Justice Health and
Forensic Mental Health Network

Justice Health NSW Procedure

Enforced Medication, Seclusion and Restraint - Mental Health Unit, Long Bay Hospital

Issue Date: 24 June 2024

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Seclusion and Restraint and Enforced Medication – Mental Health Unit, Long Bay Hospital

Procedure Number	6.153
Procedure Function	Continuum of Care
Issue Date	24 June 2024
Next Review Date	24 June 2027
Risk Rating	High
Summary	This procedure is intended to provide guidance to staff in relation to medication administration prior to, during and following the administration of enforced medication and/or the process of seclusion and restraint at Mental Health Unit, Long Bay Hospital (MHU, LBH).
Responsible Officer	Nurse Unit Manager 2, Mental Health Unit Long Bay 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/6153
Change summary	New Procedure to replace policy and exclusive procedures in the MHU, LBH.
Authorised by	Service Director, Custodial Mental Health

Revision History

#	Issue Date	Number and Name	Change Summary
1	June 2024	Enforced Medication, Seclusion and Restraint - Mental Health Unit, Long Bay Hospital	New Procedure to replace policy and exclusive procedures in the MHU, LBH.

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2. Preface

This document is intended to provide guidance to Justice Health and Forensic Mental Health Network (Justice Health NSW) staff on the specific procedures in relation to seclusion and restraint processes and medication administration prior to, during and following the administration of enforced medication and acute sedation. Justice Health NSW 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 exhausted. 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/or restraint of a person.

The 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 MHU.

Restraint is defined as the restriction of an individual's freedom of movement of the patient and can be categorised as either physical, mechanical and/or chemical restraint. Please note, the physical restraint of a patient in the Mental Health Unit is completed by Corrective Services NSW (CSNSW) with Justice Health NSW staff managing the physical health of the patient during the restraint process.

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. Within the Mental Health Unit, seclusion refers to patients who have been involuntarily placed alone in their cell by Justice Health and Forensic Mental Health Network (Justice Health NSW) staff following authorisation by a Medical Officer (MO).

It does not refer to segregation or CSNSW lock-in periods. Segregation is taken to mean segregated custody or confined to a cell for the reasons of security, discipline or safety by CSNSW. CSNSW lock-in periods refer to CSNSW locking in patients into their cells at night, at lunch time to facilitate CSNSW officer breaks, when CSNSW does not have adequate staffing, or in response to an incident to maintain security and order in the unit. The use of seclusion in psychiatric inpatient facilities involves the curtailment of the freedom of the patient. This action should only occur as a last resort where no other less restrictive form of intervention is available in the management of disturbed behaviour.

Enforced medication is a procedure whereby psychotropic medication is coercively administered by clinical (nursing and/or medical) staff to a patient detained in a mental health facility subject to the Mental Health Act 2007 or the Mental Health and Cognitive Impairment Forensic Provisions Act 2020. It is utilised only where it is reasonable and necessary to do so, for the purposes of providing clinical care, where less restrictive approaches to obtaining a patient's compliance with a request to accept prescribed medication have already failed.

All staff employed in the Mental Health Unit are trained in the Violence Prevention and Management (VPM) Personal Protection module. The Personal Safety workshop provides skills in de-escalation techniques and physical evasion techniques. The Violence Prevention and Management in the Workplace Training Program has been developed by HETI to meet

the minimum requirements outlined in PD2017_043 Violence Prevention and Management Training Framework for NSW Health Organisations.

3. Procedure Content

3.1 Restraint

3.1.1 The physical restraint of a patient in the Mental Health Unit is completed by CSNSW with Justice Health NSW staff managing the physical health of the patient during the restraint process.

3.1.2 Justice Health NSW staff will only request health initiated restraint by CSNSW to administer enforced medication to non-consenting patients detained in a mental health facility subject to the Mental Health Mental Health and Cognitive Impairment Forensic Provisions Act 2020 (MHCIFP Act).

3.2 Enforced Medication

3.2.1 The administration, monitoring and evaluation of enforced medication must comply with all relevant legislative requirements and professional guidelines regarding medication administration, as set out in the Guidelines 6.051 Guidelines for Psychotropic Medication.

3.2.2 In particular, as per s85 of the Mental Health Act 2007, a medical practitioner must not cause drugs to be administered to a person in 'a dosage that, having regard to professional standards, is excessive or inappropriate.' Any intervention must take into account the patient's religious and/or cultural values, rights, best clinical practice, risks, wellbeing of the patient and others and the therapeutic outcome of the proposed treatment.

