### Feedback and Questions on Proposed Restrictive Practices Legislative Framework

Thank you for the opportunity to provide feedback on the proposed public consultation paper. Below are my observations, concerns, and questions related to the implications of the legislative framework for the acute care setting, particularly concerning infrastructure, implementation, and alignment with existing policies.

**General Concerns:**

1. **Clarity on Interaction with Existing Policy:** The NSW Health Policy Directive 2020\_004 *Seclusion and Restraint in NSW Health Settings* applies to all NSW Health staff working in health settings, including mental health settings. It is critical to clarify whether the new legislative framework will override, complement, or operate alongside this directive. Specific details on when and where the framework will apply in acute healthcare settings need to be explicitly stated and discussed with acute health stakeholders.

**Specific Feedback and Questions:**

**Proposal 2: Annual Reporting to the Senior Practitioner**

The framework proposes that government agencies in health, education, and justice settings provide annual compliance reports to the Senior Practitioner.

* **Who would fulfill this role in acute healthcare?**
  + What qualifications or experience would be required of the Senior Practitioner in acute care?
  + How will this role be integrated into the clinical governance of acute settings?
* **Logistical Concerns:**
  + Acute care operates 24/7, including overnight, weekends, and public holidays. How will this role be managed after hours to ensure consistent decision-making?
  + What funding and support will be allocated to train individuals for this specialized role in behaviour support and restrictive practices?

**Authorizing Restrictive Practices:**

The framework requires that restrictive practices be authorized by a Senior Practitioner (or delegate) and included in a Behaviour Support Plan (BSP). This contrasts with the current consent-based model used in acute inpatient settings.

1. **Alignment with Existing Models:**
   * How will the framework address the contrast between authorization models (BSP-driven versus consent-based)?
   * What accommodations will be made for urgent or emergent scenarios where a BSP is not readily available, such as:
     + Sudden changes in a patient’s cognitive condition?
     + Acute presentations where the patient has no prior history of challenging behaviours or aggression?
2. **Acute Scenarios and BSP Implementation:**
   * Many patients in the community do not exhibit challenging behaviours in their usual environments. In acute settings, pain, unfamiliarity, or fear may trigger behaviours. Without immediate access to behaviour consultants, what guidelines will apply?
   * Given the detailed nature of BSPs, how will these be adapted for acute care settings where clinical decisions must be made rapidly?
3. **Emergency Situations:**
   * What specific rules or exemptions will apply during emergencies, such as:
     + A sudden deterioration in cognitive function or a mental health crisis?
     + Acute patient assessments where agitation may hinder care?

**Prohibited Practices and Training Needs:**

The framework identifies several prohibited practices. While these align with principles of safety and dignity, clarity is needed for exceptional circumstances that arise in acute care:

1. **Supine Restraint:**
   * For cases like potential spinal injuries where the application of a hard collar is required, will exceptions be allowed to reduce the risk of further injury?
2. **Pin Downs:**
   * In scenarios where patients are in an agitated state and require urgent assessment (e.g., potential head injury, drug intoxication, or mental health crisis), what guidelines will apply?
   * If restrictive practices are limited for NDIS participants, how will acute clinicians address the need for equitable care during such situations?
3. **Takedown Techniques:**
   * While takedowns should be used only as a last resort, clarity is needed on their permissibility during life-threatening situations in emergency departments. How will this be documented and reviewed to ensure compliance without compromising safety?
4. **Physical Restraint for Medical Procedures:**
   * Situations where physical restraint may inadvertently resemble prohibited practices include:
     + Holding a patient’s arm to obtain emergency bloodwork.
     + Extending a joint to apply a back slab after a fracture.
     + Applying pressure to a bleeding chest wound.
   * Will there be explicit allowances for such practices during life-saving or emergent interventions?

**Summary of Key Needs:**

1. **Clear Guidelines:**
   * Explicitly define how the legislative framework will interface with existing NSW Health policies.
   * Provide clear rules and exceptions for acute and emergency care settings.
2. **Support for Implementation:**
   * Allocate funding for training acute care clinicians in behaviour support and restrictive practices.
   * Develop simplified and adaptable BSP templates for use in acute care.
3. **Provisions for Emergencies:**
   * Ensure the framework includes provisions for urgent, life-saving interventions that may conflict with restrictive practice guidelines.
4. **Collaboration with Stakeholders:**
   * Engage with acute healthcare professionals to ensure the framework is practical and effective without compromising patient safety.

Thank you for considering this feedback. I look forward to further discussion and clarification to ensure that the framework supports safe and equitable care for all patients, including those with complex needs in acute settings

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