RESTRAINT AND RESTRICTIVE PRACTICES POLICY

POLICY

Reference	CPG-TW-R&RPP		
Approving Body	Safeguarding Steering Group		
Date Approved	26/06/2023		
For publication to external SFH website	**Positive confirmation received from the approving body that the content does not risk the safety of patients or the public:**		
	YES	**NO**	**N/A**
	X		
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Version	2.0		
Summary of Changes from Previous Version	• There has been a full re write of this policy to align to national guidance and service developments		
Supersedes	• v1.0, Issued 4th November 2019 to Review Date August 2023 (ext3)		
Document Category	• Clinical		
Consultation Undertaken	• U&EC Representatives • Safeguarding Steering Group		
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Date of Environmental Impact Assessment (if applicable)	22/06/2023		
Legal and/or Accreditation Implications	Unlawful use of restraint, and inappropriate techniques, open the Trust and its staff up to potential criminal or civil claims for assault, unlawful deprivation of liberty, and scrutiny from regulators		
Target Audience	All staff who may be required to implement restrictive interventions or restraint		
Review Date	June 2026		
Sponsor (Position)	Chief Nurse		
Author (Position & Name)	v2.0, Head of Safeguarding (Lisa Nixon) on behalf of Restrictive Practices Specialist (Rachel McCubbin)		
Lead Division/ Directorate	Corporate		
Lead Specialty/ Service/ Department	Nursing/ Safeguarding		
Position of Person able to provide Further Guidance/Information	Restrictive Practices Specialist		

Associated Documents/ Information	**Date Associated Documents/ Information was reviewed**
Appendix 2 – Assessment Tool and Care Plan for the Use of Mittens in Adult Patients	Reviewed alongside this policy (v2.0)
Template control	June 2020

CONTENTS

1.0 INTRODUCTION

Sherwood Forest NHS Foundation Trust (SFHFT/ The Trust) is committed to delivering the highest standards of healthcare, and ensuring the safety and welfare of its patients, visitors, and employees.
The Trust recognises that people's behaviour can escalate to the point where restrictive practices or restraint may be needed to protect that person, staff or other users of Trust premises and to prevent significant injury or harm. This policy is written to support staff in de-escalating the patient and providing a supported pathway in the use of restrictions and restraint.

The Trust;

- Acknowledges there will be occasions when an individual's behaviour may necessitate the use of restrictive practice or restraint
- Recognises that the object of restraint is to maintain the safety of the person being restrained, staff and public present, whilst establishing an appropriate degree of control of the situation.
- Advocates that the use of restrictive practices or restraint will only be considered when all other practical means of managing the situation, such as de-escalation, verbal persuasion, distraction and consideration of medical and physical causes have been unsuccessful in the circumstances.
- Believes that the management of difficult and challenging behaviour requires decency, honesty, humanity and respect for the rights of the individual whilst being balanced against the risk of harm to themselves, staff and members of the public.
- Expects that restrictions and restraint used should be proportionate, reasonable and necessary. This will be the least restrictive, for the shortest time possible and focus on person centred care, and de-escalation at all times.
- Will review incidents where restraint is deployed, to ensure that the restraint used is reasonable, proportionate and necessary. In line with 'Use of Force legislation'.

In addition, the Trust recognises that there will be circumstances where children and young people require restrictive physical intervention and therapeutic holding, managed in a safe controlled manner, for procedures, treatment, safety and care delivery.

This policy relates to the de-escalation and supported use of restrictive practices of patients by Trust staff as a last resort.

This policy is intended to provide guidance in relation to the nature, circumstances and use of restrictive practices, including training and techniques currently adopted by the Trust. Its aim is to help all involved to act appropriately, in a safe manner and, to ensure effective responses in potential difficult situations. It sets out a framework of good practice, recognising the need to ensure that all legal, ethical and professional considerations have been taken into account.

The policy covers all staff and persons within SFHFT, and others who are acting on behalf of the Trust, including Trust contractors and sub-contractors. It covers interventions for adults, children and young people. Sections will be divided where specific strategies are required due to age or presentation.

2.0 POLICY STATEMENT

This policy is intended to provide staff with supportive guidance on de-escalation techniques and understanding the use of restrictive interventions and restraint, to practice in accordance with the law, professional standards and Trust policy.

Its aim is to help all involved act appropriately in a safe manner and to ensure effective responses in potential difficult situations, with a focus on using the least restrictive option available, if de-escalation has not been successful.

Decisions about restrictive practices or restraint are not easy or straightforward. It is acknowledged that decisions in urgent and emergency situations may have to be made quickly and without consultation with colleagues. Sometimes such interventions may lead to complaints by patients or their relatives.

Unlawful restraint may give rise to criminal or civil liability. It is self-evident that staff may be required to account for their actions in such circumstances. However the Trust will always support employees who act in a way that is deemed reasonable and measured at the time of the incident and in accordance with professional standards, training and current legislation.
This policy, in line with the Trust's values promotes patient centred care and services whilst providing a safe environment, including respect and compassion, whilst focusing on continuous improvement in the pursuit of excellence.

3.0 DEFINITIONS/ ABBREVIATIONS

The Mental Capacity Act 2005 (MCA) defines restraint as when someone "uses, or threatens to use force to secure the doing of an act which the person resists, OR restricts a person's liberty whether or not they are resisting". Section 6 of the MCA states that restraining people who lack capacity will only be permitted if, in addition to it being in their best interests, the person taking action reasonably believes that it is necessary to prevent harm to the person. In addition, the amount or type of restraint used, as well as the amount of time it lasts, needs to be proportionate to the likelihood and seriousness of potential harm.

Definitions of the types of restraint are outlined below:

- **Physical restraint:** any direct physical contact where the intention of the person intervening is to prevent, restrict, or subdue movement of the body, or part of the body of another person.
- **Prone restraint**: (a type of physical restraint) holding a person chest down, whether the patient placed themselves in this position or not, is resistive or not and whether the person is face down or has their face to the side. It includes being placed on a mattress face down while in holds; administration of depot medication while in holds prone, and being placed prone onto any surface.

- **Chemical restraint** the use of medication which is prescribed and administered for the purpose of controlling or subduing disturbed/violent behaviour, where it is not prescribed for the treatment of a formally identified physical or mental illness.
- **Mechanical restraint:** the use of a device (e.g. belt or cuff) to prevent, restrict or subdue movement of a person's body, or part of the body, for the primary purpose of behavioural control.

Principles: *Positive and Proactive Care* states that: "The legal and ethical basis for organisations to allow their staff to use restrictive interventions as a last resort is founded on eight overarching principles". These are:

- Restrictive interventions must never be used to punish or for the sole intention of inflicting pain, suffering or humiliation.
- There must be a real possibility of harm to the person or to staff, the public or others if no action is undertaken.
- The nature of techniques used to restrict must be proportionate to the risk of harm and the seriousness of that harm.
- Any action taken to restrict a person's freedom of movement must be the least restrictive option that will meet the need.
- Any restriction must be imposed for no longer than absolutely necessary.
- What is done to people, why and with what consequences must be subject to audit and monitoring and must be open and transparent.
- Restrictive interventions must only ever be used as a last resort.
- People who use services, carers and advocate involvement is essential when reviewing plans for restrictive interventions.

4.0 ROLES AND RESPONSIBILITIES

Title	Organisational Role	Key Responsibilities
Trust Board	Strategic	Strategic overview and final responsibility for setting the direction of this policy Ensure that it fulfils its statutory responsibilities
Chief Executive	Executive Lead	The Chief Executive has overall responsibility for all Trust polices and ensuring an appropriate process for the production, management and monitoring of polices is in place
Chief Nurse	Executive Lead	The Chief Nurse is responsible for the Trust strategic direction for this policy. Agree action plans to address issues relating to this policy. Updating the Trust Board regularly on issues relating to restraint.
Executive Medical Director	Executive Lead	The Executive Medical Director is responsible for ensuring that there is an up to date policy that meets both legal and best practice guidance and that professional conduct relating to consent is maintained.

Triumvirate	Operational	Will be responsible for implementing this policy at local level.
Matrons /ward Leaders	Operational	The Matrons across the Trust will support the Chief Nurse in the operational implementation of this policy and support the process of risk management and incident reviews as required. They will ensure that any restraint is recorded via the DATIX process.
Restrictive Practices Specialist Practitioner/ Restrictive Practices Specialist Practitioner/ Accredited Security Management Specialist Restrictive practices trainer/ advisor	Operational	Provide appropriate training to staff across the Trust. Ensure that security staff respond, support and assist staff as required and to ensure a restraint is always clinically led (clinical lead and supervision) Review all DATIX raised around restraint or restrictive interventions, provide overview and learning from incidents involving restraint. Liaise with relevant external agencies as appropriate. Be involved in the de-brief and any subsequent follow up activity. Provide regular updates to the Risk Management Group. Ensure security involvement in planning the Trust response to an expected situation where the need for restraint is considered probable. Advise the Trust and its employees on any change in security legislation or guidance around restraint. Identify training needs of security staff in relation to restraint Ensure all security staff apply a uniform approach to a request for restraint. Ensure the Risk Committee are kept fully informed of any incidents, the outcome and any learning that needs to take place. Identify from incident data and risk assessments all high risk areas and support managers to implement appropriate arrangements. To deliver restrictive practice training to risk assessed areas of the Trust
The Person in Control	Operational	The person leading the implementation of any restrictive intervention will ensure this is clinically led (Doctor, Registered practitioner, Nurse looking after patient, ward sister/ charge nurse or Duty Nurse Manager) and will: • Assume the lead role for any restraint that does take place, which is informed by an assessment of risk and clinical judgement. • Have a sufficient understanding of restraint processes, Use of Force legislation and the law, and of this policy to **ensure** a satisfactory outcome for all involved. • Inform appropriate medical staff and the Duty Nurse Manager with appropriate urgency.

