Restrictive Practice Policy

Including guidance on restrictive interventions, and physical restraint in adults and children, the application of hand control mittens and the use of seclusion

V5.1

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Restrictive Practice Policy – Summary Page

Including guidance on restrictive interventions, and physical restraint in adults and children, the application of hand control mittens and the use of seclusion

Restrictive Practice: This policy is designed to define restrictive practice and to allow the practitioner to ensure that the care or treatment that they are offering is lawful, necessary, proportionate, and the least restrictive option reasonably available. These issues should be applied in conjunction with principles of dignity, equality, respect, fairness and autonomy.

Restrictive Interventions: "deliberate acts on the part of other 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 is necessary"

Department of Health, April 2014

Physical restraint (adults and Children): "any direct physical contact where the intervener's intention is to prevent, restricts, or subdue movement of the body, or part of the body of another person"

Department of Health, April 2014

Where the use of restraint, holding still and containment is concerned, practitioners must consider the rights of the adult and child and the legal frameworks surrounding the interventions.

Hand Control Mittens: The guideline and the mittens assessment tool aims to support practitioners to ensure that the application of mittens is lawful, legitimate, proportionate, and the least restrictive reasonable option available.

The use of Mittens is recognised as a form of restraint. There are various forms of restraint e.g. Nasal bridle to secure NG feeding tubes, however mittens may be regarded in this situation as the least restrictive and safer alternative.

Seclusion: This document sets out the best practice guidance for staff working in the Royal Cornwall Hospitals Trust (RCHT). It provides a framework for the seclusion of a patient who lacks capacity or is detained under the Mental Health Act (MHA) 1983. Seclusion is the isolation of a patient for a minimum period against their wishes, under supervision in a designated room, which they are unable to leave or is locked. This document provides clear instructions on how seclusion must be implemented. Seclusion is only applicable to individuals over 16 years of age.

Nasal bridles: This documents offers guidance on the use of nasal bridles. A nasal bridle is a method of securing the Nasogastric feeding tube inside the nose which potentially reduces the likelihood of the tube being dislodged and/or displaced.
Restrictive practice - guidance flowchart

Is the patient behaving in a way that is a risk to themselves or others?

Yes

Is this an emergency situation where immediate harm needs preventing?

Yes

Are there environmental factors which may be causing or contributing to this behaviour?

No

Are there underlying physiological, psychological, pharmacological or pathological reasons for the behaviour?

No

Does the patient have Mental Capacity with regards to their risk behaviours?

Yes

Have you obtained the persons consent to use the restrictive practice?

Yes

Use restrictive practice

No

Do not use restrictive practice

No

Do not use restriction consider other measures to manage the risk behaviour

No

Adapt or modify the environment if possible

Yes

Address underlying causes

Common law use 'reasonable force to protect, under the circumstances'* to prevent harm. Document and Datix the incident

* Criminal Law Act Section 3 (1967)

Is restriction in the patient’s best interest?

Yes

Use restrictive practice

No

Do not use restrictive practice

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**Child Holding Algorithm**

**Pre-procedure Action**

**Identify procedure to be carried out**

Carry out a holistic assessment of child (including psychosocial and cognitive ability)

Explain procedure to the parent/carer and child (including the possibility of being held)

**Obtain Consent for Procedure**

Refer to Trust policy on consent (Ref: 0356). Consent obtained

**There is a need to hold the child**

NB: Holding should be used as a last resort, ensure practitioner has necessary skills to maintain safety of the child, family and staff at all times

- **Yes**
  - Non Urgent
    - Debrief Child/ Family, Initiate Care Plan
    - Consider alternative intervention
    - Try later after further preparation
  - Urgent
    - Revisit preparation
    - Child history consider Urgency of situation

- **NO**
  - Life Threatening
    - Prepare the child where possible

**Action during Procedure**

- If consent is withdrawn or child becomes distressed or attempts to carry out procedure within local guidelines fails, stop procedure when safe to do so except in life threatening situations.

**Post Procedure Action**

- Debrief Parent / Carer & Child
- Reward Child

**Document Events**

Update Care Plan. Devise strategies to prevent holding of the child again if there are to be on-going interventions

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Introduction

10.1. Restrictive practices definition: "Making someone do something they don't want to do or stopping doing something they want to do" (A positive & proactive workforce, Skills for Care. April 2014)

10.2. Restrictive practice may involve the physical containment of a patient by care staff or security, with or without the use of mechanical aids. It may include the use of equipment (for example door locks) to ensure that the patient cannot move out of a prescribed area.

More subtle forms of restrictive practices may also be used, for example removing a walking aid from the patient's reach, not supporting an immobile patient if they wish to move or leave the use of electronic devices to alert staff to the movement of a patient, and chemical restraint.

10.3. While the emphasis should be on pre-emptive action, wherever possible, in order to prevent the need to restrain, there are some occasions in which the risks to the service user, or others, of inaction may outweigh those of taking action.

10.4. This version supersedes any previous versions of this document.

2. Purpose of this Policy

2.1. This policy is designed to define restrictive practice and to allow the practitioner to ensure that the care or treatment that they are offering is lawful, necessary, proportionate, and the least restrictive option reasonably available. These issues should be applied in conjunction with principles of dignity, equality, respect, fairness and autonomy.

3. Scope

3.1. This policy sets out the best practice guidance for all staff working at the Royal Cornwall Hospital Trust (RCHT).

3.2. This policy applies to patients who require restrictive practice while receiving treatment; this would include those patients lacking the mental capacity to make specific decisions about their own health and personal safety needs.

4. Definitions

4.1. Restrictive practice is defined as: "Making someone do something they don't want to do or stopping doing something they want to do" (A positive & proactive workforce, Skills for Care. April 2014)

4.2. Restrictive Interventions are defined as: "Deliberate acts on the part of other 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 is necessary"
(Positive & Proactive Care: reducing the need for restrictive interventions. DoH. April 2014)

4.3. Physical Restraint is defined:
"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)

4.4. Physical restraint must be reported on DATIX 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.

5. Ownership and Responsibilities

5.1. Chief Executive
The Chief Executive and wider Trust Board have key roles and responsibilities to ensure the Trust meets requirements set out by statutory and regulatory authorities such as the Department of Health, Commissioners and the Care Quality Commission. The Trust’s Chief Executive has overall responsibility to have processes in place to:
• Ensure that clinical staff are aware of this policy and adhere to its requirements
• Ensure that appropriate resources exist to meet the requirements of this policy

5.2. Executive Directors
The Executive Directors are responsible for ensuring that all operational managers in their area are aware of this policy, understand its requirements and support its implementation with relevant staff.

5.3. Associate Medical Director/Consultants
The Associate Medical Director and Consultants are responsible for ensuring procedures are understood and carried out by medical staff involved in the implementation of this policy.

5.4. Departmental Managers
Departmental Managers are responsible for implementing the policy with their immediate staff and ensuring that they carry out the duties prescribed in this policy.

5.5. Members of Clinical Teams
Clinical team members have responsibility to comply with the requirements of this and associated policies and have a legal duty to have regard to it when...
working with, or caring for adults who may lack capacity to make decisions for themselves.

5.6. Quality, Safety and Compliance Team
The Quality, Safety and Compliance Team are responsible for informing the Care Quality Commission (CQC) of all DOLS applications and outcomes. This is a statutory requirement.

5.7. Mental Health and Wellbeing Specialist Nurse
The Mental Health and Wellbeing Specialist Nurse is responsible for:
- The day-to-day management of the Mental Health Act (MHA) in accordance with statutory legislation, Codes of Practice, national guidelines and local policies and procedures.
- Patient applications to Mental Health Review bodies, and MHA Managers.
- Provides of advice, support and training in relation to the Mental Health Act 1983 and 2007, the Mental Capacity Act 2005 (MCA), Deprivation of Liberty Safeguards 2007 (DOLS) and other associated statutory legislation, national guidance, policy or procedures.
- The development and review of Trust policies and procedures relating to the application and administration of the MHA 1983 the MCA 2005, DOLS 2007 and related Codes of Practice.
- To support and advice with regard to the application and administration of the MCA and DOLS within the Trust.

5.8 Management of aggression & Violence Training Team
The team will review all relevant categorised Datix incidents. Members of the team contacting the reporter (copying in incident handler), offering support, advice and training input.
Team to work closely with local mangers, providing appropriate training and advice around training needs.
To provide report to Health & Safety Committee & Safeguarding Adults Operational Group.

5.9. The Safeguarding Adults Operational Group
The Safeguarding Adults Operational Group is authorised by the RCHT Trust Board to investigate any clinical or associated activity that impacts on adults in our care and to develop, comply and monitor systems and processes to ensure the issues of safeguarding of adults in the Trust are adopted and embedded within the Terms of Reference of the group; this includes restrictive practice.

