CHIEF PSYCHIATRIST APPROVED FORM – FORENSIC 10

RESTRAINT(FORENSIC)

Mental Health Act 2013

Sections 92, 95-96

TCHI (Patient ID): _____

Family Name: _____

Given Names: _____

Date of Birth: __ / __ / _____ Gender: ☐ M ☐ F ☐ TG / IT

Address: _____

Telephone: _____ Mobile: _____

AFFIX STICKER HERE

FT213410

(Tick ☑ as appropriate, format time as 00:00 (24 hour) and date as DD/MM/YYYY)

PART A: AUTHORISATION OF RESTRAINT

CHIEF PSYCHIATRIST / DELEGATE / MEDICAL PRACTITIONER / APPROVED NURSE TO COMPLETE

This authority is applicable for up to three (3) hours restraint. Only the Chief Psychiatrist (CP) or Delegate may authorise restraint of a child and the chemical or mechanical restraint of an adult. Consecutive episodes of seclusion of an adult beyond six (6) hours is considered a new episode and can only be authorised by the Chief Psychiatrist (CP) or Delegate of the CP.

Patient *(full name in BLOCK letters)*:

Person authorising restraint *(full name in BLOCK letters)*:

Status of person authorising: ☐ Chief Psychiatrist or Delegate ☐ Medical Practitioner ☐ Approved Nurse

Type of restraint authorised:

☐ Chemical (medication type/dosage):

☐ Mechanical (authorised devices as approved by the Chief Psychiatrist):

☐ Physical

I **am satisfied** that it is necessary to restrain the patient named above *(tick all that apply)*:

☐ To facilitate the patient's treatment

☐ To ensure the patient's health or safety

☐ To ensure the safety of other persons

☐ To facilitate the patient's transfer to another facility

☐ To prevent the patient from destroying or damaging property

☐ To prevent the patient's escape from lawful custody

☐ To provide for the management, good order or security of the secure mental health unit

☐ To facilitate the patient's lawful transfer to or from another facility

I am satisfied that the restraint is a reasonable intervention in the circumstances for the following reasons:

I authorise restraint for a period of: **hours** **minutes** (maximum 3 hours, unless ceased sooner)

Commencing on: **Date:** DD / MM / YYYY **Time:** 00 : 00

Authorised on: **Date:** DD / MM / YYYY **Time:** 00 : 00

Is the person authorising the restraint completing this form:

☐ **Yes – authorised person sign here:** _____

(CP/Delegate/Medical Practitioner/Approved Nurse signature):

☐ **No – two members of nursing/medical staff to complete below**

We confirm restraint has been authorised by the person named above for the patient named on this form.

1. Dr/Nurse *(full name in BLOCK letters)*:

ID Card/Payroll/Registration number:	**Date:** DD / MM / YYYY
Signature:	**Time:** 00 : 00

2. Dr/Nurse *(full name in BLOCK letters)*:

ID Card/Payroll/Registration number:	**Date:** DD / MM / YYYY
Signature:	**Time:** 00 : 00

COPY TO: ☐ Patient ☐ Chief Psychiatrist ☐ TASCAT ☐ Legal Orders Coordinator

☐ If there is consent – copy to patient support person/representative

☐ If patient is a child copy to parent/support person/representative

OTHER: ☐ Statement of Rights provided to patient

☐ Explanation to patient in language and form that patient can understand

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PART B: CLINICAL/MEDICAL OBSERVATIONS

MEMBER OF NURSING STAFF / MEDICAL PRACTITIONER / APPROVED MEDICAL PRACTITIONER TO COMPLETE

Patient *(full name in BLOCK letters)*:

Date and time restraint commenced: **Date:** DD / MM / YYYY **Time:** 00 : 00

Date and time restraint ceased: **Date:** DD / MM / YYYY **Time:** 00 : 00

Date of Observation/ Assessment	Time of Observation/ Assessment	Comments/Observations	Name/ID Card/Payroll Number and Status
DD/MM/YYYY	00 : 00		
DD/MM/YYYY	00 : 00		
DD/MM/YYYY	00 : 00		
DD/MM/YYYY	00 : 00		
DD/MM/YYYY	00 : 00		
DD/MM/YYYY	00 : 00		
DD/MM/YYYY	00 : 00		
DD/MM/YYYY	00 : 00		
DD/MM/YYYY	00 : 00		
DD/MM/YYYY	00 : 00		
DD/MM/YYYY	00 : 00		
DD/MM/YYYY	00 : 00	*3 hours – Restraint ceases OR continues (see Part C)*	
DD/MM/YYYY	00 : 00		
DD/MM/YYYY	00 : 00		
DD/MM/YYYY	00 : 00		
DD/MM/YYYY	00 : 00		
DD/MM/YYYY	00 : 00		
DD/MM/YYYY	00 : 00		
DD/MM/YYYY	00 : 00		
DD/MM/YYYY	00 : 00		
DD/MM/YYYY	00 : 00		
DD/MM/YYYY	00 : 00		
DD/MM/YYYY	00 : 00		
DD/MM/YYYY	00 : 00	*6 hours – Restraint ceases OR new authorisation made*	

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Given Names: _____

Date of Birth: __ / __ / _____ Gender: ☐ M ☐ F ☐ TG / IT

Address: _____

Telephone: _____ Mobile: _____

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(Tick ☑ as appropriate, format time as 00:00 (24 hour) and date as DD/MM/YYYY)

PART C: CONTINUATION OF RESTRAINT

CHIEF PSYCHIATRIST / DELEGATE / MEDICAL PRACTITIONER / APPROVED NURSE TO COMPLETE

Continuation of restraint for an additional three (3) hours must be authorised before the end of the initial three (3) hours of restraint. Only the Chief Psychiatrist (CP) or Delegate may authorise restraint of a child or chemical/mechanical restraint of an adult. Consecutive episodes of seclusion of an adult beyond six (6) hours is considered a new episode and can only be authorised by the Chief Psychiatrist (CP) or Delegate of the CP.

Patient *(full name in BLOCK letters)*:

Date and time restraint first commenced: **Date:** DD / MM / YYYY **Time:** 00 : 00

Date and time restraint will cease if not continued: **Date:** DD / MM / YYYY **Time:** 00 : 00

Person authorising *(full name in BLOCK letters)*:

Status of person authorising: ☐ Chief Psychiatrist or Delegate ☐ Medical Practitioner ☐ Approved Nurse

I confirm that the patient named above was assessed by *(insert name of medical practitioner who assessed patient)*:

Assessment completed on: Date: DD / MM / YYYY Time: 00 : 00

I authorise the continuation of restraint for an additional period of: __ hours_____minutes
(maximum 3 hours unless ceased sooner)

Unless ceased sooner, the patient's restraint is to end on **Date:** DD / MM / YYYY **Time:** 00 : 00

Conditions imposed on continuation *(if applicable)*:

Continuation authorised on: Date: DD / MM / YYYY Time: 00 : 00

Is the person authorising the restraint CONTINUATION completing this form?

☐ **Yes – authorised person sign here:** _____
(CP/Delegate/Medical Practitioner/Approved Nurse signature):

☐ **No – two members of nursing/medical staff to complete below**

We confirm that the restraint has been authorised by the person named above for the patient named above, for the reasons given above:

1. Full name *(full name in BLOCK letters)*:

ID Card/Payroll/Registration number:	Date: DD / MM / YYYY
Signature:	Time: 00 : 00

2. Full name *(print clearly in BLOCK letters)*:

ID Card/Payroll/Registration number:	Date: DD / MM / YYYY
Signature:	Time: 00 : 00

COPY TO: ☐ Patient ☐ Chief Psychiatrist ☐ TASCAT ☐ Legal Orders Coordinator
☐ If there is consent – copy to patient support person/representative
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OTHER: ☐ Statement of Rights provided to patient
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FT2134410

PART A: AUTHORISATION OF RESTRAINT - INSTRUCTIONAL INFORMATION

The Chief Psychiatrist (CP) or a delegate, a medical practitioner or an approved nurse may authorise physical restraint of an adult.

