

Mechanical restraint

Chief Psychiatrist's Guideline

Key message

Mechanical restraint is an extremely restrictive intervention that is subject to minimum statutory requirements defined and prescribed by the *Mental Health Act 1986*.

The clinical decision to apply mechanical restraint should only be taken when other less restrictive treatment options have been tried or considered and excluded as inappropriate.

At all times the safety and the personal dignity of the person being restrained must be protected. Any interference with the person's rights, privacy, dignity and self-respect are to be kept to the absolute minimum necessary in the circumstances.

Introduction

Mechanical restraint is a very restrictive intervention. This guideline is designed to ensure that when mechanical restraint is applied, it is used safely and appropriately, in a manner that is respectful of the person's dignity and rights.

This guideline discusses the provisions of the *Mental Health Act 1986* (the Act) in relation to mechanical restraint, answers common questions, discusses legal, clinical and treatment issues and defines expectations and minimum standards of practice. This guideline applies to the use of restraint on all persons, regardless of age, who are receiving treatment for a mental disorder in an approved mental health service.

The decision to apply mechanical restraint is a clinical one, taken after other less restrictive options have been considered, tried and excluded. Once the decision has been made to apply mechanical restraint, careful clinical monitoring and review must be provided and the episode reported as required by regulation.

Each approved mental health service must have local policies and procedures governing the use and management of mechanical restraint that incorporates the standards set out in this guideline. It is expected that staff will have a sound knowledge of policies and procedures and the Act, and that the service will conduct local quality assurance activities on the use of mechanical restraint.

Definitions

Mechanical restraint

Section 81 (1A) of the Act defines mechanical restraint as:

the application of devices (including belts, harnesses, manacles, sheets and straps) on the person's body to restrict his or her movement, but does not include the use of furniture (including beds with cot sides and chairs with tables fitted on their arms) that restricts the person's capacity to get off the furniture.

Mechanical restraint means that a part or all of a person's body has a device or devices applied that restricts that person's free movement. A device may also include items like 'posy restraints' or the person's clothing to fasten them to furniture.

Mechanical restraint does not include the use of seat belts for transportation, including the seat belt on a wheelchair, or the management of a person who, for their protection, may be placed in a bed with cot sides, or on a bean-bag, or in a large reclining chair to minimise the risk of accidental harm or damage from a fall. However, persons who are managed in this manner still require thorough assessment, close observation, monitoring and review.

Authorised psychiatrist

The authorised psychiatrist is a qualified psychiatrist appointed under s.96 of the Act, as the authorised psychiatrist for an approved mental health service. The authorised psychiatrist may delegate to a qualified psychiatrist any power, duty or function of the authorised psychiatrist other than the power to delegate. For the purpose of this guideline, the term 'authorised psychiatrist' refers to the authorised psychiatrist or delegate.

Continuous observation

s. 81(1D)(a)

The person restrained must be under continuous observation at all times by a registered nurse or registered medical practitioner. This level of observation reflects the seriousness of the intervention. The focus of attention during observation must be the person's safety and dignity and any change in the person's physical or mental status.

Continuous observation is the minimum standard. However, it may be necessary for the person to be monitored on a one-to-one basis or specialised, with the nurse being within an arm's length of the person at all times.

The registered nurse or medical practitioner assigned to continuously observe the person must ensure that the person has a management plan in place and that a record of the period of mechanical restraint is established to document observations and clinical reviews.

Reviewed as clinically appropriate

s. 81 (1D) (b)

The mechanically restrained person must be reviewed at intervals of not more than fifteen minutes. However, if assessment of the person indicates the need for more frequent review, this must be implemented. The review must ensure that the restrained person is physically safe and comfortable, and that their mental and physical status and the need for continuing restraint is assessed. Assessment details to be included in each review shall be specified in the person's management plan and may include:

- **physical observation** - including pulse, respiration, blood pressure, skin colour and skin condition at restraint site/s, posture, level of consciousness and comfort level
- **mental status observation** - including pattern and content of speech, attention, level of motor activity.

Examination by a medical practitioner

s. 81 (1D)(c)

A registered medical practitioner must conduct an examination of the restrained person at not more than four-hourly intervals. The examination shall cover the person's mental and physical status, be as thorough as the circumstances permit and include an assessment of the need to continue the mechanical restraint based on the criteria specified in the Act. The criteria are that mechanical restraint is necessary for medical treatment or to prevent the person from causing injury to herself/himself or any other person or to prevent the person from persistently destroying property. The first examination should occur as soon as possible after the medical practitioner is first notified of the restraint.

