Justice Health and
Forensic Mental Health Network

NSW GOVERNMENT

Justice Health NSW Procedure

Seclusion and Restraint

Issue Date: May 2023

Together for
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Seclusion and Restraint

Procedure Number 6.088

Procedure Function Continuum of Care

Issue Date May 2023

Next Review Date May 2026

Risk Rating High

Summary The Forensic Hospital (FH) is committed to the prevention, reduction and where safe and possible the elimination of the use of restrictive practices. Seclusion and restraint are not treatments and must only be used as a last resort, after less restrictive alternatives have been trialled or considered. The principle of least restrictive practice means staff will maximise a person's choices, rights and freedom as much as possible while balancing healthcare needs and safety for all. Seclusion and restraint must end as soon as the patient has regained behavioural control and the immediate risk of serious harm has been minimised. The safety of staff and patients must be maintained at all times, including during the planning, initiation, undertaking, monitoring and cessation of the seclusion and restraint of a person.

Responsible Officer Service Director, The Forensic Hospital

Applies to
- ☐ Administration Centres
- ☐ Community Sites and programs
- ☐ Health Centres - Adult Correctional Centres or Police Cells
- ☐ Health Centres - Youth Justice Centres
- ☐ Long Bay Hospital
- ☒ Forensic Hospital

CM Reference PROJH/6088

Change summary Included section on enforced treatment and acute sedation.

Authorised by Forensic Hospital Policies, Procedures and Guidelines Committee

Revision History

#	Issue Date	Number and Name	Change Summary
1	May 2021	DG55710/21	DG56200/21
2	May 2023	DG34050/23	DG45813/23
3	April 2024	DG14335/24	DG7185/24

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2. Preface

The Forensic Hospital (FH) is committed to the prevention, reduction and where safe and possible the elimination of the use of restrictive practices. Seclusion and restraint are not treatments and must only be used as a last resort, after less restrictive alternatives have been trialled or considered. The principle of least restrictive practice means staff will maximise a person's choices, rights and freedom as much as possible while balancing healthcare needs and safety for all. Seclusion and restraint must end as soon as the patient has regained behavioural control and the immediate risk of serious harm has been minimised. The safety of staff and patients must be maintained at all times, including during the planning, initiation, undertaking, monitoring and cessation of the seclusion and restraint of a person.

Ministry of Health (MOH) Policy PD2020_004, Seclusion and Restraint in NSW Health Settings, outlines the principles, values and procedures in relation to the use of seclusion and restraint in NSW Health settings. All clinicians must ensure seclusion and restraint practices are completed as mandated in PD2020_004. This procedure includes additional information in relation to some of the specific seclusion and restraint processes within the Forensic Hospital.

As per PD2020_004 Seclusion can be defined as the confinement of a person, at any time of the day or night, alone in a room or area from which free exit is prevented. Seclusion applies even if the person agrees or requests the confinement. However, if isolation is requested by a person and they are free to leave at any time then this does not meet the definition of seclusion. The Forensic Hospital has specifically designed and designated seclusion rooms. These seclusion rooms provide a safe, secure and low stimulus environment for patients that pose a significant risk to others and cannot be safely managed or contained within the ward area. Each seclusion room has a means to allow continual observation and engagement.

As per PD2020_004 restraint is defined as the restriction of an individual's freedom of movement and can be categorised as either physical and/or mechanical restraint. All staff employed in The Forensic Hospital are trained in Violence Prevention and Management (VPM) and Mechanical Restraint (MR) as part of orientation. This includes de-escalation, relational security as well as physical and mechanical restraint techniques. The aim of this training is to ensure that if physical and/or mechanical restraint is required it is carried out as safely as possible and in a consistent manner. This includes when a patient is restrained in the prone position (Safety Notice 006/23).

The Violence Prevention and Management in the Workplace Training Program has been developed by HETI to meet the minimum requirements outlined in PD2017_043. The program provides staff with the necessary skills, knowledge and attitudes expected in the prevention and management of aggressive, intimidating, threatening and/or violent behaviour. Mechanical Restraint training is additional training not included in the general VPM training. Procedure 6.068 Mechanical Restraints outlines their use and approval process.

Where there is an adverse outcome associated with seclusion and restraint, Procedure 8.007 Injury or Illness – Management and Mandatory Reporting must be followed.

