CHIEF PSYCHIATRIST APPROVED FORM – CIVIL 10

RESTRAINT (INVOLUNTARY)

Mental Health Act 2013

Sections 57 - 58

TCHI (Patient ID): _____

Family Name: _____

Given Names: _____

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

Address: _____

Telephone: _____ Mobile: _____

AFFIX STICKER HERE

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

FT2134005

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 of the CP may authorise the restraint of a child or the mechanical or chemical restraint of an adult. Consecutive episodes of restraint of beyond six (6) hours a new episode and can only be authorised by the Chief Psychiatrist (CP) or Delegate of the CP.

Patient *(full name in BLOCK letters)*:

Name of the approved facility where the patient is located: ☐ Millbrook Rise (South) ☐ Roy Fagan (South) ☐ Royal Hobart Hospital (South) ☐ Launceston General Hospital (North) ☐ North West Regional Hospital (Burnie)

Person authorising *(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 affect the patient's transfer to 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.

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

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

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

Address: _____

Telephone: _____ Mobile: _____

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FT21340 05

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

PART B: CLINICAL/MEDICAL OBSERVATIONS

MEMBER OF NURSING STAFF / MEDICAL PRACTITIONER TO COMPLETE

Patient *(full name in BLOCK letters)*:

Name of the approved facility where the patient is located: ☐ Millbrook Rise (South) ☐ Roy Fagan (South) ☐ Royal Hobart Hospital (South) ☐ Launceston General Hospital (North) ☐ North West Regional Hospital (Burnie)

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 (Nurse/MP
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	*6 hours – Restraint ceases OR new authorisation made*	

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

Address: _____

Telephone: _____ Mobile: _____

AFFIX STICKER HERE

FT213405

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

Patient *(full name in BLOCK letters)*:

Name of the approved facility where the patient is located: ☐ Millbrook Rise (South) ☐ Roy Fagan (South) ☐ Royal Hobart Hospital (South) ☐ Launceston General Hospital (North) ☐ North West Regional Hospital (Burnie)

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 continuation *(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 *(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)

Restraint is to end on **Date:** DD / MM / YYYY **Time:** 00 : 00

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

Conditions imposed on continuation *(if applicable)*:

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 person named above has authorised the continuation of the period for which the patient named above must be restrained, for the period referred to above, subject to the conditions (if any) specified above:

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

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

2. Name 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
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OTHER: ☐ Statement of Rights provided to patient
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FT213405

PART A: AUTHORISATION OF RESTRAINT

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

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

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

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

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

An involuntary patient in **an approved hospital or assessment centre** may be placed under restraint if authorised as being necessary to:

- Facilitate the patient's treatment, or
- Ensure the patient's health or safety, or
- Ensure the safety of other persons, or
- Effect the patient's transfer to another facility, whether in Tasmania or elsewhere, and
- The person authorising the restraint is satisfied that it is a reasonable intervention in the circumstances, and
- The restraint lasts for no longer than authorised, and
- The means of restraint employed in the specific case is, in the case of a mechanical restraint, approved in advance by the CP or a delegate.

Restraint must be managed in accordance with Standing Orders and Clinical Guidelines issued for this section.

Restraint may be authorised for an initial period of up to three (3) hours. Before the end of the initial period of restraint, a medical practitioner must assess the patient to see if the restraint should continue or cease. if the medical practitioner considers that restraint is still necessary, continuation of the restraint authority may occur once only for an additional three (3) hours resulting in a maximum restraint of six (6) hours. (See part c of this form) After a maximum of six (6) hours, restraint must end.

Whether or not to end a period of restraint is a clinical decision made by clinical staff. If clinical staff on duty believe that the restraint is no longer necessary, then it must be ceased immediately by a medical practitioner or approved nurse.

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

Authorisations must be made prior to commencement of restraint and cannot be retrospective.

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.

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.

A patient's restraint is not taken to have been interrupted or terminated by reason of scheduled observations, examination or assessment or the giving of necessary treatment or general health care.

If clinical staff on duty believe that the restraint is no longer necessary, then it must be ceased immediately by a medical practitioner or approved nurse.

PART C: CONTINUATION OF RESTRAINT

A period of restraint may be continued only once. In no circumstances is the period of restraint continuation to exceed three (3) hours. Therefore, the total maximum restraint time is 6 hours. Following the maximum 6 hours restraint, a new authorisation must be made.

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

The CP (or delegate) may impose conditions on the restraint of the patient at any point during the period of restraint.

Consecutive episodes of restraint of an adult beyond six (6) hours can only be authorised by the CP or Delegate of the CP in accordance with Clinical Guidelines and Standing Orders.

Clinical assessment to determine if continuation of restraint is needed must be done in person.

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