Health
South Eastern Sydney
Local Health District

SESLHD PROCEDURE COVER SHEET

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EXECUTIVE SPONSOR or EXECUTIVE CLINICAL SPONSOR	SESLHD Aged Care and Rehabilitation Services Stream Director
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POSITION RESPONSIBLE FOR THE DOCUMENT	Nurse Manager, Aged Care & Rehabilitation Clinical Stream
KEY TERMS	Restrictive practice
SUMMARY	The aim of this document is to describe the circumstances under which a restrictive practice or restraint may be used and to provide clinical guidance to ensure patients are managed safely and optimally within the acute, sub-acute and aged care facility environments.

Feedback about this document can be sent to seslhd-policy@health.nsw.gov.au

1. POLICY STATEMENT

South Eastern Sydney Local Health District (SESLHD) is committed to principles of restrictive practice minimisation. SESLHD considers the use of a restrictive practice must be reserved for circumstances where it is necessary for patient's safety or critical need and only to be implemented when all other options have been considered and have been unsuccessful. Health services must support people's rights to balance safety from harm and freedom of choice.

Use of restrictive practice can increase the risk of injury to a patient in hospital. Risks include injury or death through strangulation or asphyxia resulting from the use of a restrictive practice. Immobilisation through a restrictive practice can result in chronic constipation, incontinence, pressure injuries, loss of bone and muscle mass, walking difficulties, increased feelings of panic and fear, boredom and loss of dignity. Restrictive practices can have a dehumanising effect on the patient and restrict individualised treatment (Commonwealth of Australia 2012).

Except in a critical need situation, a person must not be subject to a restrictive practice without consent either from the patient themselves or the consent of a guardian, who has been authorised with a restrictive practices function.

In general the law protects an individual's right to:

- freedom of movement
- immunity from unwarranted interference from bodily contact by others
- immunity from conduct by others that would subject the person to unreasonable risk of injury.

Restrictive practice should only be used as a measure of last resort and is applied to:

- enable administration of life saving treatment or care that otherwise could not be administered
- protect patients or clients from self-injury, or injury to others when no other means of protection is practical

This procedure must be used in association with NSW Ministry of Health Policy Directive PD2020_004 - Seclusion and Restraint in NSW Health Settings.

2. BACKGROUND

The aim of this document is to describe the circumstances under which a restrictive practice may be used, and to provide clinical guidance to ensure patients are managed safely and optimally, within the acute, sub-acute and aged care facility environments.

Specific groups of patients may be more vulnerable to risk of physical and psychological harm from the use of restrictive practices.

For these groups of patients, it is important to adopt non-restrictive means of managing disturbed and / or aggressive behaviour whenever it is possible:

- Young people
- Older people
- Pregnant women
- Patients with physical health issues (e.g. obesity, diabetes, cardiac disease and metabolic disorders)
- Patients with a history of trauma / detention who may be re-traumatised by the episode of restraint (e.g. refugees, people who have been abused at any stage of their life)
- Patients with an intellectual disability and those with cognitive impairment such as dementia or delirium
- People who are under influence of drugs or other substances
- People who have engaged in a physically exhausting combative struggle for longer than two minutes.
- People from culturally and linguistically diverse background • Aboriginal and Torres Strait Islander people.

This procedure does not include:

- Children (person's under the age of 18)
- Situations that occur within community based Drug & Alcohol Services
- Situations where violence, or imminent risk of violence relating to Code Black when acting in accordance with the self-defence sections 418 of the Crimes Act 1900 or the Mental Health Act 2007. See NSW Ministry of Health Policy Directive PD2020_004 - Seclusion and Restraint in NSW Health Settings.
- When affecting an arrest under Section 100 of the Law Enforcement Act 2002 refer to Protecting People and Property - NSW Health Policy and Standards for Security Risk Management in NSW Health Agencies
- Minimal restrictive environmental strategies, such as secure gates or doors with keypad entry, which are used in some ward areas and specialised units. These strategies are used to keep patients with cognitive impairment safe from harm while still allowing freedom of movement around the ward.