Varying the interval for a medical examination s81(1E)

The authorised psychiatrist may vary the interval for the medical examination if she or he believes it is appropriate. The requirement for a four-hourly review is a minimum standard and the decision to extend the time period between examinations is a serious one. It should not be done if the person has been in the unit for less than twenty-four hours or if the person has received an injectable form of psychotropic medication in the preceding twenty-four hours. If the authorised psychiatrist varies, by extension, the interval for medical examination, this must be reported to the Chief Psychiatrist at the end of each month (for further details see *What monitoring is necessary? and What documentation is required for the use of mechanical restraint?*).

Without delay

s. 81 (1)(b)(ii)

When a senior registered nurse on duty authorises mechanical restraint in an emergency, he/she must notify a registered medical practitioner without delay. This means that the nurse must immediately contact a medical practitioner who will be responsible for conducting a physical and mental status examination. Most commonly the medical practitioner will be employed by the service and contact will occur by telephone or in person as soon as restraint has occurred.

As soon as practicable

s. 81 (1B)

When mechanical restraint is authorised by the senior registered nurse on duty, the Act requires that the nurse notify the authorised psychiatrist as soon as practicable. This means that if the emergency use of mechanical restraint occurs during ordinary business hours it would be appropriate for the registered nurse to discuss the matter with the authorised psychiatrist almost immediately either directly or by telephone. The emergency use of seclusion outside ordinary working hours should be reported to the authorised psychiatrist as soon as practicable. Local policies and procedures should define out-of-hours arrangements for clinical staff. However, if the senior registered nurse on duty believes it is clinically indicated, he/she should contact the authorised psychiatrist immediately.

The authorised psychiatrist must sign the MHA 28 *Approval of/Authority for Use of Mechanical Restraint* and the episode should be discussed at the ward/unit handover and clinical review meeting.

Legal considerations

Who can be mechanically restrained?

In an emergency, any person receiving treatment for a mental disorder at an approved mental health service may be mechanically restrained. However, if the person is not an involuntary patient, a forensic or security patient, consideration should be given as to whether the person meets the criteria for involuntary detention under the Act.

When can mechanical restraint be applied?

Section 81(1)(a) of the Act states that restraint can only be applied if that restraint is considered necessary:

- (i) for the purpose of the medical treatment of the person; or
- (ii) to prevent the person from causing injury to himself or herself or any other person; or
- (iii) to prevent the person from persistently destroying property.

Wherever possible, alternative, less restrictive ways of managing the person should be used and mechanical restraint should be discontinued as soon as less restrictive management becomes possible.

What does the Act require?

Section 81 of the Act states that mechanical restraint is lawful if:

- its use is necessary;
- it has been approved or authorised;
- the person is continuously observed;
- the person is reviewed at not more than fifteen minute intervals;
- the person has a medical examination at not more than four-hourly intervals; and
- the person is supplied with appropriate bedding, clothing, food, drink and adequate toilet arrangements.

How is mechanical restraint approved?

s. 81(1)(b)(ii)

Mechanical restraint is approved by the authorised psychiatrist.

How is mechanical restraint authorised?

s. 81(1)(b)(ii)

In an emergency, mechanical restraint may be authorised by the senior registered nurse on duty. A registered medical practitioner must be notified without delay that the patient has been mechanically restrained.

What documentation is required for the use of mechanical restraint?

Approval of/authority for use of mechanical restraint MHA 28

An approval of/authority for use of mechanical restraint MHA 28 form must be completed by the person authorising or approving the mechanical restraint. When mechanical restraint occurs as an emergency or as a single planned event, an MHA 28 form must be completed for each episode. However, if the management plan is to use mechanical restraint on multiple occasions over a week, for example, each meal time for 30 minutes, this may be recorded on a single form, signed and dated by the authorised psychiatrist. An approval in these circumstances may be made for up to one week. The form must also show:

- the commencement, finish, and total time for the mechanical restraint
- when the restraint is authorised by the senior registered nurse on duty, the name of the medical practitioner who is notified, the name of the authorised psychiatrist who is notified, and the date and time that the notifications occurred
- the legal status of the restrained person
- the reason the person was restrained
- the type of restraint applied
- in the case of variation to the interval for medical examinations, the frequency of medical examinations, the reasons for variation, the signature of the authorised psychiatrist and the date.

