Approved procedure 10

Controlled Document

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| **Target Audience** | Approved Treatment Facilities under the Mental Health and Related Services Act |
| **Jurisdiction** | Northern Territory |
| **Document Owner** | Chair Mental Health and Related Services Act Approved Procedures and Quality Assurance Committee |
| **Approval Authority** | Chief Executive |
| **Author** | Approved Procedures and Quality Assurance Committee |

# Purpose

To guide health care clinicians through the process of using mechanical restraint on patients in line with requirements of Section 61 of the *Mental Health and Related Services Act 1998* (the Act).

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| **Note**All services within NT Health are required to comply with the requirements of the NT Health Seclusion and Restraint Policy, which is located on the staff intranet (PGC). The NT Health policy calls upon this Approved Procedure for the mechanical restraint of patients under the *Mental Health and Related Services Act 1998*. In the event of any inconsistency between the NT Health Policy and this Approved Procedure, the Approved Procedure prevails.  |

# Procedure Summary

Refer to Appendix A - Procedural flowchart for mechanical restraint for an overview of this procedure (located at the end of this procedure).

# Definition

Under section 61(1) of the Act mechanical restraint means the application of a device (including a belt, harness, manacle, sheet and strap) on a patient's body to restrict the person’s movement but does not include the use of furniture (including a bed with cot sides and a chair with a table fitted on its arms) that restricts the person’s capacity to get off the furniture.

In this case, patientmeans a person who is being assessed or receiving treatment under the Act in an ATF.

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

# Introduction

Mechanical restraint is an intervention of last resort, used when other options have failed to maintain safety for the person experiencing distress, staff or others.

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

Although mechanical restraint is not routinely used within mental health facilitiesin theNorthern Territory,it remains an option for ATF within the Act and this procedure outlines the legal requirements, should use of these provisions be necessary.

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| **Explanatory Note**Mechanical restraint, is on occasion used in the general hospital setting in the emergency departments and general wards in respect of persons being treated under the Act. Given that Royal Darwin and Alice Springs Hospitals are ATFS, the reporting and practice conditions stipulated in this procedure would apply in these circumstances.Mechanical restraint may also occur to adequately control a patient to ensure the wellbeing and safety of the patient and/or others:* during transportation;
* prior to assessment and entry into mental health services; or
* to return an absconded involuntary patient.

This is permitted in certain circumstances under various provisions of the Act, and still considered to be an intervention of last resort, used when other options have failed to maintain safety for the person experiencing distress, staff or others.Further information can be found in:* **Approved Procedure 2 Entry to mental health services**
* **Approved Procedure 8 Leave of absence, missing or absconded (involuntary) patients**
* **Approved Procedure 28 Transport of patients.**

**Please note:** Police and Corrections officers also have provisions to use mechanical restraint under the *Correctional Services Act 2014 and the Police Administration Act 1978*. In these cases, clinicians are not required to be authorising mechanical restraint that they deem to be unnecessary and not consistent with section 61(3) of the Act. Clinicians should however note the presence of mechanical restraint applied by police or corrections officers on the authorisation form (**Form 21 Mechanical Restraint**). This will then ensure that it is recorded in the patient’s record and placed on the mechanical restraint register. Where mechanical restraint is applied outside of a mental health specific service area within the ATF, mental health personnel should draw attention to the legislative requirements outlined in this procedure. This is to ensure that appropriate records can be kept and notifications made, in order to ensure that the rights of individuals with mental illness are being observed as required by the Act. It will also ensure that external bodies (i.e. the Tribunal and Community Visitor Program) are aware that an episode of mechanical restraint has occurred, which may be subject to their review processes. |

### Methods of restraint

The person in charge of an ATF should ensure that:

* Only approved mechanical restraint devices are used for the management of challenging behavior.
* There is register of approved devices for use within the facility and that the list must be available for inspection.
* The need, appropriateness and safety issues are fully considered prior to implementation of new practice/methods of restraint.