3. DEFINITIONS

Capacity	Generally, when a person has capacity to make a particular decision they can: • understand the facts and choices involved • weigh up the consequences, and • communicate the decision (NSW Attorney General's Dept.2008)

Critical need situation	A situation in which actions are required to provide lifesaving treatment, in self-defence, to protect the patient, others, and/or property.
Restrictive Practices	A restrictive practice is an intervention which has the effect of restricting the rights, freedom of movement or access of a person who is displaying a behaviour of concern.
Restraint	Restraint refers to the use of manual force, a mechanical device or a medication or chemical substance for the primary purpose of restricting a person's movement in an emergency situation of aggressive behaviour, where that person is deemed to be at an immediate risk of harm to self or others.
Chemical restrictive practice	Is the use of medication or chemical substance for the primary purpose of restricting a person's movement. It does not include the use of medication prescribed by a medical practitioner for the treatment of, or to enable treatment of, a diagnosed mental disorder, a physical illness or a physical condition (Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019). Chemical restrictive practice must not be implemented until alternatives are explored extensively through assessment.
Mechanical restrictive practice	Is the application of devices to a person's body to prevent, restrict, or subdue a person's movement for the primary purpose of influencing a person's behaviour but does not include the use of devices for therapeutic or non- behavioural purposes.
Environmental	An environmental restrictive practice is one that restricts a person's free access to all parts of their environment, including items and activities.
Seclusion	Is the confinement of a person, at any time of the day or night in a room or area from which free exit is prevented. Seclusion also applies if the person (i.e. patient/client) agrees to or requests confinement and cannot leave of their own accord. If a staff member is with the person, this does **not** meet the definition of seclusion.

Physical restrictive practice	Physical restrictive practice refers to the use of the skilled 'hands on' immobilisation (human to human) to restrict a person's movement in an emergency situation of aggressive behaviour, where the person is at an immediate risk of harm to self or others or to ensure the provision of essential medical treatment (PD2020_004 - Seclusion and Restraint in NSW Health Settings in NSW Ministry of Health Policy).
	Physical restrictive practice does not include the use of hands-on technique in a reflexive way to guide or redirect a person away from potential harm/injury, consistent with what could reasonably be considered the exercise of care towards a person.
A Person responsible	In NSW the Person Responsible is – 1. An appointed guardian (including an Enduring Guardian) who has the function of consenting to medical, dental and health care treatments or, if there is no guardian, 2. The most recent spouse or de facto spouse (including same sex partner) with whom the person has a close, continuing relationship or, if there is no spouse or de facto spouse, 3. An unpaid carer who is now providing care to the person or arranged/provided this support before the person entered residential care or, if there is no carer 4. A relative or friend who has a close personal relationship with the person.
Guardian with a restrictive practice function	A guardian who has been appointed by the NSW Civil and Administrative Tribunal (NCAT) Guardianship Division and who has specifically been approved to consent to 'restrictive practices'. This may require application to the NCAT Guardianship Division.
Challenging Behaviours	A behaviour that causes physical and /or psychological discomfort or harm, to the person, or others.

4. RESPONSIBILITIES

4.1 Nurses will:

- Familiarise themselves with this procedure
- Implement this procedure consistently throughout their practice
- Identify potential risk of aggression through assessment in association with the multi-disciplinary team

- Develop a management plan to reduce the risk of aggression
- Maintain communication with the treating team
- Raise any concerns about staff or patient safety to their supervisors or nurse unit managers
- Attend education sessions relating to the de-escalation and management of patient aggression
- Ensure that they receive training in restrictive practice management.

4.2 Medical staff will:

- Familiarise themselves with this procedure
- Implement it consistently throughout their practice
- Identify the risk of aggression in association with the multi-disciplinary team
- Contribute to development of a management plan to reduce the risk of aggression
- Maintain communication with the treating team
- Attend education sessions relating to the de-escalation and management of patient aggression
- Raise concerns about staff or patient safety to their senior manager.

4.3 Line Managers/Supervisors will:

- Ensure that medical and nursing staff are provided with training in this procedure and its implementation
- Monitor compliance with this procedure, audit and report on the use of restrictive practice within the unit
- Provide ongoing training and support to nursing and medical staff in implementing this procedure
- Provide advice and support to assist clinical staff who raise concerns about staff or patient safety and escalate further if necessary.

4.4 District Managers/ Service Managers will:

- Ensure that compliance with the procedure is monitored, and support the implementation of education programs related to this procedure
- Investigate any concerns that are raised by staff regarding compliance with this procedure
- Investigate issues related to patient and staff safety and this procedure that have been escalated to them.

