Safer Care Victoria

SAFER CARE VICTORIA

Governance framework for reducing restrictive practices in healthcare settings

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Except where otherwise indicated, the images in this document show models and illustrative settings only, and do not necessarily depict actual services, facilities or recipients of services. This document may contain images of deceased Aboriginal and Torres Strait Islander peoples.

In this document, 'Aboriginal' refers to both Aboriginal and Torres Strait Islander people. 'Indigenous' or 'Koori/Koorie' is retained when part of the title of a report, program or quotation.

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VICTORIA State Government

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Foreword

We are proud to present the governance framework for reducing and, where possible, eliminating restrictive practices in healthcare settings as a key step in our whole-of-health response to delivering safe, respectful and person-centred care. Restrictive practices should only ever be used as a last resort – and only in circumstances where there is no safer alternative.

In Victoria, a restrictive practice is any intervention that limits a person's freedom of movement or ability to act – for example, by using medication, physical force, devices or environmental barriers. As leaders across the health system, we have a shared responsibility to reduce reliance on these practices, to eliminate them where possible, and to support approaches that promote consumer dignity, autonomy and recovery.

This governance framework reflects a unified vision: one where every part of the health system – whether in mental health, acute care, aged care, disability or emergency services – works together to prevent distress, respond compassionately and build environments that support wellbeing and safety for consumers and staff. It draws on evidence, best practice guidelines and the lived experience of people receiving care, alongside the expertise and dedication of our health workforce.

We acknowledge the over-representation of Aboriginal peoples in restrictive practices and commit to working in partnership to eliminate these practices.

This framework will work alongside the Victorian *Aboriginal Health and Wellbeing Partnership Agreement* and the Closing the Gap frameworks. Aligning this framework with Victoria's Treaty commitment and truth-telling process will ensure systemic reform, equity and reconciliation, making this framework a vehicle for healing and trust building.

PURPOSE AND INTENDED USE

The *Governance framework for reducing restrictive practices in healthcare settings* is intended to be a practical, action-oriented guide for health services to support the reduction and, where possible, elimination of restrictive practices across all health settings. The framework is designed to be actively used by services to inform local governance, policy, workforce capability and clinical practice, and to drive consistent, safe and rights-based responses to situations of behavioural distress. Health services are expected to implement the framework to identify current practice gaps, strengthen preventative and therapeutic approaches, embed shared accountability and support measurable improvements in consumer and staff safety.

The framework should be applied alongside existing legislative, policy and regulatory requirements and used to inform service planning, quality improvement activities and decision-making at the organisational, service and clinical levels.

We recognise and honour the significant efforts already underway across services to reduce restrictive practices. This framework builds on that momentum by providing clear principles, aligned processes to guide continuous improvement. It is not just a governance framework – it is a commitment to cultural change, to workforce development and to better outcomes for the individuals, families and communities we serve.

By embedding this approach across the health system, we move closer to a system that leads with compassion, values human rights and delivers care in ways that are safe for both consumers and staff.

We acknowledge the contributions of all leads, disciplines and consumers who have helped shape this work.

Thank you for your leadership and partnership in advancing this critical work.

Anna Love
Chief Mental Health Nurse

Karrie Long
Chief Nursing and Midwifery Officer

Acknowledgements

Safer Care Victoria would like to sincerely thank the following people for their time, commitment and expertise in developing the *Governance framework for reducing restrictive practices in healthcare settings* for the Victorian context.

We also gratefully acknowledge the support of the Victorian Government Library Service for its valuable assistance in conducting literature searches and sourcing key materials to help inform this work.

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Introduction

Governance in health care encompasses the integrated systems, structures, practices and culture that ensure the delivery of safe, effective and high-quality care. Strong governance applies a cycle of continuous planning, monitoring, evaluation, learning and improvement, creating accountability at every level of the organisation. Within this framework, particular attention is given to understanding, minimising and, where possible, eliminating the use of restrictive practices across all health settings.

In alignment with the *National Safety and Quality Health Service Standards,* this framework responds to Standard 5.35, which requires that when restraint is assessed as clinically necessary to prevent harm, health services must have robust systems in place to:

- minimise and, where possible, eliminate the use of restraint
- govern the use of restraint in line with legislation
- report use of restraint to the governing body.

These actions must be taken with a strong focus on upholding the consumer's human rights while prioritising safety for all.

By embedding strong consumer- and workforce-informed governance structures, health services can proactively:

- prevent restrictive practices
- support the workforce with evidence-based alternatives
- minimise the risk of occupational violence
- foster a culture of continuous improvement.