### Pre–application of restraint

The primary focus of clinicians working within an inpatient setting is to assist patient recovery, and mechanical restraint is considered the very last resort for management of a patient’s behaviour and is not a therapeutic intervention. To avoid the use of mechanical restraint staff should actively implement interventions based on a comprehensive assessment and planning process resulting in a clearly articulated Individual Care Plan (ICP) comprehensively documented in the patient’s clinical record. Discussion and planning with the patient must take place to ensure the ICP incorporates action to taken should the patient’s behaviour and/or mood significantly deteriorate.

Staff are to be familiar with relevant strategies to defuse and de-escalate potentially or actual volatile situations. Management of patients must incorporate appropriate behavioural management strategies to reinforce the desired behaviour and reduce incidents that may eventuate in the use of mechanical restraint.

Where a patient’s behaviour is becoming increasingly disturbed, clinical staff should:

* Regularly monitor the patient’s mental state and undertake appropriate risk assessment;
* Actively engage with the patient to discuss their situation and feelings;
* If patient speaks a language other than English, ensure an interpreter is booked and used for daily nursing interactions, medical reviews and debriefings;
* If the patient is Aboriginal or Torres Strait Islander, engage the assistance of an Aboriginal mental health worker;
* Provide diversionary activities;
* Regularly review the patient’s management and medication regime i.e. discussion of patients at handover and ward rounds and clear and accurate documentation of the plan;
* Timely and judicious use of prescribed medication;
* Consider moving the patient into a less stimulating area of the ward, and offer the client an opportunity for voluntary ‘time out’;
* Engage with the patient’s primary carer or people identified by the patient to identify strategies that may assist.

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| **Practice Note**The *National Standards for Mental Health Services* require that no patient is disadvantaged on the basis of their culture and that services are accessible and equitable for all. Staff should work knowledgeably and sensitively with people from different cultural backgrounds who may display unfamiliar behaviours and responses when in situations that are confusing, distressing or frightening to them.In the absence of a staff member who can speak the language of the patient and provide support, it would be helpful for patients from culturally and linguistically diverse backgrounds to be provided with written or audio information in their own language relating to their rights and responsibilities as patients of the ATF. Utilisation of the Aboriginal Interpreter Service (AIS) or Telephone Interpreter Service (TIS), or a sign language interpreter for deaf patients, to provide verbal information to patients relating to their own ICP should also occur.Provision of culturally sensitive service as outlined above may well ameliorate difficult situations and prevent the need to use mechanical restraint. |

# Procedure

## Requirements under the Act

### Requirements for the application of mechanical restraint

Subsection (2) and (2A) stipulates that mechanical restraint must not be applied to a patient under the Act unless it is in accordance with the provisions of Section 61 and occurs within an ATF.

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| **Practice Note**These provisions cannot be used to justify the mechanical restraint of anyone not being assessed or treated under the provisions of the Act at an ATF.Currently the Northern Territory has two ATFs, these being Alice Springs and Royal Darwin Hospitals**.** |

Section 61(3) states that mechanical restraint in an ATF may only be applied where less restrictive methods of control are not applicable or appropriate. Mechanical restraint is required to be necessary for the:

1. purpose of medical treatment of the patient;
2. prevention of the patient from causing injury to himself or herself or any other person;
3. prevention of the patient from persistently destroying property; or
4. prevention of the patient from absconding from the facility.

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| **Practice Note:**The principles of the Act requires that, as far as practicable and appropriate, family members are consulted and involved in the person's treatment and care. If possible, clinicians should endeavour to contact the carer or other suitable family member prior to the application of mechanical restraint to discuss the situation and need for such. |

### Approval of mechanical restraint

Mechanical restraint must not be applied unless it has been approved by an authorised psychiatric practitioner (APP) or in the case of an emergency, by the senior registered nurse on duty (RNOD) under the provisions of section 61(4).

However section 61(5) requires that if the senior RNOD has approved application of mechanical restraint, they must notify the person‑in‑charge (PIC) of the ATF and an APP as soon as practicable after approval.