The clinical observations page of the form is to be used to maintain a record of clinical observations and medical reviews.

If the period of mechanical restraint applied in an emergency covers a change of shift, and the authorised psychiatrist has not yet been notified, it is recommended that a new authority be completed at shift change by the senior registered nurse on duty so that accountability and responsibility for its continuation rests with the senior registered nurse on duty.

Monthly report to the Chief Psychiatrist, mechanical restraint register MHA 29.

Section 81(3) of the Act requires the authorised psychiatrist to send a monthly report of mechanical restraint to the Chief Psychiatrist specifying in each case the:

- form of mechanical restraint used, for example, left wrist, trunk, whole body
- reasons why restraint was used
- name of the person who approved or authorised its use
- name of the person who applied the restraint. This is usually the senior registered nurse on duty who oversees the application of restraint to a patient and has responsibility for providing appropriate treatment and care.
- period of time for which the person was kept restrained
- reason for varying, by extension, the requirement for a medical examination at four-hourly intervals, if that occurred.

Only RAPID/CMI generated registers signed by the authorised psychiatrist are to be forwarded to the Chief Psychiatrist by the twentieth day of the following month in which restraint occurred.

Clinical record documentation

To satisfy the requirement for good clinical practice, the person's clinical record should demonstrate that the requirements of this guideline and local policies and procedures has been met. This includes:

- a patient management plan
- the rationale for the decision to mechanically restrain the person
- the medical and psychiatric assessment
- the clinical review, to be conducted as clinically appropriate but at intervals of not more than fifteen minutes (the assessment details to be included should be specified in the person's management plan and may include recording details of the mental status, vital signs, skin colour and skin condition at the restraint site)
- a description of the person's condition at the commencement of restraint
- notation of any observable change
- any medication or treatment provided
- the response to treatment
- the outcome of the four-hourly medical review, and if the authorised psychiatrist varies the requirement for the medical review, the rationale for this decision
- details of second opinions and/or case management reviews.

When should mechanical restraint be ceased?

s. 81(1F)

The Act requires that if the senior registered nurse on duty, a registered medical practitioner or the authorised psychiatrist believes that the mechanical restraint is no longer necessary, it must be removed immediately.

The ending of mechanical restraint is an active clinical decision made by clinical staff. A break for toileting or exercise does not constitute the end of a period of mechanical restraint. Further, a break should not be used to remove the requirement for four-hourly medical examination. If a decision is made to cease an episode of mechanical restraint and it needs to be reapplied, this marks the commencement of a new period of mechanical restraint which requires a new approval or authority.

What monitoring is necessary?

s. 81(1D)(a), (b),(c)

The Act requires that the restrained person must be:

- Under continuous observation by a registered nurse or registered medical practitioner (the person must be within visual range at all times).
- Reviewed at intervals of not more than fifteen minutes by a registered nurse (the person's physical and mental well-being must be assessed as often as indicated, but at not more than fifteen minutes intervals).

- Examined by a medical practitioner at not more than four-hourly intervals. The examination shall include a physical and mental status examination and risk assessment. The authorised psychiatrist may vary the intervals that the person is medically examined if she or he believes it is appropriate. If the authorised psychiatrist varies the period between medical examinations, by extension, she or he must, at the end of each month, notify the Chief Psychiatrist of the reason for the variation. The examination must not be extended if the person has been in the unit for less than twenty-four hours or if the person has received an injectable form of psychotropic medication in the preceding twenty-four hours.

Care planning

While the application of restraint always requires planning, the extent to which planning can occur will vary from case to case. In an emergency, the opportunity to plan will be more limited and the application of restraint will be based on well-established and well-understood principles and practice. Where restraint is a planned intervention, it can be more formally planned. Care planning should include:

- Consideration of other less restrictive interventions.
- On all occasions the person must be informed of the decision to apply mechanical restraint, why this decision has been made and how they will be observed, managed and reviewed. This is best done by one staff member talking to the person in a quiet, clear and non-threatening manner.
- Where the person resists the intervention, participating staff should be aware of their individual and collective responsibilities, including who will talk to the person and who will be responsible for applying the restraint.
- Clothing should be comfortable, appropriate and protect the person's self-respect and dignity. There is no requirement for the person to be in night attire.
- Potentially dangerous items, such as penknives, nail files and cigarette lighters should be removed from the person and stored appropriately. The staff member responsible for monitoring should also take responsibility for ensuring that the person's needs are met.
- Placement in the unit is a clinical decision based on meeting clinical needs, legal requirements for observation and the person's need for privacy and socialisation.
- Debriefing and support should be provided to the person during and after the period of restraint. Although restraint is applied for sound clinical reasons it is a very intrusive procedure which requires sensitivity and skill in its management. Debriefing should also be offered to other persons and may include the person's family and other visitors, co-patients and staff.
- A management plan should be developed to include primary diagnosis, assessment of clinical needs, treatment objectives and outcomes. It should contain sufficient detail to allow for effective continuing care. The plan should include.
 - identification of health problems and risks and how they are to be managed (strategies to manage the identified risks might include the use of psychotherapeutic techniques, counselling, specialising and or medication)
 - the time and frequency for medication review.
 - the scope of the clinical review

- management of the restraint site/s
- details of how the person's dietary needs are to be met
- details of how the person's hygiene and elimination needs shall be met (wherever possible, the person should be accompanied to the bathroom for these purposes)
- details of how the person's need for exercise shall be met
- When the treatment plan for the episode of restraint is to be reviewed.

Clinical considerations

Medical assessment

Mechanical restraint should not be initiated unless a thorough medical assessment has occurred. In an emergency, mechanical restraint may be applied prior to a medical assessment. However the medical assessment must be conducted as soon as possible. Particular emphasis should be placed on seeking a history of the presentation from the person, their family and other people with the person. This should include information about the possible ingestion of alcohol, illicit drugs and overdose, deliberate or accidental. Information on medication prescribed should also be obtained. The physical and mental state examination should be as thorough as the circumstances allow and should include an assessment of the risk to the person from deliberate or accidental self-harm. Clinical staff should be aware of the risks associated with the likelihood of increased agitation resulting from restraint being applied.

Recently admitted persons

Occasionally, a patient is admitted to hospital who is profoundly psychotic, unable or unwilling to give coherent responses to questions and violently opposed to being physically examined. While this makes adequate assessment difficult, as thorough an assessment as possible must take place before medication is administered. Staff should be aware that the person may have ingested large amounts of alcohol or drugs prior to admission and/or may have unrecognised medical conditions such as epilepsy, diabetes or concomitant conditions such as chest infection or head injury which may pose a threat to life. Medical and nursing staff responsible for mechanical restraint must be aware of the clinical manifestations of alcohol and substance use or withdrawal, particularly in recently admitted persons.

Second opinion

Where mechanical restraint is used for extended periods of time or on a recurrent basis, it is good clinical practice to obtain a second opinion or hold a case conference to review case management as soon as practicable.

Degree of vigilance

Medical and nursing staff vigilance should reflect the seriousness of the intervention. Attention should be focused on the person's safety and dignity and the indication of any change in their physical or mental status.

Whether to use medication

The decision to prescribe medication before or during the period of mechanical restraint involves balancing the risks and benefits of not administering medication. However, in circumstances where assessment is difficult, the risk of adverse effects from medication is greatly increased. Determinants include the safety and well-being of the person, the needs of ongoing management, achieving the best treatment outcomes in the shortest possible time and the safety of other patients and staff.

Principles of prescribing

Medical staff prescribing for persons who are or may be mechanically restrained must be familiar with the possible adverse effects of medication prescribed and the cumulative effects of medication from repeated administration. Prescribing psychotropic medication should be in accordance with RANZCP guidelines. The use or withdrawal from benzodiazepines may heighten anxiety and aggression in some people. The prescribing of medication as necessary (PRN) must specify the dose, route of administration, the interval between doses and the maximum dosage within a specified period. Indications for the use of prn medication must also be specified.

Observations

The Act requires that the person who is mechanically restrained must be continuously observed by a registered nurse or medical practitioner. In some circumstances, the level of observation and care may need to be increased so that nursing is on a one-to-one basis, with the nurse being no more than an arm's length from the person at all times. It is the responsibility of the medical and nursing staff to identify and implement the level of observation required. These decisions must be constantly reviewed. If large doses of medication are given in an injectable form, the doctor should specify the observations required to identify potential side-effects. Respiratory depression, hypotension or laryngeal spasm can occur with psychotropic medication and could be fatal.