		• Ensure that wherever possible de-escalation techniques are used throughout a restraint process • Request that Security and / or the Police attend if the incident requires and clinically lead this. • Arrange for family, friends or carers to be contacted / be involved if they may have a calming influence on the patient • Ensure the intervention is reported via DATIX. • Undertake a post incident debrief
Security Staff		For such a situation where restraint may be required a minimum of 2 security personnel are required to assist the nursing team. • The security staff must be trained in IKON techniques and restraint as per Trust requirements and National Standards. • Must be clinically led - liaise at the scene with medical/nursing staff to transfer information and receive instruction from the clinical team. • Security staff can restrain if it is the only option available to reduce the risk to themselves and others including to allow medication to be administered when instructed by the clinical team. Security staff called for assistance to facilitate a restraint must always be under clinical supervision. All nursing staff are trained in Basic Life Support and one member of staff will be allocated this observation role. This person must remain responsible for ensuring the patients well- being and overseeing the restraint (clinical lead). • Security staff may prevent a patient leaving the area/hospital if they are advised by the senior nurse/manager present or if the patient has been assessed as lacking mental capacity to decide whether to leave, and must be prevented from leaving either in their best interests, or because a Deprivation of Liberty Safeguards authorisation is in place.
All clinical staff		All clinical staff will ensure that they have read and adhere to this policy as and when required. The member of staff identifying the challenging behaviour (including violent/ aggressive behaviour) or intent will: • Attempt to de-escalate by reassurance and other means. • If de-escalation is failing then notify Security Services at once and take reasonable steps to ensure safety of patients, visitor and staff is protected • Ensure all restrictive practices are clinically led • Wherever possible and if it is safe do to so move other patients away from the vicinity • Report the incident to the Person in Control of the area

5.0 APPROVAL

This policy has been approved by the Safeguarding Steering Group

6.0 DOCUMENT REQUIREMENTS

6.1 Legal Requirements

6.1.1 Legal framework

The legal framework underpinning the lawful use of restraint is complex and underpinned by the Human Rights Act 1998, with various statutes and the common law making restraint lawful in certain situations:
Mental Capacity Act 2005 (MCA), and particularly by the Deprivation of Liberty Safeguards (DOLS) which were added in 2009. The requirements of the legislation can pose challenges to the provision of patient care, support and treatment in a health care.

Mental Health Act 1983 (MHA) for those who fulfil the criteria for detention – largely sections 2, 3, 4 and 5(2). Where applicable restraint is only lawful to further the management of the underlying mental health disorder.

Criminal Law – section 3 of the criminal law act 1967 states that 'a person may use such for as is reasonable in the circumstances in the prevention of crime'.

Common law - Common Law recognises that there are many circumstances in which one person may use force upon another without committing a crime (for example in self-defence). Common Law provides a potential defence for a person's physical actions provided that:

- The use of force was necessary
- The person's use of force was reasonable in the circumstances
- The level of force was proportionate to the amount of harm likely to occur

The doctrine of necessity gives a general power to take steps that are reasonable, necessary and proportionate to protect people from the immediate risk of significant harm, whether or not the patient lacks capacity to make decisions for himself.

Police officers have certain additional powers

Use of force - All uses of force must be rights-respecting, lawful and compliant with the Human Rights Act 1998. Human rights are the fundamental freedoms and protections which everyone is entitled to. They cannot be taken away; but some rights can be restricted in specific circumstances for a legitimate reason, as long as that restriction is proportionate. Some rights, including freedom from torture, inhuman and degrading treatment are absolute and can never be restricted. Understanding the legal rights and responsibilities could help to speed up your decision-making process and increase the likelihood of a safe, effective solution. If the situation continues to escalate then you may be required to resort to force. Any force used should be reasonable, necessary, proportionate and justifiable in

the circumstances. If force is used, you must be able to account for your actions and ensure that they're recorded as soon as possible.

Self-defence is part of private defence; the doctrine in English law that states you can act in ways that otherwise would be illegal to prevent injury to yourself or others, or to prevent crime. You have the same right to act to protect others as to protect yourself. This defence arises both from Common Law and the Criminal Law Act.

MCA applies to all people over the age of 16 years of age. See the Trust's MCA Policy

6.1.2 Legal distinctions

The MCA and the DOLS operate to differentiate patients into three categories:

1. Patients who have the capacity to consent to the use of a method of restraint;
2. Patients who lack the capacity to consent to the use of a method of restraint, and for whom the use of such restraint would constitute a **restriction** of their liberty; and
3. Patients who lack the capacity to consent to the use of a method of restraint, and for whom the use of such restraint would constitute a **deprivation** of their liberty.

Distinguishing between the second and third category (i.e. between restriction and deprivation of liberty) is vital in determining whether the use of restraint is legally defensible, and this distinction is one of degree rather than the nature of the restraint.

In practice, restrictive practice may restrict or deprive a patient's liberty, depending on the extent of its use, and the degree to which it stops them doing something they would otherwise want to do. In other words, the same restrictive practice may be used in different ways with the consequences of a restriction or deprivation of liberty.

If an appropriate scenario is identified in which it is believed that a patient will need to be deprived of their liberty in hospital, in his/her best interests and to prevent him/her from coming to harm, the Trust (the 'managing body') must review the case and apply to Nottinghamshire County Council (the 'supervisory body') for a Deprivation of Liberty Safeguards (DOLS) authorisation. (Please see the Mental Capacity Act Policy for instructions on how to seek a DOLS authorisation). Staff may also contact the Trust's Legal Services Department for advice in this matter.

6.1.3 Legal issues of physical restraint in acute hospital:

Patients with decision-making capacity

As with all health-care interventions, a patient is presumed to have the capacity to give or refuse consent to the use of a particular restrictive practice, unless there is evidence that he/she is unable to understand, retain and weigh up information and then communicate a decision due to an 'impairment of, or a disturbance in the functioning of, [his/her] mind or brain'. A patient's capacity to make such a decision will depend on the nature of the decision and may fluctuate over time.

Patients whose decision-making capacity is not impaired, and who are refusing to give consent to a particular restrictive practice being used, cannot be restrained against their

will, even if their decision appears to be unwise. The only exemption to this general rule is in those situations in which the act of restraint prevents immediate and serious harm to themselves or to other people.

Person's requiring interventions whilst on hospital sites

There may be occasions where a person on the hospital site but not a patient becomes unwell or displays behaviours that lead staff to believe there may be a risk to themselves or other people within the facility. Decisions regarding interventions need to be made using the principles of common law/ criminal law as identified within the legal definitions paragraph above.

Patients who lack decision-making capacity and whose liberty is being restricted

Some patients admitted to hospital will be physically unwell and suffering a disorder of the mind (such as delirium or dementia), which means they may lack the capacity to make certain decisions about their care. If incapacity is established using the test from the MCA (see Mental Capacity Act Policy **Mental Capacity Act (MCA) Policy)** then such a patient must be treated in his/her best interests, a judgment made after examining, among other things, the patient's known beliefs and values, and consulting people involved in the patients care/life. If restraint is used, it must only be in the patient's best interests and the least restrictive alternative but must also (a) act to prevent him/her from coming to harm and (b) be of a type and degree that is proportionate to the risk of him/her suffering harm.

Patients who lack decision-making capacity and who are being deprived of their liberty

The introduction of the DOLS as an amendment to the MCA, acknowledges that, in some cases, patients who lack decision-making capacity will require care to be provided in ways that deprive them of their liberty, in order to act in their 'best interests', and to prevent them from coming to harm.

The **DOLS** is a regulatory procedure that provides the lawful basis for necessary deprivations of liberty, in order to ensure that health and social care practice is consistent with the requirements of the Human Rights Act 1998. DOLS are relevant to acute medical settings in circumstances, such as the management of behavioural changes after head injury or cerebrovascular accident, where patients may be kept in hospital for a long period under close supervision and restrained if they attempt to leave the ward or engage in repeated episodes of self-harm. The DOLS are not, however, an appropriate way of managing short-term mental disorder (e.g. delirium), or behavioural problems, caused by physical illness when the treatment of the physical illness is likely to lead to a rapid resolution of the mental disorder or behavioural problems

Deprivation of Liberty Safeguards (DOLS) Policy (for adults 18 years and over)

6.2 Behaviour

6.2.1 Managing Challenging Behaviour

By understanding what causes challenging behaviour it is sometimes possible to deescalate the situation and avoid using restraint. We are all capable of displaying challenging behaviour when faced with certain situations. It is a reaction to what is happening around us and a way of communicating our emotions when we may not be able to do so verbally.