3.2.3 The administration of enforced medication must be delivered in accordance with a standard that would be widely accepted by peer professional opinion as competent professional practice, while taking into account the patient's rights. The treatment implemented must achieve optimum health outcomes for the patient, while also reducing ongoing risks to themselves and others.

3.2.4 Where a patient requires 'acute sedation' for the purpose of managing, in the immediate to short term, behaviours that arise from a mental condition and may pose a risk to self or others, please initiate as per the Procedure 1.517 Acute Sedation.

3.2.5 The principle of providing the least restrictive intervention in order to ensure safe and effective care must remain the overarching principle in clinical decision making. Enforced medication will only be used as an intervention when all other non-coercive strategies for delivering prescribed medication to a patient have been exhausted. This may occur either in response to an acute event associated with a high risk of harm to patients, staff or others, or in less acute circumstances where a condition of persistent non-cooperation with staff in the process of medication administration has deemed any less restrictive approach as unsafe to implement.

3.2.6 Where a patient has provided informed consent to medication administration and there are no CSNSW security, discipline or safety concerns requiring the use of restraint, the medication must be administered without the use of physical or mechanical restraint. Where a patient withdraws their consent to medication administration during the administration process, the clinician must stop the intervention immediately. Importantly, consent may be withdrawn verbally or through action such as moving away or covering the intended injection site. Any ambivalence about consent should be taken as absence of consent, and the intervention stopped. The clinician must engage with the patient and discuss the reasoning for their decision. Where a patient continues to withhold their consent for administration of medication, the clinician must escalate this for MDT discussion and management.

3.2.7 There are two administration of enforced medication processes that can occur at the Mental Health Unit: Enforced Medication Administration –

a) Joint Planned Intervention, the process where the patient receives medication with physical or mechanical restraint, where it is clinically required and authorised by two medical officers. The restraint is carried out by CSNSW staff when a patient is non-compliant with the administration of medication and less restrictive measures have been exhausted.
b) Enforced Medication Administration – Consenting Patient, the process where the patient is accepting of the medication administration but receives medication with the use of physical or mechanical restraint by CSNSW staff due to CSNSW security, discipline or safety measures and the use of restraint is not clinically required and authorised by the authorised medical officer.

3.3 Enforced Medication Administration – Joint Planned Intervention

3.3.1 The process of an enforced medication administration – planned joint intervention must only occur in G ward, Mental Health Unit.

3.3.2 Where it is determined a patient requires enforced medication administration – joint planned intervention, the clinical team must adhere to the Local Operating procedure – Enforced Medication Administration to ensure a safe intervention.

3.3.3 Post administration of a enforced medication episode the NUM/NiC must complete a enforced medication notification email to the Chief Executive, General Manager Forensic Mental Health, NSW Clinical Director Forensic Mental Health, Clinical and Deputy Director Custodial Mental Health, Service Director Custodial Mental Health, Nurse Manager Custodial Mental Health, Custodial Mental Health Nursing Unit Manager Long Bay Correctional Complex, Nursing Unit Manager Mental Health Unit, outlining the following items:

- Patient's name
- Location
- Admission type
- MIN
- Reason
- Staff involved and role:
- Total duration of restraint
- Was any mechanical restraints used
- Type of medication administered
- Was the Nursing Unit Manager or Nurse Manager involved? If so, who?
- Was the Medical Officer involved?
- Was the patient injured?
- IMS+ number

3.3.4 The patient's designated carer and/or principal care provider (as defined by the NSW Mental Health Act 2007, Section 72) must be informed of any health-initiated restraint episode as soon as practical after the event. They must be informed of the rationale for intervention and any consequences of intervention.

3.3.5 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 continued contact attempts made until contact is established.

3.3.6 Where there is no designated carer, the patient's preferences regarding contacting their family must be taken into account prior to any contact being made.

3.4 Enforced Medication Administration – Consenting Patient

3.4.1 Where a patient requires their prescribed depot medication administered, the clinician must engage with the patient to determined through a mental health and risk assessment process that this can be completed without the use of restraint.

3.4.2 The clinician must gain consent from the patient without the presence of CSNSW officers.

3.4.3 The NUM or NiC discuss depot medication administration requirements at the morning safety huddle with CSNSW team.

3.4.4 The NUM/NiC complete a joint risk assessment discussion to outline the identified risks from a Justice Health NSW and CSNSW perspective.