The integration of Standard 5.35 reinforces the obligation to safeguard the dignity, rights and wellbeing of consumers in care while driving systemic and cultural shifts towards safer consumer-centred approaches. We recognise that Aboriginal people are overrepresented in restraint practice, and this framework commits to embedding cultural safety and antiracism as a non-negotiable.

Delivering on the *Governance framework for reducing restrictive practices in healthcare settings* requires shared accountability and commitment across every level of the health service:

- The board plays a critical role in setting the strategic direction, ensuring oversight and fostering a culture where safety, dignity and human rights are prioritised.
- Executive leadership and directors must translate this vision into operational policy, resourcing and organisational priorities, ensuring the reduction and, where possible, elimination of restrictive practices is embedded into everyday systems and structures.

- Clinical leaders are responsible for modelling evidence-based, person-centred approaches, mentoring staff and creating safe environments that support consumers and staff.
- Every staff member, regardless of their role, contributes to this collective effort by upholding respectful, compassionate care and by actively engaging in practices that prevent and minimise restrictive interventions.

Together, these shared responsibilities create the conditions for meaningful change, ensuring that reducing and eliminating restrictive practices is both a cultural shift and a core expression of high-quality, person-centred health care.

Recognising the diversity of Victoria's health services, it is acknowledged that organisations will be at varying stages of governance maturity and system readiness in their journey to reduce and, where possible, eliminate restrictive practices. This framework does not prescribe a one-size-fits-all approach but instead establishes a shared statewide goal – a collective commitment towards safer, more person-centred models of care. Through progressive implementation, shared learning and continuous improvement, all services can advance towards reducing and ultimately eliminating restrictive practices across the health system.

While reducing restrictive practices is a critical priority, it must be approached with careful attention to safety. Ensuring the protection of consumers and staff remains fundamental to every decision we make. By holding these principles in balance, we strengthen our commitment to delivering safe, respectful and person-centred care.

Finally, this framework represents a point-in-time reflection of the current priorities and collective intent to strengthen governance and improve safety outcomes; it is a first step and will be updated to ensure ongoing currency. It sits within a broader ecosystem of intersecting work and reform efforts aimed at reducing restrictive practices. Please refer to *Appendix 2: Visual summary,* which showcases the interconnected frameworks, legislation and strategic initiatives that align to support the framework in healthcare settings. This visual serves as a strategic snapshot, illustrating how these complementary efforts collectively reinforce the framework's goals.

Consumer survey

In 2025 Safer Care Victoria conducted a survey to gather qualitative data on consumer and family/supporter experiences of restraints in public hospitals, excluding mental health units. The survey results showed that more than 83% of those who were restrained did not feel respected during the process and that there was minimal or unsatisfactory explanation for the restraint.

'The restraints were always left attached to my bed – which felt like a threat'

– Consumer Survey respondent

'The staff would contact my [next of kin] and explain to her what was done but never take the time to debrief with me or explain what/why it was done'

– Consumer Survey respondent

'There was never any recognition of escalating distress, which I think would have prevented restraints'

– Consumer Survey respondent

Overview

This framework has been developed and structured to align with the *Victorian clinical governance framework* following a similar approach and alignment to governance planning. It has been laid out under the 4 key improvement cycle domains of **Plan, Monitor, Learn and Improve**, presented in a table format to guide health services in applying consistent and practical governance.

The pillars of this framework are not intended to be read in isolation. They are interconnected and must be applied together to support a coordinated and holistic approach across all levels of healthcare delivery.

Any existing policies, frameworks and legislative underpinnings that are relevant to the governance of restrictive intervention can be found in Appendix 2 and the reference list.

Pillar 1
Leadership and culture

Establishes supportive environment for initiatives to reduce restrictive practices within the organisation.

Pillar 4
Risk monitoring

Continuously collects and assesses data to mitigate potential risks.

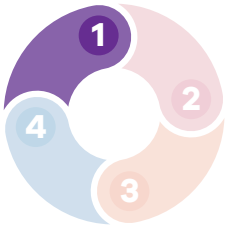
Pillar 2
Partnering with consumers

Embeds consumer voice centrally into decision-making for better outcomes.

Pillar 3
Workforce and clinical practice

Ensures a skilled and motivated workforce delivering high-quality evidence based care.

Pillar 1:
Leadership and culture



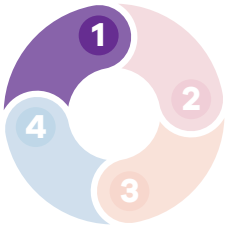
Establishes supportive environment for initiatives to reduce restrictive practices within the organisation.

