Leicestershire Partnership NHS Trust

Restrictive Practices Policy

Providing staff within Leicestershire Partnership NHS Trust with clear direction and process for using restrictive practices with patients in Mental Health and Learning Disabilities Child and Adult Services.

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Contents

Version Control and Summary of Changes

Version number	Date	Comments (description change and amendments)
1	October 2023	First version

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Equality Statement

Leicestershire Partnership NHS Trust (LPT) aims to design and implement policy documents that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. It takes into account the provisions of the Equality Act 2010 and promotes equal opportunities for all. This document has been assessed to ensure that no one receives less favourable treatment on the protected characteristics of their age, disability, sex (gender), gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy and maternity.

Due Regard

LPT will ensure that Due regard for equality is taken and as such will undertake an analysis of equality (assessment of impact) on existing and new policies in line with the Equality Act 2010. This process will help to ensure that:

- Strategies, policies and procedures and services are free from discrimination.
- LPT complies with current equality legislation.
- Due regard is given to equality in decision making and subsequent processes.
- Opportunities for promoting equality are identified.

Please refer to due regard assessment (Appendix 4) of this policy

Definitions that apply to this Policy

Safety Interventions	The training package currently used by the Trust that all clinical staff must attend, to support the management of disturbed behaviour and a minimum will learn “breakaway” techniques. (Previously known as MAPA)
PBS	Positive Behaviour Support is a form of applied behavior analysis that uses a behavior management system to understand what maintains an individual's challenging behavior and how to change it.
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 than is necessary’.
Physical Restraint	Any direct physical contact where the intention of the person intervening is to prevent, restrict, or subdue movement of the body, or part of the body of another person.
Prone restraint	(a type of physical restraint) holding a person chest down, whether the patient has placed themselves in this position or not, is resistive or not and whether the person is face down or has their face to the side. It includes being placed on a mattress face down, while in holds; administration of depot medication while held in prone position and being placed in prone onto any surface.
Prolonged restraint	Manual restraint over 10 minutes. NG 10 – NICE Guideline Violence and aggression: short-term management in mental health, health and community settings, suggests that seclusion or rapid tranquilisation should be considered in this instance.
Chemical restraint	The use of medication, which is prescribed and administered for the purpose of controlling and subduing disturbed or violent behaviour, where it is not prescribed for the treatment of a formally identified physical or mental illness.
Rapid tranquillisation	The use of injectable medication to control severe mental and behavioural disturbance, including aggression associated with mental illness
Mechanical Restraint	The use of a device (e.g. belt or cuff) to prevent, restrict or subdue movement of a person’s body, or part of the body, for the purpose of behavioural control.
Seclusion	The supervised confinement and isolation of a person, away from other users of services, in an area from which the person is prevented from leaving.
Long-Term Segregation	Long-term segregation refers to a situation where, in order to reduce a sustained risk of harm posed by the patient to others,

(LTS)	which is a constant feature of their presentation, a patient is not allowed to mix freely with other patients on the ward/unit on a long term basis. In such cases, it should have been determined that the risk to others is not subject to amelioration by a short period of seclusion combined with any other form of treatment; the clinical judgement is that if the patient were allowed to mix freely in the general ward environment, other patients or staff would almost continuously be open to potentially serious injury or harm.
Post Incident Debrief	Any incidents that involve restrictive interventions should have a post incident debrief to find out if the staff or patients involved received any physical or psychological harm. The patient who was involved in the incident should be given the opportunity when they have recovered their composure to discuss the incident with a member of staff.
Blanket Restrictions	The Mental Health Act Code of Practice (2015) defines blanket restrictions as “rules or policies that restrict a patient’s liberty and other rights, which are routinely applied to all patients, or to classes of patients, or within a service, without individual risk assessments to justify their application.” The Code’s default position is that “blanket restrictions should be avoided unless they can be justified as necessary and proportionate responses to risks identified for particular individuals”. The Code does allow that secure services will impose blanket restrictions on their patients.
Mental Health Units	As defined by the Mental Health Units (Use of Force) Act 2018: • *acute mental health wards for adults of working age and psychiatric intensive care units* • *long stay or rehabilitation mental health wards for working age adults* • *forensic inpatient or secure wards (low, medium and high)* • *child and adolescent mental health wards* • *wards for older people with mental health problems* • *wards for people with autism or a learning disability* • *specialist mental health eating disorder services* • *inpatient mother and baby units* • *acute hospital wards where patients are "detained under the Mental Health Act 1983 for assessment and treatment of their mental disorder”* *The following services are considered to be outside of the definition of a mental health unit (this is not an exhaustive list) and therefore not covered by the requirements of the act:* • *accident and emergency departments of emergency departments* • *section 135 and 136 suites that are outside of a mental health unit* • *outpatient departments or clinics* • *mental health transport vehicles*

1.0 Purpose of the Policy

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

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

The policy will describe the best practice when managing patients who may require restrictive interventions and methods to reduce the needs to use them.

Decisions about restrictive interventions or restraint are not easy or straight forward and are often made very quickly to ensure the safety of the people involved, both the patients and staff. This means that there is not always the opportunity for user involvement, or the opportunity to seek advice from senior colleagues.

Due to the nature of restrictive practices, this is often an area that patients and their relatives will make complaints about, so it is important that all restrictive practices are only carried out as a lawful, necessary, reasonable, proportionate to the risks and documented accurately.

Unlawful restraint may give rise to criminal or civil liability, which is why there is such an importance attached to accurate documentation, so that staff can account for their actions in such circumstances. The Trust will always support employees who act in a way that is deemed reasonable and measured at the time of the incident, and in accordance with professional standards and training.

The policy is in line with the Trust's values in that staff act in a trustworthy manner, respecting the patients and treating them with compassion, whilst acting with integrity. This policy supports both staff and patient safety and if followed should reduce the risk to patients and the public.

2.0 Summary and scope of policy

This policy aims to ensure that all staff are provided with the information required to enable them to adhere to the principles that underpin the use of restrictive practices and the aim to reduce the use of restrictive practices within the Trust. These principles follow safe and therapeutic responses to disturbed behaviour (Code of Practice, 1983) current best practice guidance, with a revised focus following the Mental Health Units (Use of Force) Act 2018.

The Trust provides a service to people who may require support to when presenting with behavioural disturbances and this policy and associated procedural guidelines

aims to promote a consistent positive and therapeutic approach to averting behavioural disturbances, through early recognition and de-escalation.
The governance arrangements within this policy ensures that the Trust takes all reasonable steps to promote appropriate use of and prevention strategies and avoid the misapplication of restrictive practices, particularly physical interventions in line with procedural guidelines.

