

RESTRAINT AND RESTRICTIVE PRACTICES POLICY

		POLICY
Reference	CPG-TW-R&RPP	
Approving Body	Safeguarding Steering Group	
Date Approved	October 2019 (virtual)	
Issue Date	4 th November 2019	
Version	1.0	
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	<ul style="list-style-type: none"> • CPG-TW-ResP, Restrictive Practices for Adult Patients Policy, v1.2 Issued March 2019 to Review Date October 2019 • CPG-TW-H&RCUHI, Holding and Restraining Children Undergoing Health Interventions Guideline, v3.1, Issued 30th January 2019 to Review Date October 2019 	
Document Category	<ul style="list-style-type: none"> • Clinical 	
Consultation Undertaken	<ul style="list-style-type: none"> • Nursing, Midwifery and AHP services • Nursing, Midwifery and AHP Board • Bronze, Silver and Gold on-call • Legal Department • Emergency Department Leads • Critical Care Leads • Paediatric Leads 	
Date of Completion of Equality Impact Assessment	25 th September 2019	
Date of Environmental Impact Assessment (if applicable)	3 rd October 2019	
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	October 2022	
Sponsor (Position)	Chief Nurse	
Author (Position & Name)	Head of Safeguarding, Tina Hymas-Taylor	
Lead Division/ Directorate	Corporate	
Lead Specialty/ Service/ Department	Nursing/ Safeguarding Team	
Position of Person able to provide Further Guidance/Information	Local Services Management Specialist/ Restrictive Practices Specialist Practitioner	
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 and updated with this revised policy	

CONTENTS

Item	Title	Page
1.0	INTRODUCTION	3
2.0	POLICY STATEMENT	3-4
3.0	DEFINITIONS/ ABBREVIATIONS	4
4.0	ROLES AND RESPONSIBILITIES	5-7
5.0	APPROVAL	7
6.0	DOCUMENT REQUIREMENTS	7-26
6.1	Legal Requirements	7
6.2	Behaviour	9
6.3	Types of Restraint	11
6.4	Unacceptable Methods of Restriction	16
6.5	Decision Making and Assessment	17
6.6	Physical Monitoring	19
6.7	Post Restraint Arrangements	19
6.8	Restraint in Critical Care Unit (CCU) Only	20
6.9	Restrictive practice in the care of Children and Young People (including paediatric and non-paediatric areas)	21
7.0	MONITORING COMPLIANCE AND EFFECTIVENESS	27
8.0	TRAINING AND IMPLEMENTATION	28
9.0	IMPACT ASSESSMENTS	28
10.0	EVIDENCE BASE (Relevant Legislation/ National Guidance) and RELATED SFHFT DOCUMENTS	29
11.0	KEYWORDS	29
12.0	APPENDICES	
Appendix 1	Application in practice flow chart	30
Appendix 2	Assessment Tool and Care Plan for the Use of Mittens in Adult Patients	Hyperlinked to intranet
Appendix 3	Equality Impact Assessment	31-22
Appendix 4	Environment Impact Assessment	34

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 violence and aggressive behaviour can escalate to the point where restraint may be needed to protect the person, staff or other legitimate users of Trust premises and facilities from significant injury or harm, even if all best practice to prevent such escalation is deployed.

The Trust also recognises that at times there will be a need to implement restrictive interventions in the patients best interests for example whilst sedated in the Critical Care Unit, this policy also provides guidance relating to management in such cases.

Physical intervention must only be considered once de-escalation and other strategies have failed to calm the situation. These interventions are management strategies and are not regarded as primary treatment techniques. When determining which interventions to employ, the clinical need, safety of patients and others must be taken into account. The intervention selected must be a reasonable and proportionate response to the risk posed by the person.

This policy is intended to provide guidance in relation to the nature, circumstances and use of approved restraint techniques currently adopted by the Trust. Its aim is to help all involved act appropriately in a safe manner, thus ensuring effective responses in potential or actual difficult situations. It sets out a framework of good practice, recognising the need to ensure that all legal, ethical and professional issues have been taken into consideration.