AIM

Strong leadership and a positive safety culture are essential to understanding, reducing and, where possible, eliminating restrictive practices across all healthcare settings. This pillar ensures leaders at all levels champion evidence-based approaches that prioritise consumer dignity, safety and rights, as well as the safety and wellbeing of staff. This is done by fostering a culture in which organisations understand that restrictive practices have no inherent therapeutic benefit to a person and do not keep staff safe compared with less-restrictive alternatives. This pillar ensures cultural safety is a non-negotiable and that antiracism measures will be embedded into leadership culture.

Restrictive practices are recognised as undesirable and should only be used as a last resort. Organisations can drive meaningful change through ongoing education, structured reporting, consumer involvement, self-determination principles and targeted interventions to enhance safety and promote best practice.

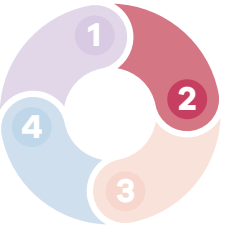
Pillar 1: Leadership and culture



OBJECTIVES

Pillar 1 objectives	Plan	Monitor	Learn	Improve
1 **The organisation's culture and leadership set the standard that restrictive practices do not provide therapeutic benefit to consumers.**	Incorporate the framework into existing quality and safety governance systems.	The governance group will monitor and track key metrics and disseminate information.	Gather staff and other organisational information about the consumer experience.	Introduce and continuously improve alternatives to restrictive practices.
2 **Establish accountability and transparency when using restrictive practices.**	Implement systems for documenting and monitoring the use of restrictive practice in clinical settings.	Ensure monitoring and evaluation includes relevant evidence from staff identifying restrictive practices and their management.	Continuously review incoming data insights.	Assess insights and determine goals and areas of focus for improvement over time.

Pillar 2:
Partnering with consumers



Embeds consumer voice centrally into decision-making for better outcomes.

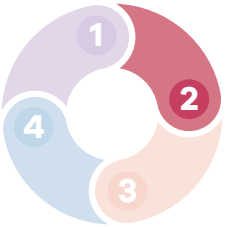
AIM

Effective partnerships with consumers are essential for reducing and, where possible, eliminating restrictive practices and improving care experiences. We acknowledge the over-representation of Aboriginal peoples in restrictive practices and commit to working in partnership with consumers to reduce and eliminate these practices.

Organisations must ensure consumers have access to clear, accessible, culturally appropriate and easy-to-understand information about their rights, how to make a complaint and how decisions about restrictive practices are made.

Embedding the lived experience voice in governance, service design and improvement fosters a consumer-centred approach that prioritises prevention and promotes informed choice while improving public trust and collaboration between staff and service users. Regular reviews from lived experience insights should drive continuous improvement, ensuring services remain responsive and adaptable.

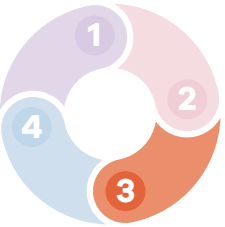
Pillar 2: Partnering with consumers



OBJECTIVES

Pillar 2 objectives	Plan	Monitor	Learn	Improve
1 **Ensure clear communication and shared understanding of processes for reducing and, where possible, eliminating restrictive practices.**	Implement a model of shared decision-making. Deliver communication in multi-modal formats, outlining consumer rights.	Embed and track consumer and lived experience participation in governance structures.	Review governance systems and reporting. Incorporate key consumer elements into staff onboarding and essential education programs. Include consumer stories.	Use consumer and staff feedback to refine communication and essential educational programs.
2 **Collect consumer feedback on experiences of restrictive practices.**	Collect feedback from consumers on the care they received.	Collect and analyse feedback, monitoring complaints and compliments about restrictive practices.	Use feedback to explore what matters most to consumers and what makes for a high-quality care experience.	Enhance the consumer experience, harnessing system agility to incorporate recommendations from feedback.
3 **Ensure consumers are central in decisions about the use of alternative strategies.**	Prevent restrictive practices by empowering consumers to make informed choices through a person-centred care approach. Promote, access and utilise consumer supports or advocacy services in a timely manner.	Incorporate consumer feedback in all governance meetings.	Identify barriers and enablers to inform decision-making to address alternatives to restrictive practice.	Regularly review consumer insights and feedback to improve consumer involvement in care. Ensure the consumer voice is clearly articulated in post-incident debriefings.

Pillar 3:
Workforce and clinical practice



Ensures a skilled and motivated workforce delivering high-quality evidence based care.

AIM

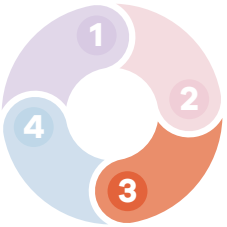
This pillar recognises that both clinical and non-clinical staff require skills, confidence and resources to consider and deliver alternatives to restrictive practices, which requires investment in:

- learning, training and education
- building capacity and capability
- mentoring
- clinical or discipline-specific supervision and reflective practice opportunities
- culturally appropriate Aboriginal-led antiracism training.