5. PROCEDURE

5.1 Situations when restrictive practice may be used:

- When there is a critical care need where actions are required to provide lifesaving treatment, in self-defence, to protect the patient, others, and/or property

- Restrictive practice should only be applied or administered after all other options have been considered and have been unsuccessful
- Restrictive practice must only be used for the minimum amount of time and in the least restrictive manner, and the need for restraint should be reviewed regularly by the treating medical team and nursing staff
- If security staff are required to manually restrain a patient it must occur under the direction and supervision of a senior medical or nursing clinician
- Restrictive practice must be reviewed every 24 hours in a hospital environment and every 42 days in the aged care facility.

5.2 Consent

It may be unlikely, but the option of the patient providing their own consent to have a restrictive practice must be considered first.

- If the patient does not object to restrictive practice then **written consent** of the person responsible or enduring guardian is sufficient
- If the patient objects to being chemically restricted (to be chemically restricted is a major medical treatment) e.g.: verbally indicates they don't want the drug, simply refuses to cooperate with its administration by spitting it out or keeping mouth closed or pushing nurses away, then the 'person responsible' or 'enduring guardian' cannot override that objection without the approval of the guardianship tribunal
- If the application of a restrictive practice (mechanical and chemical) is urgently required in a critical need situation it may be applied without consent initially (see Section 5.2.1 The Principle of Necessity below). This is short term 72 hours only
- If it is foreseen that ongoing restrictive practice might be necessary as part of an ongoing clinical management plan then a guardianship application for appointment of a guardian with a 'restrictive practices' function must be made to the NSW Civil and Administrative Tribunal (NCAT) Guardianship Division. Only the patient or a guardian with specific authority to approve restrictive practices can provide consent for mechanical/chemical restrictive practice
- Each time a restrictive practice is re-ordered the consent should be obtained from a guardian with a restrictive practices function. A behavioural management plan must be implemented with each re-order
- Behavioural management plan must be implemented
- Patient Restrictive Practice Chart should be completed for each episode of restrictive practice
- Person responsible fact sheet: https://www.ncat.nsw.gov.au/Documents/gd_factsheet_person_responsible.pdf • The NCAT (Guardianship Division) can be contacted 24 hours, seven days per week on 02 9556 7600.

5.2.1 The Principle of Necessity

In an unforeseen crisis situation where a patient is acting in a way that puts him/her at risk of death or serious harm and it is not practicable to obtain consent, the common law principle of

'necessity' provides a defence for a health worker who uses reasonable restraint. Some considerations with restrictive practice include:

- To be used only as a last resort
- The least restrictive alternative is used
- The team leader should provide guidance
- At all times a clinician must monitor and document the restrictive practice on the Patient Restrictive Practice Chart (being created)
- Use of a restrictive practice without consent under the principle of necessity is only lawful for as long as it is not practicable to obtain consent from a guardian with restrictive practices function.

5.2.2 Mental Health Act

Coercive powers under the Mental Health Act can only be used to treat and detain patients against their wishes when they have a mental illness or a mental disorder. Mental health certificates **cannot be used** to pursue acute medical or surgical treatment in patients who lack capacity or who are objecting. Usually in a general hospital the appropriate legislative power to authorise restraint should come from the Guardianship Act.

6. PATIENT ASSESSMENT

Comprehensive individualised medical and nursing assessment of the patient must be performed and documented prior to considering the use of a restrictive practice. The assessment should include the following:

6.1 Physical assessment

A full physical assessment should be undertaken to detect underlying causes of behaviour and/or delirium such as presence of infection or pain. A non-verbal validated pain scale such as the Abbey Pain Scale or Pain ad should be considered.

6.2 Mental/Cognitive State

The patient should be assessed for intrinsic or extrinsic (environmental) triggers for behaviour. Where the patient is alert and not confused, the reasons for the patient's behaviour and the issue of a physical restrictive practice should be discussed with the patient prior to application.

Where a patient is confused, his or her behaviour should be carefully observed to determine any treatable causes of agitation or combativeness. Reversible causes may include delirium, sensory overload, sensory deprivation, hallucinations and delusions.

SESLHDPR/345 - Prevention, Diagnosis and Management of Delirium in Older Persons

6.3 Medication review – should be carried out to identify any possible adverse effects of medications that may be affecting the person's behaviour.