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

The aim of this policy is to provide staff with the guidance needed to practice in accordance with the law, professional standards and Trust policy.

The policy outlines the general principles that must be applied to practice across the Trust, including the legal position where appropriate.

Decisions about restrictive interventions 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 and training.

The policy is in line with the Trust's values in that our services and care are patient centred; safe, are provided with respect and compassion and focus 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.
The Security Manager / Local Security Management Specialist (LSMS)/ Restrictive Practices Specialist Practitioner	Operational	Ensure all security staff respond, support and assist staff in a restraint Review all DATIX raised around restraint or restrictive interventions, provide overview and learning from all 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

		<p>incidents, the outcome and any learning that needs to take place.</p> <p>Identify from incident data and risk assessments all high risk areas and support managers to implement appropriate arrangements.</p>
The Person in Control	Operational	<p>The person leading the implementation of any restrictive intervention will: (this is usually the ward sister/ charge nurse or Duty Nurse Manager)</p> <ul style="list-style-type: none"> • If they consider restraint is likely, request (without delay) that: Security and / or the Police attend. • 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, of 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 • Arrange for the family, friends or carer to be contacted / be involved if they may have a calming influence on the patient • Ensure the intervention is reported via DATIX.
Security Staff		<p>For such a situation a minimum of 2 security personnel are required to assist the nursing team.</p> <ul style="list-style-type: none"> • The security staff must be trained in restraint as per National Standards. • Liaison at the scene with medical/nursing staff to agree restraint technique and security will lead. • 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 - it is not always necessary to await medical staff as nurses may be competent in the administration of sedation, all nursing staff are trained in Basic Life Support techniques and one member of staff will be allocated this observation role. This person must not be involved in the restraint role but remain responsible for ensuring the patients well- being. • Security staff may prevent a patient leaving the area/hospital if they are advised by the senior nurse/manager present, that 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		<p>All clinical staff will ensure that they have read and adhere to this policy as and when required.</p> <p>The member of staff identifying the violent or aggressive behaviour or intent will:</p> <ul style="list-style-type: none"> • 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 • Wherever possible and if it is safe do 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.
- Common law
 - The doctrine of necessity – there is a general power to take steps that are reasonably 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.
 - To prevent a breach of the peace – harm to a person of their property in their presence.
- Police officers have certain additional powers

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, a restraint technique may restrict a patient's liberty, or deprive a patient of his liberty, depending on both the extent of its use, and the degree to which it stops him doing something he would otherwise want to do. In other words, the same restraint technique 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 his 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 method of restraint, 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 method of restraint 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 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), 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 not only be in the patient's best interests and the least restrictive alternative, but 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

6.2 Behaviour

6.2.1 Managing Challenging Behaviour

Successful management of challenging behaviour is underpinned by having an understanding of 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 patient through the use of 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 first strategy when faced with an escalating situation. De-escalation or diffusion refers to talking with an angry or agitated patient in such a way that violence is averted and the person regains sense of calm (NICE 2015).

6.2.2 Behaviour 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 in order to establish what sort of therapeutic behaviour management might be of benefit. This will involve identifying the underlying cause of the behaviour (agitation, wandering, absconding etc.) and deciding whether the behaviour needs to be prevented. Possible causes to consider are:

- 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's mental health is an issue, 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 dealing with 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 restraints does not ensure safety and staff must be aware of the need for vigilance and constant supervision of these patients at all times.

Bedrails must only be used following assessment of need and to safeguard patients. Bedrails are not 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](#).



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

Any staff using physical restraint must:



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

Ensure that **one member of staff leads the team and assumes control of the person being restrained** throughout the process (person in control). He or she must ensure that the restrained person's (it is advisable the person leading the intervention does not become part of the restraint intervention):

- Head and neck is appropriately supported and protected
- Airway and breathing are not compromised
- Monitor the person's overall physical and psychological well-being throughout.
- For safety reasons, during a 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.
- 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 and necessary and proportionate to a specific situation, and be applied for the minimum possible amount of time.
- Any person subject to restraint must be physically monitored throughout the incident. Post-restraint, the person who has been restrained will be reviewed for placement on the observations as identified by clinical staff. During this time physical observations must be recorded and the observing nurse be fully aware of the possibility of restraint/positional asphyxia.

