Committee for Examinations
Objective Structured Clinical Examination
Bye Station 1
Sydney April 2018

The Royal Australian & New Zealand College of Psychiatrists

BYE STATION 1 NOTES

The following information is provided for you to read during the bye station. You may make notations on this document and on your notepad. You may take this document and your notes into the station. Please leave this document with the examiner when you exit Station 1.

- You have **twenty (20) minutes** in this Active Bye Station to review the provided information including a complaint and the associated incident report and background documentation regarding restraint, and to start working on your responses to the tasks outlined below based on this information.
- After you leave the bye station you have **five (5) minutes outside the examination room** to read and continue working on the responses you will present to the examiners.

Instructions to Candidate

This is a **VIVA** station.

You are working as a junior consultant psychiatrist in an adult general inpatient ward in the Western Health Service.

The service has received a complaint about a recent episode of restraint involving a young man whose care has been transferred to you since the incident. The previous psychiatrist involved in his care has since retired and so no longer works for the mental health service.

The director of the service has asked to meet with you to discuss your recommendations as to how the complaint should be dealt with, and discuss whether you see any issues that the service needs to follow up. You have been given copies of the complaint, the associated incident report, the Western Health Service policy on restraint and an excerpt from the RANZCP position statement on restraint (2016).

Using the information that you have reviewed in the active bye your tasks are to:

- Outline your assessment of the facts of the complaint in relation to the Incident Report, the service policy and the RANZCP Position Statement (2016).
- Describe your approach to responding to the complaint.
- Propose a brief outline of an action plan for service improvement and your role in its implementation.

You will not be given any time prompts.

In this bye station, you have been given:

- **Attachment 1** - Letter of complaint from Sean and Sally Wright, dated 4th April 2018;
- **Attachment 2** - Incident Report 1087, dated 9th March 2018;
- **Attachment 3** - Western Health Ward Policy on Personal Restraint;
- **Attachment 4** - An excerpt from the RANZCP Position Statement 61, minimising the use of seclusion and restraint in people with mental illness (2016).

ATTACHMENT 1

Nurse in Charge
Acute Adult Inpatient Services
Mental Health Services

Dear Nurse in Charge,

We are writing to express concern about the experience that our son, Robert (Robbie) Wright, had during his recent stay in hospital.

Robbie was admitted to the more open part of the psychiatric ward on the 8th March 2018. On his second day in hospital he was forcibly taken to the intensive mental health care ward where staff held him down, and gave medication into his muscles and veins. Robbie was very frightened at the time as he believed that his life was in danger from the staff and this made him struggle quite desperately against being held down. He has a history of asthma and he has told us that he felt as though he was going to suffocate, plus he had bruises on his arms from the way he was manhandled.

Overall Robbie spent just over three weeks in hospital and is now much better, although not yet back to his normal self. He looks back on his first few days in hospital with terror, and would be fearful to set foot into the hospital again.

Although we are grateful for the help Robbie received once back on the open ward, we have concerns about several aspects of what happened and would like to talk with you about them. We believe that:

- It was unnecessary to use force in order to transfer him. If either of us had been asked to come into the hospital we could have talked Robbie into accepting the move without force;
- The force used was excessive. Robbie has never been a violent person and, although he was very unwell, he did not threaten himself or anyone else;
- We should have been contacted about the medication that was going to be given and its side effects.

We look forward to meeting with you to talk about our concerns.

Yours truly,
Sean and Sally Wright
4th April 2018

ATTACHMENT 2

Incident Report 1087 Name: Robert Wright **DOB:** 26 July 1999

Date of incident: 8th March 2018

Time of incident: 14:40

Staff member reporting: XXXXXXXXXX, Registered Nurse

Other staff involved: XXXXXXX, XXXXXXX, XXXXXXX

Background:

Mr Wright is an 18-year-old Year 12 student admitted voluntarily to the hospital with first episode psychosis on 8th March 2018. This was his first presentation to Mental Health Services. He had no past history of self-harm, harm to others or active substance abuse. The episode was thought to be secondary to genetic vulnerability and psychosocial stress (exams and relationship breakdown).

