SESLHD PROCEDURE COVER SHEET

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FUNCTIONAL GROUP(S)	Aged Care and Rehabilitation
KEY TERMS	Restrictive practice, restraint, and challenging behaviour.
SUMMARY	The aim of this document is to describe the circumstances under which a restrictive practice may be used and to provide clinical guidance to ensure patients are managed safely and optimally within the acute and sub-acute environments.

Restrictive practices with adult patients in acute and subacute settings

SESLHDPR/483

1. POLICY STATEMENT

South Eastern Sydney Local Health District (SESLHD) is committed to the principles of restrictive practice minimisation. SESLHD considers the use of a restrictive practice must be reserved for circumstances where it is necessary for patient's safety or critical need and only to be implemented when all other options have been considered and have been unsuccessful. Health services must support people's rights to balance safety from harm and freedom of choice.

The use of a restrictive practice can increase the risk of injury to a patient in hospital. Risks associated with the use of a restrictive practice can include injury or death through strangulation or asphyxia. Immobilisation as a result of the use of a restrictive practice can cause chronic constipation, incontinence, pressure injuries, loss of bone and muscle mass, impaired mobility, increased feelings of panic and fear, boredom and loss of dignity. Restrictive practices can have a dehumanising effect on the patient and restrict individualised treatment (Commonwealth of Australia, 2012).

In general the law protects an individual's right to:

- freedom of movement
- immunity from unwarranted interference from bodily contact by others
- immunity from conduct by others that would subject the person to unreasonable risk of injury.

Restrictive practices should only be used as a measure of last resort and is applied to:

- enable administration of life saving treatment or care that otherwise could not be administered
- protect patients from self-injury, or injury to others when no other means of protection is practical

This procedure must be used in association with NSW Ministry of Health Policy Directive PD2020_004 - Seclusion and Restraint in NSW Health Settings. Note, this procedure is not related to seclusion and situations where violence, or the imminent risk of violence related to a Code Black when acting in accordance with the self-defence sections 418 of the *Crimes Act 1900* (NSW) or the *Mental Health Act 2007* (NSW).

2. BACKGROUND

The aim of this document is to describe the circumstances under which a restrictive practice may be used, and to provide clinical guidance to ensure patients are managed safely and optimally, within the acute and sub-acute wards/units.

Specific groups of patients may be more vulnerable to risk of physical and psychological harm from the use of restrictive practices. These include:

- 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
- 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.

It is important to adopt non-restrictive means of managing disturbed and / or aggressive behaviour whenever it is possible.

This procedure does not include:

- Children (person's under the age of 18);
- Situations that occur within community based Drug & Alcohol Services;
- Situations where violence, or imminent risk of violence relating to Code Black when acting in accordance with the self-defence sections 418 of the *Crimes Act 1900* (NSW) or the *Mental Health Act 2007* (NSW). See NSW Ministry of Health Policy Directive PD2020_004 - Seclusion and Restraint in NSW Health Settings.
- When affecting an arrest under Section 100 of the *Law Enforcement (Roles and Responsibilities) Act 2002* (NSW), refer to Protecting People and Property - NSW Health Policy and Standards for Security Risk Management in NSW Health Agencies
- Minimal restrictive environmental strategies, such as secure gates or doors with keypad entry, which are used in some ward areas and specialised units. These strategies are used to keep patients with cognitive impairment safe from harm while still allowing freedom of movement around the ward.
- Restrictions put in place for public health response;
- Residential aged care facility, Garrawarra Centre; where there is a local Business Rule on Restrictive Practices.

3. DEFINITIONS

Capacity	Generally, when a person has capacity to make a particular decision they can: • understand the facts and choices involved • weigh up the consequences, and • communicate the decision (NSW Attorney General's Dept.2008)
Critical need situation	A situation in which actions are required to provide lifesaving treatment, in self-defence, to protect the patient, others, and / or property.
Restrictive practices	An intervention which has the effect of restricting the rights, freedom of movement or access of a person who is displaying a behaviour of concern.
Restraint	Refers to the use of manual force, a mechanical device or a medication/ chemical substance for the primary purpose of restricting 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.
Chemical restrictive practice	Is the use of medication or chemical substance for the primary purpose of restricting a person's movement. It does not include the use of medication prescribed by a medical practitioner for the treatment of, or to enable treatment of, a diagnosed mental disorder, a physical illness, or a physical condition (Quality of Care Amendment (Minimising the Use of Restraints Principles, 2019). Chemical restrictive practice must not be implemented until alternatives are explored extensively through assessment.
Mechanical restrictive practice	Is the application of devices to a person's body to prevent, restrict, or subdue a person's movement for the primary purpose of influencing a person's behaviour but does not include the use of devices for therapeutic or non- behavioural purposes.
Physical restrictive practice	Refers to the use of the skilled 'hands on' immobilisation (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 or to ensure the provision of essential medical treatment (PD2020_004 - Seclusion and Restraint in NSW Health Setting, Ministry of Health Policy).