3.4.5 Consent must be confirmed again prior to administration. Where a patient withdraws their consent to medication administration during the administration process, the clinician must stop the intervention immediately. Importantly, consent may be withdrawn verbally or through action such as moving away or covering the intended injection site. Any ambivalence about consent should be taken as absence of consent, and the intervention stopped. The clinician must engage with the patient and discuss the reasoning for their decision. Where a patient continues to withhold their consent for administration of medication, the clinician must escalate this for MDT discussion and management.

3.4.6 Where CSNSW determine from a security, discipline or safety perspective that they determine the need for CSNSW initiated restraint to be utilised, the NUM must ensure this is discussed with the MDT available. In the event that the NUM/NiC and CSNSW supervisor complete a joint risk assessment and due to dissenting opinions in relation to the management strategies to complete the medication administration process, this must be escalated to the supervisor, the functional manager makes a decision in regard to use of restraint.

3.5 Enforced Medication Joint Planned Intervention - Documentation and Communication

3.5.1 Any episodes of enforced medication must be documented in proportionate detail in the patient's progress notes, outlining the alternative interventions attempted and confirmation that enforced medication was used as a last resort.

3.5.2 The medications administered to the patient before, during or after the incident must be documented in the eMeds section in JHeHS..

3.5.3 A detailed description of interactions, behaviours and assessment must be documented at least every 2 hours in the patients' health record.

3.5.4 Vital signs must be documented on the SAGO chart.

3.5.5 If any member of the team has concerns about proceeding, the process must stop, and the concerns escalated through the Custodial Mental Health management team. Issues, unresolved through management escalation, must be resolved through escalation to the General Manager Forensic Mental Health and NSW Statewide Clinical Director Forensic Mental Health.

3.5.6 All episodes of enforced medication require an ims+ to be completed through the NSW Health SharePoint by the NiC or an appointed clinician.

3.6 Seclusion

3.6.1 As per Policy Directive PD2020_004 Seclusion and Restraint in NSW Health Settings, 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. Within the Mental Health Unit, seclusion refers to patients who have been involuntarily placed alone in their cell by Justice Health and Forensic Mental Health Network (Justice Health NSW) staff following authorisation by a Medical Officer (MO).

3.6.2 It does not refer to segregation or CSNSW lock-in periods. Segregation is taken to mean segregated custody or confined to a cell for the reasons of security, discipline or safety by CSNSW. CSNSW lock-in periods refer to CSNSW locking in patients into their cells at night, at lunch time to facilitate CSNSW officer breaks, when CSNSW does not have adequate staffing, or in response to an incident to maintain security and order in the unit. The use of seclusion in psychiatric inpatient facilities involves the curtailment of the freedom of the patient. This action should only occur as a last resort where no other less restrictive form of intervention is available in the management of disturbed behaviour.

3.7 Initiating Seclusion

3.7.1 Where a clinician has determined that a patient requires seclusion, this restrictive intervention must be discussed within the multidisciplinary team prior to the seclusion being initiated. The Nurse in Charge (NiC) or NUM must notify the CSNSW Functional Manager that a patient requires seclusion.

3.7.2 The NiC must ensure a joint safety huddle is completed to discuss management of the patient whilst initiating seclusion, this could involve, cell type, courtyard access, safety clothing, property, searching, food type etc.

3.7.3 Where the patient requires to be escorted to seclusion, the clinician must request CSNSW to carry this out. At the commencement of the seclusion, the patient must be searched as per CSNSW local operating procedures.

3.7.4 Where possible baseline vital signs (respiratory rate, blood pressure, temperature and pulse rate) and physical observations should be checked and recorded at the commencement of seclusion.

3.7.5 The patient must have continual visual observations by a clinician once seclusion is initiated. Where possible, staff must attempt to engage the patient throughout the episode of seclusion.

3.7.6 Any concerns/identified risks or any deterioration in the patient's physical condition, mental state or cognitive state must be managed promptly and immediately raised with the NiC and/or MO.

3.7.7 The patient must be offered and monitored for adequate food and fluid intake, a food and fluid chart must be commenced on the commencement of seclusion and throughout the episode.

3.7.8 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.

3.8 Ratifying and subsequent clinical reviews of the use of seclusion

3.8.1 After a use of seclusion or restraint is initiated, a robust clinical review must be ratified by a senior clinician as soon as possible. A senior clinician being the NiC, After Hours Nurse Manager; NUM, psychiatric registrar, consultant psychiatrist, or medical superintendent etc. This review cannot be carried out by a senior clinician that was involved in the decision to initiate the seclusion episode. Reviews are to be carried out in-person or, where required, via phone or videoconference.