- The policy aims to outline and define restrictive practices.
- Enable the practitioner to ensure that their practice is lawful, necessary, reasonable and proportionate.
- Guide the practitioner in applying the least restrictive option available
- Promote open communication
- Ensure that dignity, respect, accountability, autonomy and fairness are the fundamental elements of the management of behavioural disturbances
- Ensure that particular patient groups are not subjected to increased restrictions and that there are systems in place to monitor this.

Responses to behavioural disturbance include;

- **Proactive interventions** e.g. Positive Behavioural support plans, No Force First model, Trauma Informed Care approach, medication intervention/review enhanced levels of observation.

- **Active interventions** e.g. De-escalation

- **Reactive interventions** e.g., Physical restrictions, body maps, debriefing of patients and staff, rapid tranquilisation, restraint and seclusion procedure, long term segregation procedure.

3.0 Introduction

Leicestershire Partnership NHS Trust (The Trust) is committed to creating high quality and compassionate care and wellbeing for all and so aims to reduce the need for restrictive interventions for those people that are cared for by the Trust.
The Trust recognises that violent and aggressive behaviour can escalate to the point where restrictive practices may need to be used to protect the person, staff or other users of Trust premises and facilities from significant harm, even if all attempts have been made to deescalate the situation using de-escalation techniques.

This policy provides guidance and information, in line with Mental Health Act Code of Practice (Chapter 26, Safe and Therapeutic Responses to Disturbed Behaviour), and contemporary evidence base in relation to the safe and therapeutic management of violence and aggression in healthcare settings. The need of the policy is from the Department of Health's Policy "*Positive and Proactive Care: Reducing the need for restrictive interventions (2014)*".

The policy also outlines the Trust's commitment to protect human rights and freedoms and to reduce the disproportionate use of force and discrimination against people sharing particular protected characteristics under the Equality Act 2010, including people from black and minority ethnic backgrounds, women, girls and disabled people, which is described in the *Mental Health Units (Use of Force) Act, 2018.*

This policy is relevant to all directorates. It covers interventions for adults, children and young people.

The Trust recognises and accepts its organisational responsibility for the Least Restrictive Practices Programme and management of violence and aggression in accordance with relevant legislation and national best practices. "Least Restrictive Practices" falls under the High Standards programme, as part of the Step up to Great Strategy. The Trust has a nominated executive lead for Least Restrictive Practice and the Mental Health Units (Use of Force) Act 2018, which is the Executive Director of Nursing, AHP's and Quality. This responsibility is delegated to the Deputy Director of Nursing, AHPs and Quality.

Restrictive interventions must only be considered once all attempts at de-escalation have been exhausted and have failed to calm the situation. These interventions should not be considered as a primary treatment. Staff should consider the clinical need, the safety of the patient and others when deciding which interventions to use. The intervention must be a reasonable and proportionate response to the risk being posed by the person.

The Care Quality Commission (CQC) will monitor the Trust on its Reducing Restrictive Practices Strategy and policy supporting this.

4.0 Duties within the Organisation

4.1 The Trust Board has a legal responsibility for Trust policies and for ensuring that they are carried out effectively.

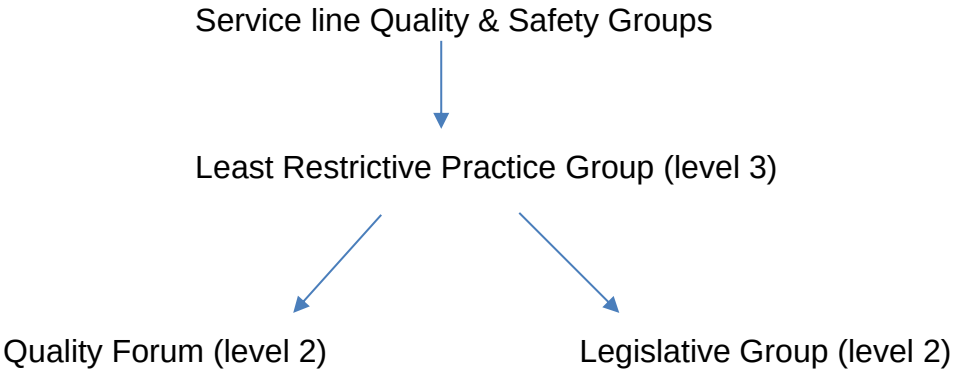
The Trust Policy Committee is mandated on behalf of the Trust Board to adopt policies

The Trust has a nominated executive lead for Mental Health Units (Use of Force) Act and least restrictive practices, which is the Executive Director of Nursing, AHP's and Quality. They have responsibility for a Restraint/Restrictive Practices Reduction Plan. This will ensure:

- Policy and procedures are embedded.
- The Trust is working towards a goal of reduced restrictive practices for the patients that they care for and eliminating the inappropriate use of force.

- That staff work in an area where patients are cared for in a least restrictive manner.
- That patients' Human Rights are adhered to whilst they are under our care.

4.2 The Least Restrictive Practice Group has level 3 governance responsibility for this policy.



4.3 The Least Restrictive Practice Lead will:

- Review all incident reports related to restraint or restrictive practices to ensure that these are completed accurately.
- Highlight incidents that have seclusion, prone or prolonged restraint to Ward Sisters/Charge Nurses for further analysis.
- Provide an overview and learning for all incidents involving restraint.
- Support teams with individual plans to reduce the need for restrictive practices
- Support teams to implement proactive strategies to reduce the need for restrictive practices.
- Escalation to Executive Lead any of areas of concern/areas of good practice related to restrictive practice

4.4 The Security Management Advisor (SMA) has responsibility for:

- Review all incident reports related to violence, aggression or security breaches, in order to identify trends, control measures and develop risk reduction strategies
- Provide assistance and advice on the use of CCTV images following incidents
- Liaise with external stakeholders as required.
- Lead on day to day work in the Trust to tackle violence against staff and professionals in accordance with NHS Protect national framework and guidance.
- Providing reports and trend analysis to the Health & Safety Committee regarding violence and aggressive incidents.

4.5 Directorate Directors and Heads of Service are responsible for:

- Responsibility to ensure safe practices within their operational service areas e.g. effective management/escalation of risk; investigation of complaints and incidents, post incident review and support procedures, compliance with policy and staff training requirements.

4.6 Managers and Team leaders are responsible for:

- Monitor the implementation of this policy.
- Take action to ensure that all staff are appropriately trained in MAPA relevant to their role and responsibility.
- Ensure that inductions include information of management of violence and aggression, using least restrictive principles.