There are certain groups of people who are much more likely to communicate through their behaviour for example people with dementia, learning disabilities, sensory impairment and mental health problems. We also need to be aware of other factors. Below are some examples that can change a person's behaviour to be more challenging to us.

All staff should be aware of the following factors that may provoke disturbed/ violent behaviour:

- Boredom and lack of environmental stimulation
- Too much stimulation, noise and general disruption
- Excessive heating, overcrowding and lack of access to external space
- Personal frustrations associated with being in a restricted environment
- Difficulties in communication
- Emotional distress eg following bereavement
- Antagonism, aggression or provocation on the part of others
- The influence of alcohol or drugs
- Physical illness
- Unsuitable mix of patients

Successful management of challenging behaviour is underpinned by understanding the reasons for the behaviour and the identification of appropriate interventions which staff can use when interacting with the patient.

The gradual resolution of a potentially violent and/or aggressive person using verbal and physical expressions of empathy, alliance and non-confrontational limit setting base on respect is essential (RCN 2013).

The use of de-escalation techniques must be the primary strategy when faced with an escalating situation. De-escalation or diffusion refers to talking with or distracting an angry or agitated person in such a way that violence is averted and the person regains sense of calm (NICE 2015).

6.2.2 Behaviour, Escalation and Underlying Condition

Understanding a patient's behaviour and responding to individual needs must be at the centre of patient care. All patients must be assessed comprehensively to establish what sort of therapeutic behaviour management might be of benefit. This will involve identifying any underlying cause of the behaviour (agitation, wandering, absconding etc.) and deciding how best to manage the behaviour

Possible clinical causes to consider include but not limited to:

- Need to empty bladder or bowel
- Anxiety or distress
- Mental illness – (e.g. dementia, schizophrenia)
- Delirium (acute confusion) due to:
- Infection/ Pyrexia
- Hypoxia
- Electrolyte or metabolic imbalance
- Pain or discomfort
- Constipation/dehydration
- Hypotension
- Other form of memory impairment
- Drug dependency or withdrawal (including alcohol, nicotine, sleeping tablets and illicit drugs)
- Brain insult/injury or cerebral irritation
- Reaction/side effect of medication
- Intoxication (due to alcohol, drug overdose or drugs of abuse)
- Pregnancy and postnatal conditions
- Communication; religious and cultural issues
- Impact of Disability, Learning Difficulties

 **Any new agitation or confusion in a patient must be flagged up and documented in accordance with the Trust Policy for Performing and Responding to Observations in Adult Patients within the National Early Warning System / NEWS assessment.**

If a patient is queried to have mental health issues, the mental health liaison services must be contacted for advice and support. Often behaviour can be problematic for staff; however this does not necessarily mean that preventing this behaviour is in the best interests of the patient concerned.

For additional information on the assessment and management of behavioural problems and managing agitation in patients with dementia see the Dementia Care Pathway and supporting assessments.

Having identified the reason for the behaviour, the Clinical Team must then decide on the appropriate strategy for managing this in conjunction with other members of the multidisciplinary team (to include treatment of the underlying cause). This must be documented in the medical or nursing/multidisciplinary notes or on the “request for consultation” (as appropriate).

Where these strategies for behaviour management are unsuccessful restraint or restrictive interventions may become necessary – but remember these must only be used as a last resort.

6.3 Types of Restraint

Restraint is an intervention that prevents a person from behaving in ways that threaten to cause harm to themselves, to others, or to property. Restraint can occur in a number of ways including:

- Physical restraint
- Mechanical Restraint
- Pharmacological or chemical restraint
- Rapid tranquilisation

6.3.1 Physical Restraint

"Any direct physical contact where the intervener's intention is to prevent, restrict, or subdue movement of the body, or part of the body of another person"
(Positive & Proactive Care: reducing the need for restrictive interventions. DoH - April 2014)

- The use of Physical restraint must be reported on the DATIX incident reporting system when there is: - direct physical contact, with or without resistance.

- Where the intention is to prevent, restrict or subdue movement of the body, or part of the body of another person, by two or more staff.

Careful deliberation must precede the application of this practice and an assessment of mental capacity must be undertaken. The use of physical restraint does not ensure patient safety and staff must be aware of the need for vigilance and constant supervision of these patients at all times.

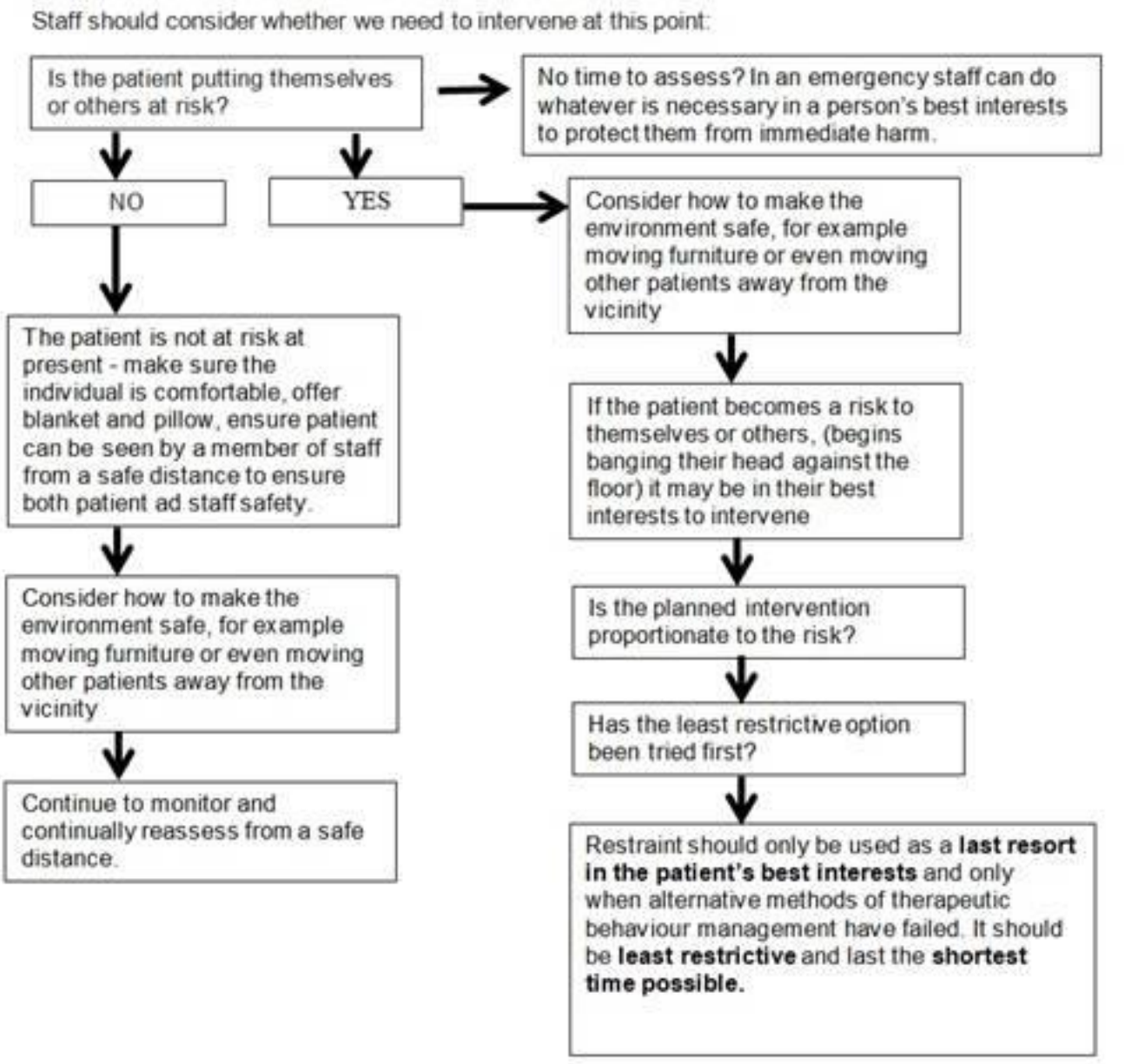
Bedrails Policy.

The Mental Capacity Act (2005) Section 6(4) of the Act states that someone is using restraint if they: use force - or threaten to use force - to make someone do something that they are resisting, or restrict a person's freedom of movement, whether they are resisting or not.

It adds restraint is only permitted if the person using it reasonably believes it is necessary to prevent harm to the person who lacks capacity and if the restraint used is a proportionate response to the likelihood and seriousness of the harm

Even if an individual's behaviour potentially presents a risk to themselves or others, colleagues must always consider the least restrictive option. For example, by taking steps to make the environment safe that the individual is in, we may reduce the overall risk and as a result mitigate and avoid the need for restraint.