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| **Practice Note:**Upon application of mechanical restraint, the person approving it must complete **Form 21 Mechanical Restraint**.The approval for mechanical restraint must be based on a face-to-face clinical review of the patient and this review must occur even if consecutive approvals are made by the same authorised clinician.If the restraint has been approved by the senior RNOD, they must advise the PIC of the ATF, and also notify the APP to arrange for a review of the patient within one (1) hour. If necessary, the APP is to re-determine the use of mechanical restraint under the circumstances. If the APP determines that mechanical restraint is no longer required, the mechanical restraint must be removed without delay and the PIC of the ATF is to be notified as soon as practical.The review by the APP should be undertaken ‘as soon as practicable’, which, for the purposes of this procedure should be interpreted to mean no more than three (3) hours from the time that the APP is contacted by the senior RNOD. This will effectively mean that mechanical restraint authorised by a senior RNOD can continue for a maximum period of four (4) hours.If, within the period from when the APP is contacted to when the review is undertaken, the senior RNOD determines that mechanical restraint is no longer required, the senior RNOD must ensure that the mechanical restraint is removed without delay and notify the APP and the PIC of the ATF as soon as practical.Family and carers are to be informed of the incident as soon as practicable and explain reasons for the use of restraint. |

### Types of mechanical restraint

Section 61(6) allows for the form of mechanical restraint and its duration to be determined by the APP or senior RNOD who approves it. However if it has been approved by the senior RNOD, it is required to be reviewed and, if necessary, re‑determined by an APP as soon as practicable afterwards.

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| **Practice Note:**Consideration should be given to determining the most appropriate type of mechanical restraint to use in individual situations. Hard shackles or canvas clothing are not considered appropriate items to use for restraint purposes. Their use in exceptional circumstances must be guided by a multidisciplinary care plan and thorough evaluation of risk.Staff are only to use authorised types of mechanical restraint, at no time are staff to improvise the type of mechanical restraint. |

### Patient consent, review and observation requirements

Section 61 (7) allows for mechanical restraint to be applied without the patient's consent and 61(8) requires that a patient to whom mechanical restraint is applied must:

1. be kept under continuous observation by a registered nurse or medical practitioner;
2. be reviewed, as clinically appropriate to his or her condition, by a registered nurse at intervals not longer than 15 minutes;
3. be examined by a medical practitioner at intervals not longer than 4 hours;
4. be supplied with bedding and clothing that is appropriate in the circumstances;
5. be provided with food and drink at appropriate times;
6. have access to adequate toilet facilities; and
7. be provided with any other psychological and physical care appropriate to the patient's needs.

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| **Practice Note**Once mechanically restrained, for the safety of the person, a registered nurse must continuously observe, and where possible, engage with a person in mechanical restraint for the duration of the practice. A Registered Nurse must also visit and review the person in intervals no longer than every 15 minutes. For people at higher risk during the intervention, more frequent and additional monitoring may be indicated, for example where acute sedation has been used. Clinical monitoring must include vital signs (respiratory rate, 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.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.Clinical observations must be conducted in person and must not be undertaken using closed circuit television (CCTV). The observing NT Health staff must consult with the relevant clinical team in response to any escalation of the person where there are indicators that the person is becoming highly distressed and/or appears to be deteriorating in wellbeing or health. Security staff are not to replace NT Health medical practitioners for clinical observation of a person.Any variation to the frequency and type of observations and reviews and the reason why the variation occurred must also be documented.Each time a patient is reviewed, it is to be done with the intention to ensure the patient is safe and well, and also to ascertain whether the mental and or behavioural state of the patient is such that mechanical restraint can be terminated. Assessing a patient’s suitability for ceasing cannot be done comprehensively without an attempt to engage and interact (where safe and possible). Not interacting/engaging with patients may result in a longer use of restraint than necessary.The clinician(s) allocated the duty of observing and/or reviewing the patient must * Record the exact times of their observations and any relevant information including the provision of care, bedding, clothing, food, drink, toileting, medical reviews and observations of the patient’s condition.
* Consult with the senior RNOD if observations indicate that application of restraint is no longer necessary, in order that the patient is released without delay, s61(11).
* Provide a summary of the patient’s time in mechanical restraint in the patient’s clinical record:
	+ prior to each review by an APP or medical officer; and
	+ at the end of the period of the application of restraint; or
	+ at the end of their shift,

whichever comes first.Throughout the entire period in which the patient is being mechanically restrained, they must also be reviewed at a minimum every four (4) hours by a medical practitioner who has been trained appropriately to undertake this task.The senior RNOD must also request a medical review at any time if they are concerned about the patient’s physical or mental deterioration. Every attendance by a medical practitioner and their review must be documented.All details are to be recorded in event reports, patient clinical notes and/or mechanical restraint register in a manner and format approved by the PIC of the relevant ATF in line with the approved procedures |

### Length of duration and removal of restraint

Mechanical restraint must not be applied to a patient who is admitted as a voluntary patient for longer than a continuous period of 6 hours under the requirements of section 61(10).