4.7 Ward Sisters Charge Nurses will:

- Ensure that this policy is embedded in clinical areas.
- Have a personalised plan for their area on reducing restrictive practices
- Will complete analysis of incidents that involve prolonged or prone restraint and incidents of seclusion.
- Will support Multidisciplinary Team with decisions related to the care of patients who have required restrictive practices.
- Ensure that incidents are reported accurately in their ward areas.
- To sign off incidents and share any learning with the wider teams.

4.8 Consultant Psychiatrists / Responsible Clinicians will:

- Ensure that this policy is discussed and embedded within MDT practices
- Ensure that they induct junior doctors and discuss this document with them
- Participate in MDT discussions and decisions made to ensure that least restrictive principles are considered for patients
- Work closely with the ward sisters/charges nurses to ensure that incidents of seclusion and restraint are appropriately reviewed and reflected on within the MDT

4.9 All Clinical Staff will:

- Ensure that their practices are in line with least restrictive practices.
- To attend and engage in training that is appropriate for their area of work.

Consent

• *Clinical staff must ensure that consent has been sought and obtained before any care, intervention or treatment described in this policy is delivered. Consent can be given orally and/ or in writing. Someone could also give non-verbal consent as long as they understand the treatment or care about to take place. Consent must be voluntary and informed and the person consenting must have the mental capacity to make the decision.*

• *In the event that the patient's capacity to consent is in doubt, clinical staff must ensure that a mental capacity assessment is completed and recorded. Someone with an impairment of or a disturbance in the functioning of the mind or brain is thought to lack the mental capacity to give informed consent if they cannot do one of the following;*

- *Understand information about the decision*
- *Remember that information*
- *Use the information to make the decision*
- *Communicate the decision***5.0 <u>Pro-active strategies</u>**

5.1 Safewards:

All Mental Health inpatient areas should be working towards completing the 10 Safewards interventions. When all 10 interventions are implemented, the Safewards interventions produced at 15% decrease in the rate of conflict and a 24% decrease in the rate of containment.

The interventions are:

- Reassurance
  Making sure support is available during difficult times on the ward

- Clear Mutual Expectations
  An agreement about what the patients and staff expect from each other.

- Soft Words
  Sometimes there are situations where patients are told no or asking them to do things they don't want to do. Soft words are saying it in a way that everybody understands and explaining why, to reduce confrontation.

- Talk Down
  Using de-escalation skills with our patients. Ensuring that you are in control of your own feelings, taking the person to a quieter area, spending time understanding what the problem is and then trying to resolve it, whilst showing respect and empathy.

- Positive Words
  Ensuring that during handover, something positive is said about each patient, so as not to always focus on the negative behaviours of the patients.

- Bad News Mitigation
  Sometimes we can be aware of upcoming bad news for patients, such as losing a tribunal, not getting the leave they expect, either spending time in the ward round with the multidisciplinary team or intercepting a patient following the receipt of the bad news to allow them to process the news.

- Know each other
  Sharing information with the patients so they can get to know appropriate details about you. Such as favourite films, music etc., so that patients are able to see past the uniform.

- Mutual Help Meetings
  A voluntary meeting with patients and staff, ideally each morning to help plan for the day, with a set agenda so people can help others during the rest of the day.

- Calm down methods
  Calm down boxes with things that can help distract patients and help them to relax when they are starting to become distressed.

- Discharge Messages
  Messages left from patients who have been discharged who give hope to those still on the ward.

5.2 Safety Huddles:

Safety huddles were initially used in acute hospital settings to reduce the risk of falls and other incidents, however when transferred to a mental health setting, it has been found that they reduce the incidence of violent and aggression incidents, seclusions, absconsions and self-harming behaviours.

Wards will meet each day (ideally each shift), with all staff on shift, including doctors, house keepers, therapists as well as the nursing team. They will discuss any areas of concern and those patients who may need extra intervention and to ensure that everyone feels safe in their ward area.

5.3 Dynamic Risk Assessment:

As part of the safety huddle, there is the opportunity to use an actuarial prediction instrument such as the BVC (Brøset Violence Checklist) rather than unstructured clinical judgement alone, to monitor and reduce incidents of violence and aggression and to help develop a risk management plan in inpatient psychiatric settings. (Appendix 6)

5.4 Sensory Modulation Strategies

The use of sensory modulation has been shown to decrease the need for restraint and seclusion and promote trauma-informed care. The use of sensory approaches reduced levels of emotional disturbance as well as the frequency of seclusion episodes in an inpatient mental health environment.

The grounding and stabilising aspects of sensory modulation are a significant factor in de-escalation for clients who experienced psychosis, elevated mood, dissociation and overwhelming anxiety or who wanted to harm themselves.

People using sensory modulation to calm themselves down are far less reliant on PRN medication or do not even require its use, or the use of seclusion or restraint, to manage emotional distress and dysregulation.

There are three sensory systems that support sensory modulation these are;

- Tactile (deep pressure not light touch)
- Proprioception (repetitive linear movement)
- Vestibular (repetitive linear movement)

Some strategies that can be offered are;

- Walking /pacing
- Walking with a heavy backpack on
- Rocking chairs / seating
- Weighted blankets (no heavier than 20% of person's weight and the person can remove independently)
- Cross trainers
- Cycling
- Treadmill
- Hammocks
- Swings
- Beanbags
- Dancing
- Yoga
- Shower with a wet towel over shoulders
- Vibration cushions
- Sucking a sour sweet or liquorice
- Drumming
- Singing
- Drinking a warm drink (tea/coffee/hot chocolate / herbal tea etc)

This is not an exclusive list and risk assessments need to be put in place for your clinical area.

5.5 Risk Assessment and Collaborative Care Planning:

Dealing with clinical risk is an essential and unavoidable aspect of the work of health practitioners and risk management is a core component of healthcare. It is important that all clinical staff are familiar with the principles of good practice which underpin effective risk management for their specific area of practice.

Clinical risk assessment in practice requires the gathering of information from as many sources as possible in a spirit of collaboration and co-production with the service user and their carers, based on knowledge of the research evidence, the service users experience and social context, and clinical judgement and should be carried out within the multidisciplinary team to increase the sharing of information and promote a multi-perspective approach. It is important to consider the patient's wishes when contacting their families and carers as it could be harmful to patients who are survivors of domestic abuse or violence.

Risk assessment and management plans should be developed and reviewed and whenever new relevant information becomes available or there is a change in the service user's clinical presentation or circumstances.

On admission all service users must have an up-to-date risk assessment completed including a robust formulation using the 5P's to formulation approach and a risk management plan which then supports the overarching collaborative care plan, and

any intervention care plans in relation to the service users' care.