Restraint on the ground

Face down/ prone restraint must never be used. However, if the floor is used then this must be used for the shortest period of time and only for the purpose of gaining reasonable control.

6.3.2 Mechanical Restraint

Mechanical restraint must be used as a last resort when all other less restrictive options have been tried and failed.

a) Mittens

Use of mittens for mechanical restraint

Prior to considering use of mechanical restraint devices 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 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 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 the 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 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, but only for a child, young person or adult who is highly aroused, agitated, overactive, aggressive, is making serious threats towards others, or is being destructive to their surroundings and when other therapeutic or restrictive interventions have failed to contain the behaviour. An antipsychotic, an antidepressant, or both must not be prescribed in response to challenging behaviour without an appropriate clinical reason.

Chemical restraint must be used only as part of an agreed support plan and must be delivered in accordance with evidence-based best practice guidelines and by staff with the relevant qualifications, skills and experience to administer it. Prescribers must provide information, to those who provide care and support, about 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 Restriction

The following methods of restriction are unacceptable, however if the patient requests or is consenting to any of the following it may be considered and applied as appropriate. This must be 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, one reason being that it 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. Again they must not be used with the intention of restraining a person. Low chairs also pose risks to staff in relation to manual handling.

6.4.5 Chairs whose construction immobilises patients

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

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 who they must ask to have them unlocked to exit the ward. If a patient is asking to leave and being prevented by the locked door that patient is being restricted.

6.4.7 Arranging furniture to impede movement

Other methods of dealing with behaviour such as wandering must be pursued. Any equipment, including furniture, must only be used for the purpose for which it is intended.

6.4.8 Inappropriate use of night clothes during waking hours

This is demeaning and must not be used as a way of restraining people.

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

As with the above, these are not acceptable ways of restraining people in any care setting. 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 other than exceptional circumstances e.g. medical reason. Utilisation of seated, supine or 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 and underlying condition and treatment

- Understanding a patient's behaviour and responding to their individual needs must 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

- It is necessary to consider a patient's mental capacity as consent must be gained from patients to use any type of restriction unless they lack capacity to make this decision and the restrictive practice is sanctioned under the Mental Capacity Act or the Mental Health Act.

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 practice a balance must be achieved between minimising risk of harm or injury to the patient and others, and maintaining the dignity, personal freedom and choice of the patient.



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 restriction is deemed appropriate the following points must be considered; the practice needs to have a legitimate aim. It must be 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 by the practice must be involved in the decision making process to the fullest possible extent of their understanding.

The practice that is implemented must be proportional, 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 of the practice in meeting its aims must be continually reviewed and the practice must continue only for as long as it remains both necessary and effective.

If the patient has capacity to give valid consent and their agreement or consent can be gained, without undue pressure, from the person then the restriction can be put in place so long as it does not contravene the law. It must be remembered that the person has the right to withdraw their agreement or consent and they must be informed of this right at 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, and Public Health Act.

The Deprivation of Liberty Safeguards (DoLS) 2007 (came into force 2009) and the 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 or restraint used in delivering that care are so extensive as 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.

This must be documented as part of the risk assessment and also in the Plan of Care. Monitoring must be undertaken by the Clinical Team in attendance and must include observations e.g. Pulse, Blood Pressure, Respiration, SPO2, GCS etc.

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 illicit substances
- If the person has a known medical condition which may inhibit cardio-pulmonary function e.g. obesity (when face down), asthma, heart disease etc.

6.7 Post Restraint Arrangements

Post Incident Support

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

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

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 interventions the staff involved will meet together. This time will be used to discuss any issues anyone may have as well as reviewing the details of the incident itself. Any significant points raised must be documented and discussed with the LSMS.

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 support or feedback process.