Please see assessment flow chart example below:



Any staff using physical restraint must:

Wherever possible use de-escalation techniques irrespective of the stage of the restraint.

Ensure that the nurse in charge/registered professional **leads the team and assumes overall control of the person being restrained** throughout the process (person in control). If the Security Team have been contacted to support the lead must provide a full handover and instruction of what support with restrictive practice is required from the security team. He or she must ensure that;

- The Head and neck is appropriately supported and protected
- The Airway and breathing are not compromised
- The person's overall physical and psychological well-being Is monitored throughout.
- For safety reasons, during the restraint it is only permissible to hold / apply pressure to the person's limbs. Under no circumstances must direct pressure be applied to the neck, thorax, abdomen, back or pelvic area, due to the risk of positional asphyxiation.
- Every effort must be made to use skills and techniques that do not use the deliberate application of pain.
- The level of force applied must be reasonable, necessary and proportionate to the specific situation, and must only be applied for the minimum amount of time.
- The person is physically monitored throughout the incident. Post-restraint, the person who has been restrained will be reviewed for placement on the enhanced observations pathway as identified by clinical staff. During this time physical observations must be recorded. staff must be aware of the possibility of restraint/positional asphyxia.

Prone Restraint

Prone restraint must be avoided - due to the risk of positional asphyxia.

'People must not be deliberately restrained in a way that impacts on their airway, breathing or circulation The mouth and/or nose must never be covered and techniques should not incur pressure to the neck region, rib cage and/or abdomen. There must be no planned or intentional restraint of a person in a prone/face down position on any surface, not just the floor.'

Para 70 DOH – Positive and Proactive Care: reducing the need for restrictive interventions

Restraint on the ground

An individual must never be taken to the floor during a restraint. However, if the incident ends up on the floor or with the patient in a prone position, this must only be used for the shortest period of time possible and only for the purpose of gaining reasonable control. The individual must be turned over onto their back (supine) or sat up as soon as practicably possible.

6.3.2 Mechanical Restraint

Bedrails must only be used following assessment of need and to safeguard patients. Bedrails are not to be used as a form of restraint where restraint is defined as: 'the intentional restriction of a person's voluntary movement or behaviour'. Bedrails will not prevent a patient from leaving their bed or falling elsewhere and must not be used for this purpose. For further information see Trust bedrails policy

Mechanical restraint in the form of mittens must only be used as a last resort when all other less restrictive options have been tried and failed.

6.3.2 a) Mittens

Use of mittens for mechanical restraint
Prior to considering use of mittens for mechanical restraint all less restrictive options must have been explored. These include alternative routes of medication administration, re-siting of lines (e.g. intravenous/ NG tube/ tracheostomy), 1:1 nursing, and distraction therapy.

Mechanical restraint devices must never be used as a substitute for any of these measures, when there are other non-restrictive measures available to adequately manage the situation or need.

The use of mechanical restraint does not negate the need for 1:1 nursing observation

Indications for use of mittens in all in-patient clinical areas:

Some patients need specific supportive treatments in hospital e.g. feeding tubes; intravenous lines, tracheotomy tubes to support airway. At times additional care is needed to maintain this vital support where patients feel it is an irritant and make attempts to remove tubes or lines. Tubes may be placed to provide fluid, medications or nutrition to a patient. Other tubes facilitate breathing, assist in maintaining heart rate, or support elimination. Restriction of a patient's movements is only considered when a patient attempts to remove tubing puts them at risk of significant harm. This can often be because of restlessness or confusion.

Absolute contraindications to mechanical restraint:

- Any patient with unstable orthopaedic injuries
- Insufficient number of nurses on a shift to have a 1:1 nursing ratio
- Insufficient staff that are trained to use the restraint
- Over a renal shunt.

Relative contraindications to physical restraint

- Patients who are anti-coagulated or have a coagulopathy.
- Open wounds or skin grafts on affected limbs
- General condition of the patient's skin and increased 'Waterlow Score' must prompt consideration as to whether physical restraint is appropriate for the patient. (mittens do not restrict movement)

The mechanical restraint option of applying the mittens must have been agreed with the patient's Consultant/Lead Clinician on duty, Site Coordinator (out of hours, the Night Team Leader), and discussed with the patient's relatives/carer (this must take place as part of the decision-making process or at the earliest opportunity).

On initiation of using mittens (mechanical restraint), the Site Coordinator/Night Team Leader must report this immediately via the Trust's Incident Reporting system. The Head of Nursing responsible for the clinical area must be verbally informed as soon as possible of this decision.

Applying Mittens

- The patient's mental capacity must have been assessed and recorded using the 2 stage test MCA (2005) code of Practice (Chapter 4) and the decision to apply the mittens must have been made in the patient's best interest and must satisfy MCA (2005) code of Practice chapter 6 as described. The best interest decision must include the physical restraint algorithm, Appendix 1.
- The mitten device is used to restrain patient's hands. This aims to prevent patients from dislodging invasive equipment, removing dressing, or scratching. Inspect hand and wrist area where restraint is to be placed. Assess condition of skin underlying area on which restraint is to be applied. This will provide baseline observation to monitor patient's skin integrity

Restraints must not be placed over access devices such as an arterial line or an AV dialysis shunt.
Nurses must be familiar with the devices used for patient care and protection.
Only 'Peekaboo' mittens are approved for use in the Adult In-patient clinical areas. Incorrect application of restraint device may result in patient's injury or death.

Procedure

- Approach the patient in a calm, confident manner and explain what you plan to do.
- Have the appropriate equipment ready
- Provide privacy & ensure dignity is maintained throughout.
- Be sure patient is comfortable and in the correct anatomical position. This is to prevent contractures and neurovascular impairment (this is particularly relevant to CCU)
- Pad skin and bony prominences (if necessary) that will be under the restraint. This will reduce friction and pressure from restraint to skin and underlying tissue.
- Apply selected restraint. **Always refer to manufacturer's instructions.**
- Correct placement of restraint, skin integrity, pulses, temperature, colour, and sensation of the restrained body part **must be assessed at least hourly.** Frequent assessments prevent complication, skin breakdown, and impaired circulation.
- Restrained patients must **never** be left unattended. They will be cared for with a 1:1 nurse patient ratio. Hence mittens are an addition to 1:1 care not an alternative.
- Restrained patients must have the circulation checked hourly under the mittens and this must be documented on the care plan.

- The patients care plan must reflect the management of the mittens and refer to this as a form of restraint.
- For documentation/ record keeping use Appendix 2: Assessment Tool and Care Plan for the Use of mittens in Adult Patients available to print from the intranet.

b) Nasal Bridles

- Refer to the Appendix for Safe practice for the Insertion and Management of a Nasal Bridle (NB) in adults to secure a NGT in the Trust's Nasogastric/ Nasojejunal Feeding Tubes Policy

c) Mechanical Restraint by Police, Prison Service or other approved agency

Where patients are already lawfully detained by law enforcement agencies, the use of handcuffs or other restraint to prevent escape must be considered by those providing health care, against the risks they create to the patient, their best interests, and the practicalities of administering treatment. Suitable compromise must be negotiated. If agreement cannot be reached or there are on-going concerns about patient safety these must be immediately escalated up the law enforcement team's hierarchy. Any on-going concerns must be discussed with the Trust's legal team.

6.3.3 Pharmacological or Chemical Restraint

Chemical restraint refers to the use of medication, prescribed and administered for the sole purpose of quickly controlling or subduing disturbed/violent behaviour, where it is not prescribed for the treatment of a formally identified physical or mental illness. It must not be used routinely or as a first response, except in circumstances where a child, young person or adult is highly aroused, agitated, overactive, aggressive, and is making serious threats towards others, or is being destructive to their surroundings, and when other therapeutic/ restrictive interventions have failed to contain their behaviour. An antipsychotic, antidepressant, or both must not be prescribed in response to challenging behaviour without an appropriate clinical reason.

Chemical restraint must be used as part of an agreed support plan, must be delivered in accordance with evidence-based best practice guidelines and administered by staff with the relevant qualifications, skills and experience to administer it. Prescribers must provide information, to those who provide care and support; to include any physical monitoring that may be required, in addition to information about the medication to be used, and how it must be administered (the route of medication).

Special Circumstances –Critical Care

Within Critical Care the use of or titration of sedative medication is a routine and necessary way of safely managing patients with delirium as a result of their illness or pre-existing mental health conditions. This management is used across all age ranges to ensure they remain compliant with critical care treatment to prevent the pulling out of essential lines / airways which would result in serious or catastrophic harm to the patient, management of this kind would not be subject to the guidelines above

6.3.4 Rapid Tranquilisation

Rapid tranquilisation is defined by the NICE (DH 2005) as "the use of medication to control severe mental and behavioural disturbance, including aggression associated with the mental illness of schizophrenia, mania and other psychiatric conditions. It is used when other less coercive techniques of calming a service user, such as verbal de-escalation or intensive nursing techniques, have failed. It usually involves the administration of medication over a time-limited period of 30-60 minutes, in order to produce a state of calm/light sedation". See page 22 for the specific management of children and young people.