3. Procedure Content

3.1 Initiating seclusion and restraint

1. Seclusion and restraint must be used as a last resort to prevent serious harm or to ensure that essential medical treatment can be provided, and after less restrictive alternatives have been trialled or considered.
2. Staff are to follow restraint practices taught in VPM and MR training and must avoid restraining in a way that interferes with the person's airway, breathing and/or circulation.
3. The safety of staff and patients must be maintained at all times, including during the planning, initiation, undertaking, monitoring and cessation of the seclusion and restraint.
4. The initiation of seclusion and restraint should be conducted in conjunction with Procedure 9.020 Code Black (Psychiatric Emergency, Armed Hold-up, Hostage) – Management.

3.2 Observation and engagement during seclusion and restraint

1. Baseline vital signs (respiratory rate, blood pressure, temperature, Sp02 and pulse rate) and physical observations should be checked and recorded prior to commencement of seclusion and then at prescribed intervals by the MO or as required when safe to do so.
2. During a restraint resulting in a reportable incident staff should complete the physical observations outline in the Dynamic Risk Assessment in the Restraint Register.
3. Staff must pay particular attention to the potential risk of positional asphyxiation during restraint and raise any concerns they may have immediately to the restraining team.
4. If full vital signs and physical observations are not able to be obtained this must be documented in the patients' health record stating the reason why the observations could not be obtained. Continued attempts must be made to obtain these observations.
5. All patients must have continual visual observations by a clinician for the entire duration of the seclusion and restraint episode. Where possible staff must attempt to engage the patient. Any concerns or identified risks should be immediately raised with the Nurse in Charge (NiC) and/or Medical Officer (MO).
6. Any deterioration in a patient's physical condition, mental state or cognitive state must be managed promptly.
7. All patients must be offered and monitored for adequate food and fluid intake. A food and fluid chart must be commenced immediately for all patients in seclusion.
8. For seclusion events consideration must be given by the NiC into the allocation of the observing nurse. The observing nurse should be someone who works regularly with the patient and has a good understanding of the patient's presentation and care. Gender sensitivities and the level of experience of the observing nurse should also be taken into account.
9. Staff rotation is encouraged to prevent fatigue.
10. In the event of an emergency follow Policy 5.017 Management of Emergencies – Forensic Hospital and Procedure 6.070 Code Blue (Medical Emergency) – Management.

3.3 Ratifying and subsequent clinical reviews and use of seclusion and restraint

1. Restraint that forms part of standard clinical care practices (i.e. Escorts, Therapeutic Activities, etc.) can be ratified by a senior clinician and do not require subsequent medical reviews for continuation or cessation unless a reportable incident during the restraint occurs.

2. For seclusion and restraint resulting in a reportable incident a MO is required to ratify the event:
   a) MO review within the first hour.
   b) MO review every 4 hours after initial ratification.
   c) Consultant Psychiatrist review if 24 hours or more.
3. They must document the continuation or cessation of seclusion and restraint in the respective register and the patients' health record, including:
   a) Reason for ratification (continuing or ceasing).
   b) Observation level.
   c) Physical and Mental State Assessment.
4. For cessation of seclusion and restraint section 3.12 must be followed.
5. Reviews or ratification cannot be carried out by any person involved in the decision to initiate seclusion and/or restraint.
6. An additional review must take place, at every handover, between the unit outgoing NiC and incoming NiC. This review can be verbal or face to face.
7. Reviews by MO's must be carried out in person.

3.4 Enforced Treatment and Acute Sedation

1. PD2020_004 indicates that the use of restraint practices may be utilised as a way to ensure essential medical treatment can be provided. This may take the form of enforced treatment such as medication administration and other prescribed medical interventions.
2. Acute sedation may also be utilised during incidents of seclusion and restraint and is defined as the temporary use of medication to reduce agitation, irritability and acute severe behavioural disturbances (ASBD) for the purpose of assessment and treatment. It seeks to reduce psychological suffering and maintain a safe environment for the patient and others.
3. Wherever practicable, the circumstances (if any) in which enforced treatment and/or acute sedation is to be used this should be established in advance in each patient's treatment plan.
4. The use of acute sedation as an unplanned response to ASBD should be exceptional. Medication should never be used to manage patients as a substitute for inadequate staffing. Guideline 6.049 Medication Guidelines, Guideline 6.051 Guidelines for Psychotropic Medications and Guideline 6.054 High Risk Medicine Management Framework should be followed for appropriate administration and prescription of medications.
5. It is vital to ensure patients are given every reasonable opportunity to accept treatment voluntarily. Staff must be cognisant that they must always work in a least restrictive manner, meaning if safe and reasonable to reduce the amount of restriction placed on a patient through the use of restrictive practice such as physical and mechanical restraint and seclusion. This should be done at every stage of the intervention.
6. During any enforced treatment and/or acute sedation observations and engagement should be completed as per section 3.2. Additional observation when administering specific medication must be adhered to under the direction of a MO and as indicated in Guideline 6.049 Medication Guidelines, Guideline 6.051 Guidelines for Psychotropic Medications and Guideline 6.054 High Risk Medicine Management Framework.