Collaborative care planning prioritises the preferences and values of the service user with lived experience of mental health issues, their carers, families, and social groups. Collaborative care plans should be meaningful to the service user using their own words and phrases, empowering service users to take ownership in their own care. A more holistic and personalised approach to each service user allows them to be partners in their own care, to the extent they desire.

During admission the admitting nurse must consider any past and current risks, alongside the patient's risk factors, and review what has worked (and not worked) previously before having a collaborative conversation with them to discuss how to help them during their admission.

Some service users may have a positive behaviour support plan (PBS) already in place and this should be regularly reviewed to clarify that proactive, active, and reactive strategies are relevant to support the service user to keep them well, but also when they are starting to deteriorate. These plans should focus on the service users' strengths.

It is important that staff consider and incorporate the CHIME principles/factors when completing a collaborative care plan with a service user to support and aid their recovery.

The goal of CHIME is to allow service users to conceptualise their own mental health and wellbeing during their personal recovery.

Personal recovery means having meaning in your life, without ongoing difficulties to your mental health and wellbeing. This doesn't mean that your symptoms have gone; it means that you can manage these symptoms and still have a fulfilling life with purpose to each day. This can also mean understanding your feelings, such as why you feel the way you do and learning ways to control unwanted feelings –like anger, frustration, and stress.

CHIME PRINCIPLES/factors

Connectedness – feeling connected to someone, or something
Hope – having hope for the future, or that tomorrow will be a new day
Identity – having an identity outside of your diagnosis
Meaning – having a reason in your life
Empowerment – feeling in control and empowered to do what you want

Note: In relation to restrictive practices, staff should consider patient's physical health and how risks can be minimised to reduce the use of force, e.g., cardiac

issues, pregnancy, obesity and sickle cell anaemia and include these within the patient's care plan. Any risks should be clearly documented if restrictive practices should not be used then this should be clearly alerted on the electronic record, risk assessment and care plans. Following the use of restrictive practices, care plans should be reviewed and updated to reflect the physical, psychological and emotional effects of being subjected to restrictive practices.

5.6 Positive Behaviour Support (PBS):

Some areas are trained in using PBS and their patients will have PBS plans. These plans will help understand why patients behave in the way that they do and give staff instructions on how best to work with the patient and how to stop the behaviours from happening.

Please refer to the Trust's Positive Behaviour Support Care Pathway for Challenging Behaviour on StaffNet.

6.0 Active Strategies:

6.1 Risk Management Planning

If the proactive strategies are not working, and the patient is starting to become agitated, it is important to consider how to reduce these behaviours before they escalate. Ideally this would mean referring to the patient's collaborative care plan or PBS plan that they have in place and starting to act on the active strategies that are in place.

There may be times when patients are newly admitted or in our Place of Safety Unit and these plans are not yet in place. It is always important to get the patient's engagement, however this is dependent on the patient's mental capacity to implement their PBS plan. If the patient lacks mental capacity, a plan to manage these risks must be completed in their best interests

6.2 Prescribed medication

During a patient's admission, it is likely they will be prescribed psychotropic medications to help with their symptoms that they are presenting with. It is important that patients are offered their medication at the prescribed times and that if they are not taking these medications, that it is highlighted to the MDT. Nursing staff should continue to assess the patient's response to their treatment plan and hand this information over to the MDT in the daily reviews, but also within the patient's ward round. It may be that there needs to be amendments made to their treatment plan.

If a patient requires further medication, they can be offered PRN (as required)

medications (see reactive strategies).

6.3 Blanket Restrictions

During a hospital stay, it may be necessary to have blanket restrictions in place to maintain the safety of patients. The Mental Health Act Code of Practice state that these should be avoided unless they can be justified and are proportionate to the risk in place. If there are blanket restrictions, these should be reviewed monthly by the Ward Sister/Charge Nurse and discussed with the Matron for oversight.

Further details of the blanket restrictions in place across the Trust and the application and monitoring of blanket restrictions are detailed in the *Trust's Blanket Restrictions Policy.*

6.4 Searching:

It may be necessary to search patients on return to the wards. This should not happen routinely and should form part of the patient's risk plan, if there is concern that a patient may bring in a prohibited/restricted item. Staff should adhere to the *Searching of Inpatients and their property policy* when carrying this out.

6.5 Therapeutic Observations:

All patient on Mental Health and Learning Disability inpatient wards, will be subject to therapeutic observations. At times, these may feel restrictive for patients due to having staff observing them. Staff must work in line of the *Supportive Observation and Engagement of Inpatients Policy* to ensure that more restrictive observations are on for the shortest time and reviewed daily.

6.6 Risk Assessment for Physical Interventions

Prior to commencing any physical interventions, where a patient's behaviour is escalating and not responding to active strategies or the patient has complex physical health comorbidities, such as pregnancy and sickle cell anaemia. An assessment of their health status should be undertaken and documented within the electronic patient record, using the template in **Appendix 11.**

If a risk assessment has not been conducted previously, and physical interventions are used in an emergency situation, then it should be completed retrospectively. E.g., after episode of rapid tranquilisation administration.

7.0 Reactive Strategies

7.1 Seclusion-wear/Tear proof clothing:

For some patients who are a risk to themselves from ligaturing with their clothing, instead of having patients on long term enhanced levels of observations, it may be appropriate for them to use tear-proof clothing. This usually comes in the form of a t-shirt and shorts.

Their rooms will be removed of all items that may be used to harm themselves and bedding changed to a seclusion blanket. This should form part of an MDT decision and care plan for the patient and reviewed daily and used for the shortest time possible. This care plan should be used for a short period of time and not in conjunction with other plans. e.g.: patients in tear-proof clothing, should not be accessing leave off the ward.

When patients are supported to change into seclusion wear/tear proof clothing, staff should ensure that there are considerations for gender and dignity and consider that this is a very traumatic intervention and should be approached in a supportive manner.

7.2 PRN Medication including Rapid Tranquilisation:

At times, patients may require medication on top of their regular prescribed medications called PRN (Pro re nata), when they become distressed. Nursing staff should attempt to use other methods of de-escalation prior to using PRN medication, and sometimes it is about spending time with patients to help them work through uncomfortable feelings, however it can be useful to use medications when patients' feelings are beginning to overwhelm them. Patients should firstly be offered oral PRN medication, in line with the *Rapid Tranquilisation Policy*.

If the patient is presenting with acute disturbed behaviour and is refusing oral medication after multiple prompts, it may be necessary to administer the medication intramuscularly (IM), which may require the patient to be held physically. The patient should be given enough medication to help reduce any dangerous behaviour but allow for staff to be able to work with them.

