Justice Health and
Forensic Mental Health Network

NSW GOVERNMENT

Justice Health NSW Procedure

Mechanical Restraints

Issue Date: May 2025

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Mechanical Restraints

Procedure Number 6.068

Procedure Function Continuum of Care

Issue Date May 2025

Next Review Date May 2028

Risk Rating High

Summary This procedure provides directions on the approval, use, maintenance and reporting requirements in relation to Mechanical Restraint use for Forensic Hospital patients.

Responsible Officer Forensic Hospital, Service Director

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/6068

Change summary Addendum now part of procedure content.

Authorised by Forensic Hospital Policies, Procedures and Guidelines Committee

Revision History

#	Issue Date	Number and Name	Change Summary
1	December 2017	DG8794/18	DG8797/18
2	January 2019	DG1264/19	-
3	January 2021	DG5303/21	-
4	January 2022	DG4822/22	DG4828/22
5	August 2024	DG55382/24	-
6	May 2025	DG17766/25	DG17767/25

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2. Preface

MoH Policy PD2020_004 Seclusion and Restraint in NSW Health Settings defines mechanical restraint (MR) as **"***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".*

The use of MR is an extremely restrictive level of restraint and must only be used in exceptional circumstances with prior approval from the Clinical Director Forensic Hospital (CDFH) or delegate. The application of MR may cause distress for patients, carers and staff members; therefore, it must only be applied when absolutely necessary. Care and support must be provided to a patient who is experiencing emotional distress or trauma.

MR must follow these basic principles:

1) The scale, use and nature of the MR must be proportionate to the risks posed by the behaviour of the individual, and the nature of the harm that they might cause.
2) The level and duration of restraint must be the least restrictive necessary to achieve the aims of the intervention.
3) MR should form only one component of a broader approach to behaviour management, treatment or therapy.
4) Being viewed by staff and other patients whilst in MR could be regarded as degrading. Clinical teams must give due consideration to minimising this issue and restraint should only be used where any such infringement of a patient's dignity is necessary and proportionate to their presenting risk(s).
5) Patients should be involved in decisions about the use of MR and their views, along with the views of the patient's designated carer/principal care provider should be taken into account.
6) MR is not approved to be used with Adolescent patients unless approved by CDFH for exceptional circumstances.

The Mental Health Act 2007 outlines the following principles which must guide staff when considering the use of any restrictive practice:

1) To provide the best possible care in the least restrictive environment.
2) To provide high quality treatment and care in accordance with professionally acceptable standards.
3) To ensure that any restrictions to a consumer's liberty and interference with their rights, dignity and self-respect is kept to a minimum.

It is recognised that there are risks associated with the use of MR, particularly when utilised over prolonged periods. The most significant risks are:

1) Risk of injury to limbs or skin tissue as a result of applying restraint devices incorrectly or applying them too tightly.
2) Risk of positional asphyxia associated with the application of MR around the chest/torso.
3) Risk of psychological harm to both the patient and staff involved.

The Safer Handling MR are the only approved MR devices for use within the Forensic Hospital (FH). Safer Handling MR is a licensed restraint device and must only be utilised using the approved taught techniques by clinicians that have successfully completed the approved Forensic Hospital Mechanical Restraint Workshop.

In all circumstances MR use must have pre-authorisation from the CDFH (or delegate).

The use of MR may be:

1) **Planned** – this use of MR is pre-approved and documented in a patient's TPRIM for use during prescribed activities i.e. escorts, patient re-integrating with peers/staff.
2) **Unplanned** - this use of MR is pre-approved and documented in a patient's TPRIM for use at times of extreme aggression when all least restrictive restraint measures have been tried and MR is risk assessed as necessary.
3) **Emergency** – this use of MR is utilised during an emergency situation when all less restrictive restraint measures have been tried and MR is risk assessed as necessary.