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

6.8 Restraint in Critical Care Unit (CCU) 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 involves 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 is necessary as part of the package of care required 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 physical restraint attached to the patient's limbs will be implemented to minimise risk to the patient.

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

CCU 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 in their application 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, holding still 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 to 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 alternative practice.

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 Physical 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.

Nursing

- 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

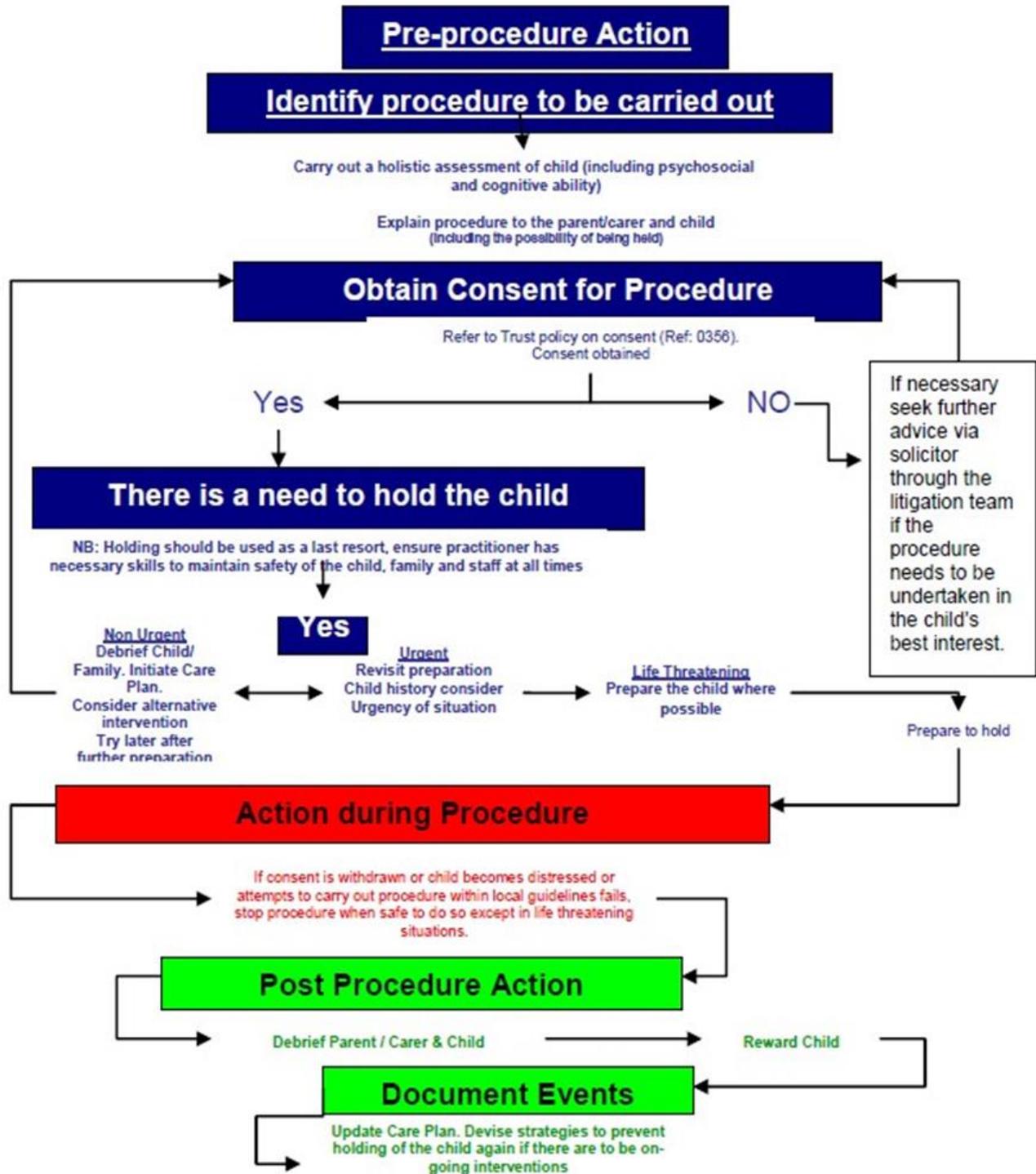
- Good decision making about restrictive physical interventions and therapeutic holding requires that in all settings where children and young people receive care and treatment there is:
 - An ethos of caring and respect for the child's rights, where the use of restrictive physical interventions or therapeutic 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 Holding Algorithm