Section 61(11) requires that if a medical practitioner, senior RNOD or an APP determines that the patient no longer satisfies the requirements for the application of restraint under subsection (3),they must, without delay, release the patient from the restraint.

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| **Practice Note**Mechanical restraint should be removed as soon as possible to avoid muscle breakdown and maintain skin integrity. If restraint is prolonged:* Release each limb, one at a time if necessary, for 10 minutes each hour
* Release the device and allow the person to stand/roll/walk at least every four hours.
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### Register and event records to be kept

Subsections (12), requires a PIC of an ATF to ensure that a record is kept of the:

1. form of mechanical restraint applied; and
2. reasons why mechanical restraint was applied; and
3. name of the person who approved the mechanical restraint being applied; and
4. name of the person who applied the mechanical restraint; and
5. period of time the mechanical restraint was applied.

The PIC must also ensure that a copy of the record kept under subsection (13), is placed on the patient's medical records and the principal community visitor must ensure that the record is inspected by a community visitor at intervals not longer than 6 months (subsection (14)).

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| **Practice Note**All details are to be recorded in event reports, patient clinical notes and/or a mechanical restraint register in a manner and format approved by the PIC of the relevant ATF in line with the approved procedures. |

### Notifying the adult guardian

If the patient has an adult guardian or decision maker, the PIC of the ATF must ensure that the adult guardian or decision maker is notified of the following as soon as practicable after the application of the restraint under the provisions of subsection (15):

1. that mechanical restraint was applied to the patient;
2. the form of mechanical restraint applied;
3. the reasons why mechanical restraint was applied; and
4. the period of time the mechanical restraint was applied.

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| **Practice Note**An email notification may be sufficient if the adult guardian or decision maker has agreed to this form of communication in advance, on admission of the patient. Some adult guardians or decision makers may wish to receive a notification via telephone call (and subsequently may elect to only make this between certain times).**Form 56 Adult Guardian Notification** has been developed to assist with communications between the ATF and adult guardians. |

## Operational requirements not prescribed by the Act

### Applying mechanical restraint

ATF policy documents detailing the clinical processes relating to mechanical restraint should be followed for application. It should also be noted that the broader policy objectives both nationally and locally are to facilitate a reduction in the use of mechanical restraint in mental health facilities.

If there is no alternative other than to mechanically restrain a patient, restraint is to be applied in a safe, secure and appropriate manner so the patient cannot harm themselves, accidentally or intentionally.

During restraint the person must be in a supine position with the head of the bed raised to promote adequate respiration. If the person is moving significantly and a risk of tipping the barouche/bed is present:

* Lower the barouche/bed to reduce the centre of gravity
* Where possible, have one side against a wall
* Raise the head of the barouche/bed to reduce forward momentum

An oxygen mask with 2L of O2 should be considered for use if the person is spitting.

There can be significant risks associated with mechanical restraint, including:

* Emotional trauma
* Re-traumatisation
* Bruising
* Neuropathy
* Positional asphyxia
* Death

Apart from the requirements under the section 61(7) of the Act, where a person is mechanically restrained, arrangements should be in place for:

* 15 minute minimum blood pressure, pulse, respirations and pulse oximetry
* Access to emergency resuscitation equipment
* Any additional monitoring indicated by the agents used (e.g. ECG monitoring)
* Communication to be maintained with the person by the appointed response team
* Personal comfort (e.g. hair not falling into face)
* The cessation of restraint as soon as the person’s safety can be maintained or they can assure staff that they or others are not at risk

### Post mechanical restraint activities

Post event strategies should be engaged within 4-8 hours of patient’s release from mechanical restraint.