Only the CP or a delegate may authorise the physical restraint of a child. See Factsheet for further information.

Only the CP or a delegate may authorise the chemical or mechanical restraint of an adult or a child.

Chemical restraint means medication given primarily to control a person's behaviour, not to treat a mental illness or physical condition.

Mechanical restraint means a device that controls a person's freedom of movement.

Physical restraint means bodily force that controls a person's freedom of movement.

A forensic patient may be restrained if authorised as being necessary for a prescribed reason, if the person authorising the restraint is satisfied that the restraint is a reasonable intervention in the circumstances, the restraint lasts for no longer than authorised, and the restraint is managed in accordance with any relevant standing orders or clinical guidelines.

The restraint is authorised as being necessary to:

- Facilitate the patient's treatment, or
- Facilitate the patient's general health care, or
- Ensure the patient's health or safety, or
- To ensure the safety of other persons; or
- Prevent the patient from destroying or damaging property, or
- Prevent the patient's escape from lawful custody, or
- Provide for the management, good order or security of the secure mental health unit, or
- Facilitate the patient's lawful transfer to or from another facility, whether in Tasmania or elsewhere; or
- A reason sanctioned by standing orders.

In the case of mechanical restraint, the means of restraint (device) has been approved in advance by the Chief Psychiatrist.

A patient may not be placed under restraint as a means of punishment or for reasons of administrative or staff convenience.

In the case of chemical restraint, or mechanical restraint to transport the patient from one approved facility to another, the period authorised may not exceed six (6) hrs.

In all other cases, the period authorised may not exceed three (3) hrs.

The restraint must not be applied for a period exceeding (3) three hours unless the patient has been assessed by a medical practitioner within those (3) three hours and a medical practitioner or approved nurse authorises continuation of the restraint. Restraint may only be extended once, resulting in a maximum restraint period of six (6) hours – see Part C

PART B: CLINICAL / MEDICAL OBSERVATIONS

A patient who has been placed under restraint must be clinically observed by a member of the approved hospital's nursing staff at intervals not exceeding 15 minutes or at such different intervals as standing orders may mandate.

A patient who has been placed under restraint must be assessed by a medical practitioner at intervals not exceeding three (3) hours to see if the restraint should continue or be terminated.

Regardless of authorisation, restraint must not be maintained to the obvious detriment of the patient's mental or physical health.

Note: restraint may only be continued once after the initial (3) three hour authorisation following assessment by a medical practitioner, resulting in a maximum (6) six hour total restraint, after which a new restraint authorisation must be made.

PART C: CONTINUATION OF RESTRAINT

A period of restraint may be continued only once.

The period of extension must be authorised in advance by a Medical Practitioner or Approved Nurse and authorisation may only be given if the patient has been assessed by a medical practitioner immediately prior to the decision to extend the patient's restraint.

A forensic patient's restraint may be extended only once for a period of three hours, resulting in a total of 6 hours of restraint.

The CP (or delegate) may impose conditions on any restraint extension and must stipulate the maximum timeframe for the restraint's continuance.

Consecutive episodes of restraint of an adult/child beyond six (6) hours is considered a new episode and can only be authorised by the CP or Delegate of the CP.

CONTACT DETAILS:

Chief Psychiatrist:	Phone: (03) 6166 0778	Email: chief.psychiatrist@health.tas.gov.au
TASCAT – Protective Stream:	Phone: (03) 6165 7491	Email: applications.mentalhealth@tascat.tas.gov.au