Brief Description of Incident:

On the first day of admission Mr Wright had been withdrawn and difficult to engage. On the second day at 11h30, he became agitated and required prn olanzapine after review in the morning ward round. He settled a little but at lunch he refused to leave his room to eat. He became increasingly insistent that he did not want food or any contact from the staff, and his level of physical agitation was such that he was escorted to the High Dependency Area at 14h40.

Interventions:

1) Patient put under the Mental Health Act and transferred to the High Dependency area of the ward.
2) Administration of olanzapine 10mg IMI at 14h43 by XXXXXX.
3) Patient physically restrained in prone position by team until situation controlled at 14h55.
4) Patient secluded until sleeping comfortably in supine position at 15h10, at which point door opened.
5) Physical observations made every 15 minutes and all within normal limits.
6) Patient reviewed by registrar at 16h45.

Outcome of interventions:

1) Patient received bruising to upper limbs and upper back as a result of struggle.
2) Patient sedated and slept after medications.
3) Staff member XXXXXX received kick to right lower leg as patient was transferred to the bed for medication.

Documentation completed:

As per protocol. An account written into patient's notes.

Communications:

Patient's parents unavailable by telephone.

Recommendations for prevention of further incidents:

Review of patient's treatment plan as patient was insufficiently medicated prior to transfer.

ATTACHMENT 3

FROM Western Health Policy	RESTRAINT MINIMISATION & SAFE PRACTICE
	Approved Restraint

CATEGORY OF RESTRAINT	Personal Restraint
APPROVED FOR	Planned and Unplanned restraint events
INDICATIONS FOR USE	1. When a person is making a serious and determined attempt(s) or act(s) of self-harm and is unable to stop of their own volition. 2. When a person makes a serious or sustained attack on another person. 3. When a person damages the environment in such a way that a real danger is created to her / himself or others and the situation cannot be defused by other interventions. 4. When all other interventions fail and it is necessary to give an essential treatment to a patient who is resistive and who is under compulsory assessment / treatment. This may also apply to emergency situations where a person is an informal / voluntary patient. 5. When it is necessary to prevent a person at high risk going absent without leave. 6. When a patient under a compulsory assessment / treatment order, attempts to leave and cannot be persuaded to stay. 7. When using restraint is necessary to detain a person under provisions of the Mental Health Act. 8. When a person is behaving in a physically intimidating and / or verbally threatening manner which staff believe may result in injury (physical / psychological). 9. When Personal Restraint is part of an agreed treatment regime e.g. providing personal security for a patient.
HOW IS THIS EPISODE REPORTED & RECORDED	• Record time restraint applied and removed, initiating clinician, any adverse outcomes and if evaluation was completed. • Document the restraint event. • Comment on: o Precipitating behaviours prior to using restraint. o Alternative strategies tried prior to restraint usage. o All interventions during restraint episode including monitoring requirements. o Any communication with family / carers. o Criteria used for removing restraint. o Document clinicians involved in initiating restraint and ongoing monitoring / termination of restraint. o Any adverse outcomes for either staff or patient.