Training and guidelines to support clinical practice include direction related to:

- prevention and alternative strategies
- early intervention approaches
- authority and application
- monitoring, documentation and reporting
- post-intervention debriefing and support that is culturally appropriate.

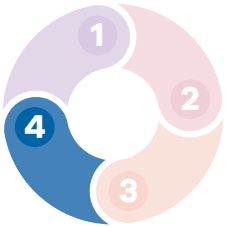
Pillar 3: Workforce and clinical practice



OBJECTIVES

Pillar 3 objectives	Plan	Monitor	Learn	Improve
1 Build understanding of restrictive practices and processes for the safest possible use.	Develop and deliver targeted training on restrictive practices, tailored to different cohorts and settings. Integrate legal, ethical, clinical and holistic principles, underpinned by consumer perspectives, with clear learning objectives for each audience. Incorporate policies and procedures to support practice.	Embed monitoring of training programs into governance processes and evaluate their impact on restrictive practices.	Measure the effectiveness of training by tracking the reduction of restrictive practice. Establish feedback mechanisms to identify future training needs.	Ensure education content aligns with best practice through continuous improvement. Adapt training content and delivery based on identified gaps and opportunities.
2 Build workforce de-escalation capability, focusing on clinical skill development.	Provide accessible, discipline- and role-specific training and coaching in prevention and de-escalation strategies, using multidisciplinary, scenario-based learning to enhance skills.	Monitor staff training records and assessments.	Evaluate de-escalation strategies using incident reviews and workforce and consumer feedback.	Implement a continuous training refresher strategy that integrates workforce and consumer feedback, along with evolving best practices.
3 Foster a safe, supportive workplace that encourages open dialogue on challenges related to restrictive practices.	Enable staff to openly discuss concerns and challenges related to restrictive practices.	Facilitate post-incident reflective practice sessions to support learning and improvement.	Review the themes of issues raised in feedback.	Integrate staff feedback into strategic planning and ongoing engagement.
4 Provide guidance and resources to help clinical settings apply best practices, ensure oversight and create environments that reduce and, where possible, eliminate the use of restrictive interventions.	Review and audit existing service procedures, documentation and guidelines to build on current practices and identify opportunities for enhancement.	Review documentation related to restrictive practices to ensure procedures are being followed and to support continuous quality improvement.	Create opportunities to strengthen tools and resources through regular updates informed by feedback and best practice guidelines.	Use feedback and audit findings to strengthen procedures and documentation through ongoing updates.

Pillar 4:
Risk monitoring

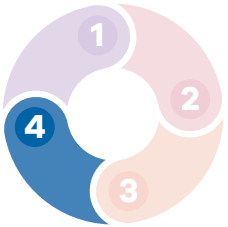


Continuously collects and assesses data to mitigate potential risks.

AIM

This pillar promotes using data to identify, assess and mitigate risks while exploring opportunities for improvement associated with restrictive practices, ensuring the safety of both staff and consumers. It emphasises the importance of embedding regular data monitoring and evaluation, ensuring risk findings are escalated rapidly. This pillar recognises the importance of collecting and reporting on Aboriginal-specific data and the involvement of Aboriginal cultural advisors in governance and incident reviews.

Pillar 4: Risk monitoring



OBJECTIVES

Pillar 4 objective	Plan	Monitor	Learn	Improve
1 **Ensure restrictive practice events are recorded and data trends identified.**	Implement consistent data collection methods in line with relevant accreditation standards and mandatory reporting requirements across the health service.	Create a data distribution process to enable service-wide reviews. Include relevant safety data that notes the consumers and staff who have been affected.	Share relevant restrictive practice data with stakeholders to support transparency for both consumers and the workforce.	Develop performance measures to analyse and inform service improvement. Identify areas within organisations that require targeted support.

Intended outcomes

The *Governance framework for reducing restrictive practices in healthcare settings* is designed to support health services to move from intent to sustained, accountable action. Through implementing this framework, services are expected to:

- establish clear governance and oversight for using restrictive practices
- strengthen transparency and accountability
- routinely collect, analyse and use data to inform decision-making and continuous improvement.

Over time, this approach will enable services to:

- better understand the drivers, frequency and impact of restrictive practices
- identify opportunities for prevention and early intervention
- demonstrate measurable reductions in their use.

Ultimately, the framework supports a consistent, system-wide shift towards safer, more therapeutic and person-centred responses, ensuring restrictive practices are used only as a last resort and subject to robust oversight and review.

Appendix 1: What does 'good' look like?