6. Standards and Practice

6.1 Types of Restrictions
6.1.1 Restrictive practice is not confined to physical restraint; it also refers to actions or inactions that contravene a person's rights. Listed below are some restrictive categories. It must be remembered that to apply any of these to an individual there must have a lawful and legitimate right and reason to do so. The following list is not exhaustive.

- Physical restraint (See Appendix 1)
  "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)

- **Mechanical restraint**
  A device used on a person to restrict free movement such as placing a person in a chair which they are unable to get up from.

- **Environmental restriction**
  The design of the environment to limit people’s ability to move as they might wish, such as locking doors or sections of a building, using electronic key pads with numbers to open doors, complicated locking mechanisms and door handles.

- **Chemical restraint**
  The use of drugs and prescriptions to modify a person’s behaviour. Medication that is prescribed to be taken ‘as and when required’ can be used as a form of restraint unless applied responsibly. For more information please refer to: Guideline for ‘Guideline for the use of medication to manage acutely disturbed or violent behaviour in adult patients of RCHT (Rapid Tranquillisation)’

- **Forced care**
  Actions to coerce a person into acting against their will, for example having to be restrained in order to comply with the instruction or request.

- **Cultural restriction**
  Preventing a person from the behaviours and beliefs characteristic of a particular social, religious or ethnic group

- **Decision making**
  Making a decision on the person’s behalf or not accepting or acting on a decision the person has made.

- **Contact with community**
  Preventing the person from participating in community activities, including work, education, sports groups, community events or from spending time in the community such as parks, leisure centres, shopping centres

- **Contact with family and friends**
  Preventing or limiting contact with the person’s friends and family, for example not allowing the person to receive visitors, make phones calls or not allowing contact with a specific friend or family member.

**6.2 Unacceptable Methods of Restriction**

6.2.1 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.
• **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.

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

• **Using low chairs for seating.** Low chairs should only be used when their height is appropriate for the user. Again they should not be used with the intention of restraining a person. Low chairs also pose risks to staff in relation to manual handling.

• **Chairs whose construction immobilises patients** e.g., reclining chairs, bucket seats. Reclining chairs should be used for the comfort of the user and not as a method of restraint.

• **Locked doors.** On the occasion that doors are locked clear signage should be displayed informing patients and the public that doors are locked and who they should 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.

• **Arranging furniture to impede movement.** Other methods of dealing with behaviour such as wandering should be pursued. Any equipment, including furniture, should only be used for the purpose for which it is intended.

• **Inappropriate use of night clothes during waking hours.** This is demeaning and should not be used as a way of restraining people.

• **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.

• **Isolation**
  It is important to note that patients may be “isolated” for infection control reasons and if a patient is cared for in a side room, when he or she wishes to be on the main ward, this may be construed as restraint. This is a complex issue, which should be discussed on a case by case basis with the multidisciplinary team, including the Infection Control Team. For further information refer to the **RCHT Seclusion Guidelines**.

• **Planned prone physical restraint**
  The utilisation of a planned prone restraint should not be used other than exceptional circumstances e.g. medical reason. Utilisation of seated, supine or release of person to be considered as alternatives.
6.3 Decision making and Assessment

6.3.1 Individual assessment should 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 should be at the centre of patient care. All patients should 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 should 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.

6.3.2 Assessment should 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.

6.3.3 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, 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 should be observed during the implementation of any restrictive practice.
- The effectiveness of the practice in meeting its aims should be continually reviewed and the practice should continue only for as long as it remains both necessary and effective.

6.3.4 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 should be informed of this right at the outset.

6.3.5 If the person withdraws their consent but it is felt that the restriction should continue, this can only be achieved if the practice is sanctioned under law; examples include the Mental Capacity Act, Mental Health Act, Criminal Law, Public Health Act.
6.4 Restrictive practice decision making flowchart

**Restrictive practice - guidance flowchart**

Is the patient behaving in a way that is a risk to themselves or others?

- Yes
  - Is this an emergency situation where immediate harm needs preventing?
    - Yes
      - Common law use 'reasonable force to protect, under the circumstances*' to prevent harm. Document and Datix the incident
    - No
      - Are there environmental factors which may be causing or contributing to this behaviour?
        - Yes
          - Adapt or modify the environment if possible
        - No
          - Are there underlying physiological, psychological, pharmacological or pathological reasons for the behaviour?
            - Yes
              - Address underlying causes
            - No
              - Does the patient have Mental Capacity with regards to their risk behaviours?
                - Yes
                  - Have you obtained the persons consent to use the restrictive practice?
                    - Yes
                      - Use restrictive practice
                    - No
                      - Do not use restrictive practice
                - No
                  - Do not use restriction consider other measures to manage the risk behaviour

* Criminal Law Act Section 3 (1967)
6.5 Deprivation of Liberty

6.5.1 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.

6.5.2 The safeguards apply to people in England and Wales who have a mental disorder and lack capacity to consent to the arrangements made for their care or treatment, but for whom receiving care or treatment in circumstances that amount to a deprivation of liberty may be necessary to protect them from harm and appears to be in their best interests. A large number of these people will be those with significant learning disabilities, or older people who have dementia or some similar disability, but they can also include those who have certain other neurological conditions (for example as a result of a brain injury).

6.5.3 For more information please see the RCHT Mental Capacity Act, Independent Mental Capacity Advocacy and Deprivation of Liberty Safeguards Policy.

6.6 Duty of Care

6.6.1 The Government best practice guidance *Independence Choice and Risk* (2007), states 'Duty of Care' as, 'an obligation placed on an individual requiring that they exercise a reasonable standard of care while doing something (or possibly omitting to do something) that could cause harm to others. Exercising 'duty of care' to a person cannot be used to justify restrictive practices except where a person has capacity and gives consent to the practice or where the practice is sanctioned under the Mental Health Act or the Mental Capacity Act.

6.7 Care Planning

6.7.1 It is essential that any restriction is identified and justified in the care plan; this should include

- Rationale for the use of restraint.
- The frequency of re-assessment of the need for restraint. Review times should be specified in advance.
- All discussions that have taken place to allow the patient to give informed consent and to assess best interests.
- Discussions with relatives, carers and others with regard to the restraint.
- Details about the use of the restraint itself.
- Which legislative framework is being used to legitimise the restriction; e.g. MCA, MA etc.

6.7.2 A Core Care Plan titled: Clinically Related Challenging Behaviours is available on the staff intranet at: Royal Cornwall Hospitals Trust > Our Services > A-Z Services > F > Forms > Forms To Print.
http://www.rcht.nhs.uk/DocumentsLibrary/RoyalCornwallHospitalsTrust/W ebsites/Internet/OurServices/AZServices/F/Forms/FormsToPrint/CHA291 3CarePlanClinicallyRelatedChallengingBehaviours.pdf

Core care plan also found on Datix, as print option.

6.7.3 Any person affected by the restriction needs to be involved in the decision to the fullest possible extent. Clear communication is essential.

6.7.4 Restrictions where possible must be a multi-disciplinary decision, consulting family; un-befriended patients will require an Independent Mental Capacity Advocate (IMCA).

6.7.5 In cases where it is not possible to establish a person's view, e.g. due to mental incapacity, staff will need to consider if the restriction is likely to cause more harm than good.

6.8 Recording Restrictive Practice

6.8.1 This must be documented in the medical records, with a Mental Capacity assessment where appropriate. All documentation in relation to restraint should be clear, detailed and contemporaneous.

6.8.2 Physical restraint must be reported on DATIX 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.

6.8.3 Any injuries to a patient, member of staff or visitor to the Trust premises, involving the use of restraint, should be reported on DATIX. Incidents should also be documented in the nursing / multidisciplinary notes.

6.9 Advice on Restrictive Practice

6.9.1 For further support and advice on the use of restrictive practice please contact:
- Safeguarding Nurse for Adults on ext. 2446 or 07825 904386
- Learning Disability Team on ext. 2875 or by bleep via RCHT switchboard.
- Mental Health and capacity lead Specialist Nurse on ext. 2446 or 07789 876247
- DOLs Lead for Cornwall County Council, Paul Wilkins, on 07910800537
- Security team on 2147
- Complex Care and Dementia liaison psychiatry via ext. 1300
- Psychiatric Liaison Service via ext. 1300

6.10 Training and Advice on Physical Restraint

The Management of Aggression and Violence Practitioners manage all training in relation to physical restraint, for advice or details of the training available contact Learning and Development on ext.: 5148
7 Dissemination and Implementation

7.1 This policy is to be implemented and disseminated through the organisation immediately following ratification and will be published on the organisations intranet site document library. Access to this document is open to all.