Where rapid tranquilisation is administered, staff must take the patient's physical observations after administration and every 10 minutes until ambulatory. These should be documented within the patients' electronic record (Brigid), using NEWS2. If the patient refuses to have their physical observations taken, non-touch observations should be taken, e.g. AVPU and respiration rate.

7.3 Physical Restraint:

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

Any use of Physical Restraint must be reported on the electronic incident reporting form (eIRF) and should accurately describe the holds used, by whom and for what length of time.

The inpatient staff are trained in Safety Interventions (Previously MAPA - Management of Actual or Potential Aggression) training at either medium or high-risk level to be able to support patients in crisis. Staff working in Acute, PICU, Forensic, LD or CAMHS areas will be trained in Emergency and Advanced Safety Interventions, as will any other staff identified to have the need for this level of training, whereas all other areas will do Foundation Level.

Sometimes, it may be necessary to hold patients to ensure the safety of the patient involved, or other patients, or the staff on the ward. Ideally this should be conducted in a planned manner, to ensure that it is carried out in the safest manner, with all staff allocated a role. The staff should consider the patient's physical wellbeing prior to restraint and complete a dynamic risk assessment related to this. E.g. if the patient has cardiac issues, whether it is safe to restrain them.

It is essential that one staff member takes the lead in restraint situations and is both the decision maker and engages with the patient to keep them informed of what is going to happen. This person can be any band or role and it is best that it is somebody who knows the patient and what has been going on for them. This person is the **incident coordinator.**

This person should not become involved in the restraint where possible, so they are able to review all aspects of the incident. They should:

- Ensure the head and neck is appropriately supported and protected.
- That the airway and breathing are not compromised
- Monitor the person's overall physical and psychological well-being throughout
- Ensure that there is no pressure put on the patient's limbs/chest/back during the restraint and be aware of positional asphyxia and compartment syndrome.
- Ensure that the patient has physical observations and is reviewed following the incident.

Staff should consider the level of risk that is being posed as to the type of holds they use. Staff can apply low, medium or high level holds in a variety of positions.

Physical restraint **must not** be punitive.

All staff trained in using physical interventions must be trained in basic life support as a minimum and be aware of medical emergency procedures and be able to undertake vital signs monitoring and input on Brigid. If there are concerns about a patient's physical health during a restraint, staff must raise the alarm and assess the patient using ABCDE approach, and act accordingly.

7.4 Restraint for patients in Eating Disorder Services

Disordered eating 'behaviours can include restriction of dietary intake, binging, purging (including vomiting, laxative misuse, and misuse of Insulin in those with T1 diabetes) and excessive exercise, or a combination of any of these. Eating difficulties may relate to differing psychopathology and therefore accurate diagnosis and formulation is essential.' (RRN 2022, Appendix 5)

Supportive refeeding may include enteral feeding such as nasogastric (NG) tube or Percutaneous Endoscopic Gastrostomy (PEG) feeding (which is usually only used in the management of long-term enteral feeding and rarely in eating disorders). These interventions may need to be completed with the use of physical restraint in the most complex cases.

The use of NGT feeding under restraint should always be a risk based decision for each occurrence, carried out as infrequently as possible to follow principles of least restrictive practice and prevent traumatisation of patients and those around them.

Dietetic guidelines have been developed on the best practice for delivering enteral nutrition under restraint.

The key principles of this guidance include: • delivery of feed via push syringe bolus (not gravity bolus or enteral pump) • reducing the number of episodes of feeding to twice a day, and • increasing the volume of the bolus delivered as tolerated up to 1000ml per bolus."(RCPHSY, 2022)

7.5 Legal frameworks related to restraint.

Should the need to physically restrain a patient outside of Trust property, the staff involves should carefully consider the legal frameworks and the risks that they are being presented with. The staff have a duty of care towards the patient, whilst they are under our care so need to act accordingly.

If it is expected that a patient may require physical restraint, whilst outside of Trust property and they lack capacity for this, then it may be that a DOLS application is completed, under the Mental Capacity Act (MCA).

If there is not a framework in place to approve the restraint (i.e. DoLS) then staff example where restraint is in response to unexpected behaviour or to prevent harm in

an emergency. If the patient lacks capacity, then it would be under Section 5 of MCA that it is in the patient's best interests and to protect the patient and/or public. If a patient requires continued restraints of this type, then a DoLS should be applied for.

If restraint is required when providing medical treatment, such as holding somebody's arm, whilst taking bloods, this should be incident reported and if regularly required, should be robustly care planned.

Should a patient require a procedure or treatment where a degree of force is required beyond the description above, then an application should be made to the Court of Protection for serious medical treatment to ensure proportionate levels of restraint are being applied.

For patients detained under the Mental Health Act, who are subject to Section 17 leave from our Trust, LPT staff are authorised to use holds to administer treatment for the patient's mental health.

Medical treatment for mental disorder e.g. bloods for Lithium/Clozapine or overdose management within acute hospital sector. If a patient in detained under Part II of the Mental Health Act (e.g. Section 2 or 3) and they require treatment, which is deemed to be a cause or consequence of their mental disorder, this can be given, without the patient's consent and using restraint if necessary. For more details on consent to treatment, please refer to the Trust's *Consent to Treatment Policy.*

Staff should always use approved holds as trained in Safety Interventions training and document these within their record keeping and eIRF.

Common law is the power "for every constable and also every citizen" to prevent a breach of the peace "by arrest or other action short of arrest". Common law can be used to defend the use of restraint where there is no opportunity to form a judgement about a patient's capacity, best interests and it is necessary to take immediate action to prevent serious harm or loss of life.

7.6 Disengagement Skills:

Staff who attend Safety Intervention training are taught disengagement techniques, which whilst these are not classed at restrictive practices are used to help a staff member to escape, but may lead into a restrictive intervention to support the person who was originally holding the staff member.

The techniques are based on biomechanical benefit (movement)

- **Hold and stabilise** (for low-risk behaviours) – to limit the person's movement e.g. if somebody is holding you, you hold on to them, to stabilise the person's movement and prevent harm.

- **Pull/Push** (for medium risk behaviours) – to move in opposite directions. Pulling away is a natural reaction but does not always work if the person has a strong grip. Pulling and pushing at the same time weakens the person's grip. This movement will allow the person to move from within the person's weakest point at the thumb, to allow a release.
- **Lever** (for high risk behaviour) – Combining momentum (energy and speed) with movement (rotation) around a single point (e.g. elbow, shoulders and hips), this creates whole body energy through the arms and/or legs to increase the effectiveness of the lever.

These skills can be used for staff to escape from a variety of holds such as:

- Wrist
- Clothes
- Hair
- Neck (Neck is also taught as a separate high-risk skill, if the person is using two hands)
- Body
- Bite

7.7 Emergency Responses:

The goal of emergency responses is to gain a release from a hold, while minimising harm to the person in distress. They can be used for the individual being held to escape but also for somebody to rescue the person being held.