Pillar 1: Leadership and culture

- New or enhanced leadership commitment (executives, board, champions)
- Improved or reviewed policies, procedures and practices
- Funding and resources are more closely examined
- Reviewed or established governance committees (for example, a quality and safety committee)
- Improved reports on clinical performance and safety
- Increased staff awareness of governance roles
- Enhanced compliance with clinical standards
- Self-determination embedded in governance structures
- Cultural safety practices and antiracism measures embedded into everyday practice

Pillar 2: Partnering with consumers

- An increase in understanding and collaboration of the consumer perspective
- Working in partnership with Aboriginal Community Controlled Organisations
- Consumer engagement mechanisms developed or reinforced
- Consumer and carer feedback are embedded in service improvement and decision-making
- Consumer and carer feedback are embedded in workforce training and development
- Consumer experience data collected and utilised (ensuring data pertaining to Aboriginal people is transparent)
- Opportunities created for action plan development based on incident reviews
- Incorporation of 'just culture' principles and guidelines on engaging consumers in feedback

Pillar 3: Workforce and clinical practice

- Increase in skilled workforce (clinical, quality, risk professionals)
- Reviewed or newly developed clinical guidelines and pathways
- Opportunities to monitor clinical guidelines and pathways
- Staff are upskilled and trained in alternatives to restraint and other safety, ethical and quality improvement topics, with lived experience informing de-escalation strategies
- Health services have the required resources to support the alternatives needed
- Aboriginal-led and culturally appropriate training is delivered

Pillar 4: Risk monitoring

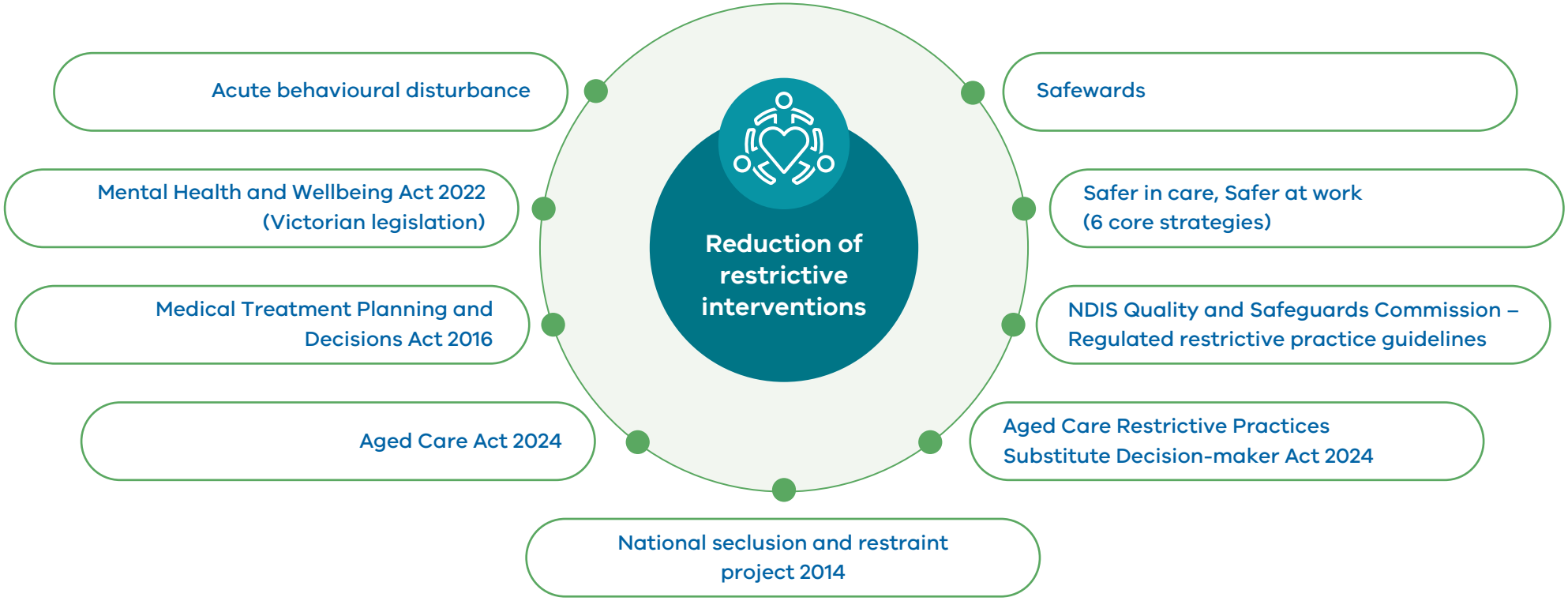
- Accessing or utilising current data collection systems and IT infrastructure
- Implement risk management and incident reporting systems
- Increased occurrences for new or regular clinical audits (file audit, training audits, etc.)
- Audit and review findings are shared
- Continuous improvement based on evidence and data
- Principles of self-determination are explicit in continuous improvement