3. Procedure Content

3.1 Situations when MR may be Utilised

1. In all situations, the use of MR must be a reasonable and proportionate response to the risks presented by the patient to themselves and/or others. MR may be considered appropriate as a last resort management strategy in the following situations:
   a) To assist with the safe re-integration of a patient into the unit following a prolonged period of seclusion or isolation, this may include contact with peers.
   b) To assist in the management of extreme assaultive behaviour causing frequent and/or significant staff or patient injuries.
   c) To assist in the management of extreme self-destructive behaviour or self-harm.
   d) To enable medical treatment to be administered to the patient.
   e) For use on patient escorts as defined by the Procedure 6.156 SCALE, Internal Ground Access and Outside Leave.
   f) To assist in reducing the risk of absconding whilst on external leave.
   g) To safely move a patient engaging in highly assaultive behaviour or rapidly changing risk patient from one location to another.

3.2 Approval – Planned and Unplanned Use of MR

1. The Multi-Disciplinary Team (MDT) must only consider seeking approval for the use of MR when all other less restrictive interventions have been utilised without success in the past or considered but excluded as inappropriate or unsuitable in the circumstance.
2. In exceptional circumstances there may be instances whereby known individual patient risks warrant MR. In this circumstance an application for MR may be made prior to admission, pre-admission applications should be made in consultation with the CDFH.
3. Where the MDT believes MR would assist in the management of a patient, they must demonstrate a clear clinical rationale for use that is clearly documented in the patients' health record.
4. The patient's treating Consultant Psychiatrist (Consultant), or delegate should meet with the patient and/or their designated carer/principal care provider to discuss the potential plan to utilise MR and document their views within the patient's health record. This may not be possible in all circumstances due to the risk it may present. If this is not possible, this must be documented in the patients' health record with rationale for not engaging the patient/designated carer/principal care provider.

5. The MDT must complete the *Mechanical Restraint Approval* (eForm).
6. When the *Mechanical Restraint Approval* (eForm) has been completed by the MDT, the patient's treating Consultant (or delegate) must electronically authorise the eForm in JHeHS.
7. The treating Consultant (or delegate) will e-mail the CDFH via [redacted] to review and formally request approval for the use of MR.
8. The CDFH (or delegate) must review the *Mechanical Restraint Approval* (eForm) within two working days of receipt.
9. The CDFH may request additional information.
10. The CDFH must review the *Mechanical Restraint Approval* (eForm) and support or reject MR use for a patient.
11. The CDFH has the final decision-making authority in relation to the use of MR for the individual patient.
12. If approved the CDFH must electronically authorise the eForm in JHeHS.
13. The CDFH will make the treating team aware of the decision via email.
14. Where the use of MR is approved, the Nurse Unit Manager (NUM) (or delegate) will be responsible for ensuring that the approval for MR use is communicated via e-mail to the MDT including the full nursing team with details of the approval.
15. Please note, planned or unplanned use of MR cannot commence until the above process has been completed.
16. All approvals are time limited to three (3) months maximum and a new application must be made after this time.

3.3 Approval – Emergency Use of MR

1. In an emergency situation where MR is required, pre-approval will not have been sought as per section 3.2.
2. The MDT present during the incident must only consider the use of MR when all other less restrictive interventions have been utilised without success or considered but excluded as inappropriate or unsuitable in the circumstance.
3. Where MR has been risk assessed as necessary, the Psychiatry Registrar (Registrar) must contact the CDFH when available within working hours or the On-Call Consultant Psychiatrist (as delegate) for out of hours approval. The On-Call Consultant Psychiatrist may consider seeking further advice from the CDFH.
4. The Psychiatry Registrar must summarise the patient's clinical background, historical and current risks. They must also clearly outline the aims, goals, expected outcomes of implementing MR, and how and when MR should be used to the CDFH or delegate.
5. The CDFH or delegate must provide verbal approval or non-approval on receiving the verbal clinical handover.
6. The Registrar must document the CDFH or delegate's decision in the patient's health record as soon as practicable.
7. The *Mechanical Restraint Approval* (eForm) must be completed as soon as practical to signify the use of MR in this situation.

8. MR must only be used for the incident which it has been approved for. If the patient requires further use of MR in the short term, verbal approval must be sought each time. Consideration should be given to completing the approval process outlined in section 3.2 relating to Planned and Unplanned use of MR.