7.2 This policy document will be held in the public section of the Documents Library with unrestricted access, replacing the previous version which will be archived in accordance with the Trust Information Lifecycle and Corporate Records Management Policy.

7.3 This policy will be disseminated through the Safeguarding Adults Operation Group membership, the Senior Nurse, Midwifery and AHP Group, the Matron’s and Senior Matrons weekly briefing and the RCHT daily communication all user email

7.4 Reference to relevant sections from this Policy will be utilised at all RCHT Level 1 and 2 Safeguarding Adults mandatory training and at specific mental capacity training

8 Monitoring compliance and effectiveness

8.1 Auditing of the implementation of the restrictive practice policy across clinical areas will be undertaken to monitor the effectiveness and usage of this policy. The monitoring of compliance with this policy will be overseen by the RCHT Safeguarding Adults Operational Group.

| Element to be monitored          | The use of restraint within RCHT
|                                  | Compliance with this policy
|                                  | The reporting and documentation of incidents
|                                  | The use of the clinically related challenging behaviours core care plan
| Lead                             | Management of Violence and aggression Lead
|                                  | Specialist Nurse for Mental Health and Capacity Lead Nurse.
| Tool                             | The RCHT DATIX system
|                                  | Medical and Nursing Documentation
| Frequency                        | Annually.
| Reporting arrangements           | The completed audit reports will be discussed at the Safeguarding Adult Operational Group.
| Acting on recommendations and Lead(s) | Where the report indicates sub optimal performance the Chair of the SAOG will nominate a group member to produce an action plan. The SAOG will be responsible for monitoring progress and will undertake subsequent recommendations and further action planning for all deficiencies identified within agreed timetables.
| Change in practice and lessons to be shared | Required changes to practice identified will be documented in the action plan outcomes. The membership of the SAOG will identify a lead to take each change forward across divisions as appropriate. Lessons will be shared with all relevant parties.

9 Updating and Review

9.1 This policy has been agreed by Trust Board and the staff and management side of the Health and Safety committee. It has been viewed by Learning and Development & Safeguarding Adults Operational Group.
9.2 This policy will be reviewed every 3 years or earlier in view of developments which may include legislative changes, national policy instruction (NHS or Department of Health) or Trust Board decision.

10 Equality and Diversity

10.1 This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the 'Equality, Diversity & Human Rights Policy' or the Equality and Diversity website.

Royal Cornwall Hospitals NHS Trust is committed to a Policy of Equal Opportunities in employment. The aim of this policy is to ensure that no job applicant or employee receives less favourable treatment because of their race, colour, nationality, ethnic or national origin, or on the grounds of their age, gender, gender reassignment, marital status, domestic circumstances, disability, HIV status, sexual orientation, religion, belief, political affiliation or trade union membership, social or employment status or is disadvantaged by conditions or requirements which are not justified by the job to be done. This policy concerns all aspects of employment for existing staff and potential employees.

10.2 Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is in the appendices
Appendix 1.

Restrictive Interventions / Physical Restraint

1. Restrictive Interventions (including use of Physical Restraint) definition:
"deliberate acts on the part of other 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 is necessary"

*Positive & Proactive Care: reducing the need for restrictive interventions. DoH. April 2014*

**Physical Restraint definition:**

"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*

2. Training

Physical restraint training to be provided by those identified within the Trust, as qualified to do so.

“Staff in NHS hospitals….. should have completed an appropriate course taught by a qualified trainer”

All new employees will attend Trust Induction, which will outline basic health & safety responsibilities and provide an awareness of violence & aggression risks.

**Conflict Resolution Training** for all frontline staff within the Trust is mandatory. This training will form part of Trust induction program. All training will meet the aims and outcomes as laid out in – Conflict Resolution Training: Implementing the learning aims & outcomes. NHS Protect. 2013. Frontline staff being those staff who ordinarily deal with members of the public or patients, as part of their job role. Training need identified within Electronic Staff Records (ESR).

**Personal Safety Training:** based upon localised Violence & aggression risk assessment, staff working in ‘high risk’ areas, will receive Personal Safety Training as mandatory, in addition to CRT. Localised risk assessment for training to be in conjunction with advice from the Trust Management of Aggression & Violence Team. Training need identified within Electronic Staff Records (ESR).

**Managing Clinically Related challenging Behaviour / Restraint Training:** based upon localised risk assessment, managers to be advised by Trust Management of Aggression & Violence Team as to training needs; in order staff to receive bespoke restraint training. (See – training analysis / matrix).

In the case of clinical areas who’s role is in predominantly supporting older persons with dementia, it is important all staff from those areas receive relevant training to this patient population group. Any restrictive interventions training should be supported with training on understanding reasons for challenging behaviour, assessing capacity and approaches to the challenging behaviour.

Trust Learning & Development Department provide / record all of the above training, along with other bespoke training packages.

'It is the responsibility of department/ward manager to determine what training is required by their staff according to job role. Staff must be made available to attend the training they require and ensure they remain in date’.

(Management of Violence & Aggression Policy 2014)

**3. Use of Physical Restraint:**

Where possible staff implementing Physical Restraint should be trained to do so, as identified

Violence, Aggression & Challenging behaviour Risk Assessment Matrix [for determining Mandatory / Training Requirements]

Management of Violence & Aggression Policy 2014. Appendix

**Planned prone physical restraint**

The utilisation of a planned prone restraint should not be used other than exceptional circumstances e.g. medical reason. Utilisation of seated, supine or release of person to be considered as alternatives.
Following restraint / use of restrictive interventions –
Based on clinical assessment of the patient restrained in terms of complex care needs & risk factors, or following parenteral sedation / rapid tranquillisation; staff are to monitor the vital signs of the patient every fifteen minutes for a minimum of one hour. (See Rapid tranquillisation Policy 2013). Or until there are no further concerns about their physical health status. (Nice 2015 Violence & Aggression: short term management in mental health, health & community settings).

4. Planned Interventions
Persons implementing planned Restraint must reasonably believe that restraint is necessary to prevent harm and the level of restraint used is proportionate in response to the likelihood and seriousness of harm.

“The level must be justifiable, appropriate, reasonable and proportionate to a specific situation and should be applied for the minimum amount of time”.

“Other than to mitigate significant risk of immediate harm or danger under criminal / common law, any physical interventions or physical restraint are not to include the use of pain, pain compliance or techniques likely to cause pain”.
(Positive & Proactive Care: reducing the need for restrictive interventions. DoH. April 2014)

Staff applying physical restraint should be made aware of physical and emotional risks to the person being restrained, in particular including risk of positional asphyxia. Particular consideration should be given around the physical vulnerabilities of those patients with identified complex care needs, elderly or frail patients and the potential risks to women with unidentified pregnancies. Through training staff should also be made aware of how culture or ethnicity may play a part in how emotions are expressed (and the risk how this may lead to a disproportionate use of restraint for example to black young men).

Staff should also be trained in Basic Life Support (BLS – Resuscitation Council UK), along with having immediate access to Immediate Life Support (ILS – Resuscitation Council UK) and medical cover.

Where an individual is ‘restrained’ in a supine position whilst resisting, or at length in a seated position, staff implementing the Physical restraint are to ensure a third staff member is present to monitor the physical health and wellbeing of the person until the situation has de-escalated to a more minimal level of interventions.

This will involve communication with the individual, observation and possibly protection of the persons head.

There must be no planned or intentional prone / face down restraint as part of utilisation of planned intervention. "If exceptionally a person is restrained unintentionally in a prone / face down position, staff should either release their holds or reposition into a safer alternative as soon as possible”.
(Positive & Proactive Care: reducing the need for restrictive interventions. DoH. April 2014)

All measures are to be made to monitor the person during such transition (and record details on incident report e.g. reason for, duration)
In the case of Security Officers implementing the above, they do not carry medical responsibility for a patient and therefore may request nursing or medical staff to be in attendance throughout the implementation of physical interventions.

Good practice Core care plan – clinically related challenging behaviour:
Core care planning being integral part of Positive Behavioural Support process. (Where staff identify causes / antecedents, behaviours likely and consequences / ways to resolve the challenging behaviours). Whether based around known behaviours or responding to crisis.

(This may include guidance from external care organisations on specific approaches to the management of challenging behaviours, where they already have positive behavioural support plans / documented plans of care).

Assessment of Mental Capacity should be demonstrated as per Trust Policy. (Refer to RCHT Mental Capacity Act, Independent Mental Capacity Advocacy and Deprivation of Liberty Safeguards Policy)

5. Emergency Interventions

As above. However, due to the very nature of ‘emergency’ situation, staff may be required to implement the Physical restraint as part of ‘use of reasonable force’ – Section 3 Criminal Law Act Sec. 3 1967 / Common Law, use of reasonable force. (If in the event of preventing immediate harm to a person).