	Physical restrictive practice does not include the use of hands-on technique in a reflexive way to guide or redirect a person away from potential harm/injury, consistent with what could reasonably be considered the exercise of care towards a person.
Person responsible	In NSW the Person Responsible is – 1. An appointed guardian (including an Enduring Guardian) who has the function of consenting to medical, dental and health care treatments or, if there is no guardian, 2. The most recent spouse or de facto spouse (including same sex partner) with whom the person has a close, continuing relationship or, if there is no spouse or de facto spouse, 3. An unpaid carer who is now providing care to the person or arranged/provided this support before the person entered residential care or, if there is no carer 4. A relative or friend who has a close personal relationship with the person.
Guardian with a restrictive practice function	A guardian who has been appointed by the NSW Civil and Administrative Tribunal (NCAT) Guardianship Division and who has specifically been approved to consent to 'restrictive practices'. This may require application to the NCAT Guardianship Division.
Challenging behaviours	A behaviour that causes physical and /or psychological discomfort or harm, to the person, or others. For example, aggression, self-harm.

4. RESPONSIBILITIES

4.1 Medical / nursing/ allied health staff will:

- Familiarise themselves with this procedure
- Implement this procedure consistently throughout their practice
- Document challenging behaviours on the 24 hours Behaviour Monitoring Record.
- Maintain communication with the multidisciplinary team
- Raise any concerns about staff or patient safety to their supervisors or nurse unit managers
- Attend training offered by your facility, related to the use of restraint and the de-escalation and management of patient aggression and be aware of the impacts of such practices.

4.2 Line Managers will:

- Ensure that staff are aware of and adhere to this procedure as outlined.

5. PROCEDURE

5.1 Situations when a restrictive practice may be used:

- When there is a critical care need and actions are required to provide lifesaving treatment, in self-defence, to protect the patient, others, and/ or property
- Restrictive practice should only be applied or administered after all other options have been considered and/or implemented and have been deemed unsuccessful
- Restrictive practice must only be used for the minimum amount of time and in the least restrictive manner, and the need for restraint should be reviewed regularly by the treating multidisciplinary team.

5.2 Consent

- If the application of a restrictive practice is urgently required in a critical need situation it may be applied without consent initially (see Section 5.2.1 The Principle of Necessity)
- If it is foreseen that ongoing restrictive practice might be necessary as part of an ongoing clinical management plan, then a guardianship application for appointment of a guardian with a 'restrictive practices' function must be made to the NSW Civil and Administrative Tribunal (NCAT) Guardianship Division
- Only the patient or an appointed guardian, with specific authority to approve restrictive practices, can provide consent to the use of mechanical/chemical restrictive practice
- Each time a restrictive practice is re-ordered the consent should be obtained from a guardian with a restrictive practices function
- Ensure the use of professional interpreters for patients with low or no English proficiency where possible, and if appropriate and possible with carers/family
- If the patient objects to being chemically restricted (e.g. verbally indicates they don't want the medication, simply refuses to cooperate with its administration by spitting it out or keeping mouth closed or pushing nurses away, then the 'person responsible' or 'enduring guardian' (without restrictive practice functions appointed) cannot override that objection without the approval of the guardianship tribunal
- 24 hour Behaviour Monitoring Record must be implemented with each re-order (SMR110.061)
- Patient Restrictive Practice Chart (SES110.040) should be completed for each episode of restrictive practice
- Person responsible fact sheet: https://ncat.nsw.gov.au/search.html?searchtext=person+responsible The NCAT (Guardianship Division) can be contacted 24 hours, seven days per week on 02 9556 7600.

i. **The Principle of Necessity**

In an unforeseen crisis situation where a patient is acting in a way that puts them at risk of death or serious harm and it is not practicable to obtain consent, the common law principle of 'necessity' provides a defence for a health worker who uses reasonable restraint. Some considerations with restrictive practice include:

- To be used only as a last resort
- The least restrictive alternative is used
- The intervention is lead and supervised by a senior clinical staff member
- At all times a clinician must monitor and document details of the restrictive practice on the Patient Restrictive Practice Chart (SES110.040).
- Use of a restrictive practice without consent under the principle of necessity is only lawful for as long as it is not practicable to obtain consent from a guardian with restrictive practices function.

ii. ***Mental Health Act 2007*** **(NSW)**

Coercive powers under the *Mental Health Act 2007* (NSW) can only be used to treat and detain patients against their wishes when they have a mental illness or a mental disorder. Mental health certificates **cannot be used** to pursue acute medical or surgical treatment in patients who lack capacity or who are objecting.