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

- All staff that carries out 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.
- A lead person must be identified to coordinate the process. Identify a person to 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. Use the whole hand to support around a limb.
- Physical restraint must never be used in a way that might be considered indecent, or that could arouse sexual feelings or expectations.
- Apply a firm but even pressure when holding ensuring circulation and breathing is not compromised.
- 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 individual, officers are to be in constant supervision by care / nursing staff on or from the unit. They will seek 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 restraint interventions (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.

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

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 Specialist Practitioner for Restrictive Practices

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 interventions the staff involved will meet together. This time will be used to discuss any issues anyone may have as well as reviewing the details of the incident itself. Any significant points raised must be documented and discussed with the LSMS/ restrictive practices specialist practitioner.

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 support or 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 and restrictive interventions. This will be led by the Local Security Management Specialist and 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/ Local Security management specialist	Monthly review of DATIX reports including completed debrief forms.	Monthly review/ quarterly reporting	Safeguarding Steering Group
Appropriate & proportionate use	Deputy Chief Nurse, LSMS Specialist Practitioner for Restrictive Practices Head of Safeguarding and Named Nurse for Safeguarding Adults.	Multi-professional review of incidents	Bi-monthly or more frequently if needed	Risk Committee

8.0 TRAINING AND IMPLEMENTATION

Training

The Trust emphasis of training and education will be on dealing effectively with situations in order to obviate the need for restraint. Conflict Resolution training is mandatory for all front line staff every 3 years as face to face training. This training focuses on the basic reasons on why and how individuals become more challenging and looks at the possible causes for this.

Staff will also discuss clinical holds via MCA and DoLs training.

Clinical holding can be used by any staff member but where a ward cannot manage a patient's behaviour using low levels of clinical hold and the patient's behaviours poses significant harm to themselves or to others, they will call for support, this will be via switchboard and a call for security support along with senior nursing support. These staff will have received additional restrictive intervention training and will include:

- Duty Nurse Managers
- Emergency department staff
- EAU
- Ward 25
- Ward 51 & 52
- Ward 53 & 54
- Virtual Ward Staff
- Safeguarding staff including LD, Dementia and Mental Health staff-
- Security Staff

Face to face Managing Challenging Behaviour & Restrictive Practice Training will be provided for the above staff.

This training is provided by the trust working in partnership with IKON Training. This training is tailored and bespoke to our clinical staff to help assist them in managing difficult and challenging patients without the current default to rely on security.

Course Contents:

- Theory – Behaviour changes, signs of violence and aggression, de-escalation skills, medical implications of techniques and policies and procedures.
- Physical – Posture and stance, breakaway and release skills, relocation/distraction skills, safe holding techniques.

The training is to be undertaken every year 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,