Appropriate action to restrain or remove a person, in order to prevent harm to self or others may be conducted under this basis or under ‘common law’. (This in itself may impose a duty of care on healthcare and social care staff to which they provide services).

This should be to resolve emergency situations only, thereafter for repeated or prolonged incidents of Physical Restraint, the use of the Mental Health Act should be considered. (Or removal from site under the direction of medical or nursing staff, where appropriate by Security Officers / Police).

Use of rapid tranquillisation (ref rapid Tranquillisation policy 2013) for the control of acutely disturbed, violent (or Deliriums) behaviour.

6. Security Team response

Whether a ‘planned’ intervention, or emergency call (as per Trust procedure for summoning response team ext. 2999); those staff requesting response team assistance are to -

- Ensure adequate hand over of information is given to the team (this may include issues around capacity, MHA sections or medical complications). In clinical areas, response team may seek clarification from nursing / medical staff over capacity (see policy MCA), in order to act.
- Be available to handover information on attendance.
• In clinical areas provide staff member to provide medical responsibility if required. (See above). This also the case when responding to a patient with dementia, learning disability or mental health, where cognitive & communication impairment are paramount.
• Be available for response team to ‘stand down’ and leave.
• Report / document incident. Both incident areas & Security team to Datix incident.

7. Incident reporter

Physical restraint must be reported on DATIX 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.

DATIX reports identifying physical restraint activity will be reviewed by the Trust ‘specialist’ Violence and Aggression trainers, to monitor activity and provide support and guidance to staff involved, along with quality assured training in terms of appropriateness.

In clinical areas, the application of physical interventions should also be documented within medical notes, as a record of activity relating to patients.

8. References:

A positive & proactive workforce, Skills for Care. April 2014

Positive & Proactive Care: reducing the need for restrictive interventions. DoH. April 2014

Guidelines for the use of medication to manage acutely disturbed or violent behaviour in adult RCHT patients. Rapid Tranquilisation Policy. RCHT 2013.


Mental Health 1983 Act Code of Practice.


9. Additional advice:

  

- Mental Health Act 1983 (revised 2007)

  The Mental Health Act code of practice revised 2008 can be found on the department of health website.

- Mental Capacity Act 2005

  The Mental Capacity Act code of practice 2007 can be found on the department of health website.

- Deprivation of liberty Safeguards

  The Deprivation of liberty Safeguards code of practice 2008 can be found on the department of health website.

- Human rights, human lives

  The Human Rights, Human Lives hand book for public authorities can be found on the Ministry of Justice Website

- Human rights in healthcare

  The Human Rights in Action framework for local action can be found on the department of health website.
Training Matrix

The management of clinically related challenging behaviour will always involve risk and should be viewed as a last resort.

The purpose of the training matrix is to ensure that all staff regardless of position and AfC banding are fully conversant with their own training needs/requirements. All staff have an individual responsibility to ensure their own safety.

Managing clinically related challenging behaviour / Restraint Training is based upon localised risk assessments which must be completed and reported incidents of clinically related challenging behavior. It is imperative that staff receive bespoke restraint training.

It remains the responsibility of department/ward manager to determine what training is required by their staff according to their job role.

Staff must be made available to attend the training they require and ensure they remain in date. See Management of Violence & Aggression Policy – 2014 / Appendix 7: Violence, aggression & challenging behaviour risk assessment matrix for determining training requirements).

In order to guide department/ward managers in identifying appropriate levels for their staff; the following matrix identifies the levels of restrictive interventions / restraint training available.

This matrix should be considered alongside local risk assessment of challenging behaviour, incident review & always in conjunction with advice from the Trust management of Aggression & Violence Team.
### Restrictive interventions / restraint training analysis.

<table>
<thead>
<tr>
<th>Staff groups / wards where a requirement*</th>
<th>How often (minimum)</th>
<th>Duration of training / covering</th>
<th>Delivery method</th>
<th>Delivered by whom</th>
<th>Record of attendance held</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Dept. / Urgent Care Nursing, clinical Healthcare support workers &amp; Assistant Practitioners.*</td>
<td>2 yrly</td>
<td>Bespoke to needs. Support supine on trolley, seated &amp; stood</td>
<td>Face to face, practical.</td>
<td>See Training Matrix</td>
<td>Electronic staff record system (ESR)</td>
</tr>
<tr>
<td>Medical admissions Unit. *as above</td>
<td>2 yrly</td>
<td>Half day. Support supine on bed, seated and stood</td>
<td>Face to face, practical.</td>
<td>See Training Matrix</td>
<td>ESR</td>
</tr>
<tr>
<td>Kerensa, Tintagel. *as above</td>
<td>2 yrly</td>
<td>Bespoke to needs. Support seated, stood and supine on bed where appropriate</td>
<td>Face to face, practical.</td>
<td>See Training Matrix</td>
<td>ESR</td>
</tr>
<tr>
<td>Medical wards WCH *as above</td>
<td>2 yrly</td>
<td>Half day. Support supine on bed, seated and stood</td>
<td>Face to face, practical</td>
<td>See Training Matrix</td>
<td>ESR</td>
</tr>
<tr>
<td>Fistral *as above</td>
<td>2 yrly</td>
<td>Bespoke to needs. Support seated, stood and supine on bed where appropriate</td>
<td>Face to face, practical.</td>
<td>See Training Matrix</td>
<td>ESR</td>
</tr>
<tr>
<td>Recovery *as above</td>
<td>2 yrly</td>
<td>Bespoke to needs. Support supine &amp; seated on trolley</td>
<td>Face to face, practical.</td>
<td>See Training Matrix</td>
<td>ESR</td>
</tr>
<tr>
<td>All other wards based upon localised risk assessment. *as above</td>
<td>2 yrly</td>
<td>Bespoke to needs.</td>
<td>Face to face, practical.</td>
<td>See Training Matrix</td>
<td>ESR</td>
</tr>
</tbody>
</table>

*as above

---

Restrictive Practice Policy
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td>Awareness only, as part of induction reading materials.</td>
<td>As laid out - Conflict Resolution Training: Implementing the learning aims &amp; outcomes. NHS Protect. 2013. Recognition / assessing risks, reporting, alerts, de-escalation, lawful use of force to protect.</td>
<td>Physical disengagement techniques from grabs and difficult behaviour / assaults. CRT refresher included.</td>
<td>Managing bedside / clinically related challenging behaviour - bespoke sessions based on localised need. Basic holding around a bedside, tailored around patient group, individual patients, or staff / nursing interventions. Including basic releases.</td>
<td>Specialist restrictive interventions based around clinical environments</td>
<td>Comprehensive level of restrictive interventions covering all levels / hierarchy of techniques.</td>
</tr>
<tr>
<td>Delivery method &amp; duration</td>
<td>Electronic educational booklet</td>
<td>Face to face / classroom - 3hrs.</td>
<td>Face to face / classroom - 3.5hrs</td>
<td>Face to face in clinical areas. 40-60 mins.</td>
<td>Face to face in clinical areas. 40--60 mins</td>
<td>Face to face / classroom - 3.5hrs</td>
</tr>
<tr>
<td>Staffing groups</td>
<td>All staff on Induction</td>
<td>All frontline staff</td>
<td>Based upon local violence &amp; Aggression Risk Assessment</td>
<td>Based upon local risk assessment by manager, or as part of incident follow up / support, by V&amp;A Team. E.g. Trauma / Wellington / Carnkie / CCU / Wheal Prosper / SAL / Grenville.</td>
<td>As identified by V&amp;A Team: e.g. Recovery / Fistral / Kerensa / Tintagel.</td>
<td>As identified by V&amp;A Team: e.g. MAU / Medical Wards WCH / ED</td>
</tr>
<tr>
<td>Frequency</td>
<td>Once only</td>
<td>Three yearly</td>
<td>Two yearly</td>
<td>Two yearly where required.</td>
<td>Two yearly where required.</td>
<td>Two yearly where required.</td>
</tr>
<tr>
<td>Mandatory training need identified</td>
<td>Electronic staff record</td>
<td>Electronic staff record</td>
<td>Electronic staff record</td>
<td>Not mandatory - see policy Training analysis.</td>
<td>Not mandatory however advised as requirement - see policy Training analysis.</td>
<td>Not mandatory however advised as requirement - see policy Training analysis.</td>
</tr>
</tbody>
</table>
Restrictive Physical Intervention and Therapeutic Holding of Children and Young People.
Child Health Policy
Restrictive Practice Policy