6. PATIENT ASSESSMENT

A comprehensive and individualised multidisciplinary assessment of the patient must be performed and documented prior to considering the use of a restrictive practice or soon after a restrictive practice is used to manage a critical need situation.

The assessment should include the following:

6.1 Physical assessment

A full physical assessment should be undertaken to detect underlying causes of behaviour and/or delirium such as presence of infection or pain. A non-verbal validated pain scale such as the Abbey Pain Scale or PAINAD should be considered.

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.*

6.2 Mental/ Cognitive State

The patient should be assessed for intrinsic or extrinsic (environmental) triggers for behaviour. Where the patient is alert and not confused, the reasons for the patient's behaviour and the issue of a physical restrictive practice should be discussed with the patient prior to application.

There should be consultation with carers/family members to identify a baseline of usual behaviour and information sought as to the patient's personal preferences and routines.

Where a patient is confused, their behaviour should be carefully observed to determine any treatable causes of agitation or combativeness. Reversible causes may include delirium, sensory overload, sensory deprivation, hallucinations and delusions. Refer to: SESLHDPR/345 - Prevention, Diagnosis and Management of Delirium in Older Persons

6.3 Medication review

Medications should be reviewed to identify any possible adverse effects and/or withdrawal effects that may be affecting the person's behaviour.

6.4 Environmental assessment

A common trigger for aggression is fear resulting from misinterpretation of the environment and miscommunication.

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

When a disturbed behaviour occurs, do not enter the patient'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.

6.5 Behaviour Support Plan

- Following a comprehensive patient assessment and consultation with the patient's guardian, family, or carer, an individualised behaviour support plan should be developed and documented for the health care teams to follow. The behaviour support plan should detail identified stressors or triggers for the challenging behaviour, as well as alternative strategies that are known to be helpful to prevent and manage the behaviour.
- The management plan should include an increase of observations of the patient using the 24hr Behaviour monitoring record (SMR110.061)
- Patients should be nursed in a quiet area where they can be easily observed, and staff must be aware of the safety issues.
- Only when all possible management strategies have been trialled and deemed unsuccessful, may the need for the use of a restrictive practice be considered, this decision should be made collaboratively by the treating multidisciplinary team.
- Consider the use of Person-centred Profile SES060.159.
- Refer to the SESLHDPR/345 - Prevention, Diagnosis and Management of Delirium in Older Persons for the non-pharmacological strategies for the patient who is experiencing confusion.

7. AUTHORISATION

The use of all restrictive practices must be authorised in writing by a Medical Officer on the Patient Restrictive Practices Chart (SMR110.040).

8. MECHANICAL RESTRICTIVE PRACTICE

Injuries and death have occurred as a direct complication of mechanical restrictive practice use.

Within SESLHD, only approved, purpose designed manufactured restraints may be used. Improvised restraint arrangements such as bandages, sheets and meal trolleys must **never** be used as a restraint.

Only the following restraints may be used:

- Padded limb restraint
- Padded mitten restraint
- A chair that is used to inhibit the patient's movement e.g. water chair, air chair.

Any restraint used must meet the requirements of the NSW Ministry of Health Policy Directive PD2020_004 - Seclusion & Restraint in NSW Health Settings.

8.1 Mandatory procedures for using a mechanical restrictive practice

- Only a Senior Medical Officer can authorise the use of mechanical restrictive practice, which must be ratified as soon as possible or within one hour after the intervention was initiated. A medical review is still to occur if the intervention was ceased prior to Snr Medical Officer authorisation.
- If security staff are required to manually restrain a patient, it must occur under the direction of senior medical staff and the supervision of nursing staff.
- Following application of mechanical restraints (padded limb mitten, padded mitten or chair) in a critical need situation, the need for a mechanical restrictive practice must be reviewed as soon as possible after the period of critical need has passed.
- Mechanical restraint must be removed every hour for at least 10 minutes. The release of the patient's limbs from mechanical restraints can be staggered or alternated to manage risk.
- In non - critical situations a medical officer must document authorisation for the use of mechanical restrictive practices following consent from a guardian who has the function to consent to 'restrictive practices' and in consultation with the multi-disciplinary team.
- If the requirement for mechanical restrictive practices continues, appropriate assessments must be conducted and a senior medical officer must review the person as frequently as possible, at a minimum every four hours, until the intervention is ceased.

