to deliver meaningful feedback, action and improvement.

- All instances of seclusion and restraint (i.e. reasons, nature, extent, commencement/completion of any restraint or seclusion) must be recorded in the patient's clinical record and in a Register (or similar, preferably electronic records), which is to be regularly reviewed at a senior level.
- All instances of seclusion and/or restraint should also be reported in Incident Information Management System (IIMS) in accordance with the PD2014_004 Incident Management Policy.
- Data collection and transparent reporting systems should inform local quality improvement and benchmarking activities.
- Data collection for specialised mental health public hospital acute service units should be consistent with the requirements of the Mental Health Seclusion and Restraint Data Set Specification.
- Local health districts and specialty health networks must submit seclusion and restraint data from mental health facilities and declared emergency departments to the Ministry of Health
- Collaborate with patients, family/carers, advocates and staff in the review of data and quality improvement activities. Feedback and reflection enable staff, patients and organisations to learn from their own and other's experiences.

DRAFT SECLUSION AND RESTRAINT IN NSW HEALTH FACILITIES POLICY DIRECTIVE AND GUIDELINE

CONSULTATION FEEDBACK

Please use this form to provide feedback on the draft *Seclusion and Restraint in NSW Health Facilities Policy Directive* and the draft *Seclusion and Restraint in NSW Health Facilities Policy Guideline*.

Please email your completed form to MOH-SeclusionPrevention@health.nsw.gov.au by close of business, 3 May 2019.

Feedback provided on behalf of: ☐ myself ☐ my service ☐ my organisation

Name:
Service:
Organisation:
Email:

1. Questions for consideration

Questions	Response	Page #
Are there any relevant policies or legislation missing from this draft policy directive and guideline?		
Are there any mandatory requirements that should be added or changed?		
Are there any principles or values that should be added or changed?		
Please identify any issues that would be a barrier to implementation of the policy directive.		
Please identify any areas in the draft policy directive and guideline that need to be clarified or simplified; please provide alternative wording where possible.		

2. Feedback on specific section

Policy Directive		Page	Comments/suggestions
	Policy Directive		
	Purpose	#	
	Mandatory requirements	#	
	Implementation	#	
	Key definitions	#	
	Data collection and reporting	#	
Policy Guideline		**Page**	**Comments/suggestions**
1	**Background**		
1.1	About this document	1	
1.2	Introduction	2	
1.3	Key definitions	2	
1.4	Legal and legislative framework	3	
1.5	Other relevant information	4	
2	**Key Principles and Values**		
2.1	Human rights	6	
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2.3	Core values	7	
2.4	Person-Centred care and partnership principles	7	
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3.3	A Family Focused Approach to Practice	12	
3	**Key Principles and Values**		
3.1	Prevention strategies	10	

3. General feedback

Is there any other feedback about the policy directive or guideline that you would like to provide?	

4. Submission

Thank you for making the time to provide feedback.

Please email your completed form to MOH-SeclusionPrevention@health.nsw.gov.au by close of business, 26 April 2019.

It is anticipated that the policy directive and guideline will be finalised and distributed in May 2019.