**Child Holding Algorithm**

**Pre-procedure Action**
- Identify procedure to be carried out
  - Carry out a holistic assessment of child (including psychosocial and cognitive ability)
  - Explain procedure to the parent/carer and child (including the possibility of being held)

**Obtain Consent for Procedure**
- Consent obtained
- Refer to Trust policy on consent (Ref: 0356)

**There is a need to hold the child**
- Non Urgent
  - Debrief Child/ Family, Initiate Care Plan, Consider alternative intervention, Try later after further preparation
- Urgent
  - Revisit preparation, Child history consider Urgency of situation
  - Life Threatening
    - Prepare the child where possible

**Action during Procedure**
- If necessary seek further advice via solicitor through the litigation team if the procedure needs to be undertaken in the child’s best interest
- Prepare to hold
- If consent is withdrawn or child becomes distressed or attempts to carry out procedure within local guidelines fails, stop procedure when safe to do so except in life threatening situations

**Post Procedure Action**
- Debrief Parent / Carer & Child
- Reward Child
- Update Care Plan. Devise strategies to prevent holding of the child again if there are to be on-going interventions
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1. **Introduction**

1.1. This 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.

1.2. This version supersedes any previous versions of this document.

2. **Purpose of this Policy/Procedure**

2.1. The purpose of this 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.

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

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

3. **Scope**

3.1. This policy applies to all staff undertaking Restrictive physical intervention or therapeutic Holding in the care of children/young people and infants.

4. **Definitions / Glossary**

4.1. **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”

4.2. **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 should 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.’

5. **Ownership and Responsibilities**

5.1. Registered nurses are bound by a ‘duty of care’ and are accountable for promoting and protecting the rights and best interests of their patients.
5.2. Role of the Managers
Line managers are responsible for:

- Ensuring all staff have read and have access to this policy prior to undertaking restrictive physical intervention or therapeutic holding.
- Ensuring all staff have appropriate training in this practice.

5.3. Role of the Child Health Practice Development Forum and Audit and Guidelines meeting.
The Child Health Practice Development Forum and Audit and Guidelines meeting is responsible for:

- Reviewing best practice and ensuring Policy is updated regularly and in accordance with national guidance relating to children and young people.

5.4. 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. Standards and 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 should 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 should 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 should 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 specialists).

6.2. 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. 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.

- In all but the very youngest children, obtain the child’s consent or assent (expressed agreement) and 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 should 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 should not be made to feel guilty if they do not wish to be present during procedures. Nurses should 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.

6.3. Action During Procedure.

All staff that carry out Restrictive physical intervention or Therapeutic holding must be trained by the nominated trust trainers.

- Follow the algorithm in point 6.1 to ensure appropriate preparation and debrief.
- A lead person should 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 should be agreed with the parents child/young person and clearly documented in the care plan. For example two unsuccessful attempts at bloods/cannulation should 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 reporting system-
Datix. This should be reported by those working in the area where the incident occurred.

7. **Dissemination and Implementation**

7.1. This document is available to all staff who are likely to carry out Restrictive Physical Intervention and Therapeutic Holding. Ward Managers who will be responsible for ensuring all staff read this document and sign to say they have done so and attend training updates as required.

7.2. **Training.**

All staff carrying out Restrictive physical intervention and therapeutic holding will be asked to read and sign to confirm they have read this policy. Restrictive Physical Intervention and therapeutic holding training is provided by those identified within the trust, as qualified to do so, to all staff involved with this practice.

Training must be up to date, relevant, purposeful, evidence based and given by experts. Detailed records of training and proof of competency are essential as well as a system of monitoring competency and regularly updating skills.

Datix reports identifying physical intervention activity will be reviewed by the Trust specialist violence and aggression trainers, to monitor activity and provide support and guidance to staff involved, along with quality assured training in terms of appropriateness.
8. Monitoring compliance and effectiveness

<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>Compliance with reading policy. Compliance with training. Documentation of interventions where therapeutic holding/physical restraint has been necessary.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead</td>
<td>Ward Managers. Senior Matron Child Health.</td>
</tr>
<tr>
<td>Tool</td>
<td>Risk management and incident review</td>
</tr>
<tr>
<td>Frequency</td>
<td>Monthly risk management meetings</td>
</tr>
<tr>
<td>Reporting arrangements</td>
<td>Risk management meeting minutes and monthly newsletter to report incidents and learning outcomes.</td>
</tr>
<tr>
<td>Acting on recommendations and Lead(s)</td>
<td>Staff will be informed of necessary actions by Ward managers, Lead nurses, and Matrons, and newsletter.</td>
</tr>
<tr>
<td>Change in practice and lessons to be shared</td>
<td>Required changes to practice will be identified at risk management forums and disseminated via the Child Health Risk Management Newsletter. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant staff. Actions and learning outcomes will be shared with all relevant staff via Risk Management Newsletter at Practice development Forum and Ward Mangers meetings.</td>
</tr>
</tbody>
</table>

9. Updating and Review

9.1. This policy will be reviewed every three years. Any version activity is to be recorded in the Version Control table as part of the document control process.

10. Equality and Diversity

10.1 This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the 'Equality, Diversity & Human Rights Policy' or the Equality and Diversity website.

Royal Cornwall Hospitals NHS Trust is committed to a Policy of Equal Opportunities in employment. The aim of this policy is to ensure that no job applicant or employee receives less favourable treatment because of their race, colour, nationality, ethnic or national origin, or on the grounds of their age, gender, gender reassignment, marital status, domestic circumstances, disability, HIV status, sexual orientation, religion, belief, political affiliation or trade union membership, social or employment status or is disadvantaged by conditions or requirements which are not justified by the job to be done. This policy concerns all aspects of employment for existing staff and potential employees.

10.2 Equality Impact Assessment
The Initial Equality Impact Assessment Screening Form is in the appendicies.
Restrictive Practices – Clinical Guideline for the use and application of hand control mittens in adults only.

1. Aim/Purpose of this Guideline

This guideline relates to the use and application of hand control mittens in adult patients where it is felt their safety is compromised and medical treatment cannot be delivered effectively and safely. The guideline applies to all health care practitioners involved in the recommendation and/or use of hand control mittens.

Ward managers are responsible for ensuring the implementation of this guideline, associated guidelines and for monitoring compliance. They should ensure health care professionals access appropriate training. This policy is to be read in conjunction with RCHT Mental Capacity Act and RCHT Deprivation on Liberty Safeguards Guidance and Procedure.

2. The Guidance

Its aim is to guide decision-making when treating agitated or cognitively impaired patients and who often lack mental capacity. The guideline and the mittens assessment tool (see document) aims to support practitioners to ensure that the application of mittens is lawful, legitimate, proportionate, and the least restrictive reasonable option available. These issues should be applied in conjunction with principles of dignity, equality, respect, fairness and autonomy.

The use of Mittens is recognised as a form of restraint although they are not considered to be a deprivation of liberty (DOL). There are various forms of restraint e.g. Nasal bridle to secure NG feeding tubes, however mittens may be regarded in this situation as the least restrictive and safer alternative. The use of Mittens is ethically sensitive and this needs to be managed whilst providing optimal treatment. Mittens may be used in patients considered to lack capacity to recognise and manage risks and harm associated with removal of a medical device i.e. rigid cervical collar, NG feeding tube but only if use of mittens is considered proportionate to the likelihood and seriousness of harm and all other non-restrictive and innovative alternatives has failed.

Mittens are designed to restrict the movement of one or both hands and are used with patients who are acutely ill (a number of these may be agitated or restless) have long term illness or have a cognitive impairment due to head injury, dementia or other conditions. This frequently often leads to the patients attempting to remove essential medical devices
e.g. rigid cervical and soft collars, Nasogastric feeding tubes, nasal bridles, urinary catheters, vascular access device and other appliances which then may need to be reinserted.

- **Nasogastric feeding tubes** (see page 50) Patient removal of NG tubes can lead to aspiration of feed, chest infection and irregular administration or omission of feed, water and/or medication resulting in inadequate nutrition, fluid and electrolyte imbalance.

- **Nasal Bridle** If a nasal bridle is forcibly pulled out of the nose trauma to nasopharynx could ensue. For this reason bridles should not be inserted in acutely confused patients, or those who have repeatedly pulled out Nasogastric tubes (see nasal bridle policy). Mittens may be considered as an alternative, safer and lesser restraint than a nasal bridle.

- **Hard cervical collar** Risk of removal of hard collar may lead to pain, ligament damage, neuropathy, delayed union or malunion of fracture site and/or paralysis.