- NCAT Guardianship Application is required for use of restrictive practices beyond the period of critical need.

9. CHEMICAL RESTRICTIVE PRACTICE

It is recommended that a senior medical officer prescribe medications for chemical restrictive practices. If a junior medical officer prescribes the medication, it must be in consultation with a senior medical officer (minimum of registrar level).

Medications commonly used for chemical restrictive practice include sedatives and antipsychotics. The risks of these medications include over-sedation, increased falls risk and extrapyramidal side effects from anti-psychotics.

Extrapyramidal physical symptoms may include:

- tremor
- slurred speech
- akathesia (restlessness)
- dystonia (involuntary muscle contractions)
- anxiety
- distress
- paranoia
- bradyphrenia (slowed thinking)

9.1 Mandatory procedures for using chemical restrictive practice

- The medication and dosage must be the most appropriate for the situation and prescribed within usual clinical practice guidelines (Therapeutic Guidelines: Psychotropic – Pharmacological management for acute behavioural disturbance in adults, March 2021)
- Medication should be prescribed, and administration documented on an approved medication chart.
- Medical Authorisation must be documented on a Patient Restrictive Practice Chart (SMR110.061)
- Close observation and clinical monitoring of vital signs and level of sedation is required for patients that receive chemical restraint and acute sedation.
- The 24hr Behaviour Monitoring record must be used to monitor and document the patient's behaviour and level of sedation. Vital signs must be documented in Between The Flags form in EMR.

10. NURSING MANAGEMENT OF THE PERSON REQUIRING RESTRICTIVE PRACTICE.

10.1 Observations:

- NSW Health requires high levels of clinical care, monitoring and reporting when restrictive practices are used. Any deterioration in a person's physical condition, mental state or cognitive state must be managed promptly.

- For the safety of the person, NSW Health clinical staff must continuously observe, and where possible, engage with a person in four-limb mechanical restraint for the duration of the practice.
- NSW Health clinical staff must continuously observe and, where possible, engage with the person for the first hour. After the first hour, NSW Health staff must clinically observe a person in restraint at least every 15 minutes.
- For people at higher risk during the intervention, more frequent and additional monitoring may be indicated. The recommendation is to use continuous oxygen saturation and the use of the sedation and agitation scale when acute sedation has been used.
- Clinical monitoring must include vital signs (respiratory rate, oxygen saturation, blood pressure, temperature and pulse rate). The frequency of monitoring vital signs must be determined by the clinical team, parameters set and reviewed when required and documented on the **Patient Restrictive Practice Chart.**
- It may not be possible to monitor all of the vital signs if, by doing so, safety of the staff or person being secluded is compromised. However, in those circumstances, continuous visual observation is required to ensure safety. If vital signs cannot be taken, staff must ensure the reasons are documented in the health care record.
- Neurovascular observations of effected limbs in patients with mechanical restrictive practices must be monitored and documented every 15 minutes.
- Observations of patients under restrictive practices must be conducted in person and must not be undertaken using closed circuit television (CCTV).

10.2 Care provided during the period of restrictive practice should include:

- Provision of adequate hydration and nutrition
- Regular toileting
- Active or passive exercises
- Reassurance and constant, clear explanation to address the emotional needs of the patient.
- Adequate pain/symptom management

Monitoring and documentation of the following:

- Physical safety
- Risk of pressure damage due to positioning
- Evidence of ongoing behavioural disturbance or agitation
- Response to medication
- Continuing assessment to detect any changes to physical condition e.g. signs of infection to alteration in biochemistry.
- Extra pyramidal adverse effects for 48 hours and **notify the medical officer immediately of any side effects observed.**
- Regular pain assessment
- Environmental assessment e.g. noise, light, temperature
- Multidisciplinary team review

11. BEDRAILS

The use of bedrails is a clinical decision and their use should be in accordance with SESLHDPR/421 - Bedrails- Adult - for use in Acute and Subacute Care Settings.