3.8.2 The senior clinician must document the continuation or cessation of seclusion in the respective register and the patients' health record in JHeHS. For cessation of seclusion, section 3.8 must be followed.

3.8.3 The senior clinician must review the patients' physical and mental health and document same in the patients' health record.

3.8.4 After the initial ratification, the patient must be reviewed by a MO no less than every 4 hours during the episode of seclusion.

3.8.5 An additional review must take place, at every shift handover, between the unit outgoing NiC and incoming NiC. This review involves discussing the patient's presentation over the previous shift and reviewing the patient together to determine whether the patient requires to remain in seclusion or cessation of seclusion can be considered.

3.8.6 If Seclusion continues for 24 hours or more a Consultant Psychiatrist must review the patient face to face.

3.9 Cessation of Seclusion

3.9.1 Seclusion must cease as soon as the patient has regained behavioural control and the immediate risk of serious harm has minimised. A Senior Clinician can cease Seclusion and Restraint at any time, this includes the NiC, After Hours Nurse

Manager, NUM, psychiatric registrar, consultant psychiatrist, or medical superintendent.

3.9.2 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.

3.9.3 Prior to the cessation of a seclusion episode a safety huddle is to be conducted to identify the management plan for when the patient returns to the normal routine of the unit.

3.9.4 This discussion and a comprehensive management plan should be documented through the patient's health record and Care Plan prior to seclusion being ceased.

3.9.5 If there is concern raised by any member of the MDT in relation to the cessation of seclusion, this must be escalated to the NUM/AHNM.

3.9.6 In the event whereby seclusion was ceased by the senior nurse, the consultant psychiatrist, M.O. and NUM/DDON/AHNM must be notified.

3.9.7 A MO must conduct a comprehensive assessment within one hour of the cessation of the seclusion episode.

3.9.8 The patient must be afforded the opportunity of a post seclusion debrief. The patient debrief or refusal must be documented in the individual patient`s health record. The patients experience and feedback needs to be included in the seclusion review process.

3.9.9 Following the post restraint debrief, the MDT must discuss and review the Patient Care Plan with the patient.

3.10 Seclusion Documentation and Communication

3.10.1 Where a clinician has determined that a patient requires seclusion, this restrictive intervention must be discussed within the multidisciplinary team prior to the seclusion being initiated. The Nurse in Charge (NiC) or NUM must notify the CSNSW Functional Manager that a patient requires seclusion.

3.10.2 Any episodes of seclusion must be documented in proportionate detail the patient's progress notes, outlining the alternative interventions attempted and confirmation that seclusion was used as a last resort. This includes all ratification, subsequent and cessation processes.

3.10.3 Any medications administered to the patient before, during or after the incident must be documented in the eMeds section in JHeHS.. A detailed description of interactions, behaviours and assessment must be documented at least every 2 hours in the patients' health record. Vital signs must be documented on the SAGO chart.

3.10.4 The patient's Allocated Nurse must update the patients Multidisciplinary Care Plan in JHeHS and as soon as practical from the commencement of seclusion, outlining relevant management strategies. The joint management plan is updated completed by CSNSW. The NiC must ensure all information relating to the seclusion and restraint incident is captured in the End of Shift Report.

3.10.5 All episodes of seclusion require an ims+ to be completed through the NSW Health SharePoint by the NiC or an appointed clinician.

3.10.6 If any member of the team has concerns about proceeding, the process must stop, and the concerns escalated through the Custodial Mental Health management team. Issues, unresolved through management escalation, must be resolved through escalation to the General Manager Forensic Mental Health and NSW Statewide Clinical Director Forensic Mental Health.

3.11 Carer Notification

3.11.1 The patient's designated carer and/or principal care provider (as defined by the NSW Mental Health Act 2007, Section 72) must be informed of any seclusion episode as soon as practical after the event. They must be informed of the rationale for intervention and any consequences of intervention.

3.11.2 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 continued contact attempts made until contact is established.

3.11.3 Where there is no designated carer, the patient's preferences regarding contacting their family must be taken into account prior to any contact being made.

3.12 Complaints

3.12.1 There may be instances in which patients or carers wish to voice concerns or complaints about an episode of seclusion and/or restraint. 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.

3.12.2 If this is not possible, the complaint will be managed in line with the requirements of Policy 2.015 Consumer Complaints Management. Patients and carers should be provided information regarding the complaints process.