Emergency responses create a somatic response, causing the person in distress to instinctively let go as a protective reaction.

Only the responses outlined within this policy are authorised for use within the Trust and must only be used when they are:

- Authorised and approved
- With justification
- Where it is life-threatening
- Where there is no safer alternative
- Never to coerce, punish, or gain compliance
- They must be reported as soon as possible, in the patient's electronic record and within an electronic incident reporting form (eIRF).

Emergency Responses that are approved for use by the Trust are:

- Thumb

- Dorsal hand
- Upper Outer Torso
- Sternum
- Mandibular (behind the ear)
- Columella (Nosebar) –
    - **The columella emergency response must only be used in a rescue situation with adults. The response must never be used with children or young people.**
    - The use of these interventions comes with great responsibility and a higher level of legal and professional scrutiny, so staff who use these approaches must be able to account for their actions in specific circumstances.
    - The purpose of the emergency response is to get an immediate release from extreme risk behaviour to allow you to minimise harm and/or to assist your staff, colleague, or individual in care to a place of safety.

7.8 Restraint Holds:

7.81 Seated

A person can be held by two staff in a seated position, in low, medium or high-level holds. Ideally, you want to work towards the patient being in this position, so that a staff member can engage them therapeutically to work with the person to understand what has happened to them.

Low level:

Medium level:

High level:

A third person can be utilised to support these two staff, to hold the person's shoulders or head if the person is being resistive and the people on the arms are struggling to hold them or they are spitting.

7.82 Standing

A person can be held by a single member of staff in standing in low-level holds, to remove them from one area to another. If the person cannot be managed in low holds, a second person can be utilised to hold them in medium level holds to either relocate them, or to support them into seated restraint.

Low level:

Medium level:

High Level:

While standing, a third person can be utilised to manage the shoulders or head, to slow the movements down.


7.83 Transitions

When a patient is in a standing position with three staff, it may be necessary to support them into a floor seated position and then into supine (face up). Supine is the preferred option when needing to take a patient into the floor position. There will be two staff who hold the arms, a third will support the back and then will maintain the safety of the person's head.

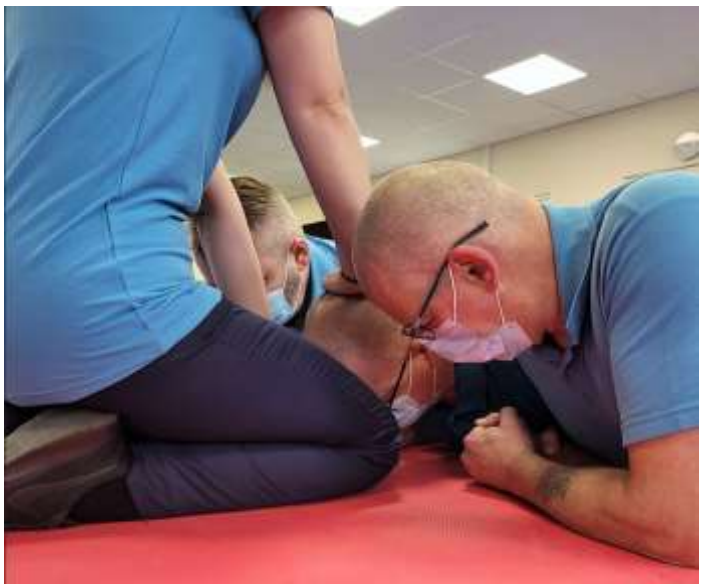

Staff are also trained in standing to kneeling transition and then into supported prone in case a patient slips/falls into this position.

7.84 Restraint on the floor:

Ideally patients should be managed either in a seated or standing position, however it may be necessary to hold patients on the floor for short periods, usually to administer medication. Patients should be held on the floor for the shortest period, before being taken back into a seated restraint. Patients should be taken into supine (face-up) position and moved into side-lay for administration of medication on the floor.

Supine:

Supported Prone:



Side lay for administration of medication in gluteal site:

Patients will have a minimum of a staff on each arm, and a staff member to manage the head (protecting the head, spine and airway). If a patient's legs become problematic, there needs to be consideration whether they are causing a problem, or whether they need to be held. An additional staff member may be required to hold the legs.

7.85 Prone Restraint:

Patients must not be restrained on mattresses/beds as this can cause issues with asphyxiation but also allows the patient to get out of holds due to the give in the mattress. If a patient requests to have medication whilst in bed, this should be done without holds, so the patient can maintain their own safety and airway.

Unless there are cogent reasons for doing so, which are clearly documented, patients should not be placed in supported prone position as a planned or intentional restraint, on any surface, not just the floor. If a person is held in prone restraint, staff should release their holds or reposition to a safer position as soon as possible. (Use of Force Act, 2018).

Due to this being a high-risk hold, there will need to be a deep dive into why this occurred, and the Ward Sister/Charge Nurse will need to submit their findings to the Least Restrictive Practice Group.

Staff who are trained in Advanced Level Safety Interventions (Previously MAPA), are taught supported prone restraint (as pictured above), where the chest is away from the floor, as the arms are under the chest. The Trust has recognised that not all incidents of prone restraint are supported, due to staff restraining on soft surfaces (mattresses) or without the patient's arms under the chest and has included the option to report unsupported prone. This is not an approved position and should be seen as a patient safety concern and should be reviewed formally to understand why.

7.86 Safety Pods:

Following a trial, Safety Pods are being rolled out to reduce the need for restraints on the floor. Staff will place the patient on the Safety Pod, whilst in holds to support them in a semi-recumbent position.

7.87 Prolonged restraint:

NICE Guideline Violence and Aggression: short-term management in mental health, health and community settings defined prolonged restraint as a manual restraint over 10 minutes and that seclusion or rapid tranquilisation should be considered in this instance.

It is not expected that restraints will routinely last over 10 minutes and as such the ward sister/charge nurse is expected to report the narrative related to the incident and any lessons learned to reduce that chance that this incident will occur again at the Least Restrictive Practice Group, to be reported to the relevant commissioners.

7.9 Negligible use of force:

The duty to keep a record of the use of force does not apply if the use of force is negligible, as outline in the Mental Health Units (Use of Force) Act, 2018. The use of force can only be considered negligible where it involves light or gentle and proportionate pressure. The Trust have decided that all incidents where physical interventions are taught in Safety Interventions (Previously MAPA) must be reported, and that negligible force would be that of moving and handling. This should still be described within the patient's care plan, with consent in place and reviewed accordingly.