Appendix 2: Visual summary

COLLABORATIVE INITIATIVES FOCUSED ON MINIMISING THE USE OF RESTRICTIVE PRACTICES IN HEALTHCARE ENVIRONMENTS

Governance framework for reducing restrictive practices in healthcare settings

A unified vision, one where every part of the health system – whether in mental health, acute care, aged care, disability, or emergency services – works together to prevent distress, respond compassionately, and build environments that support wellbeing for all. It draws on evidence, best practice guidelines, and healthcare leaders to reduce restrictive practices.



Appendix 3: Vignettes

To further support the understanding of restrictive interventions, 4 vignettes are included. The vignettes have been developed and adapted from scenarios that commonly occur within health care.

When reading each vignette, consider the key objectives and the cycle of continuous improvement in each framework pillar. Although each vignette has a specific setting and context described, the key learnings and themes can be applied in any healthcare setting.

VIGNETTE 1: AGED CARE SETTING

Mrs E has been living in a memory support unit for the past 6 months. She tends to wander more so in the evenings and frequently attempts to leave the unit by hovering near the doors. Mrs E was being prescribed regular sedative medication in the late afternoon to try to keep her in bed. This was considered chemical restraint.

The care team discussed Mrs E's existing comprehensive behavioural assessment and explored other options to support her. The team spoke to the family, who identified that in the evening, around 7 pm, her husband would return home from work, and this may have been contributing to Mrs E's attempts to leave the unit around this time.

The team considered opportunities in the unit's environment to support Mrs E. They created a small, familiar 'bus stop' seating area with a photo of her late husband at the usual exit point. In addition, dedicated staff members began a 'winding down' routine at 6:30 pm, including a cup of tea, a hand massage and listening to her preferred 1940s' music.

A pain review was conducted, and low-dose paracetamol was administered before the evening routine to rule out pain-related agitation.

The team monitored Mrs E's evening behaviours and noted that, within a week, Mrs E's attempts to exit reduced significantly. The sedative medication that had been administered was avoided entirely, preserving her cognitive function, dignity and independence. The progress that she made was communicated back to her family.

VIGNETTE 2: DELIRIUM ON A MEDICAL WARD

Mr L is a 78-year-old male being cared for in a public hospital on a general medical ward. He had been admitted from home with a suspected urinary tract infection that his GP managed with oral antibiotics for the preceding 5 days. Mr L had been unable to sleep at home and was confused and disorientated, leading to his GP referring him to an emergency department for further medical assessment and treatment.

Mr L was assessed and diagnosed with delirium, likely secondary to a urinary tract infection and dehydration. On the first night in hospital, he became increasingly confused and resisted staying in bed. He pulled at the intravenous lines that were administering necessary antibiotics and fluids to treat his UTI and dehydration.

Mr L has a supportive family who were concerned about his behaviours and that he removed his intravenous line. They met with the treating team and were given information about his treatment. They discussed strategies to help Mr L feel calmer when in hospital for medical care.

His family brought familiar items from home to help Mr L orientate himself. The staff noted the day of the week, the date and the names of his care team members on his white board next to his bed where it was readily visible. The team lowered his bed to ensure he could not injure himself if he tried to leave. A multidisciplinary team (including a psychogeriatrician) developed a behaviour support plan, which nursing staff trialled and revisited daily in handover to ensure it reflected what worked best to support Mr L.

Overnight, Mr L became increasingly confused and physically aggressive towards staff. Nursing staff had to provide urgent physical restraint to prevent him from pulling his intravenous line out after the treating team stressed the importance of him continuing his treatment. Over the subsequent 2 nights, Mr L became more settled and responded to the strategies in the behaviour support plan and was eventually transitioned to oral antibiotics. The contact nurse gave his family daily updates on his progress when they visited in the mornings.

VIGNETTE 3: AGGRESSION IN AN EMERGENCY DEPARTMENT

Ms P is a 47-year-old single female who emergency services transported to ED following intentional self-harm to her left wrist. Emergency services stated that Ms P was intoxicated and self-harming when they arrived at her home, that she had used a piece of glass from a broken bottle and was looking for another piece of glass to further self-harm. Ms P reported that the self-harm incident was the 'only way to get help'.

Ms P advised she had consumed a bottle of wine that afternoon. There was no prior information in her medical record, and she was brought in alone. She became agitated and cried intensely when staff attempted to understand what was occurring at home. The ambulance officer advised that Ms P's mother had been contacted and was en route to the hospital.