After an episode of mechanical restraint:

* Offer the person a drink, an opportunity to go to the toilet or some space to themselves for a while. It can take 60 to 90 minutes for the adrenaline release that occurs during a distressing incident to dissipate and for the person to regain physical control of themselves. (Note: certain patients, such as those with autism spectrum disorder or an acquired brain injury, may take longer to return to baseline)
* The patient should consent and not be coerced into a debriefing session. It should be voluntary and the episode should also be allowed to be discussed at a future stage if desired.
* Counselling should be offered to the patient, carers, family members and peer support workers after the episode if appropriate.

The use of mechanical restraint is traumatic for all involved and strategies need to be implemented as soon as a restraint incident ceases to ensure that everyone has an opportunity to discuss the incident.

The day after the use of mechanical restraint, the senior RNOD (who should as appropriate, not be the same nurse that initiated the use of mechanical restraint) will conduct a planned debrief with the patient. The timing of this discussion needs to be planned, and dependent on the patient’s mental state. If the patient speaks a language other than English, an interpreter will be booked and used for the debrief, wherever possible.

The patient debriefing discussion can usefully explore how the patient perceived the events, and ask for suggestions about how this could be avoided in the future when staff are supporting the patient. If appropriate, and the patient requests an explanation, the senior RNOD could provide the patient with an understanding of the reasons why restraint was used.

The primary carer of the patient will be notified of the incident, unless the patient specifically requests otherwise. Family members or friends of a patient may be distressed or confused by the use of restraint as will other patients who may have witnessed the incident. Explanation and debriefing should be offered as appropriate, within the limits of confidentiality.

The senior RNOD at the time of the incident is responsible for debriefing nursing staff following the use of restraint. This provides an opportunity to explore the distress that may arise from being exposed to disturbed patients and to physical danger or criticism, for reflection on how restraint was managed and what can be learnt from it, and for review of training needs that may come to light.

The treating team should review every episode of restraint with the intention of identifying how the patient secluded could be better managed so as to avoid further restraint incidents. Outcomes of this discussion and the management plan to avoid the use of restraint should be documented in the patient’s clinical record.

## Family/carers

If the patient has nominated family members or carers to be involved in their care, the PIC of the ATF must ensure that the family member or carer is notified of the following as soon as practicable after an episode of mechanical restraint initiated on any person under the provisions of the Act:

* that the person was restrained;
* how the person was restrained;
* the reasons why they were placed in restraint; and
* the period of time that the person was restrained.

## Use of mechanical restraint on children

The use of mechanical restraint on a patient under the age of 18 years is a serious decision. Placing a person in restraints is known to be a traumatic event, and for a child (or adult) it may compound trauma and lead to avoidance of mental health services in the future.

Patients under the age of 18 will be observed continuously/constantly to ensure that mechanical restraint can be ceased at the earliest possible opportunity.

Every effort will be made to eliminate the use of mechanical restraint on patients under the age of 18. In recognition of this, the following additional procedures are to put in place:

* A person under the age of 18 may be mechanically restrained only where it is approved:

(a) by an authorised psychiatric practitioner; or

(b) in the case of an emergency, by the senior registered nurse on duty.

* While mechanically restrained, engagement should occur with the patient, where possible, to determine and implement strategies that may have helped them in the past.
* Unless imminent danger exists to the patient or another person, a patient under the age of 18 is to spend no longer than a maximum period of four (4) hours in mechanical restraints.
* Mechanical restraint is to be removed immediately upon observation of sleeping or calm behaviour.
* All patients under the age of 18 who have been subject to mechanical restraint will be reviewed by a medical officer or APP as soon as practicable after the restraint is removed.
* A patient under the age of 18 is to be allowed to have contact with their primary carer as soon as practical after the event (or after waking, if restraint has been removed upon observation of the patient being asleep).

## Other relevant and regulatory requirements

The requirements and protections of the *Mental Health and Related Services Act 1998* apply to all patients including prisoner patients and those in police custody. However, provisions of the following legislation may at times override the requirements for the mechanical restraint of patients under the Act*:*

* *Correctional Services Act 2014*;
* *Police Administration Act 1978;*
* *Youth Justice Act 2005;* and
* Civil Aviation Regulations 1998 (Regulation 309).