6.4 Environmental assessment

A common cause of aggression in older people is their misinterpretation of the environment and miscommunication, where aggressive behaviour is often triggered by fear.

On-going engagement with the patient and their family/carer through clear, respectful and open communication allows early detection, identification and appropriate management of triggers that may lead to aggressive behaviour.

When a disturbed behaviour occurs, do not enter the patient's/individual's personal space without their permission (unless there is an immediate risk of self-harm or harm to others) as this could escalate their distress, anger and/or behavioural disturbance.

6.5 Management Plan

Refer to local guidelines for the non-pharmacological strategies for the patient who is experiencing confusion.

- There should be consultation with carers/family members to identify a baseline of usual behaviour, and information sought as to the patient's personal preferences and routines.
- If the patient has a known history of intellectual disability or dementia, consult with regular carers to ascertain current strategies that may be in place to support their management in their home.

Consider the use of Person-centred Profile SES060.159.

Key points to note:

1. Engage with the patient, their family / carer and other health professionals (using a team approach) to identify stressors/ triggers for disturbed behaviour as part of the initial and ongoing patient care

2. Undertake appropriate clinical assessment to obtain information on the patient's condition. For example, *cognitive screening tools for older persons, medical assessment of mental health patients* and *Drug and Alcohol assessment tools*

3. Develop ways to manage stressors / triggers of disturbed behaviour, and document a Management Plan for health care teams to follow.

Following assessment, a management plan aimed at identifying and reducing the cause of the behaviour should be devised and implemented in consultation with the guardian, family/carer, and documented in the patient's medical record.

Only when all possible management strategies have been trialled and deemed unsuccessful, may the need for the use of a restrictive practice be considered, this decision should be made collaboratively by the treating multidisciplinary team. See SESLHDPR/345 - Prevention, Diagnosis and Management of Delirium in Older Persons.

Patients should be nursed in a quiet area where they can be easily observed, and staff must be aware of the safety issues.

7. AUTHORISATION

The use of mechanical or chemical restrictive practice must be authorised in writing by a Medical Officer on the Patient Restrictive Practices Chart.

8. MECHANICAL RESTRICTIVE PRACTICE

Injuries and death have occurred as a direct complication of mechanical restrictive practice use.

Within SESLHD, only approved, purpose designed manufactured restraints may be used. Improvised restraint arrangements such as bandages, sheets and meal trolleys must **never** be used as a restraint.

Only the following restraints may be used:

- Padded limb restraint
- Padded mitten restraint
- A chair that is used to inhibit the patient's movement e.g. water chair, air chair.

Any restraint used must meet the requirements of the NSW Ministry of Health Policy Directive PD2020_004 - Seclusion & Restraint in NSW Health Settings.

8.1 Mandatory Procedures for using a mechanical restrictive practice

Except in a critical need situation a medical officer must document authorisation for restrictive practice, following consent from a guardian who has the function to consent to 'restrictive practices' and consultation with the multi-disciplinary team.

Following application of restraints (padded limb mitten, padded mitten or chair) in a critical need situation the need for restraint must be reviewed as soon as possible after the period of critical need has passed.

If restraint continues to be necessary then appropriate assessments must be conducted and the restraint must be authorised and documented by a medical officer. If authorisation is by a junior medical officer, he/she should consult with a senior medical officer prior to authorisation. NCAT Guardianship Application may be required. Medical Authorisation must be documented on a Patient Restrictive Practices Chart see point 8.

9. CHEMICAL RESTRICTIVE PRACTICE

Is the use of medication or chemical substance for the primary purpose of influencing a person's behaviour.

It does not include the use of medication prescribed by a medical practitioner for the treatment of, or to enable treatment of, a diagnosed mental disorder, a physical illness or a physical condition.

Chemical restrictive practice must not be implemented until alternatives are explored extensively through assessment and non-pharmacological strategies (i.e. behaviour management plan and patient-centred profile/TOP5).
It is recommended that a senior medical officer prescribe medications for a chemical restrictive practice. If a junior medical officer prescribes the medication for chemical restrictive practice it must be in consultation with a senior medical officer (minimum of registrar level). In an Aged Care Facility the resident's general practitioner may prescribe.