3.5 Safe Environment

1. Not all restraint episodes will result in seclusion. When required and safe to do so, staff will utilise alternatives to seclusion (i.e. bedroom, sensory rooms, visits rooms, etc.) as a low stimulus environment to assist in de-escalating the patient.
2. If seclusion is required the NiC must allocate a staff member to search the seclusion room, en-suite and courtyard prior to the patient entering the area.
3. Consideration must be given into the suitability of providing a thick, thin or collapsible mattress, given the individual's level of risk.
4. As a default the bathroom access should always be available. If an MDT clinical risk assessment identifies that having access to the bathroom is unsafe then this must be documented in the patients' progress notes. The patient must be offered access to the bathroom at least hourly and/or when requested.
5. Prior to staff exiting the seclusion room, the patients clothing must be searched. Shoes and any items found must be removed. Refer to Procedure 9.015 Searches for information on search processes.
6. If after searching the patients clothing, there is concern the patient may have a prohibited item or an item that could be utilised to harm themselves a personal search must be conducted.
7. If it is risk assessed that it is unsafe for the patient to have their own clothing within seclusion, staff must make every effort to maintain the person's dignity by providing safety clothing and blankets if safe to do so. Gender sensitivities must be considered when assisting the patient with getting changed into safety clothing.
8. The seclusion corridor much be kept clear to allow safe access and egress. Storage of any required items must be minimal and kept in the seclusion courtyard observation corridor.
9. Seclusion room doors should be kept open when not in use, unless risk requires them to be locked.

3.6 Access to Secure Courtyard

1. The courtyard should ideally be searched prior to providing courtyard access. If adjoining seclusion rooms are in use, this may not be possible.
2. Only one patient must access courtyard at any given time. If a situation arises whereby two patients are in adjoining seclusion rooms at the same time, it must be ensured that the individual patient has returned to their seclusion room before the other secluded patient is allowed access to the courtyard.

3.7 Documentation Requirements (Appendix 6.1)

1. Restraint Register:
   a) All restraint episodes must be documented in the Restraint Register as soon as practical after the commencement of restraint.
   b) Only one restraint register will be allocated to each unit at a time. Current Restraint Registers will be situated at the end of the paperwork pigeon holes within the unit of each staff station area. Adolescents will have their Restraint Register beside the Emergency flip chart.
   c) The authorising clinician and documenting clinician must sign and complete all allocated sections in the Restraint Register.
   d) During a restraint resulting in a reportable incident the incident co-ordinator must allocate a clinician to complete the Restraint Register in full including the Dynamic Risk Assessment.

2. Seclusion Register:
   a) The Seclusion Register must be commenced as soon as seclusion is initiated.
   b) Current Seclusion Registers are located in the seclusion corridor in the wall mounted brochure holders outside each seclusion room.
   c) Seclusion Registers are allocated to individual seclusion rooms providing ease of tracking and governance over the documentation.
   d) The authorising clinician, documenting clinician and MO must complete all allocated sections in the Seclusion Register.
   e) The Seclusion Register Observation must be documented at intervals of no longer than 10 minutes.
3. Register Storage:
   a) All new and unused Registers will be stored and managed by the AHNM.
   b) Completed Registers should be given to AHNM, before a new register is allocated.
   c) Registers are required to be stored for 7 years after use. Storage will be managed by the AHNM.
   d) The AHNM will be responsible for ordering the Registers for the hospital and distributing these to each unit.
   e) It is the responsibility of the NiC to request new seclusion and restraint registers when the current register is nearing completion (5-10 pages left).
4. Health Record:
   a) All episodes of seclusion and restraint must be documented in proportionate detail in the health record to enable a review of practice.
   b) The following documentation must be completed in the patient's health record for all episodes of seclusion and restraint resulting in a reportable incident:
      i Least restrictive interventions trialled or considered.
      ii Indication for initiating seclusion and restraint.
      iii Medication offered and/or administered.
      iv Clinical examinations undertaken and any injuries sustained.
      v Notification of Medical Officer.
      vi Notification of designated carer and/or principal care provider (outlined in section 3.11).
      vii Debriefing with patient (outlined in section 3.10).
      viii Review of TPRIM and care plan.
      ix Aggressive incidents must be documented in detail using the '5W' format.
      x A detailed description of interactions, behaviours and assessment must be documented at least every 2 hours in the patients' health record.
5. An ims+ must be recorded for all episodes of seclusion and restraint resulting in a reportable incident. The incident number must be documented in the patients' health record, seclusion register, restraint register and shift report.
6. Vital signs must be documented (outlined in section 3.2).
7. Where changes have been made to the patient's medication regime these changes must be documented by the MO in the patient's medication chart and health record.
8. Where acute sedation has been utilised, this must be documented in the patient's health record.