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| **Note**Examples of when mechanical restraint may be applied to a patient under legislation other than the MHARS Act:* A person may be in metal handcuffs when they have been transported by police or other custodial staff and may remain in metal handcuffs under police or other custodial supervision while in the approved treatment facility.
* A person who requires an examination may need be mechanically restrained by paramedics to enable them to be transported to an approved treatment facility.
* The pilot in command of an aircraft may place a person requiring transport to an approved treatment facility in mechanical restraint to ensure compliance with *Civil Aviation Act 1988*, the Regulations in or in relation to the aircraft.
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## National Disability Insurance Scheme (NDIS) participants and restrictive practices

Refer to the National Disability Insurance Scheme (NDIS) participants and restrictive practices - A guide for NT Health Mental Health Clinicians factsheet, available on the staff intranet at:

[http://internal.health.nt.gov.au/pgc/dm/Documents/Policy%20and%20Strategy/MHAOD/Policy%20Planning/NDIS/National%20Disability%20Insurance%20Scheme%20(NDIS)%20participants%20and%20restrictive%20practices.DOCX](http://internal.health.nt.gov.au/pgc/dm/Documents/Policy%20and%20Strategy/MHAOD/Policy%20Planning/NDIS/National%20Disability%20Insurance%20Scheme%20%28NDIS%29%20participants%20and%20restrictive%20practices.DOCX)

## Education and training

The PIC of the ATF is to liaise with appropriate personnel regarding the training of staff in the prevention and application of mechanical restraint and associated risks.

A trained response team should be used to apply mechanical restraint and be available for reviews of the person during the episode of mechanical restraint.

## Quality assurance

All episodes of mechanical restraint and debriefing sessions are to be recorded in the person’s Health Care Record in proportionate detail to enable a review of practice.

Patient records may include:

* Incident number;
* Frequency of observations;
* Antecedents;
* Any physical injury;
* Adherence to prevention strategies;
* Notification of family or carer;
* Alternative least restrictive interventions trialled or considered;
* Clinical examinations undertaken and outcomes;
* Reason for mechanical restraint;
* Food and fluid intake;
* Staff who initiated the use of mechanical restraint;
* Staff who approved the use of mechanical restraint;
* Start and finish time of mechanical restraint;
* Cultural background;
* Active practices to reduce duration;
* Identification of future prevention and intervention strategies;
* Debriefing, including service user and family/carer feedback, right of appeal and complaints;
* Location of restraint episode;
* Authorisation;
* Medication offered or administered;
* Multidisciplinary review;
* Reviews by senior members of clinical team and authorised clinicians; and
* Review of care plan.

The following data should also be recorded in a mechanical restraint register, which is routinely reviewed for quality improvement purposes:

* incident number (where restraint is part of a reportable incident)
* Date of mechanical restraint episode
* Name of the patient;
* Age and cultural background of the patient;
* Whether the mechanical restraint was approved/not approved under the Act i.e. it would not be authorised in the case of restraint being applied by NT Police or Corrections staff under their legislation
* Reasons for application of mechanical restraint;
* Strategies used to prevent mechanical restraint;
* Name of the person who initiated the episode of mechanical restraint;
* Name of the person who approved the mechanical restraint episodeIf authorised by a senior RNOD, the name of the APP confirming mechanical restraint order;
* Type of mechanical restraint;
* Name of the person who applied the mechanical restraint;
* Time commenced;
* Time concluded;
* Clinical examinations undertaken and outcomes, including the name of staff undertaking the examinations;
* Details of any variations in the interval at which the patient was examined; and
* Patient’s behaviour during application of mechanical restraint e.g. banging on bed, engaging in conversation.

Routine audits of mechanical restraint practices, record keeping and notification requirements should be undertaken. This information will ensure that practices are consistent with policy and legislative requirements and all relevant details and entries are being entered in clinical records, on appropriate forms and appropriately signed, dated and time stamped. This will provide a valuable source of information used to improve practices and in so doing contribute to reducing the use of mechanical restraint.