Special Circumstances –Critical Care

This may not be the case in ICU as it may be a rapid injection or increase in existing IV sedatives

Rapid Tranquilisation in children

A decision to initiate rapid tranquilisation in children must only be made by a consultant paediatrician

For information on rapid tranquilisation, see the Trusts Acute Confusion/Delirium in Adults (including Rapid Tranquilisation) – Guideline for Detection and Management

6.4 Unacceptable Methods of Restraint

The following methods of restraint are unacceptable. However, if the patient requests or is consenting to any of the following, it may be considered, applied as appropriate and clearly documented. Inappropriate use of restrictions may be viewed as abuse and a safeguarding concern. The following list is not exhaustive.

6.4.1 Inappropriate bed height

This is an unacceptable form of restraint; it also increases the risk of injury resulting from a fall out of bed.

6.4.2 Inappropriate use of wheelchair safety straps

The safety straps on wheelchairs must always be used, when provided for the safety of the user. However, patients must only be seated in a wheelchair when this type of seating is required, not as a means of restraint.

6.4.3 Using low chairs for seating

Low chairs must only be used when their height is appropriate for the user, they must not be used with the intention of restricting a person's movement. Low chairs also pose a potential risk to staff in relation to manual handling.

6.4.5 Chairs whose construction immobilises patients

Reclining chairs and bucket seats must be used for the comfort of the user and not as a method of restricting movement.

6.4.6 Locked doors

On the occasion that doors are locked, clear signage must be displayed informing patients and the public that doors are locked, and inform them who they must ask to have them unlocked to be able to exit the ward. If a wants to leave and being prevented by the locked door that patient is being restricted.

6.4.7 Arranging equipment/furniture to impede movement

Any equipment, including furniture, must only be used for the purpose for which it is intended and not positioned in a way that would restrict a persons movement. Other methods of dealing with behaviours, such as wandering for example must be pursued.

6.4.8 Inappropriate use of night clothes during waking hours

This is demeaning and must not be used as a way of restricting a persons movement.

6.4.9 Removal of outdoor shoes and other walking aids and/or the withdrawal of sensory aids such as spectacles

These are all unacceptable, Removal of sensory aids can cause confusion and disorientation.

6.4.10 Planned prone physical restraint

The utilisation of a planned prone restraint must not be used. Utilisation of seated, supine or the release of person to be considered as alternatives

6.5 Decision making and Assessment

Individual assessment must be carried out that considers:

The patient's behaviour, reason for that behaviour, underlying condition and treatment

- Understanding a patient's behaviour, the reason for that behaviour and responding to their individual needs must always be at the centre of patient care. All patients must be thoroughly assessed to establish what therapeutic behaviour management interventions may be of benefit.

The patient's mental capacity and/or mental health

- The patient's mental capacity must be assessed as consent must be gained from patients to use any type of restrictive practice, unless they lack capacity to make this decision, and the restrictive practice is sanctioned under the Mental Capacity Act or the Mental Health Act or in line with common law and the right of self-defence and defence of another.

The environment

Every effort must be made to reduce the negative effects of the care environment. Examples of negative environmental factors include: High levels of noise or disruption, inappropriate temperature, inappropriate levels of stimulation, negative attitudes of care staff, poor communication skills.

The risks to the patient and to others

- When using restrictive practices, a balance must be achieved between minimising risk of harm or injury to the patient and others, and maintaining the persons dignity, personal freedom and choice. Example: If there is risk of the patient weaponising objects and posing a risk to themselves or others the least restrictive option may be removing all objects from the room to mitigate the risk and therefore mitigate the use of restraint.

Assessment must always place the individual at the centre of the process, involving them and those who are important to them in their lives, as is practical to do so. Evidence of a person centred approach to assessment and planning must be recorded.

If a restrictive practice is deemed appropriate the following points must be considered

- It must be absolutely necessary in order to protect the health and wellbeing of the individual or to protect the safety or human rights of others (patients, staff, and visitors, public).
- All individuals who may be affected must be involved in the decision making process to the fullest possible extent of their understanding.
- It must be proportionate, i.e. the least restrictive practice required to achieve the aim.
- Principles of dignity and respect must be observed during the implementation of any restrictive practice

- The effectiveness in meeting its aims must be continually reviewed and the restrictive practice must only continue for as long as it remains both necessary and effective.
- If the patient has capacity to give valid consent and their consent can be gained, without undue pressure, the restriction can be put in place, as long as it does not contravene the law. It must be remembered that the person has the right to withdraw their consent and they must be informed of this right from the outset.
- If the person withdraws their consent but it is felt that the restriction must continue, this can only be achieved if the practice is sanctioned under law; examples include the Mental Capacity Act, Mental Health Act, Criminal Law, common law and Public Health Act.
- The Deprivation of Liberty Safeguards (DoLS) 2007 (came into force 2009). DoLS are an amendment to the Mental Capacity Act (2005). DOLS provide a legal framework, to protect those who may lack the capacity to consent to the arrangements for their treatment or care, where levels of restriction/ restraint used in delivering that care are so extensive to be depriving the person of their liberty

See application in practice flow chart Appendix 1 – to support decision making

6.6 Physical Monitoring

Physical Monitoring is important during and after restraint.

Vital signs monitoring must be undertaken by the Clinical Team in attendance. Observations must include Pulse, Blood Pressure, Respiration, SPO2, GCS etc. The nurse in charge must ensure that this is completed and is documented in the Plan of Care.

This is especially important:

- Following a prolonged or violent struggle
- If the person has been subject to enforced medication or rapid tranquilisation
- If the person is suspected to be under the influence of alcohol or elicit substances
- If the person has a known medical condition which may inhibit cardio-pulmonary function e.g. obesity, asthma, heart disease etc.

6.7 Post Restraint Arrangements

Post Incident Support

A de-brief must take place as soon as practicably possible post-incident unless there are exceptional circumstances preventing this.

The aim of a post-incident review is to learn lessons, support staff and patients, and encourage the therapeutic relationship between staff, patients and their carers.
The review must address:

- What happened during the incident
- Any trigger factors
- Each person's role in the incident
- Their feelings at the time of the incident, at the review and how they may feel in the near future
- Identify any concerns and What can be done to address these concerns

As soon as practicably possible following the use of physical restraint the staff involved should l meet together under the direction of senior nursing staff (nurse in charge) This time will be used to discuss any issues that may have been identified as well as reviewing the details of the incident itself. Any significant points raised must be documented and discussed with the practitioner for restrictive practices.

All persons involved in the use of physical interventions must be offered post-incident support by the appropriate line manager, and be involved in the debrief, support and feedback process.

The nurse in charge/ person leading the team must ensure the Trust's electronic Incident Reporting process (DATIX) is completed.

6.8 Restraint in Adult Critical Care Unit (ACCU) Only

There is a small population of critically ill adults who, once certain checks and balances have been completed, may benefit from the use of physical restraints in support of pharmacological measures in the management of their agitation / anxiety.

It is common for patients in critical care units to lack mental capacity, either temporarily or permanently. Many are sedated to help them tolerate their treatment. Particular problems can occur when sedation is being reduced during recovery, as patients may, for example, try to pull out their lines or disconnect themselves from vital life-supporting devices. It is generally accepted that in these circumstances, where a real risk of self-harm exists, restraint may be necessary.

Agitation and delirium are common in the intensive care environment and pose a significant risk to a patient's well-being. Effective management must involve a multi-disciplinary risk assessment based on harm vs. benefit. Indications for implementation of the guidelines include:

a) CAM –ICU assessment
b) Acute agitation unresponsive to other therapies

Mutual agreement between medical and nursing teams is necessary, as part of the package of care required in ensuring that appropriate care is carried out in a safe environment.

The aim is to minimise risk to the vulnerable patient, attenuate suffering and preserve patient dignity. A l restraint attached to the patient's limbs will be implemented to minimise risk to the patient.

- A l restraint - such as 'Peek a Boo' or 'Posi Mitts' (commercially available products).

ACCU Guidelines only:

- The senior nurse completes the risk assessment - reports the findings to the anaesthetic /medical staff and documents the same in patient's notes.
- Exclude or manage any identifiable organic causative factors e.g. hypoxia, hypoglycaemia, psychological disorders, neurological pathology, alcohol or drug withdrawal.
- Remove all non-essential devices.
- Ensure adequate analgesia / anxiolysis is provided and that sedation management issues are addressed.

- Ensure comprehensive communication where possible with patient and relatives, as well as other appropriate healthcare professionals. Document this in notes and if indicated seek advice from Legal Services and the Trust's solicitors.
- Ensure restraint is used for the shortest period possible. Reassess at timed intervals.
- Assess the use of restraint at the beginning of each shift and on each subsequent twice daily ward round. Document on risk assessment form.
- Ensure documentation is complete and filed in patients notes.
- Staff applying restraint must be trained and follow the restraint algorithm. Company representatives will provide training for commercially available restraint device.