POTENTIAL RISKS ASSOCIATED WITH USE i.e. what injury / harm (physical, cultural, psychological) to patient or staff may result from its use.	• Distress, agitation or confusion • Misinterpretation of use • Risks associated with reduced mobility • Isolation • Increased patient dependence • Loss of dignity • Injury • Fracture **Note**: The prone position should be avoided if at all possible and the period that someone is restrained in the prone position needs to be minimised. Whenever a patient is held face down in the prone position the maximum period of continuous restraint should not exceed three (3) minutes.
SUGGESTED ALTERNATIVES TO USING THIS INTERVENTION	Calming and de-escalation techniques. Refer to Restraint Alternatives.
MONITORING REQUIREMENTS	Monitoring requirements are based on Comprehensive Assessment however the minimum observation requirement is every 15 minutes. • Observation based on comprehensive assessment including risk assessment tools and subsequent treatment plan. • Position checks and alterations as per need. • Hygiene, nutrition, fluid & toileting as identified from assessment. • Call bell if available or alternative means of calling for assistance. • Psychological / emotional support as per individual need. • Regular medical reviews. Note where the patient is to be located e.g. not in isolation.
EVALUATION OF RESTRAINT INCIDENT	Each episode of restraint must be evaluated as soon as possible following the episode ending and will involve the multi-disciplinary team (if not possible, then on the first working day). Wherever possible, participation of the consumer, family, carer, advocate and cultural advisor (if appropriate) will be sought for the evaluation. If not involved, the reason should be noted. The evaluation should consider and address: • Adherence to the consumer's treatment plan • Alternative strategies attempted and those that could have been considered • Appropriateness of the decision to use restraint • Safety, efficacy and effectiveness of interventions • Impact on and the support needs of all participants including the consumer and other consumers on the unit • Adherence to policy • Team practices and training issues. The evaluation informs the review and update of the consumer's treatment plan by the clinical team with participation from the consumer and their family or care. Document the evaluation of the restraint event in the body of the clinical note.
DEBRIEFING	Ensure the consumer's support and debriefing needs are appropriately met. Ensure the staff are appropriately debriefed by initial post-event debriefing, and formal debriefing at a later stage.
STAFF TRAINING	• Communication, De-escalation & Interpersonal Skills Training • Personal Restraint Training / Occupational Violence Training

ATTACHMENT 4

Excerpt from Position Statement 61
Minimising the use of seclusion and restraint in people with mental illness
February 2016

The Royal Australian & New Zealand College of Psychiatrists

Purpose

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is committed to the delivery of quality mental health services that seek to improve safe practice and promote optimal outcomes to those receiving care. Therefore, the RANZCP is committed to achieving the aim of reducing, and where possible eliminating, the use of seclusion and restraint in a way that supports good clinical practice and provides safe and improved care for consumers. Reducing the use of seclusion and restraint requires commitment and leadership to changing practices and continued investment in delivering high quality care.

Definition

Both seclusion and restraint have long been used as an emergency measure to manage violent behaviour or agitation in mental health settings. The primary aim is to reduce risk of traumatic experience and / or injury for both consumers and staff involved.

- ***Seclusion*** is the confinement of the consumer at any time of the day or night alone in a room or area from which free exit is prevented.
- ***Restraint*** is the restriction of an individual's freedom of movement by physical, chemical or mechanical means. Here, 'physical' means bodily force that controls a person's freedom of movement, 'chemical' means medication given primarily to restrict a person's movement not to treat a mental illness or physical condition and 'mechanical' means a device that controls a person's freedom of movement.

While this position statement applies to the use of seclusion and restraint in mental health settings, it should also be used to inform policy in all other health, welfare or disability settings. This includes the use of seclusion and restraint on individuals with intellectual disability and in aged care settings and those presenting in emergency departments.

Evidence

Seclusion and restraint are generally used in the hope of preventing injury and reducing agitation, but studies have reported substantial deleterious physical and more often psychological effects on both patients and staff (Fisher, 1994).

It is acknowledged that there are situations where it is appropriate to use restraint and / or seclusion but only as a safety measure of last resort where all other interventions have been tried or considered and excluded. Under these circumstances, seclusion and restraint should be used within approved protocols by properly trained professional staff in an appropriate environment for safe management of the consumer. Seclusion and restraint are not a substitute for inadequate resources (such as lack of trained nursing staff). They should *never* be used as a method of punishment.

There is considerable variation in the clinical standards governing the use of seclusion and restraint in mental health services and guiding the appropriate use of the interventions or the use of alternative strategies. The aim is to reduce the use of these interventions and the adverse events that accompany them. Reduction of seclusion and restraint is possible, as demonstrated in studies such as those in the United States which have reduced use considerably without additional resources (Huckshorn, 2005). Evidence also shows that de-escalation and debriefing strategies can help minimise the use of seclusion and restraint. It requires leadership, commitment and motivation, and a change culture underpinned by recovery with a focus on workforce and training, prevention and early intervention, good clinical care, and supporting practice change.