7.10 Personal Protective Equipment:

Staff will be expected to be wearing minimum PPE for the area in which they are working, which may include gloves, aprons and goggles. Staff should follow the most up to date COVID-19 action card related to the use of PPE in their settings.

All staff working in inpatient areas should have a personal alarm, to be able to summon help from colleagues in their area, or from a response team. This must be tested on a daily basis to be sure the alarm is in working order.

Due to managing patients, who may be exhibiting risk behaviours, staff may encounter bodily fluids. In this instance, they may wish to wear coveralls and visors to protect their clothing and eyes. Patients who are spitting during physical interventions, may need support of an extra member of staff to manage the head. Under no circumstances should anything be placed over a person's head to stop them from sitting.

If a patient is a risk of biting, staff may need to wear arm protectors. This can help reduce the transmission of infectious diseases, along with both the physical and psychological damage that can occur from being bitten by a patient.

Following incidents within the Trust where there were incidents of staff being exposed to Blood-Bourne Viruses (BBV), following a bite or scratch, additional PPE as outlined above has been made available. Discussions held with the Trust's solicitors on how to accurately record patients with known BBV, and what PPE should be worn.

- This information can now be recorded in patient notes and only shared on a need-to-know basis – this information can be captured using different terminology e.g. lifelong transmissible infection
- That the patient must be told that their records will show the lifelong infection
- That it is appropriate for public protection to provide appropriate care and support to patients that staff are aware of any potential exposure and are provided with the correct PPE

7.11 Seclusion and Long-Term Segregation:

Please see the Seclusion and Long-Term Segregation Policy for its use. All incidents of seclusion must be scrutinised by the Ward Sister/Charge Nurse, with oversight from the Matron. They must complete an exception report for the Director of Nursing, AHPs and Quality and the Chief Executive to ensure that it is in line with the MHA Code of Practice. They must also review the incident at sign off to see how it could have been avoided and then feed this information back to the Least Restrictive Practices Group for shared learning.

7.12 Post Incident Reviews/Debrief:

Following an incident where restraint, rapid tranquillisation or seclusion is used, the staff should meet quickly after the incident to ensure there are no injuries and to discuss what happened during the incident, as the incident coordinator, may not have been at the incident from the outset and each person's role in the incident. This should allow for incident reports to be completed accurately.

It is important to discuss the trigger factors and what could be done to prevent this type of incident in the future. It is important to ask staff how they feel and whether they need any further support. It is recognised that staff that are involved in incidents that result in the use of restrictive practices may feel the impact emotionally and require support following the incident. However, it is the staff's responsibility to ensure that they let somebody know if they require further support after the debrief.

Directly after the incident, staff should try to rebuild therapeutic relationships with the patient where appropriate. Staff should discuss whether they want support or some time alone. Some patients may require support with ongoing distraction to manage feelings.

Other people who witnessed an incident where restrictive practices may have been used should also be offered support, as it is recognised that there are physical, psychological and emotional effects of witnessing the use of force. The principles of the staff debrief can be offered to support people. There will also be information available to patients and visitors on the use of force in our services.

The patient who was involved in the incident should be given the opportunity when they have recovered their composure to discuss the incident with a member of staff and this debrief should be recorded in their record. They should be reviewed for any injuries and given the opportunity for medical review if required. They should be offered emotional support and to consider how to reduce the chance of an incident like this from occurring again.

Staff are trained during Safety Intervention (previously MAPA) training in the IBERA Post-Crisis Debriefing Tool: 5 Simple Steps

1. Introduction – Introduce yourself to the person and how long you have to spend with them.
2. Background - Find out about the event. Use open questions to get the person to tell you their view of the event.
3. Emotional Impact - Use questions which help the person to describe their emotional response to the event or circumstances.
4. Resourcefulness - Find out how the person is handling the event and show empathy. Assess the person's response to how they are dealing with the event.
5. Action & Close - End the debriefing by asking the person if there is anything they think they should now do.

A proforma for patient post incident review is available within the Rapid Tranquilsation Policy and Seclusion and Long-Term Segregation Policy. (Also, in appendix7)

When staff need a further debrief after an incident, this should be conducted using a recommended tool, for example, 6 C's (See Debrief flowchart in appendix 9)

For some incidents, there may be the need for a more formal debrief/reflect session to support the staff team. These will take part with support from the psychology team.

Staff also have access to AMICA, the Trust's counselling service to support those with psychological difficulties following an incident, as well as support from line management and Occupational Health.

7.13 Body Maps:

When laying hands on another person, there is always a risk of injury, bruising and abrasions, however, it is expected that these would be in keeping with the event that has taken place. e.g., redness and swelling on the wrists from a physical restraint.

If a patient is physically restrained, then as part of the patient post-incident review, they should be asked whether they have any injuries, pain etc. It is expected that this occurs the day after the incident, to allow the patient time to be able to deescalate and for staff to be able to engage them. Staff should ask if they can view any areas that they are describing where they have pain and document their findings on a body map. (Appendix 8)

It is difficult to accurately age a bruise, therefore staff are not asked to make comment on the age of bruising but to describe size, colour and shape of any bruising.

7.14 Mechanical Restraint:

Currently there is no regular use of mechanical restraint within the Trust. However, some patients using our secure services, may be required to transfer patients using hand cuffs. These restraints will only be used as care planned in line with the Ministry of Justice restrictions.

If there is a need for mechanical restraints to be used in any other clinical areas, these should be following a Mental Capacity Assessment and Best Interest's meeting for the patient with the relevant parties involved, including the Safeguarding Team of the Trust, the Local Authority and Commissioners. Use of mechanical restraint should be reviewed regularly and should have a plan to move forward from their use. These devices should be prescribed by a physiotherapist and reviewed regularly whether there are safer alternatives.

7.15 Unacceptable Methods of Restrictions:

Bed Rails:
As per the Safe Use of Bed Rails for Adults Policy, bed rails must only be used to reduce the risk of a patient accidentally slipping, sliding, falling or rolling out of a bed / trolley when alternative measures have been considered and risk assessments completed. Bed rails are not designed or intended to limit the freedom of a person and are not a form of restraint.

Wheelchair Straps:
The safety straps on wheelchairs must always be used when transporting a patient. However, patients must not be strapped into wheelchairs, when seated as a form of restraint. Some people may be prescribed straps to maintain their posture, however these will be care planed and evaluated.

Use of blankets:
Patients must not be "tucked" into bed, so that they are unable to get out of the bed themselves, or to slow them down from getting out of bed. Blankets should not be tucked into or tied around bed rails, trolleys, plinths or chairs to keep people from moving.