Contra indications/Cautions:

- Radial renal fistulae.
- Un-plastered fractures of the arms.
- Severe arthritis of wrists / arms.
- Any operative sites on wrist / forearms in the vicinity of the restraint.
- Fractured clavicle / shoulder dislocation.
- Unstable spinal injury.

6.9 Restrictive practice in the care of Children and Young People (including paediatric and non-paediatric areas)

6.9.1 Overview

This section of the policy is designed to define therapeutic holding and restrictive physical intervention and allow the practitioner to ensure the care or treatment that they are offering is lawful, legitimate, and the least restrictive reasonable option available. Where the use of restraint/ clinical holding and containing children and young people is concerned, practitioners must consider the rights of the child and the legal framework surrounding children's rights.

The purpose of this part of the policy is to guide practitioners and enable them to carry out Restrictive Physical Intervention or Therapeutic Holding in a safe manner, which ensures minimal trauma and distress for the child/ young person and their family.

To highlight the necessity for the appropriate use of de-escalation technique, distraction, play therapy and alternatives.

To highlight the need for good communication, consent, training and documentation.

6.9.2 Scope

- This part of the policy applies to all staff undertaking restrictive intervention or therapeutic holding in the care of children/young people and infants.

6.9.3 Specific Definitions to Children and Young People

- **Restrictive physical intervention**: "Deliberate acts on the part of another person(s) that restrict an individual's movement, liberty and/ or freedom to act independently in order to: take immediate control of a dangerous situation where

there is a real possibility of harm to the person or others if no action is undertaken; and end or reduce significantly the danger to the person or others; and contain or limit the person's freedom for no longer than is necessary"

- **Therapeutic Holding:** This means immobilisation, which may be by splinting, or by using limited force. It may be a method of helping children, with their permission, to manage a painful procedure quickly or effectively.

Holding is a skill professionals use to carry out therapeutic interventions. It is not meant to be a quick alternative to carrying out care and must only be used as a last resort.

Therapeutic Holding is distinguished from restrictive physical intervention by the degree of force required and the intention.

Alternative terms for therapeutic holding include 'supportive holding' and 'clinical holding.'

6.9.4 Role of Individual Staff

All staff members are responsible for:

- Ensuring they have up to date training.
- Ensuring they have read and are complying with this policy and seeking advice if they are unsure of any aspect of their care.
- Ensuring they keep a record of events and plan of care for each patient.
- Ensuring they take all practical steps to comply with this policy when undertaking or assisting in interventions with children/young people.

6.9.5 Standards and Practice

The Principles of good practice

- Effective preparation, the use of local anaesthetic, sedation and analgesia, together with play specialist intervention and distraction techniques, successfully reduces the need for undue force in the use of proactive immobilisation - for example when holding a child's arm from which blood is to be taken or when administering an injection, in order to prevent withdrawal and subsequent unnecessary pain to the child.
- However, therapeutic holding without the child's consent or assent may need to be undertaken against the child's wishes in order to perform an emergency or urgent intervention in a safe and controlled manner – for example, in order to perform a lumbar puncture. When considering the use of sedation please refer to the RCHT Guidelines for the sedation of paediatric patients and young people.

General Principles

- Good decision making about restrictive physical interventions and therapeutic holding requires that in all settings where children and young people receive care and treatment there is:
- An ethos of caring and respect for the child's rights, where the use of restrictive physical interventions or therapeutic holding without the child's/young person's consent are used as a last resort and are not in the first line of intervention.

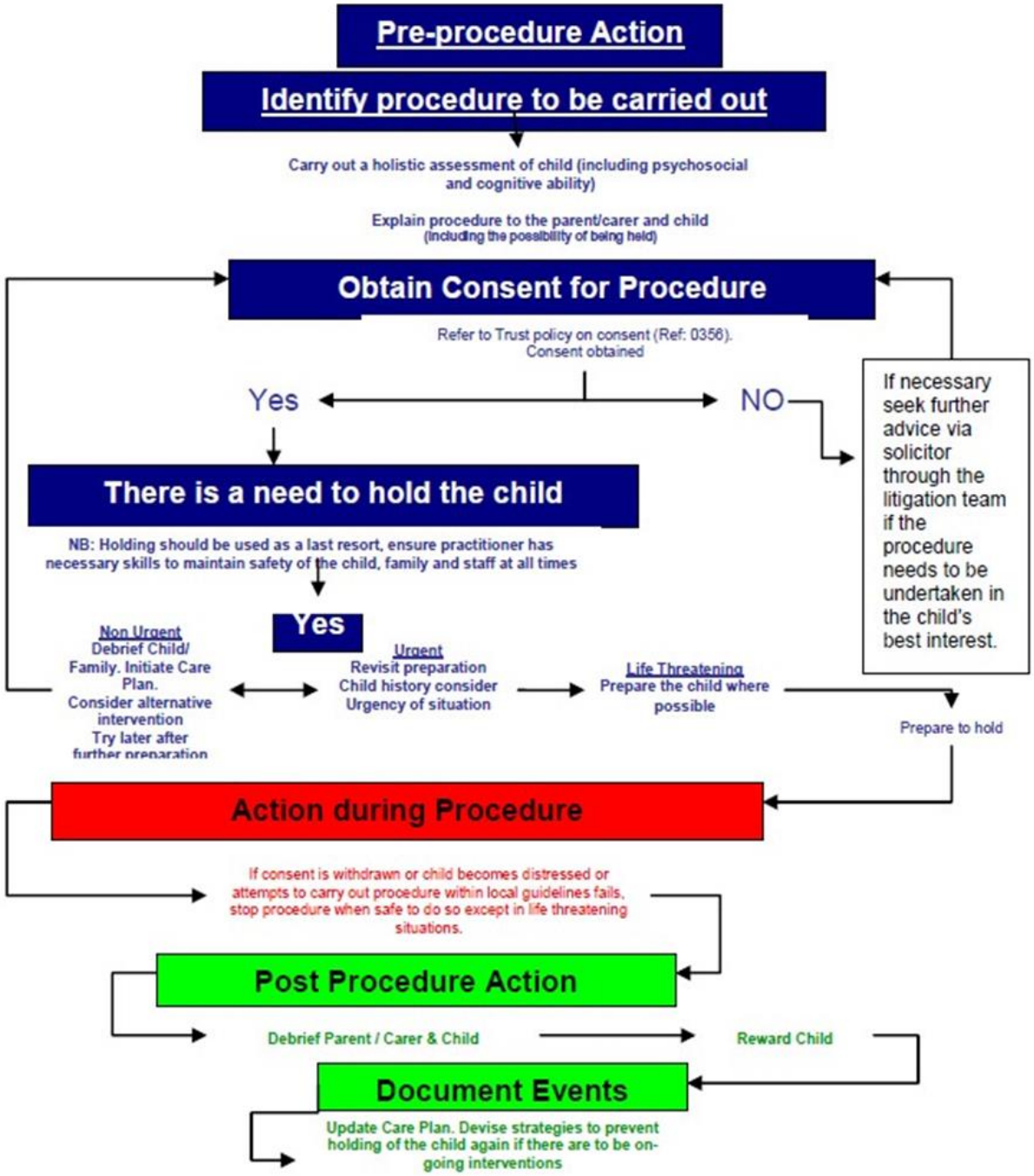
- A consideration of the legal implications of using restrictive physical intervention, where necessary, application must be made through the Family Courts for a specific issue order outlining clearly the appropriate restraint techniques to be used.
- Openness about who decides what is in the child's best interests – where possible, these decisions must be made with the full agreement and involvement of the parent or guardian.
- A clear mechanism for staff to be heard if they disagree with a decision.
- A sufficient number of staff available who are trained and confident in safe and appropriate techniques and in alternatives to restrictive physical interventions and therapeutic holding of children and young people.
- A record of events. This must include why the intervention was necessary, who held the child, where the intervention took place, the method used, the length of time and any techniques needed to reduce the future need for restrictive physical interventions or therapeutic holding.
- Where any restrictive interventions are utilised as part of a behavioural management plan, a positive behavioural support approach is to be implemented. Here staff will utilise primary
- Preventative strategies where possible, identify patterns of behaviour and secondary preventative strategies used to de-escalate situations, and review effectiveness of any interventions. Tertiary
- Strategies such as restrictive interventions must be reviewed and documented. (Guidance may be required by specialist nurses (e.g. Learning disabilities, paediatric specialist nurse i.e autism nurse, and epilepsy specialist nurse).