12. FOLLOWING THE IMPLEMENTATION OF A RESTRICTIVE PRACTICE:

Staff must document all episodes of restrictive practice in a health care record/eMR and an ims+ should be recorded where restraint is part of a reportable incident such as aggression or injury. Episodes of restrictive practice must also be documented into a restraint register in accordance with specific local facility processes.

Completion of ims+ is not required in situations in the general wards where patients are resistive to procedures and no injury to staff or patient has been sustained.

Notify the Nurse Unit Manager or Senior Nurse Manager if:

1. there are implications for the nursing workload
2. there is potential for patient self- harm or harm to others
3. a critical incident has occurred.

13. DEBRIEFING

De briefing / Post restrictive practice

De briefing of the person, family, carers, person responsible, guardian and staff must be conducted in a timely manner post restrictive practice. This is important practice, as it allows the opportunity for all staff the time to identify consistent care practices through collaboration.

The team leader should ensure all staff:

- Are allocated time out to gain control of themselves
- Orientate themselves to the basic facts of the response as staff may have arrived at different times
- Reflect on the incident
- Constructively debrief the situation, discuss interventions and the outcome
- Opportunity to discuss interventions that worked well, document and handover
- Identify any triggers pre restrictive practice that can be monitored

Further support for staff that is available:

- EAP (contact ph 1300 687 327 or via intranet page)
- Nursewell app

14. DOCUMENTATION

- Patient Restrictive Practice Chart
- Person-Centred Profile - order no. SES060.127
- Restraint registers as per local site processes
- Electronic Medical Records (eMR)
- The ward/unit should have local processes in place to collect and collate data on the use of restrictive practice.
- 24 Hour Behaviour Monitoring Record
- Violence Risk Assessment and Management Plan (eMR)

15. AUDIT

Each ward/ unit should have local processes in place to collect and collate data on use of restrictive practice. Nurse unit managers will monitor compliance with this procedure, audit and report on the use of restrictive practice within the unit.

16. REFERENCES

Legislation:

- *Guardianship Act 1987* (NSW)
- *Guardianship Regulation 2010* (NSW)
- *Mental Health Act 2007* (NSW)

References:

- AMA Position Statement 2015 'Restraint in the Care of People in Residential Aged Care Facilities' 2001 revised 2015, Australian Medical Association
- Australian and New Zealand Society for Geriatric Medicine (ANZSGN) Position Statement No 2 Physical Restraint Use in Older People, Revised September 2012
- Attorney General's Department, 2008, 'Capacity Toolkit', NSW Government
- Commonwealth of Australia, 2012, 'Decision making tool: Supporting a restraint free environment in residential aged care'
- Restrictive practices and guardianship fact sheet (nsw.gov.au)
- NSQHS Standard, (2022). Australian Commission on Safety and Quality in Health

NSW Ministry of Health policies:

- NSW Ministry of Health - Protecting People and Property - NSW Health Policy and Standards for Security Risk Management in NSW Health Agencies
- NSW Ministry of Health Guideline GL2015_007 - Management of Patients with Acute Severe Behavioural Disturbance in Emergency Departments
- NSW Ministry of Health Policy Directive PD2020_047 - Incident Management
- NSW Ministry of Health Policy Directive PD2020_004 - Seclusion & Restraint in NSW Health Settings

SESLHD policies / procedures:

- SESLHDPR/345 - Prevention, Diagnosis and Management of Delirium in Older Persons
- SESLHDPR/380 - Falls prevention and management for people admitted to acute and sub-acute care
- SESLHDPR/421 - Bedrails – Adult - for use in Acute and Subacute Care Settings.

17. EDUCATION

- My Health Learning - Aggression Minimisation in High Risk Environments (Module 2) (OHS1304)
- Post incident safety huddles: 221824316
- Manage aggressive behaviours 144148433
- Introduction to Aggressive behaviours 144148304
- De-escalate aggressive behaviours 144147947
- Injury management: 45604408
- Violence Prevention Management (VPM) training