The decision for the use of mittens should only be undertaken by a registered health professional who understands the risks and benefits associated with their application. Who is personally regulated and have professional accountability under their code of conduct, to ensure that while caring for clients they are assured they have been given/ sought information about the patient’s condition and understand the risks and implications of any proposed restraint. Mittens must be applied by a registered nurse, allied Health care professional i.e. Occupational Therapist, physiotherapist and Doctors who have had appropriate training.

This guideline outlines the steps and safeguards required to enable practitioners to follow an agreed decision making, assessment and review process using the mittens assessment tool form thus ensuring appropriate use and management of hand control mittens in adult patients within the Trust. The assessment tool aims to ensure that the patient’s mental capacity is assessed and that if a patient does not have mental capacity (this is likely to be the case in the patient group concerned) to make a decision then the healthcare professional has an obligation to act in the patient’s best interest. This is likely to involve discussion amongst the multidisciplinary team caring for the patient and with their next of kin. A consent form 4 should be completed and a mittens care plan commenced. The assessment tool, mittens care plan and consent form 4 are available on the RCHT intranet.

**The following people may be considered for the use of mittens:**

- Disorientated patients/patients with delirium
- Restless and agitated patients
- Confused patients for clinical or functional reasons

**Contraindications:**

- Highly aggressive, combative or suicidal.
- Have wound site or abrasions on the affected hand or wrist
- Have severe arthritis of the wrist or hand
- Have a renal fistula
- Have a dislocation or fracture of the affected limb or shoulder
- Have an intravenous cannula inserted on the affected hand
• Have monitoring devices attached to the affected hand
• Caution should be used if a patient has a musculo-skeletal or neurological impairment of the hand or wrist

ONLY the recommended and branded product of hand mittens are to be used (see mittens care plan and assessment tool). Alternatives such as bandaging patients hands MUST NOT be used and is not condoned. Hand control mittens CANNOT be used when a patient has full mental capacity and has refused their use. Mittens should not be applied until the mittens assessment tool has been completed and documented clearly in the medical notes.

3. Monitoring compliance and effectiveness

<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>The use of Mittens</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead</td>
<td>Tracy Lee, Merion Grimshaw</td>
</tr>
<tr>
<td>Tool</td>
<td>Retrospective notes audit of patients who have received mittens</td>
</tr>
<tr>
<td>Frequency</td>
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<tr>
<td>Reporting arrangements</td>
<td>Eldercare clinical governance meeting documented by minutes of meeting</td>
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<td></td>
<td>Strategic Nutrition Steering group</td>
</tr>
<tr>
<td>Acting on recommendations and Lead(s)</td>
<td>The Audit will be presented to the Safeguarding Adults Operational Group. Where the report indicates sub optimal performance an action plan will be produced.</td>
</tr>
<tr>
<td>Change in practice and lessons to be shared</td>
<td>Re-audit annually</td>
</tr>
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</table>
CLINICAL GUIDELINE FOR SECLUSION

SECLUSION PATHWAY

The decision is taken to implement seclusion, this may only be decision may only be taken by the nurse in charge or a medic. Where the decision to implement seclusion is taken by someone other than a doctor, the ward doctor or duty doctor should be notified at once and should attend immediately.

All alternative management options have been considered and/or attempted and failed

The patient must be assessed for mental capacity and the Mental Capacity Assessment form completed

If the patient who is considered to require, or is actually under seclusion, is not formally detained under the MHA 1983, then immediate consideration should be given to the implementation of the MHA 1983.

The patient is moved to the seclusion area, where possible all items which could cause harm to the patient or others should be removed from the area

A competent member of staff should be delegated to maintain continuous observations and record on the seclusion observation sheet.

Thorough seclusion records should be kept in the patients notes

The nurse in charge must approve all interventions that require staff to enter the seclusion area, unless the situation is so urgent as to require emergency medical intervention.

The need to continue seclusion should be reviewed every 2 hours by two nurses – one of whom was not involved in the decision to seclude.

Review by a doctor should be completed every 4 hours.

If the seclusion continues for more than 6 hours a senior manager should be contacted, if the 6 hour period occurs outside of working hours they can be contacted at the start of the next working day.

Following 8 hours of continuous seclusion or more than 12 hours of intermittent seclusion over a 48 hour period, an independent review must be completed by a consultant or senior doctor and a matron, senior nurse or other senior professional who were not involved in the incident and/or decision making which led to the

Should seclusion continue for 48 hours a multidisciplinary management and treatment review of the patient must take place.

If the seclusion is disputed by any member of the multidisciplinary team, the matter should be referred to a

When the decision is taken to terminate seclusion the nurse in charge must document on the seclusion record and inform the ward doctor or duty doctor.

Following seclusion the patient and their relatives should be given the opportunity to discuss the period of seclusion with the nurse in charge.
**Aim/Purpose of this Guideline**

1.1. According to The Mental Health Act 1983 Code of Practice “hospitals should have clear written guidance on the use of seclusion”. This document sets out the best practice guidance for staff working in the Royal Cornwall Hospitals Trust (RCHT). It provides a framework for the seclusion of a patient who lacks capacity or is detained under the Mental Health Act (MHA) 1983. Seclusion is the isolation of a patient for a minimum period against their wishes, under supervision in a designated room, which they are unable to leave or is locked. This document provides clear instructions on how seclusion must be implemented. This document is applicable only to individuals over 16 years of age.

1.2. The Code of Practice defines seclusion as “The supervised confinement of an individual patient in a room, which may be locked to protect others from significant harm. Its sole aim is to contain severely disturbed behaviour, which is likely to cause harm to others”

1.3. Wherever possible, a patient’s independence should be encouraged and supported with a focus on promoting recovery. Any restrictions should be the minimum necessary to provide care and treatment always having regard to whether the restriction can be applied in a way that is least restrictive of a person’s rights and freedom of action.

1.4. Seclusion should only occur:-
• When there is no safe alternative
• When continued physical restraint would prove harmful
• In a situation of emergency and that this is the decided best option for the patient

1.5. Seclusion should not be used: -
• Because of staff shortage
• As a punishment or threat
• As part of a treatment programme

1.6. The safety, well-being, dignity and respect for the individual is paramount at all times.

1.7. The contents of this document apply to all staff working in RCHT whose practice is within the remit of this document.

1.8. The clinical objective is to protect and maintain the safety of patients, staff and others, in situations where a risk assessment indicates there are no other reasonable or practicable actions and, where all other alternatives have been considered or attempted and failed.

**2. The Guidance**

2.1. Prior to commencing seclusion all other methods of reducing the aggressive behaviour must have been considered and/or attempted and failed. This may include verbal de-escalation, the use of a quiet area, engaging with the patient in a way which offers a distraction to the presenting behaviour or increasing levels of safe and supportive observation, (this list is not exhaustive.)
2.2. The patient must be assessed for mental capacity as per the RCHT Mental Capacity Act Policy. If the patient who is considered to require, or is actually under seclusion, has mental capacity and is not formally detained under the MHA 1983, then immediate consideration should be given to the implementation of the MHA 1983.

2.3. If the patient is assessed as not detainable under the MHA and they have mental capacity they must not be placed in seclusion against their will.

2.4. The seclusion procedure may only be initiated by a registered nurse or medic. The person initiating the seclusion may need to obtain support to move a violent or aggressive patient to the area where seclusion will take place, such as a side-room. Support should be sought from staff that have completed the physical intervention training, this can include security staff. Where possible all items which could cause harm to the patient and/or others should be removed.

2.5. The area used for seclusion must provide privacy from other patients and enable staff to observe the patient at all times. It must be safe and secure and adequately furnished, heated, lit and ventilated. The patient should have some means of calling for attention and this should be explained to them. Staff may decide what the patient is able to have in their seclusion room however the patient must always have adequate clothing. If support is required to allocate an appropriate room for seclusion the clinical site coordinators should be contacted.

2.6. Where the decision to implement seclusion is taken by someone other than a doctor, the ward doctor or duty doctor should be notified at once and should attend immediately.

2.7. The need for the implementation of seclusion and the criteria for the termination of seclusion should be explained to the patient and their relatives and should be reiterated as required. This should be fully documented in the Patient's healthcare records.

2.8. A competent member of staff must be delegated to maintain continuous observation of the secluded patient. The aim of observation is to monitor the condition and behaviour of the patient and identify the time at which seclusion can be terminated. The patient’s condition and behaviour should be documented at least every 15 minutes on the seclusion record (appendix 3). When a patient is in seclusion the seclusion record must be used, not a safe and supportive observation chart, however if seclusion is terminated and safe and supportive observations continue the safe and supportive observation care plans and safe and supportive observations charts must be used and correctly completed.

2.9. The member of staff who is observing the patient must be made aware of how to call for help and/or assistance. All staff must be made aware of the importance of responding to a call of assistance from the observing member of staff.