Therapeutic Holding

- Therapeutic holding for a particular clinical procedure also requires practitioners to:
- Give careful consideration of whether the procedure is really necessary, and whether urgency in an emergency situation prohibits the exploration of alternatives.
- Anticipate and prevent the need for holding, by giving the child information, encouragement, distraction and if necessary, using sedation. In considering the use of sedation, one must recognise that the risks associated with sedation need to be outweighed by the harm caused by therapeutic holding in the absence of sedation. Involve the play specialist from an early stage. Introduce to the child and family as soon as possible and liaise with play specialist re appropriate techniques following their assessment of the child.
- An attempt must be made to obtain consent/assent from all but the youngest of children for any situation which is not a real emergency seek the parent/carer's consent, or the consent of an independent advocate.
- Make an agreement before hand with the parents/ guardians and the child about what methods will be used, when they will be used and for how long. This agreement must be clearly documented in the plan of care and any event fully documented.
- Ensure parental presence and involvement – if they wish to be present and involved. Parents/guardians must not be made to feel guilty if they do not wish to be present during procedures. Nurses must explain parents' roles in supporting their child, and provide support for them during and after the procedure.

- Make skilled use of minimum pressure and other age appropriate techniques, such as wrapping and splinting, explaining and preparing the child/parents beforehand as to what will happen.
- Comfort the child or young person where it hasn't been possible to obtain their consent, and explain clearly to them why immobilisation is necessary.

Child restrictive practices Algorithm



6.9.6 Action During Procedure (core principles) – this applies to all ages

- All staff who perform restrictive physical intervention or Therapeutic holding must be trained by the nominated trust trainers.
- Follow the child holding algorithm in point to ensure appropriate preparation and debrief.
- The nurse in charge must be identified to coordinate the process and communicate and reassure the child/young person and family throughout.
- Consider the child/young person's age and adapt procedure in accordance with training received.
- Supportively hold the limb or body in a natural position. Avoid pressure over the face, neck, chest, abdomen, genitalia and soft tissue. Physical restraint must never be used in a way that might be considered indecent, or that could arouse sexual feelings or expectations.
- , ensure circulation and breathing is not compromised when holding.
- Other than exceptional circumstances e.g. due to medical procedure, a person is not to be restrained / held face down. Should a child / young person require physical interventions they are to be turned if required to be held face up (supine) or seated position.
- Where incidents require Trust Security to support the clinical team and the individual, officers are to be in constant supervision by the Nurse in charge from the unit. They will be under guidance from staff in terms of physical and emotional care needs.
- Restrictive physical intervention and therapeutic holding Care Plan to be commenced as per algorithm. Methods used and the circumstances in which they are used must be agreed with the parents child/young person and clearly documented in the child/young person's individual care plan. For example two unsuccessful attempts at bloods/cannulation must be followed by a rest and change in practitioner.
- Incidents resulting from the use of Restrictive physical intervention and therapeutic holding are to be reported on the Trust incident reporting system (Datix). This must be reported by those working in the area where the incident occurred.

6.9.7 Post Restraint Arrangements

Post Incident Support – this applies to both adult and child/young person interventions

All physical restraint (this does not include clinical holding) must be recorded via the Trusts incident reporting system DATIX.

The person leading the team must ensure the Trust's Incident Reporting process is completed.

A de-brief must take place as soon as practicably possible post-incident unless there are exceptional circumstances which preventing this. This will be overseen and led by the .
The aim of a post-incident review is to learn lessons, support staff and patients, and encourage the therapeutic relationship between staff, patients and their carers.

The review must address:

- What happened during the incident
- Any trigger factors
- Each person's role in the incident
- Their feelings at the time of the incident, at the review and how they may feel in the near future
- What can be done to address their concerns

As soon as practicably possible following the use of physical restraint the staff involved will meet together under the direction of the nurse in charge. This time will be used to discuss and identify any issues as well as reviewing the details of the incident itself. Any significant points raised must be documented and discussed with the practitioner for restrictive practices,

All persons involved in the use of physical interventions must be offered post-incident support by the appropriate line manager, and be involved in any debrief, support and feedback process.

If there is immediate learning this must be highlight as soon as possible. Generic learning and overviews must be fed via the Trusts governance structures initially into the Safeguarding Steering Group via a quarterly report from the Specialist Practitioner for Restrictive practices and escalated where needed to the Patient Safety and Quality Group (PSQG).

Governance

SFHFT will use its governance process to ensure that they are compliant with the legislation around restraint and monitor and analyse the use of restrictive interventions. This will be led by the Restrictive Practices Specialist. They provide an overview of incidents and analysis of risk quarterly to the Trust Risk Committee and escalations from there on via the Patient Safety and Quality Group.

7.0 MONITORING COMPLIANCE AND EFFECTIVENESS

Minimum Requirement to be Monitored (WHAT – element of compliance or effectiveness within the document will be monitored)	Responsible Individual (WHO – is going to monitor this element)	Process for Monitoring e.g. Audit (HOW – will this element be monitored (method used))	Frequency of Monitoring (WHEN – will this element be monitored (frequency/ how often))	Responsible Individual or Committee/ Group for Review of Results (WHERE – Which individual/ committee or group will this be reported to, in what format (eg verbal, formal report etc) and by who)
Incident reporting Completed risk assessments Documentation Pathways followed	Specialist Practitioner Restrictive Practices/ Accredited Security management specialist	Monthly review of DATIX reports including completed debriefs .	Monthly review/ quarterly reporting	Health and Safety Committee Safeguarding Steering Group
Appropriate & proportionate use	Deputy Chief Nurse, ASMS Specialist Practitioner for Restrictive Practices Named Nurse for Safeguarding Adults. Named Nurse for Safeguarding children	Multi-professional review of incidents	Bi-monthly or more frequently if needed	Health and safety committee Risk Committee

8.0 TRAINING AND IMPLEMENTATION

Training

The Trust's emphasis during training and education will be on de-escalating and dealing effectively with situations in order to obviate the need for restraint. Conflict Resolution training is mandatory for all front line staff as an e learning package. This training focuses on the basic principles of why and how individuals become more challenging and looks at the possible causes for this whilst providing de-escalation techniques. All clinical, patient facing staff must complete the Managing Challenging Behaviours and Conflict Resolution (including restrictive practices) ELearning course. This provides additional theory for clinically related challenging behaviours, restrictive practices, the law, use of force and associated documentation guidance and incident reporting requirements.

Challenging behaviours should be managed at ward level, however when a ward cannot manage a patient's behaviour using de-escalation and distraction techniques and the patient's behaviour poses significant harm to themselves or to others, they can call for security support via switchboard. Any restrictive practice used by the security team must always be under clinical supervision.

Staff such as nursing staff and HCA's in the risk assessed areas, highlighted through training needs analysis, will receive additional managing challenging behaviours and restrictive practices face to face training.

This will be delivered face to face in addition to the eLearning package
This training is provided by the Trust working in partnership with IKON Training. This training is tailored to clinical staffs needs and aims to help assist them in managing difficult and challenging patients without having to rely solely on security.

Course Contents:

- Theoretical knowledge complimented by the ELearning package to include legal and ethical implications, Use of Force legislation, national guidance, behavioural changes, signs of violence and aggression, de-escalation techniques , medical implications of techniques, local policies, procedures and training and guidance on appropriate comprehensive documentation.
- Hands on Physical skills to inlude safe posture and stance, breakaway and release skills, relocation/distraction skills, safe holding and IKON approved restraint techniques.

The training is to be undertaken on a two yearly basis as agreed by the Trust and IKON Training and compliances will be audited and reported to divisions.

9.0 IMPACT ASSESSMENTS

- This document has been subject to an Equality Impact Assessment, see completed form at Appendix 3
- This document has been subject to an Environmental Impact Assessment, see completed form at Appendix 4

10.0 EVIDENCE BASE (Relevant Legislation/ National Guidance) AND RELATED SFHFT DOCUMENTS

Evidence Base:

- Mental Capacity Act 2005/2009
- Positive and proactive care reducing the need for restrictive interventions (DoH) 2014
- Human Right Act 1998
- Mental Health Act 1983
- Reducing the Need for Restraint and Restrictive Intervention
- Children and Young People with Learning Disabilities, Autistic Spectrum Disorder and Mental Health Difficulties (DofE) 2017
- NICE Guidance 2015 NICE NG10 https://www.nice.org.uk/guidance/ng10#
- CQC https://www.cqc.org.uk/sites/default/files/20160422_briefguide-Restraint_physical_mechanical.pdf.pdf

Related SFHFT Documents: This policy must also be read in conjunction with / considered alongside a range of documents which are referenced throughout along with links to the relevant intranet page; the most significant being:

- Safeguarding Adults Policy
- Safeguarding Children Policy
- Mental Capacity Act (MCA) Policy
- Deprivation of Liberty Safeguards Policy
- Mental Health Act (MHA) Policy
- Prevention and Management of Violence & Aggression in the Workplace
- Guidelines for Enhanced Patient Observation (in Adult inpatients)
- Bed rails policy
- Acute Confusion/Delirium in Adults (including Rapid Tranquilisation) – Guideline for Detection and Management