The main barriers to reducing seclusion and restraint are:

- lack of identified good practice / agreed clinical standards for the use of seclusion and restraint
- lack of quality improvement activity and clinical review – i.e. poor governance
- inappropriate use of interventions and variation in practice – e.g. using threat of restraint or seclusion to coerce particular behaviour
- lack of staff knowledge or skills to prevent, identify and use alternative interventions or to safely use restraint and seclusion interventions in emergency situations
- lack of staff knowledge or skills regarding appropriate triaging of mental health presentations
- lack of staff training and knowledge about early warning signs of agitation and aggression and effective interventions to prevent the use of seclusion and restraint
- lack of staff education and training, particularly in non-mental health care settings
- lack of resources and poor facilities.

Many of the barriers above are being addressed through the MHSC initiatives in Australia and the recent updates by Te Pou and Standards New Zealand. Common themes developed in all strategies for the reduction of seclusion and restraint include:

- national direction and appropriate funding
- leadership towards organisational, clinical and cultural change
- use of data to inform practice
- improved governance and review
- workforce development, including de-escalation and debriefing strategies
- use of practical and evidence-based seclusion and restraint prevention tools
- service user development and participation
- better care planning
- consumer roles in inpatient settings
- debriefing techniques
- review of relevant mental health legislation.

The RANZCP supports the development of these strategies and believes that an increased focus on developing good clinical care, governance, research and education will help reduce the use of seclusion and restraint in practice.

The RANZCP also supports measures to improve the environment and physical layout of mental health services to help consumers to feel as safe and secure as possible. These measures can, in turn, help services to reduce the need to utilise seclusion and / or restraint practices. Potential examples include having natural light and spaces specifically designed to provide comfort to people who are in crisis or distressed and enabling doors to the main wards to be unlocked (National Mental Health Commission, 2015).

Recommendations

- The RANZCP is committed to achieving the aim of reducing, and *where possible* eliminating, the use of seclusion and restraint in a way which supports good clinical practice and provides safe and improved care for consumers.
- Seclusion and restraint are interventions and not therapies. The RANZCP acknowledges that there are situations where it is appropriate to use restraint and / or seclusion but only as a safety measure of last resort where all other interventions have been tried, or considered and excluded. Seclusion and restraint should never be used as a method of punishment but rather should aim to restore a collaborative patient–clinician relationship.
- If seclusion and / or restraint are to be used, they should only be used in line with formal policies in a safe, dignified and respectful manner as possible by appropriately trained staff.
- Prone (face down) physical restraint should only be used if it is the safest way to protect the patient or any other person. If face down restraint is used, it will be time limited. The maximum time a person will be held on the ground in face down restraint is approximately two to three minutes, the minimum amount of time necessary to administer medication and / or remove the person to a safer environment (NSW Ministry of Health, 2012).
- In the interests of consumer and staff safety, and the delivery of quality mental health services, the RANZCP fully supports systems-oriented activities such as Trauma-Informed Care that seek to minimise harm and promote improved outcomes for individuals receiving care.
- The RANZCP endorses the principles underpinning the entry on seclusion and restraint presented in *National safety priorities in mental health: a national plan for reducing harm* (National Mental Health Working Group, 2005) and in the Te Pou report (O'Hagan et al., 2008), and is encouraged to see progress in terms of the identified strategies.
- The RANZCP considers that the skills and attitudes of staff involved are the most critical aspect in reducing the use of seclusion and restraint and supports the principles of training and education for health staff in effective de-escalation and debriefing techniques.
- The RANZCP also supports environmental measures to help improve the design and physical layout of mental health services, which in turn may help reduce the need for those services to utilise seclusion and / or restraint.
- The RANZCP will work to promote quality and safe practice within its training and continuing medical education programs to contribute to the reduction of seclusion and restraint.
- The RANZCP supports a review of the term 'chemical restraint'.