Drugs commonly used for chemical restrictive practice include sedatives and antipsychotics. The risks of these drugs include over-sedation, increased falls risk and extrapyramidal side effects from anti-psychotics.

9.1 Extra-pyramidal side effects:

Extra-pyramidal symptoms are caused by dopamine blockade or depletion in the basal ganglia; this lack of dopamine often mimics idiopathic pathologies of the extra-pyramidal system.

Extrapyramidal physical symptoms may include:

- tremor
- slurred speech
- akathesia (restlessness)
- dystonia (involuntary muscle contractions)
- anxiety
- distress
- paranoia
- bradyphrenia (slowed thinking)

9.2 Mandatory Procedures for Using Chemical Restrictive Practice

- The medication and dosage must be the most appropriate for the situation and prescribed within usual clinical practice guidelines (Therapeutic Guidelines: Psychotropic – delirium management, revised February 2013)
- A record of medications given should be kept and must accompany the patient if they are moved to another location
- Medical Authorisation must be documented on a Patient Restrictive Practice Chart.

9.2.1 Nursing management of the person, in seclusion, with a mechanical or chemical restrictive practice. Observations and engagement:

- NSW Health requires high levels of clinical care, monitoring and reporting when seclusion and restraint are used. Any deterioration in a person's physical condition, mental state or cognitive state must be managed promptly.
- For the safety of the person, NSW Health clinical staff must continuously observe, and where possible, engage with a person in seclusion or four-limb mechanical restraint for the duration of the practice.
- For other forms of restraint, NSW Health clinical staff must continuously observe and, where possible, engage with the person for the first hour. After the first hour, NSW Health staff must clinically observe a person in restraint at least 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 and documented on the **Patient Restrictive Practice Chart**

- 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.
- Observations must be conducted in person and must not be undertaken using closed circuit television (CCTV).

Mechanical restraint must be removed at least hourly.

Care provided during the period of restrictive practice should include:

- provision of adequate hydration and nutrition
- regular toileting
- active or passive exercises
- emotional needs of the patient must be addressed with reassurance and constant, clear explanation

.

Monitoring and documentation of the following:

- physical safety
- skin integrity of the restrained body area and other areas at risk of pressure damage due to positioning
- evidence of ongoing behavioural disturbance or agitation
- response to medication
- Regular pain assessment
- continuing assessment to detect any changes to physical condition e.g. signs of infection or alteration in biochemistry

- an environmental assessment e.g. noise, light, temperature
- multidisciplinary team review

If antipsychotic drugs have been used, monitor for decreased level of consciousness, extra pyramidal adverse effects such as: tremor, slurred speech, restless or agitation, involuntary muscle movements, anxiety, distress, paranoia or slowed thinking processes, for 48 hours and **notify the medical officer immediately of any side effects observed.**
Some flexibility in observations is accepted so as not to unnecessarily wake/irritate the patient further, reason should be documented.

Ongoing restrictive practice in the hospital environment must be reviewed at least every 24 hours and every 42 days in the Aged Care Facility.

10. BEDRAILS

The use of bedrails is a clinical decision and their use should be in accordance with SESLHDPR/421 - Bedrails – Adult - for use in Inpatient and Residential Settings.

11. FOLLOWING THE IMPLEMENTATION OF RESTRICTIVE PRACTICE:

Staff must document all episodes of seclusion and restraint in health care record/eMR and an ims+ should be recorded where seclusion or restraint is part of a reportable incident such as aggression or injury.

Completion of ims+ is not required in situations in the general wards where patients are resistive to procedures and no injury to staff or patient has been sustained.

Notify the Nurse Unit Manager or Senior Nurse Manager if:

a. there are implications for the nursing workload
b. there is potential for patient self- harm or harm to others
c. a critical incident has occurred.

12. DOCUMENTATION

a. Patient Restrictive Practice Chart
b. Person-Centred Profile - order no. SES060.127
c. Results of the medical officers' physical examination, conclusions and management plan must be documented in the patient medical record
d. The Unit should have local processes in place to collect and collate data on use of restraints.

13. AUDIT

Each Unit should have local processes in place to collect and collate data on use of restraints. Unit managers will monitor compliance with this procedure, audit and report on the use of restraint within the unit.