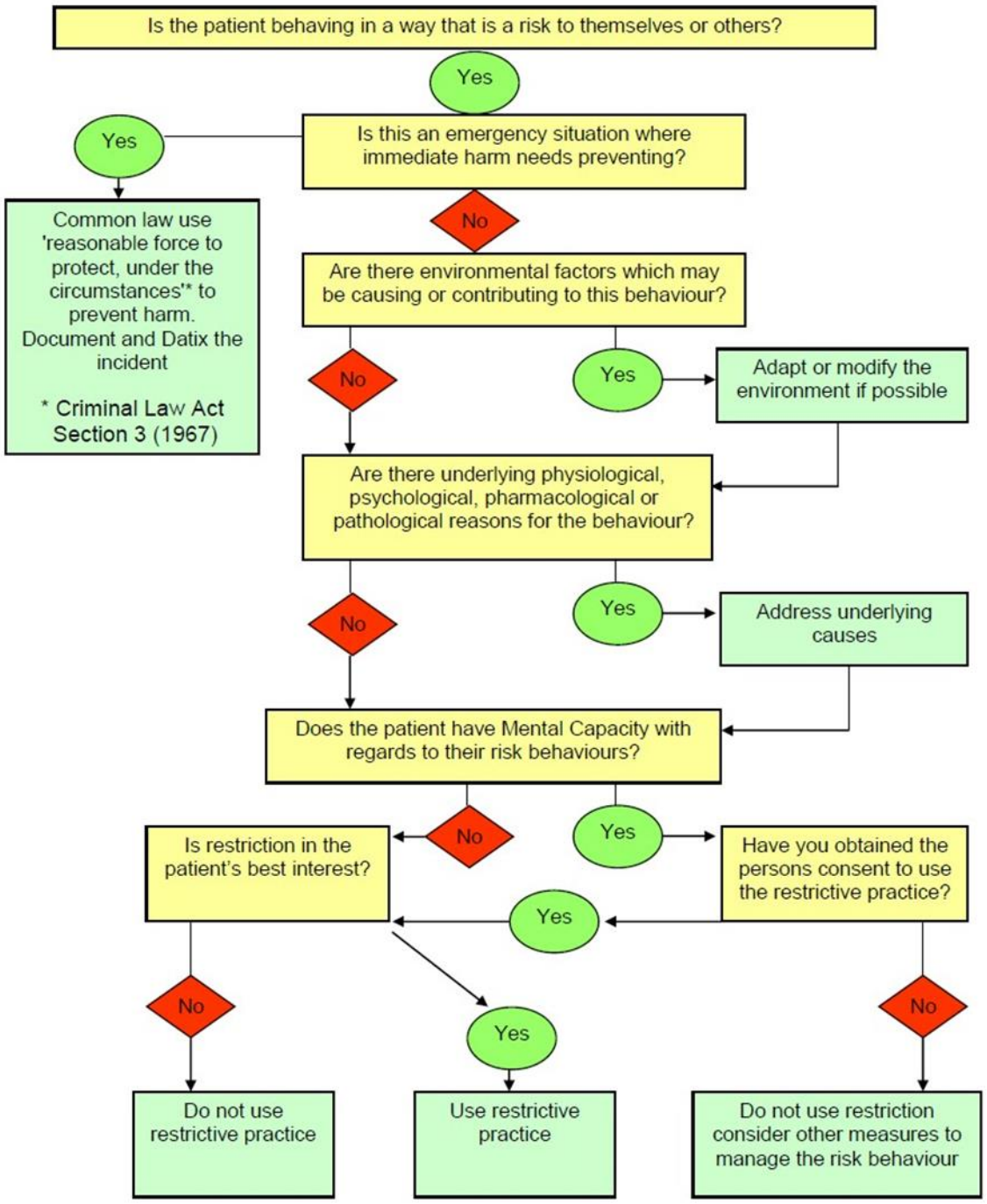
11.0 KEYWORDS

Holding, restrain, restraining, restriction, MCA, DOLs, rapid tranquilisation, mittens, physical, chemical, nasal bridle, methods, violence and aggression, care plan, types of, children and young people undergoing health interventions

12.0 APPENDICES

Appendix 1 – Application in practice flow chart (adult)
Appendix 2 – Assessment Tool and Care Plan for the Use of Mittens in Adult Patients
Appendix 3 – Equality Impact Assessment
Appendix 4 – Environmental Impact Assessment

Appendix 1 – Application in practice flow chart (adult)



On completing of a 2 stage test if the person lacks capacity, is under constant supervision and is not free to leave then a DOL must be completed as soon as is reasonable possible. The next of Kin/ Legal Power of Attorney must be informed.

APPENDIX 3 – EQUALITY IMPACT ASSESSMENT FORM (EQIA)

Name of service/policy/procedure being reviewed: Restrictive Practices /Restraint Policy			
New or existing service/policy/procedure: existing policy			
Date of Assessment: 22/06/2023			
For the service/policy/procedure and its implementation answer the questions a – c below against each characteristic (if relevant consider breaking the policy or implementation down into areas)			
Protected Characteristic	**a) Using data and supporting information, what issues, needs or barriers could the protected characteristic groups' experience? For example, are there any known health inequality or access issues to consider?**	**b) What is already in place in the policy or its implementation to address any inequalities or barriers to access including under representation at clinics, screening?**	**c) Please state any barriers that still need to be addressed and any proposed actions to eliminate inequality**
The area of policy or its implementation being assessed:			
Race and Ethnicity	This policy provides equitable care for all patients irrespective of race or ethnicity	Restraint Policy	None
Gender	This policy provides equitable care for all patients irrespective of gender	Restraint Policy	none
Age	This policy provides equitable care for all patients irrespective of age and is relevant to all patients	Restraint Policy	none
Religion	This policy provides equitable care for all patients irrespective of religion	Restraint Policy	none
Disability	This policy provides equitable care for all patients irrespective of disability	Restraint Policy	none
Sexuality	This policy provides equitable care for all patients irrespective of sexuality	Restraint Policy	none
Pregnancy and Maternity	Patients who are pregnant or postnatal will receive the same standard of mental health care as non-pregnant patients	Restraint Policy	none
Gender Reassignment	This policy provides equitable care for all patients irrespective of gender	Restraint Policy	none

Marriage and Civil Partnership	This policy provides equitable care for all patients irrespective of marital status, it does acknowledge the patients who are part of a civil partnership and identifies their rights in this area	Restraint Policy	none
Socio-Economic Factors (i.e. living in a poorer neighbourhood / social deprivation)	This policy provides equitable care for all patients irrespective of socio-economic status	Restraint Policy	none

What consultation with protected characteristic groups including patient groups have you carried out?

This policy acknowledges the needs of patients who may require restrictive interventions, but also require care from an acute perspective. To ensure that it is complaint with all legislation it has been shared with senior health colleagues within the Trust for consultation and feedback to ensure that it effectively meets the needs of all vulnerable patients.

What data or information did you use in support of this EqIA?
Number of restraints undertaken and recorded in DATIX
Serious Incident reports
Training figures

As far as you are aware are there any Human Rights issues be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments?

Ensuring that patients are aware of their rights and the legislative requirements that may affect them when they are unwell and require interventions using the Mental Health Act, Mental Capacity Act or Deprivation of Liberty Safeguards. These have all been acknowledged within this policy and the other supporting policies referenced with in this policy.

Level of impact

From the information provided above and following EQIA guidance document Guidance on how to complete an EIA (click here), please indicate the perceived level of impact:

Medium Level of Impact

For high or medium levels of impact, please forward a copy of this form to the HR Secretaries for inclusion at the next Diversity and Inclusivity meeting.

Name of Responsible Person undertaking this assessment: **Lisa Nixon**
Signature: **L.Nixon**
Date: 22/06/2023

APPENDIX 4 – ENVIRONMENTAL IMPACT ASSESSMENT

The purpose of an environmental impact assessment is to identify the environmental impact, assess the significance of the consequences and, if required, reduce and mitigate the effect by either, a) amend the policy b) implement mitigating actions.

Area of impact	Environmental Risk/Impacts to consider	Yes/No	Action Taken (where necessary)
Waste and materials	• Is the policy encouraging using more materials/supplies? • Is the policy likely to increase the waste produced? • Does the policy fail to utilise opportunities for introduction/replacement of materials that can be recycled?	No	
Soil/Land	• Is the policy likely to promote the use of substances dangerous to the land if released? (e.g. lubricants, liquid chemicals) • Does the policy fail to consider the need to provide adequate containment for these substances? (For example bunded containers, etc.)	No	
Water	• Is the policy likely to result in an increase of water usage? (estimate quantities) • Is the policy likely to result in water being polluted? (e.g. dangerous chemicals being introduced in the water) • Does the policy fail to include a mitigating procedure? (e.g. modify procedure to prevent water from being polluted; polluted water containment for adequate disposal)	No	
Air	• Is the policy likely to result in the introduction of procedures and equipment with resulting emissions to air? (For example use of a furnaces; combustion of fuels, emission or particles to the atmosphere, etc.) • Does the policy fail to include a procedure to mitigate the effects? • Does the policy fail to require compliance with the limits of emission imposed by the relevant regulations?	No	
Energy	• Does the policy result in an increase in energy consumption levels in the Trust? (estimate quantities)	No	
Nuisances	• Would the policy result in the creation of nuisances such as noise or odour (for staff, patients, visitors, neighbours and other relevant stakeholders)?	No	