18. VERSION AND APPROVAL HISTORY

Date	Version	Version and approval notes
April 2015	1	Author: Janine Masso CNC Dementia/Delirium, the following Aged Care CNCs: Gemma Price, Olivia Paulik and Bronwyn Arthur, Simmi Grover, Melissa Buchanan
October 2015	2	Reviewed by Aged Care & Rehabilitation Services Stream. Minor changes recommended by DQUMC at August 2015 meeting. Changes made and endorsed by Executive Sponsor
July 2018	3	Reviewed by Janine Masso, CNC Dementia/Delirium and Giles Yates, Project Officer SESLHD Clinical Ethics Service
October 2018	4	Draft for Comment period Clinical Risk Manager - District Mental Health Drug and Alcohol Services Primary Integrated and Community Health Aged care Clinical stream Clinical Nurse Educator - Jara Ward Aged Care Clinical Nurse Consultant | Sutherland Hospital Director Child Youth Mental Health.
February 2019	5	Feedback received from Prof B Draper and QUMC SESLHD Director of Nursing SESLHD Aged care Director SESLHD Director of Clinical Governance SESLHD Professional practice unit
March 2019	5	Tabled at the April 2019 Quality Use of Medicines Committee (QUMC) meeting. Not approved by QUMC as changes required.

November 2019	6	Changes made and approved by Executive Sponsor. Formatted by Executive Services prior to tabling at December Quality Use of Medicines Committee for approval to publish.
December 2019	6	Approved at December Quality Use of Medicines Committee. To be tabled at February 2020 Clinical Quality Council for approval.
March 2020	6	Approved at February 2020 Clinical Quality Council for approval.
September 2020	7	Minor review. Information included clinical teams required to document frequency of vital signs in eMR. Wording changed from restraint to restrictive practice. Links updated. Approved by Executive Sponsor. Published by Executive Services.
July 2021	8	Minor review: alignment with NSW Health PD2020_004- Seclusion & Restraint in NSW Health Settings; clarification of Section 11 reporting ims+; links updated. Approved by Executive Sponsor.
9 November 2023	9	Major review including Aged Care & Rehabilitation Clinical Stream, Aged Care CNC's, Pharmacy and consumers. Addition of Appendix A Approved at SESLHD Drug and Therapeutic Committee and SESLHD Clinical and Quality Council.

Appendix A:
CLINICAL ETHICS RESOURCE FOR SESLHD SECURITY STAFF TREATING PEOPLE WITHOUT THEIR CONSENT AND THE USE OF RESTRAINT

The following information has been collated as a resource by the SESLHD Clinical Ethics Service for security staff. The Clinical Ethics Service can be contacted on SESLHD-ClinicalEthics@health.nsw.gov.au

- Staff are encouraged to be cautious in deciding to treat people against their will and must ensure that they have lawful excuse to physically restrain a patient who is refusing treatment.
- All decisions to restrain persons for the purposes of delivering treatments must be medically led, who may then request the assistance of security staff. Reasons for the restraint, and legal defence used, should be clearly communicated with the broader team involved.
- In the short term, the law empowers clinical staff to restrain for the purposes of delivering medical treatment in either of two circumstances:
    1. Person who is being cared for under the *Mental Health Act 2007* (NSW)
    2. Person who is considered incapable of decision making, and is being detained using the 'Principle of Necessity' Under the *Guardianship Act 1987* (NSW).

- A person ***does not*** have be scheduled under the *Mental Health Act 2007* (NSW) to be legally restrained.
- There are conditions other than mental illness or mental disorder that may cause a patient to lose capacity, such as head injury, delirium, neurological conditions, and effects of drugs or alcohol.
- When these patients are refusing urgent and necessary treatment to save their life or prevent serious damage to their health, then as a last resort a medical practitioner can request security staff to restrain the patient using reasonable force.
- The 'Principle of Necessity' is lawful only until a valid consent can be obtained, either from NCAT or from medical guardian specifically empowered.
- 'Duty of care' is not a lawful excuse to detain a person against their will or use restraint in order deliver treatments.

Reference:
Protecting People and Property- NSW Health Policy and Standards for Security Risk Management in NSW Health Agencies Revised (Sec.14.8.1; Revised version 2022)

14.8.1 Using physical restraint on a medical practitioner's directive (referred to in this chapter as non-capacity patients)

- *Except in certain specified emergency situations, as outlined in the section 14.7 above, a decision to use physical restraint on a patient, who is not being cared for under the NSW Mental Health Act must only be made by a medical practitioner, who may then request the assistance of security staff as part of the restraint team.*
- *A medical practitioner may seek the assistance of security staff to physically restrain a patient for the purpose of administering urgent and necessary medical treatment to save the life of the patient or prevent serious injury to the patient.*
- *This direction to security staff can occur only where the medical practitioner has determined that the patient is incapable (either temporarily or permanently) of giving consent to treatment, and the medical practitioner has informed the security staff that the patient is incapable of giving consent.*