The PIC of the ATF should, in collaboration with the Clinical Nurse Manager and other key staff, monitor and regularly review the use of mechanical restraint and identify any patterns and trends, which should be raised with Approved Procedures and Quality Assurance Committee in the context of periodic reporting.

# Document Quality Assurance

|  | **Method** | **Responsibility** |
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| **Implementation**  | Document will be accessible via the MHARS Act internet and intranet pages and the PGC. | senior Compliance and Clinical Policy Co-ordinator MHAOD Branch |
| **Review** | Document will be reviewed within a period of 4 years. | Approved Procedures and Quality Assurance Committee |
| **Evaluation** | Document will be informally evaluated at time of review. | Approved Procedures and Quality Assurance Committee |

# Key Associated Documents

All related material produced by the Northern Territory Department of Health is available from: [**https://health.nt.gov.au/professionals/mental-health-information-for-health-professional**](https://health.nt.gov.au/professionals/mental-health-information-for-health-professional)

Mental Health and Related Services (MHARS) Act 1998 – available from: [**https://legislation.nt.gov.au/en/LegislationPortal/Acts/By-Title#**](https://legislation.nt.gov.au/en/LegislationPortal/Acts/By-Title)

World Health Organization. (‎2019)‎. Strategies to end seclusion and restraint: WHO Quality Rights Specialized training: course guide. World Health Organization. <https://extranet.who.int/iris/restricted/handle/10665/329605>

# Definitions and Search Terms

| **Preferred Term** | **Description** |
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| **AIS** | Aboriginal Interpreter Service |
| **APP** | Authorised psychiatric practitioner |
| **ATF** | Approved treatment facility |
| **ICP** | Individual Care Plan |
| **Mechanical Restraint** | The application of a device (including a belt, harness, manacle, sheet and strap) on a patient's body to restrict the person’s movement but does not include the use of furniture (including a bed with cot sides and a chair with a table fitted on its arms) that restricts the person’s capacity to get off the furniture.In this case, patient means a person who is being assessed or receiving treatment under the Act |
| **MHARS Act** | *Mental Health and Related Services Act 1998* |
| **NDIS** | National Disability Insurance Scheme |
| **Patient**  | A person who is being assessed or receiving treatment under the Mental Health and Related Services Act 1998 |
| **PIC** | Person in charge |
| **Senior RNOD** | Senior registered nurse on duty |
| **TIS** | Telephone Interpreter Service |

#### Alternative Search Terms

# Appendix A - Procedural flowchart for mechanical restraint

Proceed

Decision Required

Mechanical Restraint is to be removed

Refer to another procedure/flowchart

YES

**Mechanical restraint is to be removed**

NO

YES

**Person is visited by a RN every 15 minutes and examined by a Medical Practitioner every 3 hours**

**APP to review patient within 3 hours**

**Does the APP confirm the need for mechanical restraint?**

**Does the person still meet the criteria for mechanical restraint under section 61(3)?**

**Senior RNOD informs the APP and PIC of the ATF of removal of mechanical restraint**

**Mechanical restraint remains in place**

**Has mechanical restraint been applied for an hour?**

**Does the person still meet the criteria for mechanical restraint under section 61(3)?**

**Senior RNOD to arrange for a review by an APP**

**Mechanical restraint is to be removed**

**Mechanical restraint is to be removed**

**Has mechanical restraint been applied for a continuous period of 6 hours?**

**Mechanical restraint is to be removed and patient assessed for involuntary admission**

**Refer to procedures and flowcharts for Involuntary Admission**

**Is the person a voluntary patient?**

YES

YES

No

**Person is assessed by clinical staff as requiring mechanical restraint**

**Is it an emergency?**

**If an APP is not immediately available, mechanical restraint may be approved by Senior RNOD**

**Mechanical restraint is approved by APP**

**Senior RNOD notifies the APP and PIC of the ATF following application of restraint**

APP – Approved Psychiatric Practitioner

ATF – Approved Treatment Facility

PIC – Person in Charge

RN – Registered Nurse

RNOD – Registered Nurse on Duty

NO

YES

**Person is visited by a RN every 15 minutes**

**Mechanical restraint is applied**

**Mechanical restraint is applied**

YES

NO

NO

YES

NO

NO