2.10. It is the responsibility of the nurse in charge to approve all interventions that require staff to enter the seclusion area, including medical examinations, before they take place, unless the situation is so urgent as to require emergency medical intervention. At least one of the persons who enter the seclusion area to carry out an intervention must be of the same gender as the patient.

2.11. Detailed and contemporaneous records should be kept in the patients’ notes of any seclusion, the reasons for its use and subsequent activity. The principle entry should be made by the nurse in charge of the ward and the records should be countersigned by a
doctor and a senior nurse. The clinical site coordinators’ should monitor and regularly review the use of seclusion.

2.12. The need to continue seclusion should be reviewed every 2 hours by two registered nurses – one of whom was not involved in the decision to seclude. Review by a doctor should also be completed every 4 hours.

2.13. If the seclusion continues for more than 6 hours a clinical site coordinators should be contacted.

2.14. Following 8 hours of continuous seclusion or more than 12 hours of intermittent seclusion over a 48 hour period, an independent review must be completed by a consultant or senior doctor, matron, senior nurse or other senior professional who was not involved in the incident and/or decision making which led to the seclusion.

2.15. If seclusion continues past the 8 hours continuously or 12 hours intermittently, or if further episodes of seclusion are required after reaching this threshold, then a consultant and a matron or a nominated deputy must be involved in a review at least every 24 hours.

2.16. Should seclusion continue for 48 hours a multidisciplinary review of the management and treatment of the patient must take place and alternative management and/or placement options should be considered.

2.17. If the seclusion is disputed by any member of the multidisciplinary team, the matter should be referred to a clinical site coordinator.

2.18. The decision to terminate seclusion must not be taken in isolation but in discussion with the patient’s care team. When the termination of seclusion has been agreed the nurse in charge must document on the seclusion record and inform the ward doctor or duty doctor.

2.19. Ongoing support and observation should be provided in accordance with the RCHT Procedure for Safe and Supportive Observations in Adults.

2.20. Following seclusion the patient and their relatives should be given the opportunity to discuss the period of seclusion with the nurse in charge.
Restrictive Practice Policy

- Continuous observations must be maintained at all times and the observation sheet completed as directed.
- Mechanisms must be in place to allow the observer to request help or support at any time, these requests must be responded to immediately.
- All interventions that require staff to enter the seclusion area must be approved by the nurse in charge, unless emergency medical intervention is required.

### SECLUSION OBSERVATION SHEET

<table>
<thead>
<tr>
<th>Date</th>
<th>Observer (print)</th>
<th>Start Time</th>
<th>Comments – every 15 minutes</th>
<th>End Time</th>
<th>Handed Over To (print)</th>
<th>Signed by both staff (observer) (handed to)</th>
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<tr>
<td></td>
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<td>(behaviour, mental state and attitude to observation)</td>
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**SECLUSION REVIEW REQUIRED**

**SECLUSION REVIEW REQUIRED**

Page 45 of 56
### Incident details/Reason for seclusion:


### Alternative management methods considered/attempted and failed:


### Criteria for the termination of seclusion:


### Additional significant information, including disputes:


Patient and relatives informed of reasons for seclusion and termination criteria?  Yes □ No □

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<td>Time: ____________</td>
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<td>Doctor attended (print):</td>
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2 and 4 hourly Seclusion review form

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<td>Seclusion to continue □</td>
</tr>
<tr>
<td>Nurse 1 (print):</td>
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<td>Seclusion terminated □</td>
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<tr>
<td>Nurse 1 (print):</td>
<td></td>
<td></td>
<td>Seclusion terminated □</td>
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<tr>
<td>Nurse 2 (print):</td>
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<td>Sign:</td>
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<td>Designation:</td>
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<td>Doctor (print):</td>
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| Doctor (print):  |       |       | Sign:                           |
|                  |       |       | Designation:                    |
8 Hourly Seclusion Review Form

8 hour review: Date:__________  Time:__________  Patient condition and behaviour:

**Outcome:** Seclusion to continue □  Seclusion terminated □
Senior Medic (print):__________  Sign:__________  Designation:__________
Senior Nurse (print):__________  Sign:__________  Designation:__________

8 hour review: Date:__________  Time:__________  Patient condition and behaviour:

**Outcome:** Seclusion to continue □  Seclusion terminated □
Senior Medic (print):__________  Sign:__________  Designation:__________
Senior Nurse (print):__________  Sign:__________  Designation:__________

8 hour review: Date:__________  Time:__________  Patient condition and behaviour:

**Outcome:** Seclusion to continue □  Seclusion terminated □
Senior Medic (print):__________  Sign:__________  Designation:__________
Senior Nurse (print):__________  Sign:__________  Designation:__________

8 hour review: Date:__________  Time:__________  Patient condition and behaviour:

**Outcome:** Seclusion to continue □  Seclusion terminated □
Senior Medic (print):__________  Sign:__________  Designation:__________
Senior Nurse (print):__________  Sign:__________  Designation:__________

8 hour review: Date:__________  Time:__________  Patient condition and behaviour:

**Outcome:** Seclusion to continue □  Seclusion terminated □
Senior Medic (print):__________  Sign:__________  Designation:__________
Senior Nurse (print):__________  Sign:__________  Designation:__________

8 hour review: Date:__________  Time:__________  Patient condition and behaviour:

**Outcome:** Seclusion to continue □  Seclusion terminated □
Senior Medic (print):__________  Sign:__________  Designation:__________
Senior Nurse (print):__________  Sign:__________  Designation:__________
### 48 Hour Seclusion Review

**Description of patient's condition and behaviour:**

**Alternative management options considered/attempted and failed:**

**Placement options considered:**

**On-going management plan:**

**Additional significant information, including disputes:**

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Termination of Seclusion

Description of patient's condition and behaviour to support the termination of seclusion:

Management plan and on-going support for the patient:

Patient and relatives informed of the termination of seclusion?  Yes ☐ No ☐
Patient and relatives offered time to discuss the period of seclusion?  Yes ☐ No ☐

Patient and/or relative feedback:

Seclusion terminated:  
Date:  Time:  
Nurse in charge (print):  Sign:  Designation:  
Doctor informed:  Time:  
Doctor attended (print):  Sign:  Designation:  
Date:  Time:  

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**Nasal Bridle Guidelines**

A nasal bridle is a method of securing the Nasogastric feeding tube inside the nose which potentially reduces the likelihood of the tube being dislodged and/or displaced. It must be noted that there still remains a risk that the patient can still force removal of bridles and therefore they should be avoided in confused patients.

A clear documentation of Mental capacity and informed consent is required and DOLS and MDT/ Best interest meeting considered.

**Nasal bridles should not be placed without adequate training/ expertise and knowledge of the device. Please contact outreach team for support in placement if required**

**Indications:**
- Mittens failed/not appropriate
- Frequently **accidental** dislodged NG
- Difficult NG placement i.e. requiring radiological guidance and/or
- High risk of misplacement.

**Contraindications:**
- Basal skull fracture
- Mechanical obstruction of nasal airway (e.g. nasal polyps),
- Nasal trauma, surgery or ulceration
- Consider if patient on warfarin/ Clopidogrel.
- Confused and agitated patients

The insertion device for bridles contains a weak magnet which is unlikely to affect pacemakers, but as a precaution, if the AMT Bridle™ is inadvertently placed on the patient, it should be removed as soon as possible.

**Risks:**
- Nasal trauma
- epistaxis
- pressure necrosis or
- rupture/ erosion of septum from patients pulling on bridle (rare)
- Nasal redness and soreness can occur.
- Pain
- Sinusitis

**Management:**
- The bridle/ nose should be cleaned at least daily 0.9% saline
- moved gently up and down and side to side very gently once per day as this helps reduce crusting at the back of the nose
- Review on-going requirement for bridle **at least daily** and remove the device as soon as possible.
### Restrictive Practice Policy