9. The NiC must ensure all information relating to the seclusion and restraint incident is captured in the shift report.

3.8 Internal communication immediately following the commencement of seclusion and restraint

1. If not already present the NUM/AHNM and MO must be informed of the commencement of seclusion and restraint resulting in a reportable incident as soon as practical.
2. The MO must notify the Consultant Psychiatrist on call and the patients treating Consultant Psychiatrist promptly following the commencement of seclusion. This communication must be documented in the patient's health record.

3.9 Staff Debrief and Safety Huddle

1. The NiC or NUM/AHNM must make every effort to ensure all staff members who witnessed or were involved in the seclusion and restraint event are debriefed as soon as possible following the event and document this in the incident debrief register. Refer to Procedure 6.099 Incident Debrief.
2. The debriefing process should include (but is not limited too):
   a) Reflection on events leading to the need for seclusion and restraint.
   b) Discussion on least restrictive interventions which were attempted prior to the need for seclusion and restraint.
   c) Consideration of what else might have been done to prevent or minimise the disturbed behaviour.
   d) Any injuries which were sustained to either staff or patient and the management of same.
   e) Acknowledgement of what was done well and effectively.
   f) Identification of preventive strategies implemented.
3. These events can be extremely traumatic for staff. Additional support must be offered such as a follow up with the staff member's line manager / clinical supervision / Employee Assistance Program (EAP).
4. A Safety Huddle should also occur in order to plan immediate and short term interventions and management of the patient. This should be documented in the patients' health record and may require updating the patients TPRIM.

3.10 Patient Debriefing

1. Patients involved in the incident and all other patient's on the unit must be provided with additional support and given the opportunity to discuss their concerns with sensitivity and privacy.
2. The patient must be afforded the opportunity of a seclusion and restraint debrief. The following is a list of discussion points to ensure that the patient and treating team work collaboratively to meet the aims of seclusion and restraint debriefing. This is not a specific list of questions, staff should use their clinical judgment to elicit information and explore issues:
   a) The patient's recollection of the seclusion and restraint episode inclusive of the events leading up to the episode.
   b) Feedback regarding their behaviour and how that affects other people.
   c) How the patient feels about the restraint and seclusion event.

d) Reassurance that they are not being punished – rationale provided for the decision to utilise seclusion and restraint.

e) What calming strategies from the safety plan were effective or ineffective.

f) The patient's thoughts on how to avoid a similar incident in the future.

g) Patient must be informed of expectations for seclusion to cease.

h) Encouraged to utilise self-soothing strategies.

3. The patient debrief or refusal must be documented in the patient`s health record. The patients experience and feedback needs to be included in the seclusion and restraint review process.
4. Following the post seclusion and restraint debrief, the MDT must discuss and review the patient TPRIM and care plan.

3.11 Designated Carer and/or Principal Care Provider Notification

1. The patient's designated carer and/or principal care provider must be informed of any episodes of seclusion and restraint resulting in a reportable incident as soon as practical after the event. They must be informed of the rationale for the intervention and any consequences of the intervention. The patients' designated carer and/or principal care provider should be contacted daily during this episode.
2. It must be clearly documented in the patient's health record that the designated carer and/or principal care provider has been notified. If there is no response, this must be recorded in the health record and continual attempts made until contact is established.
3. For young people/Adolescents (under 18 years), the parents or guardian must be notified as soon as possible regardless of time, unless there are particular reasons this would not be in the patient's best interests. Reasons must be clearly documented in the patient`s health record.