Persistently disturbed/treatment resistant behaviour

Persons who repeatedly behave in a manner that places themselves or others at risk and who fail to respond to a full range of clinical interventions, pose particular management problems. In these circumstances, a thorough review of the person's history, treatments attempted and their duration, doses of medication administered, and the person's response to these should be completed. This should be presented to a group of skilled professionals for consideration at a case conference. Subsequently, a detailed management plan should be developed which describes the behaviour, identifies wherever possible the precipitants, and outlines a graduated series of responses. The plan should include a strategy aimed at reducing the behaviour and the necessity for mechanical restraint.

Mechanical restraint-key points and processes

Note: These steps may not occur sequentially.

- Decision is taken to apply mechanical restraint and a plan of how this is to be achieved is developed.
- The person is informed of the decision, why it has been made and the level of observation and review that will apply. The person should be reassured that she or he is safe.
- The application of the restraint should involve an appropriate number of clinical staff to ensure the safety of the person, staff and others.
- The person is continuously monitored, reviewed as clinically appropriate at not more than fifteen minute intervals, and is examined by a medical practitioner at not more than four-hourly intervals.
- A medical practitioner is notified without delay if the restraint has been applied in an emergency.
- The authorised psychiatrist is notified as soon as practicable if the restraint is applied in an emergency.
- A patient management plan is developed covering diagnosis, assessment of clinical need, anticipated outcomes, identified risks and strategies to manage those risks.
- Clothing should be comfortable, appropriate and provide for the person's dignity and self-respect.
- Dangerous items must be removed from the person and stored safely.
- Removing mechanical restraint is a clinical decision based on meeting clinical needs, legal requirements and the person's needs for privacy and socialisation.
- The person must be provided with adequate food and fluids and appropriate assistance to meet their nutritional needs.
- The person must be provided with adequate arrangements and assistance relating to elimination and personal hygiene. It is desirable that the person be accompanied to the bathroom for these purposes.
- The person should have the opportunity for physical exercise as appropriate.
- The approval for mechanical restraint must be signed by the person who authorised the restraint and the authorised psychiatrist.
- Clinical documentation must be completed.
- Debriefing of relatives, next of kin/primary carers, co-patients and staff should occur.
- A monthly report must be forwarded to the Chief Psychiatrist by the twentieth day of the following month in which restraint occurred.

Clinical standards and indicators

Standard 1: Each agency shall have established policies and procedures concerning mechanical restraint.

Indicators:

- 1.1 There is a written policy and procedure for mechanical restraint which is informed by this clinical guideline.
- 1.2 Clinical staff are able to articulate a sound knowledge of the key principles, legal requirements, guidelines and local policies and procedures relating to mechanical restraint.

Standard 2: An accurate account of each episode of mechanical restraint is documented in the clinical record and demonstrates the delivery of effective, humane, efficient and evaluated treatment and care.

Indicators:

- 2.1 Clinical record documentation of an episode of mechanical restraint complies with established policies and procedures.
- 2.2 Each person has a documented management plan that relates to the primary diagnosis, assessment of clinical needs, anticipated outcomes, risk assessment and strategies to manage those risks.
- 2.3 The rationale for the decision to mechanically restrain the person is recorded.
- 2.4 All medical and psychiatric examinations, clinical reviews and treatment are recorded.
- 2.5 The person's response to treatment and interventions are recorded.
- 2.6 The rationale for any change to the treatment plan is recorded.
- 2.7 Details of second opinions and/or case management reviews are recorded.
- 2.8 Where a variation of a four hourly review occurred by extension, the person restrained had received a medical examination, had not received an injectable form of psychotropic medication in the previous 24 hours or been admitted to the unit for less than twenty-four hours.

Standard 3: Statutory reporting requirements are achieved.

Indicators:

- 3.1 The Chief Psychiatrist receives timely monthly statutory reports of the number of episodes of mechanical restraint that have occurred in the service. This report is generated by RAPID/CMI and provided by the twentieth day of the following month in which the restraint occurred.

Services must ensure data on episodes of mechanical restraint is entered onto RAPID/CMI by the tenth day of the month following an episode of restraint.

About Chief Psychiatrist's Guidelines

The information provided in this guideline is intended as general information and not as legal advice. If mental health staff have queries about individual cases or their obligations under the *Mental Health Act 1986*, service providers should obtain independent legal advice.

3.2 The report of each episode of mechanical restraint includes:

- the type of mechanical restraint applied
- the reason mechanical restraint was applied
- the name of the person who approved/authorised the mechanical restraint
- the name of the person who applied the restraint
- the period of time the person was mechanically restrained
- if the requirement for a medical review was varied by extension, the reason that this occurred.



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