The treating team attempting to assess Ms P identified a possible referral to the mental health team for an assessment due to her self-harming. In addition, her wounds had to be examined to exclude a tendon injury. Due to her alcohol intoxication, the plan was to support Ms P in the least restrictive manner by minimising any additional sedative medication. The team decided to re-attempt their assessment when her mother arrived.

When Ms P's mother arrived she was brought into the cubicle to support her daughter. Nursing staff updated her mother on the presentation and the need to assess and clean her daughter's wounds. Ms P's mother was visibly upset to see her daughter distressed and bleeding. She stated that Ms P is an artist and was concerned that her wounds may impact her ability to paint, which is her passion. Nursing staff explained to Ms P that they would clean her wounds. Ms P appeared more settled with her mother present.

Unfortunately, Ms P soon became agitated and was unwilling to let a nurse clean her wound. As she resisted, her arm struck the nurse in the shoulder. She became verbally aggressive and yelled that she had not injured her wrist and would leave the hospital. The nurse spoke calmly to Ms P about her concerns. This resulted in Ms P becoming more agitated and yelled at both the nurse and her mother. She denied being intoxicated and believed that her mother and the nurse had been gossiping about her while she slept.

The nurse activated an emergency response due to Ms P's aggression. The behaviours of concern team arrived in the ED and attempted to talk to Ms P, offering the least restrictive options of support and treatment. Providing her with information about her wound care and the concern for her mental health did not reduce her distress. Her mother stated that she had never seen her daughter like this before and again began to cry. Ms P climbed out of her bed and tried to run towards the nearest door to exit the department. Due to the treating team's concern for her wellbeing and imminent safety issues and her mother's concern, the team applied urgent physical restraint and prevented Ms P from leaving her cubicle. A short period of mechanical restraints was applied at the time of the physical restraint. While in mechanical restraints, Ms P was administered parenteral acute sedation to reduce her psychological distress and mobility. Her wrists were examined, cleaned and sutured over the next hour.

The restraints were removed at the earliest opportunity, when Ms P had stopped demonstrating aggressive behaviours. The mental health team assessed her. Ms P was later discharged with the support of her mother and a plan was developed for ongoing community mental health follow-up.

Ms P's mother contacted the hospital patient liaison team the following day to provide feedback about her daughter's stay in the ED. Her mother was concerned about the wellbeing of the nurse who her daughter struck in the shoulder. As she described the events that she witnessed in ED, she started to cry, stating that she has been unable to stop thinking about her daughter being restrained. The liaison officer offered to meet with Ms P's mother to provide additional support in person, which they scheduled within the week.

The ED quality and safety lead gave feedback to the monthly Quality and Safety ED meeting about key themes and learnings from this incident to drive practice improvements.

VIGNETTE 4: RE-FEEDING IN EATING DISORDERS

Ms R is a 16-year-old female with an established diagnosis of anorexia nervosa and experience of trauma. Two weeks ago she was admitted to a dedicated eating disorders ward in a public hospital.

Ms R was admitted after a review of her eating disorders management plan, coordinated with her care team and her GP, due to concerns of weight loss, dehydration and syncopal episodes. Ms R reluctantly agreed to the admission but understood that she had been unable to maintain some of the agreed goals for her physical health in the community.

While on the eating disorders unit, Ms R was inconsistent with her meal plan and was reviewed regularly with the multidisciplinary care team. Several meetings were conducted with Ms R and her parents whereby the treating team discussed some of the concerns for Ms R's physical health and her most recent weight loss. All parties (including Ms R) agreed that her weight and physical parameters would be monitored and reviewed and the indicators that would trigger nasogastric feeding.

Ms R had received nasogastric feeding earlier in the year in a one-month admission to hospital and found it distressing.

Unfortunately, after a period of observation, the treating team recommended that Ms R required nasogastric feeding due to her worsening medical state. Her parents were distressed but supported any treatment to stabilise her health; they were also concerned that she may deteriorate while in hospital. Several meetings occurred with Ms R and her parents to discuss less restrictive care opportunities and what would assist Ms R to be comfortable during periods of intervention and re-feeding.

Ms R discussed using medication to relax her. She said that wearing mittens had prevented her from pulling out her nasogastric the last time she was being re-fed in hospital and woke up confused and agitated. Her parents wanted the multidisciplinary team to honour any suggestions that Ms R provided, as long as she was medically stable to receive the medication she was requesting. Ms R also requested time off the ward in the garden area of the hospital when receiving visits from her family to help her cope with the ongoing hospital stay.