3.4 Documentation Requirements – Pre MR use

1. When the use of MR has been approved for an individual patient, the information in the approved *Mechanical Restraint Approval* (eForm) must be reflected through the patients TPRIM under the section – Restrictions.
2. The following information must be documented in the patients TPRIM:
   a) The purpose of MR.
   b) Type of MR.
   c) How MR will be applied.
   d) Risk management strategies around any concerns with the use of MR including physical health.
   e) Expiry date of MR approval.
   f) **Planned Only** – Frequency and Duration of MR.

3.5 Prior to the Use of MR

1. **IMPORTANT:** to use any MR device the patient must be either be compliant with the application of the device or able to be controlled in an approved Violence Prevention and Management (VPM) hold prior to the application of the devices.
2. The Nurse in Charge (NiC) should conduct a safety huddle; roles of each member of the team will be clearly identified and allocated. The NiC must ensure that only MR trained staff members apply/remove/adjust the MR as per the licensing requirements.
   a) It is the responsibility of all staff members to inform the NiC if they are not trained in the use of MR. The individual staff member is responsible for liaising with their line manager to enrol into the next available FH MR Workshop.
   b) Where members of the team are not trained in the use of MR they are able to undertake other roles as outlined in Procedure 9.020 Code Black (Psychiatric Emergency, Armed Hold-up, Hostage) Management.
3. For **planned** use there should be a minimum of two (2) MR trained staff involved in applying, managing and removing the MR device.
4. For **unplanned/emergency** use there should be a minimum of four (4) MR trained staff involved in applying, managing and removing the MR device.
5. The NiC must delegate a staff member to collect the required equipment.
6. Before and after use of any MR device, staff applying the device(s) must inspect the equipment for wear and tear to ensure that it remains fit for purpose.
7. Any wear and tear must be managed as outlined in section 3.8.

3.6 During the use of MR

1) The patient must be on Level 1: Constant Observations (visual), Level 1: Constant Observations (arm's length), or staff must have physical control of the patient at all times

whilst in MR. This will be dependent on the type of MR the patient is in, staff risk assessment and the patients falls risk.

a) Note that if ankle cuffs are applied, then staff must have physical control of the patient at all times due to risk of falls.

2) Upon applying MR and at least every 30 minutes a clinician must;

a) Assess capillary refill/blood flow to restrained limbs; and,

b) Assess changes in skin colour/integrity.

3) Every attempt should be made where safe to do so after a risk assessment process is completed to remove/loosen the MR every 30 minutes. This is to allow for the patient to perform a range of motion exercises and complete a skin integrity check. If necessary, limbs can be released one at a time. If the risk towards others is deemed too high to remove/loosen the MR then the risk assessment and rationale for not doing this must be clearly documented in the patient's health record.

4) If the patient is placed in full body MR in either a prone or supine position or if there are any clinical concerns for the patient's physical health during restraint a clinician must be allocated to monitor the patient's physical health. The allocated staff member must:

a) Assess capillary refill/blood flow to restrained limbs.

b) Assess changes in skin colour/integrity.

c) Assess level of consciousness.

d) Assess rate, depth and rhythm of breathing.

e) Assess behaviour.

f) If able; Oxygen Saturation, Blood Pressure and Pulse.

5) This assessment must be document at regular intervals as per the Dynamic Risk Assessment on the Restraint Register.

6) Complete documentation requirements are outlined in Procedure 6.088 Seclusion and Restraint.

7) If the patient shows signs of medical distress such as cyanosis, confusion, or a reduced level of consciousness clinicians must loosen or remove the MR device immediately and further physical assessment must be completed by commencing a medical emergency response as per Procedure 6.070 Code Blue (Medical Emergency) Management

3.7 Following the use of MR

1. A staff and patient debrief should be conducted as per Procedure 6.099 Incident Debrief for all unplanned and emergency uses of MR or if a reportable incident has occurred.
2. Complete documentation requirements as outlined in Procedure 6.088 Seclusion and Restraint Process.
3. An ims+ must be recorded for all incidents, near misses and complaints in relation to MR.
4. After use of any MR device, staff who applied the device(s) must inspect the equipment for wear and tear to ensure that it remains fit for purpose.
5. Any wear and tear must be managed as outlined in section 3.8.
6. The use of MR will also be recorded through the nursing report for the MDT meeting. The MDT must review each use of MR and whether its use is still required or if the MR approval requires adjustment.