12.0 APPENDICES

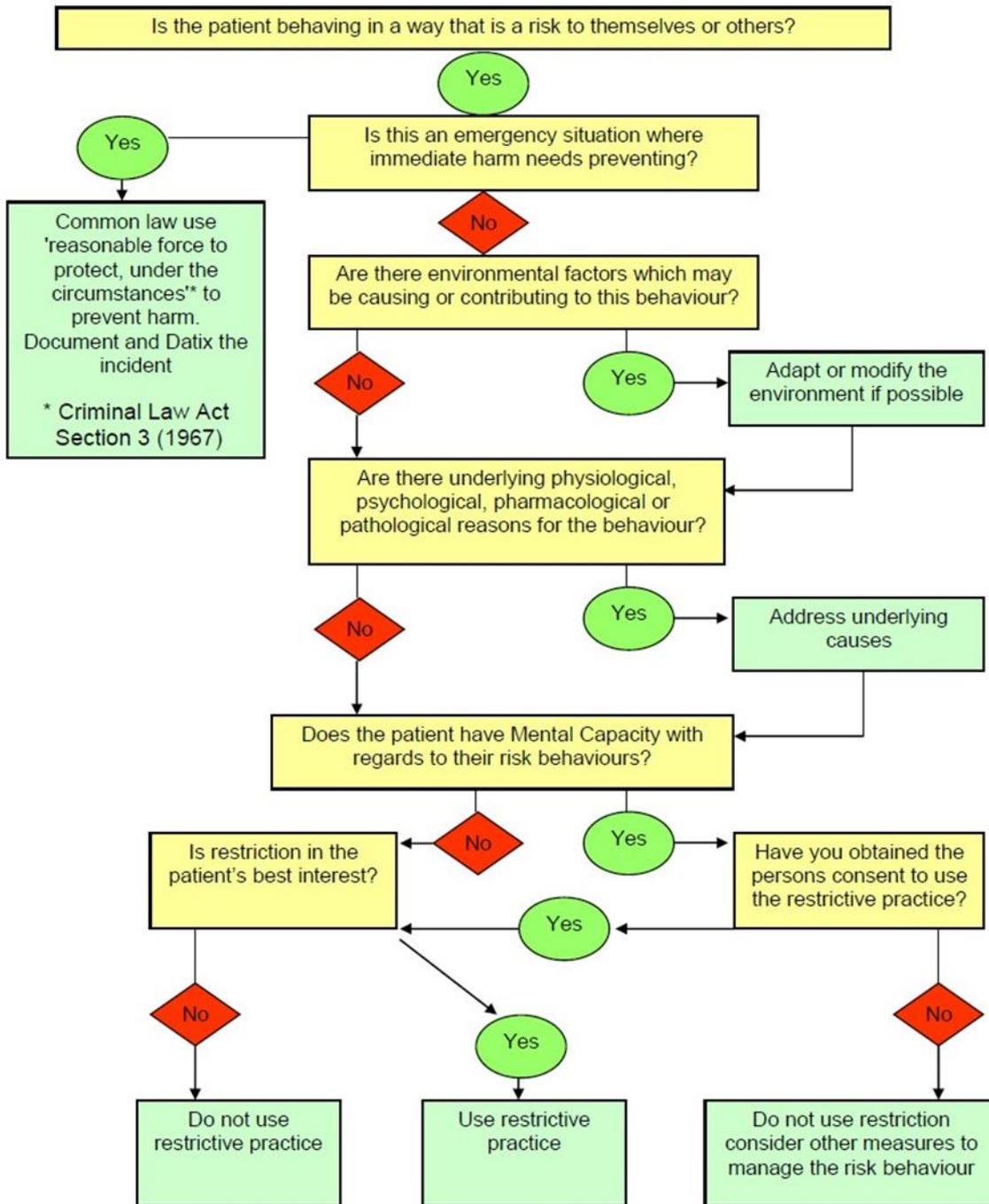
[Appendix 1](#) – Application in practice flow chart (adult)

[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)



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: 25/9/19			
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
<p>What consultation with protected characteristic groups including patient groups have you carried out?</p> <p>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 compliant 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.</p>			
<p>What data or information did you use in support of this EqlA?</p> <p>Number of restraints undertaken and recorded in DATIX Serious Incident reports Training figures</p>			
<p>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?</p> <p>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.</p>			

<p>Level of impact</p> <p>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:</p> <p>Medium Level of Impact</p> <p>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.</p>
<p>Name of Responsible Person undertaking this assessment:</p> <p>Tina Hymas-Taylor</p>
<p>Signature:</p> 
<p>Date:</p>

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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Does the policy result in an increase in energy consumption levels in the Trust? (estimate quantities) 	No	
Nuisances	<ul style="list-style-type: none"> Would the policy result in the creation of nuisances such as noise or odour (for staff, patients, visitors, neighbours and other relevant stakeholders)? 	No	