The multidisciplinary team developed a care plan that would support Ms R and the nursing staff around re-feeding. This plan was provided at the bedside for Ms R, and a copy was given to her parents. Mittens were used for periods where Ms R fell asleep and at other times when she, herself, felt agitated or when nursing staff noticed her becoming increasingly agitated. A low dose of short-acting benzodiazepine was prescribed and offered to Ms R for her to request this medication as required.

Once medically stabilised, the treating team expedited her discharge from hospital back to her community care team, which continued her treatment.

Glossary

Reducing restrictive practices in healthcare settings: A whole-of-health commitment to delivering safe, respectful and person-centred care where restrictive practices should only ever be used as a last resort.

Reporting: Collect, analyse, evaluate and manage statistical and related information on restrictive practices. For this framework, reporting up and down are both required, with dissemination of information to clinical and non-clinical staff and reporting of information to leadership and executive and board roles.

Consumer rights: The *Charter of Human Rights and Responsibilities Act 2006* describes the rights that consumers, or someone they care for, can expect when receiving health care.[1]

Consumers: Umbrella term covering consumers, carers, families and people with lived and living experience.

Workforce: Includes both clinical and non-clinical staff, as well as permanent and casual staff within an organisation.

Restraint: The restriction of a person's freedom of movement.[2] There are different types of restrictive practice. In this document, we use the following definitions:

- **Chemical restraint:** means the giving of a drug to a person for the primary purpose of controlling the person's behaviour by restricting their freedom of movement but does not include the giving of a drug to a person for the purpose of treatment or medical treatment.[3]
- **Bodily restraint:** means 'physical restraint, mechanical restraint and environmental restraint, of a person'.[3]
- **Physical restraint:** means 'the use by a person of their body to prevent or restrict another person's movement but does not include the giving of physical support or assistance to a person in the least restrictive way that is reasonably necessary to:
  (a) enable the person to be supported or assisted to carry out daily activities; or
  (b) redirect the person because they are disoriented'.[3]
- **Mechanical restraint:** means 'the use of a device to prevent or restrict a person's movement'.[3]
- **Environmental restraint:** means the practice or intervention that restricts, or that involves restricting, a consumer's free access to all parts of the consumer's environment, including items and activities, for the primary purpose of influencing the consumer's behaviour.[3]

Mentoring: Involves developing a relationship with a person who will support workforce development by sharing their expertise, values, skills and perspectives through a series of regular meetings.[4]

Clinical supervision: Supervision that aims to develop a supervisee's clinical awareness and skills to recognise and manage personal responses, value clashes, power imbalances and ethical dilemmas. This type of supervision allows deeper insight to the work using process reflection.[5]

References and other useful resources

1. Victorian Government (2006) *Charter of Human Rights and Responsibilities Act 2006 (Vic)*, accessed April 2025.
2. Australian Commission on Safety and Quality in Health Care (2021) *Action 5.35 Minimising patient harm. National Safety and Quality Health Service (NSQHS) Standards* (Comprehensive Care Standard), accessed May 2025.
3. Melbourne Social Equity Institute (2014) *Seclusion and Restraint Project: Overview*, The University of Melbourne, accessed July 2025.
4. Victorian Government; Safer Care Victoria (2019) *New to clinical leadership mentoring program*, accessed July 2025.
5. Department of Families, Fairness and Housing (2024) *Best practice supervision guidelines: family violence, sexual assault and child wellbeing*, accessed July 2025.
6. Department of Health (2023) *Aboriginal Health and Wellbeing Partnership Agreement 2023–2033*, accessed December 2025.
7. Department of Health (2024) *Chief Psychiatrist's guideline and reporting directive on restrictive interventions under the Mental Health and Wellbeing Act 2022*, accessed June 2025.
8. Safer Care Victoria (2024) *Guidance: Acute behavioural disturbance*, accessed July 2025.
9. Safer Care Victoria (2024) *Victorian clinical governance framework*, accessed July 2025.
10. Victorian Government (2022) *Mental Health and Wellbeing Act 2022 (Vic)*, accessed July 2025.
11. Department of Health (2017) *Medical Treatment Planning and Decisions Act 2016*, accessed July 2025.
12. Department of Health and Aged Care (2025) *Aged Care Act 2024*, accessed November 2025.
13. Safer Care Victoria (2025) *Safewards Victoria*, accessed July 2025.
14. Australian College of Mental Health Nurses (2019) *Safe in Care, Safe at Work (SICSAW): ensuring safety in care and safety for staff in Australian mental health services*, accessed July 2025.
15. NDIS Quality and Safeguards Commission (2020) *Regulated restrictive practices guide*, accessed July 2025.
16. Victorian Government (2024) *Aged Care Restrictive Practices Substitute Decision-maker Act 2024*, accessed July 2025.

Safer Care Victoria