3.13 Governance

3.13.1 All incidents of seclusion and health-initiated restraint (enforced medication) must be reported through ims+. A management email notification of an episode of restraint (enforced medication) must be completed.

3.13.2 Seclusion and restraint audits and data are discussed at the monthly Custodial Mental Health Clinical Governance Committee meeting and unit staff/business meetings.

3.13.3 All seclusion and restraint episodes must be reviewed by the patient's multidisciplinary team (MDT) as part of weekly MDT meeting.

3.13.4 The Official Visitors will review the seclusion and restraint registers and summary of seclusion and restraint data on their monthly visit to the Mental Health Unit.

3.13.5 Seclusion and restraint data is collated and reported quarterly to the Ministry of Health (MoH).

3.13.6 The service level action plan to prevent, reduce and, where safe and possibly eliminate the use of seclusion and restraint must be reviewed annually in collaboration with the staff, patients and families and carers.

4. Definitions

Acute Sedation

The use of a pharmacological intervention, comprising one or more psychotropic agents given via a range of different routes of administration, for the purpose of managing, in the immediate to short term, behaviours that arise from a mental condition and may pose a risk to the safety of the patient themselves, other patients, visitors or staff.

Enforced Medication

Medication given to a patient, without their consent and usually against their stated objection, with the use of, or implied use of, force to restrain the patient in order to administer the medication.

When assessing and deciding of which interventions to employ, the clinical need, level of aggression posed by the patient, level of compliance, safety of patients and others, and, where possible, advance directives of the patient should be considered. The intervention selected must be a reasonable and proportionate response to the risk of harm posed by the patient, considering the safety of the staff while performing the chosen intervention.

Must

Indicates a mandatory action to be complied with.

Patient Health Record

A hybrid record of paper-based and electronic information pertaining to the health of the patient.

Restraint

Physical Restraint – the application by staff of 'hands-on' immobilisation or the physical restriction of a person to prevent them from harming themselves or endangering others, or to ensure that essential medical treatment can be provided.
Mechanical Restraint – the application of devices to a person's body to restrict their movement. This is to prevent the person from harming themselves or endangering others, or to ensure that essential medical treatment can be provided
Chemical Restraint – the use of a medication or chemical substance for the primary purpose of restricting a person's movement
Enforced Medication: Medication given to a patient, without their consent and usually against their stated objection, with the use of, or implied use of, force to restrain the patient in order to administer the medication.

Should

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

5. Related documents

Legislations	*Mental Health Act 2007* (NSW) Mental Health and Cognitive Impairment Forensic Provisions Act 2020 (NSW) *Mental Health and Cognitive Impairment Forensic Provisions Regulation 2021* (NSW)
Justice Health NSW Policies, Guidelines and Procedures	1.174 *End of Life Care and Decision Making* 1.220 *Use of Physical Restraint on Patients in Custody* 1.319 *Patient Engagement and Observation – Forensic Hospital and Long Bay Hospital Mental Health Unit* 5.070 *Infection Prevention and Control* 6.049 *Medication Guidelines* 6.051 *Guidelines for Psychotropic Medications* 6.070 *Procedure Code Blue (Medical Emergencies) - Management* 9.020 Code Black (Psychiatric Emergency, Armed Hold-Up, Hostage) – Management.

	Clinical Emergency Response and Medical Emergency Team Emergency Response Guidelines (Adult) Joint Planned Interventions by Justice Health and Forensic Mental Health Network (the Network) and Corrective Services NSW (CSNSW) at Long Bay Hospital (LBH)
Justice Health NSW Forms	
NSW Health Policy Directives and Guidelines	Management of Withdrawal from Alcohol and Other Drugs Clinical Guidance PD2017_025 Engagement and Observation in Mental Health Inpatient Units PD2017_043 Violence Prevention and Management Training Framework for NSW Health Organisations PD2020_004 *Seclusion and Restraint in NSW Health Settings*
Other documents and resources	Australian Resuscitation Council Guidelines National Standard for User- applied Labelling of Injectable Medicines, Fluids and Lines, Australian Commission on Safety and Quality in Health Care 2015. *Australian Commission on Safety and Quality in Health Care* SESLHDPR/595 *Emergency Sedation Procedure – Acute Inpatient Mental Health Units* *Security Condition protocol between Director-General, NSW Department of Health and Commissioner of Corrective Services in relation to Forensic patients and Correctional Patients, 2011*