3.12 Cessation of Seclusion and Restraint

1. Seclusion and Restraint must end as soon as the patient has regained behavioural control and the immediate risk of serious harm has minimised.
2. A Senior Clinician can cease Seclusion and Restraint at any time, this includes; the NiC, AHNM; NUM, MO, consultant psychiatrist, or medical superintendent.
3. For cessation of Seclusion the following should occur:

   a) A safety huddle is to be conducted and documented prior to cessation of seclusion, to identify the management plan for when the patient returns to the unit.

   b) Should there be disagreement regarding initiation or continuation of seclusion, the Consultant Psychiatrist and/or NUM must inform their line manager.

   c) After discussion with members of the MDT and following a comprehensively documented assessment of the patient in which it is considered that the immediate risk of serious harm has passed, the seclusion episode can be ceased.

   d) A comprehensive management plan should be documented through the patient's health record and TPRIM prior to seclusion being ceased.

   e) In the event whereby seclusion was ceased by a Senior Clinician, the consultant psychiatrist, MO and NUM/AHNM must be notified. The MO must then conduct a comprehensive assessment within one hour.

3.13 Complaints

1. There may be instances in which patients or carers wish to voice concerns or complaints about an episode of seclusion and restraint.
2. Staff should attempt to discuss the incident and resolve these issues at the time, where possible. The patient and carer debriefing process can provide an opportunity to address the concerns. This should be documented in the patients' health record.
3. If this is not possible, the complaint will be managed in line with the requirements of Justice Health NSW Policy 2.015 Consumer Complaints and Management.
4. Patients and carers should be provided information regarding the complaints process.

3.14 Governance

1. The Forensic Hospital Data Co-ordinator is responsible for entering the seclusion and restraint data in the Seclusion and Restraint spreadsheet.
2. The Official Visitors (OV) will review the seclusion and restraint registers and summary of seclusion and restraint data on their monthly visit to the FH.
3. All incident of seclusion and restraint including audits and data are discussed and reviewed at the FH Clinical Governance Committee and unit staff/business meetings.
4. All seclusion and restraint data is sent to the Ministry of Health (MoH) quarterly in a report called the Absconding, Seclusion and Restraint Consolidated Report.
5. All seclusion and restraint episodes must be reviewed by the patient's MDT as part of weekly MDT meeting.
6. The service level action plan to prevent, reduce and, where safe and possible eliminate the use of seclusion and restraint must be reviewed annually in collaboration with the staff, patients and families and carers.

4. Definitions

Must

Indicates a mandatory action to be complied with.

Should

Indicates a recommended action to be complied with unless there are sound reasons for taking a different course of action.

Reportable Incident

Any hazard, incident or near miss

5. Related documents

Legislations	Mental Health Act 2007 Mental Health and Cognitive Impairment Forensic Provision Act 2020
Justice Health NSW Policies, Guidelines and Procedures	Policy 1.078 Care Coordination, Risk Assessment, Planning & Review Forensic Hospital Policy 1.249 Leave Ground Access and SCALE Forensic Hospital Policy 1.319 Patient Engagement and Observation – Forensic Hospital and Long Bay Hospital Metal Health Unit Policy 2.015 Consumer Complaints and Management Policy 5.017 Management of Emergencies – Forensic Hospital Procedure 6.070 Code Blue (Medical Emergency) – Management Procedure 6.068 Mechanical Restraints Procedure 6.086 Clinical Handover Procedure 6.099 Incident Debrief Procedure 6.100 Clinical Risk Assessment and Management (CRAM) Procedure 8.007 Injury or illness – Management and mandatory reporting Procedure 9.011 Documentation – Health Record Procedure 9.014 Prohibited and controlled items – Forensic Hospital Procedure 9.015 Searches Procedure 9.018 Mental Health Clinical Documentation (MH-OAT) Procedure 9.020 Code Black (Psychiatric Emergency, Armed Hold-up, Hostage) – Management Guideline 6.049 Medication Guidelines Guideline 6.051 Guidelines for Psychotropic Medications Guideline 6.054 High Risk Medicine Management Framework
Justice Health NSW Forms	Restraint Register Seclusion Register
NSW Health Policy Directives and Guidelines	PD2020_004 Seclusion and Restraint in NSW Health Settings PD2020_018 Recognition and Management of patient who are deteriorating PD2017_043 Violence Prevention and Management Training for NSW Health Organisations PD2014_028 Open Disclosure PD2020_020 Incident Management
Other documents and resources	

6. Appendix

6.1 Documentation Requirements

All Patients must be under continuous observations for the entire duration of a seclusion and/or restraint episode.