14. REFERENCES

Legislation:

- Guardianship Act NSW 1987
- Guardianship Regulation 2010
- Mental Health Act 2007

References:

- AMA Position Statement 2015 'Restraint in the Care of People in Residential Aged Care Facilities' 2001 revised 2015, Australian Medical Association
- Australian and New Zealand Society for Geriatric Medicine (ANZSGN) Position Statement No 2 Physical Restraint Use in Older People, Revised September 2012. • Attorney General's Department, 2008, 'Capacity Toolkit', NSW Government
- Commonwealth of Australia, 2012, 'Decision making tool: Supporting a restraint free environment in residential aged care'
- NCAT Factsheet - Restrictive Practices and Guardianship
- NSW Health, 2000 'Best Practice Model for the use of Psychotropic Medications in Residential Aged Care Facilities and Guidelines on the Management of Challenging Behaviour in Residential Aged Care Facilities in NSW' Therapeutic Guidelines Ltd, 2013 (etg 42 March 2014) viewed via CIAP 02.10.2014
- NSW Government, Office of Children Guardian, 2019 https://www.kidsguardian.nsw.gov.au/child-safe-organisations/working-withchildrencheck/employer/who-needs-a-working-with-children-check

Associated policies:

NSW Ministry of Health policies:

- NSW Ministry of Health - Protecting People and Property - NSW Health Policy and Standards for Security Risk Management in NSW Health Agencies
- NSW Ministry of Health Guideline GL2015_007 - Management of Patients with Acute Severe Behavioural Disturbance in Emergency Departments
- NSW Ministry of Health Policy Directive PD2020_047 - Incident Management
- NSW Ministry of Health Policy Directive PD2020_004- Seclusion & Restraint in NSW Health Settings

SESLHD policies:

- SESLHDPR/345 - Prevention, Diagnosis and Management of Delirium in Older Persons
- SESLHDPR/380 - Falls prevention and management for people admitted to acute and sub-acute care
- SESLHDPR/421 - Bedrails – Adult - for use in Inpatient and Residential Settings.

15. EDUCATION

- My Health Learning - Aggression Minimisation in High Risk Environments (Module 2) (OHS1304)

- My Health Learning - Personal Safety – face-to-face workshop • Face to Face MAPA-
  Managing actual and potential aggression • Online courses- Dementia Competency training Network.

16. REVISION AND APPROVAL HISTORY

Date	Revision No.	Author and Approval
April 2015	1	Author: Janine Masso CNC Dementia/Delirium, the following Aged Care CNCs: Gemma Price, Olivia Paulik and Bronwyn Arthur, Simmi Grover, Melissa Buchanan
October 2015	2	Reviewed by Aged Care & Rehabilitation Services Stream. Minor changes recommended by DQUMC at August 2015 meeting. Changes made and endorsed by Executive Sponsor
July 2018	3	Reviewed by Janine Masso, CNC Dementia/Delirium and Giles Yates, Project Officer SESLHD Clinical Ethics Service
October 2018	4	Draft for Comment period Clinical Risk Manager - District Mental Health Drug and Alcohol Services Primary Integrated and Community Health Aged care Clinical stream Clinical Nurse Educator - Jara Ward Aged Care Clinical Nurse Consultant | Sutherland Hospital Director Child Youth Mental Health.
February 2019	5	Feedback received from Prof B Draper and QUMC SESLHD Director of Nursing SESLHD Aged care Director SESLHD Director of Clinical Governance SESLHD Professional practice unit
March 2019	5	Tabled at the April 2019 Quality Use of Medicines Committee (QUMC) meeting. Not approved by QUMC as changes required.
November 2019	6	Changes made and approved by Executive Sponsor. Formatted by Executive Services prior to tabling at December Quality Use of Medicines Committee for approval to publish.
December 2019	6	Approved at December Quality Use of Medicines Committee. To be tabled at February 2020 Clinical Quality Council for approval.

March 2020	6	Approved at February 2020 Clinical Quality Council for approval.
September 2020	7	Minor review. Information included, clinical teams required to document frequency of vital signs in eMR. Wording changed from restraint to restrictive practice. Links updated. Approved by Executive Sponsor. Published by Executive Services.
July 2021	8	Minor review: alignment with NSW Health PD2020_004- Seclusion & Restraint in NSW Health Settings; clarification of Section 11 reporting ims+; links updated. Approved by Executive Sponsor.