**Governance Information**

<table>
<thead>
<tr>
<th>Document Title</th>
<th>Restrictive Practice Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Issued/Approved:</td>
<td>19th May 2017</td>
</tr>
<tr>
<td>Date Valid From:</td>
<td>19th May 2017</td>
</tr>
<tr>
<td>Date Valid To:</td>
<td>31st May 2018</td>
</tr>
<tr>
<td>Directorate / Department responsible (author/owner):</td>
<td>Corporate Division Lerryn Hogg / Jon Wiggans</td>
</tr>
<tr>
<td>Contact details:</td>
<td>01872 252446 / 01872 255148</td>
</tr>
<tr>
<td>Brief summary of contents</td>
<td>This policy is designed to define restrictive practice and to allow the practitioner to ensure that the care or treatment they are offering is lawful, legitimate, proportionate, and the least restrictive reasonable option available.</td>
</tr>
<tr>
<td>Suggested Keywords:</td>
<td>Restraint, Restrictive practice, Deprivation of Liberty Safeguards, DOLS, Mental Capacity, MCA, Physical restraint, Locked door, Mittens, Posey Mitts, Mitts, Hand restraints, Gloves.</td>
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<td>Target Audience</td>
<td>RCHT</td>
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<tr>
<td></td>
<td>✓</td>
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<tr>
<td>Executive Director responsible for Policy:</td>
<td>Director of Nursing</td>
</tr>
<tr>
<td>Date revised:</td>
<td>19th May 2017</td>
</tr>
<tr>
<td>This document replaces (exact title of previous version):</td>
<td>Restrictive Practice Policy</td>
</tr>
<tr>
<td>Approval route (names of committees)/consultation:</td>
<td>Steering Group RCHT Divisional Directors RCHT Nursing Midwifery and Allied Health Professionals Board Safeguarding Adults Operations group</td>
</tr>
<tr>
<td>Divisional Manager confirming approval processes</td>
<td>Corporate Division</td>
</tr>
<tr>
<td>Name and Post Title of additional signatories</td>
<td>Not Required</td>
</tr>
<tr>
<td>Signature of Executive Director giving approval</td>
<td>{Original Copy Signed}</td>
</tr>
<tr>
<td>Publication Location (refer to Policy on Policies – Approvals and Ratification):</td>
<td>Internet &amp; Intranet ✓ Intranet Only</td>
</tr>
<tr>
<td>Document Library Folder/Sub Folder</td>
<td>Clinical / Safeguarding Adults</td>
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<tr>
<td>Links to key external standards</td>
<td>• 2005 Mental Capacity Act</td>
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</table>
Related Documents:

- Positive & Proactive Care: reducing the need for restrictive interventions. DoH. April 2014
- A positive & proactive workforce, Skills for Care. April 2014
- RCHT Mental Capacity Act, Independent Mental Capacity Advocacy and Deprivation of Liberty Safeguards Policy (2011)
- Guideline for the use of medication to manage acutely disturbed or violent behaviour in adult patients of RCHT (Rapid Tranquillisation Policy)

Training Need Identified? Yes. Training is required for physical restraint. Please contact Jon Wiggins in the Learning and Development department.

Version Control Table

<table>
<thead>
<tr>
<th>Date</th>
<th>Version No</th>
<th>Summary of Changes</th>
<th>Changes Made by (Name and Job Title)</th>
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<tr>
<td>03.09</td>
<td>V1.0</td>
<td>Date first published</td>
<td>Zoe Mclean Liaison Nurse for Learning Disabilities</td>
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<tr>
<td>12.08.10</td>
<td>V2.0</td>
<td>Care plan removed</td>
<td>Zoe Mclean Liaison Nurse for Learning Disabilities</td>
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<tr>
<td>23.01.09</td>
<td>V3.0</td>
<td>Reformat in line with Trust &quot;Policy on Policies&quot;</td>
<td>Karen Powell Security Management Administrator</td>
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<td>Changes</td>
<td>Authors</td>
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<tr>
<td>09.07.12</td>
<td>V4.0</td>
<td>Reviewed and updated</td>
<td>Lerryn Hogg</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Expanded on types of restriction</td>
<td>Mental Health and Wellbeing Nurse</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Included unacceptable methods of restriction</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Included restrictive practice guidance flowchart</td>
<td>Jon Wiggans</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Leg strap protocol removed</td>
<td>Management of Aggression &amp; Violence Lead</td>
</tr>
<tr>
<td>21.02.14</td>
<td>V4.1</td>
<td>• Amendment to 5.6 changed DOLS administrator to Quality, Safety and Compliance Team.</td>
<td>Lerryn Hogg</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Change to title of the ‘rapid tranquillisation policy’</td>
<td>Mental Health and Wellbeing Nurse</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Updated definitions of restrictive practice and physical interventions.</td>
<td>Jon Wiggans</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Defined reportable incidents of restraint.</td>
<td>Management of Aggression &amp; Violence Lead</td>
</tr>
<tr>
<td>03.03.15</td>
<td>V4.2</td>
<td>• Definitions update in line with Department of Health guidance.</td>
<td>Lerryn Hogg</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Inclusion of Mittens guidance</td>
<td>Mental Health and Wellbeing Nurse</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Jon Wiggans</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Management of Aggression &amp; Violence Lead</td>
</tr>
<tr>
<td>19/02/16</td>
<td>V5</td>
<td>• Review to update in line with national guidance</td>
<td>Jon Wiggans</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Inclusion of the Seclusion Guidance</td>
<td>Management of Aggression &amp; Violence Lead</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Inclusion of Restrictive Physical Intervention and Therapeutic Holding of Children and Young People.</td>
<td>Lerryn Hogg</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Mental Health and Wellbeing Nurse</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Tabitha Fergus deputy ward manager</td>
</tr>
<tr>
<td>5/5/17</td>
<td>V5.1</td>
<td>• Nasal bridle guidance</td>
<td>Tracey Lee/Lerryn Hogg</td>
</tr>
</tbody>
</table>

**All or part of this document can be released under the Freedom of Information Act 2000**

*This document is to be retained for 10 years from the date of expiry.*

*This document is only valid on the day of printing*

**Controlled Document**

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## Initial Equality Impact Assessment Screening Form

<table>
<thead>
<tr>
<th>Name of the strategy / policy / proposal / service function to be assessed (hereafter referred to as policy) (Provide brief description):</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Directorate and service area: Corporate</td>
<td>Is this a new or existing Policy? Existing</td>
</tr>
<tr>
<td>Name of individual completing assessment: Lerryn Hogg</td>
<td>Telephone: 01872 254985</td>
</tr>
</tbody>
</table>

1. **Policy Aim***
   Who is the strategy / policy / proposal / service function aimed at?
   
   This policy is designed to define restrictive practice and to allow the practitioner to ensure that the care or treatment that they are offering is lawful, legitimate, proportionate, and the least restrictive reasonable option available.

2. **Policy Objectives***
   To ensure all staff have a good understanding of what constitutes Restrictive practice and apply it appropriately and within the law.

3. **Policy – intended Outcomes***
   Restrictive practices are use and only within law

4. ** How will you measure the outcome?**
   Audit policy implementation

5. **Who is intended to benefit from the policy?**
   All patients who requires restrictive practices a part of their care and treatment within RCHT

6a) **Is consultation required with the workforce, equality groups, local interest groups etc. around this policy?**
   Yes

b) **If yes, have these *groups been consulted?**
   Yes

C). **Please list any groups who have been consulted about this procedure.**
   RCHT Divisional Directors
   RCHT Nursing Midwifery and Allied Health Professionals Board
   Dementia RCHT links
   Care of the elderly nurse
   Safeguarding Adult Operational Group

7. **The Impact**
   Please complete the following table.

<table>
<thead>
<tr>
<th>Equality Strands:</th>
<th>Yes</th>
<th>No</th>
<th>Rationale for Assessment / Existing Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td>√</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Sex</strong> (male, female, trans-gender / gender reassignment)</td>
<td>√</td>
<td></td>
<td>This policy will have a positive effect due to providing clear guidance and reducing:</td>
</tr>
</tbody>
</table>
Restrictive Practice Policy

| Race / Ethnic communities /groups | √ | • Higher risks to elderly patients of restraint  
| Disability - Learning disability, physical disability, sensory impairment and mental health problems | √ | • Risks of restraint to women with unidentified pregnancies  
| | | • Over-use of restraint in black, young, male adults (as demonstrated in research).  
| Higher risk relating to complex care needs  
| Religion / other beliefs | √ |  
| Marriage and civil partnership | √ |  
| Pregnancy and maternity | √ |  
| Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian | √ |  

You will need to continue to a full Equality Impact Assessment if the following have been highlighted:
- You have ticked “Yes” in any column above and  
  - No consultation or evidence of there being consultation- this excludes any policies which have been identified as not requiring consultation. or  
  - Major service redesign or development

8. Please indicate if a full equality analysis is recommended. | Yes | No | √ |

9. If you are not recommending a Full Impact assessment please explain why.

It is not required

Signature of policy developer / lead manager / director
Lerryn Hogg

Date of completion and submission
05/05/17

Names and signatures of members carrying out the Screening Assessment
1.  
2.  

Keep one copy and send a copy to the Human Rights, Equality and Inclusion Lead, c/o Royal Cornwall Hospitals NHS Trust, Human Resources Department, Knowledge Spa, Truro, Cornwall, TR1 3HD

A summary of the results will be published on the Trust’s web site.

Signed_________________________ Date _________________