7. The approval to use MR and details surrounding their use should be clearly documented within the patient's MHRT report by the treating Consultant (or delegate).

3.8 Storage, Issues and Maintenance of MR Equipment

1. Each unit will have an allocated amount of MR assigned to them as indicated by their MR Equipment Register. When not in use, all assigned MR equipment will be stored in the medication room on each unit.
2. A daily count of the MR equipment must occur at least once a day and recorded in the Mechanical Restraint Equipment Register located on the unit.
3. If any MR equipment is missing a search must occur to locate the missing equipment immediately.
4. If a unit requires more equipment, a request must be made to the MR Co-ordinator. Spare MR equipment will be procured, stored and managed by the MR Co-ordinator.
5. If any MR equipment shows signs of wear and tear this must be reported immediately to the MR Co-ordinator. This equipment must be set aside and not used until the equipment has been exchanged by the MR Co-ordinator.
6. If MR is planned for regular single patient use, the patient may be allocated the same device for the period of time required. The devices will be labelled with the patients MRN number.
7. The manufacturer's guidelines for cleaning MR devices must be followed and cleaning must be undertaken after every use.
    a) If not visibly soiled, the used MR equipment should be cleaned using an antibacterial wipe before packing away.
    b) If visibly soiled, the used MR equipment should be placed in a pillowcase and machine washed at no more than 40 degrees and using mild detergent then hung to dry (do not bleach, tumble dry or dry clean).

3.9 Safer Emergency Enveloping Lifting Sling (SEELS)

1. The SEELS is a piece of specialised lifting equipment that can be used to lift and carry a patient between locations and complements the existing Soft Restraints.
2. The SEELS can be utilised in rare circumstances where lifting and carrying a patient in specialised circumstances is required.
3. The SEELS allows for a patient to be lifted and carried in either prone or supine.
4. A patient must already be in some form of MR prior to the SEELS being considered.
5. Only VPM and MR trainers have been trained in the safe application and use of the SEELS.
6. If the SEELS is required, staff must request it through the Local Incident Controller (LIC).
7. The LIC must ensure that a VPM and MR trainer is present to coordinate the safe application and use of the SEELS.
8. x1 SEELS will be in the AHNM Pharmacy and x1 SEELS will be in the FWU.

3.10 MR Data Collection

1. Data for the use of MR will be collected via the Restraint Registers.
2. This data will be managed in line with Procedure 6.088 Seclusion and Restraint Process.

4. Definitions

Must

Indicates a mandatory action to be complied with.

Should

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

5. Related documents

Legislations	Mental Health Act 2007
Justice Health NSW Policies, Guidelines and Procedures	Policy 1.078 Care Coordination, Risk Assessment, Planning and Review – Forensic Hospital Policy 1.319 Patient Engagement and Observation – Forensic Hospital and Long Bay Hospital Mental Health Unit Procedure 6.100 Clinical Risk Assessment and Management (CRAM) – Framework and Documentation Procedure 6.156 SCALE, Internal Ground Access and Outside Leave Procedure 9.025 Visits and Visitor Approval Procedure 6.097 Mental Health Review Tribunal Reports and Hearings Procedure 6.088 Seclusion and Restraint Process Procedure 6.099 Incident Debrief Procedure 9.020 Code Black (Psychiatric Emergency, Armed Hold-up, Hostage) Management Procedure 6.070 Code Blue (Medical Emergency) Management Procedure 6.094 Falls – Prevention, Assessment and Management
Justice Health NSW Forms	*Mechanical Restraint Approval* (eForm) Mechanical Restraint Equipment Register
NSW Health Policy Directives and Guidelines	PD2012_050 Forensic Mental Health Services PD2020_004 Seclusion and Restraint in NSW Health Settings
Other documents and resources	