Locked doors:
The main doors to mental health wards are usually locked, to reduce the risk of patients absconding, however there should be visible signs to alert people how they can get off the ward if they wish to and are able to. Other doors on the wards, such as bedrooms should not be locked, or closed to stop patients from exiting.

Removal of walking aids:
Patients who require walking aids, should be allowed to have these. It is not

acceptable as it creates a falls risk for the patient.

Use of beanbags/low furniture:
In some areas it will be appropriate to use bean bags, however for some patients, they may not be able to get up from being in a low position, so this should be considered.

Inappropriate/disproportionate use of restraint/restrictive practices:
If staff observe the inappropriate use of restraint (of any kind), they should report it as soon as possible to their line manager or supervisor and should complete an incident report. The incident report will flag to safeguarding, patient safety and relevant staff groups so that the manager can complete the risk assessment as part of the Trust's Allegations that an Employee/ Bank Worker may be Harming a Child, Young Person or an Adult at risk, Policy and Procedure. An investigation will be carried out following initial fact finding.

7.16 Communication in Restrictive Practices:

Use of Language around Restrictive Practices (both written and verbal):

Staff must be mindful of the language used when describing patients' behaviour and the negative connotations that their language may have. Dignity and respect must be at the centre of the care that is being delivered, especially when supporting patients who are in crisis.

Staff must demonstrate that they are acting in the least restrictive manner and that any restrictive practices are being used as a last resort and not for punitive reasons.

Staff should avoid using phrases such as:

- Kicking off
- Attention-seeking behaviour.
- Put in the box.
- IM'd/Accuphased/jabbed.
- Patient was MAPA'd.
- Patient not remorseful

Verbal communication:

Staff should use short, simple and clear instructions whilst deescalating patients. As part of active listening, they should paraphrase what the person has said, to show that they have understood what the person was saying, which will make them feel heard and understood.

Staff should use effective pauses when de-escalating people in crisis. It gives the

person the opportunity to talk and to fill the void and may give you more information about what is occurring. It allows the staff member time to gather their thoughts.
Paraverbal communication:
Staff should consider how they say what they say. They should be mindful of the tone, volume and rhythm of the speech that they use. This should be appropriate to the patient that they are engaging with.

Non-verbal communication:
Staff should maintain a safe distance when dealing with people in crisis and ensure that personal space is maintained. Staff should ensure that their postures are relaxed and non-confrontational (i.e., not crossed arms) when supporting with a person in crisis. Staff should ensure appropriate use of touch when supporting patients. Staff should ensure they listen with empathy and compassion, maintaining a non-judgemental approach.

7.17 Use of restrictive practices in particular patient groups.

We know that restrictive practices are used disproportionately on people sharing protected characteristics, particularly race, sex, age and gender, therefore, we need to ensure that we are reporting patient's protected characteristics within the incident reports so that we can monitor it.

The areas with increased risk are young girls and black men, as well as patients with a learning disability and/or autism.

As part of the Trust's Least Restrictive Practice group quarterly report, it reviews the use of restrictive practices by division, including information on ethnicity in relation to the data from the census for Leicester, Leicestershire & Rutland with support from the Trust's Equality, Diversity and Inclusion Specialist.

8.0 Training

There is a need for training identified within this policy. In accordance with the classification of training outlined in the Trust Learning and Development Strategy this training has been identified as Safety Interventions Training, Foundation, Advanced & Emergency and Disengagement. This training is accredited by the Restraint Reduction Network Standards.

9.0 Monitoring Compliance and Effectiveness

Ref	Minimum Requirements	Evidence for Self-assessment	Process for Monitoring	Responsible Individual / Group	Frequency of monitoring
7	How the organisation ensures that restrictive practices used are appropriate and proportionate	Section 6,7,8	Compliance with this policy will be monitored through the review restrictive practices used by the Directorates and Trust Group.	Directorate Incident Review Groups and Trust Reducing Restrictive Practice Group.	Monthly
7	The use of least restrictive practices is used prior to restrictive practices	Section 6,7	Audit with QI Methodology (plan do check, act) for actions.	Least Restrictive Practice Lead	Annual

10.0 Standards/Performance Indicators

TARGET/STANDARDS	KEY PERFORMANCE INDICATOR
Use of Unsupported Prone Restraint should not be used.	0 incidents of unsupported prone.
Use of supported prone should only be used where there are cogent reasons documented.	No more than 1 incident of supported prone per month.
The Trust is committed to reducing the use of restrictive practices (Seclusions, Rapid Tranquilisation and restraints).	There number of restrictive practices should be monitored via the KPIs and should continue to reduce and be monitored by the Least Restrictive Practice group.
Seclusion should be used as a last resort and for the shortest time possible.	The Trust will monitor and report on Seclusion episodes that last over 2 hours as part of its KPIs.
The Trust is committed to ensuring that particular patient groups are not disproportionately subjected to restrictive practices.	Continued monitoring of restrictive practices by gender, age and ethnicity.

11.0 References and Bibliography

The policy was drafted with reference to the following:

- Care Quality Commission, 2019. Brief guide: the use of ‘blanket restrictions’ in mental health wards. London: CQC
- Crisis Prevention Institute, 2021. Safety Interventions – Instructor Guide. CPI.
- Essex Partnership University NHS Foundation Trust, 2017, Therapeutic and Safe Interventions and De-Escalation Policy. Essex
- Department of Health, 2014. Positive and Proactive Care: reducing the need for restrictive interventions, London: DH
- Department of Health & Social Care, 2021. Mental Health Units (Use of Force) Act 2018, OGL
- Department of Health, 2019. Reducing the Need for Restraint and Restrictive Intervention, London: DH
- Department of Health, 2007, Mental Capacity Act 2005 Code of Practice, London: TSO
- Department of Health, 2015, Mental Health Act Code of Practice 1983, London: TSO
- Legislation. 1998. Human Rights Act 1998. [online] Available at: <https://www.legislation.gov.uk/ukpga/1998/42/schedule/1>
- Leicestershire Partnership NHS Trust, 2021, Mental Capacity Act Policy
- Leicestershire Partnership NHS Trust, 2021. Seclusion and Long-Term Segregation Policy.
- Leicestershire Partnership NHS Trust, 2020. Consent to examination or Treatment Policy
- Leicestershire Partnership NHS Trust, 2021. Supportive Observation and Engagement of Inpatients Policy
- Leicestershire Partnership NHS Trust, 2021. Violence Prevention and Reduction Policy
- Leicestershire Partnership NHS Trust, 2021. Allegations that an Employee/ Bank Worker may be Harming a Child, Young Person or an Adult at risk, Policy and Procedure.
- Leicestershire Partnership NHS Trust, 2020. Searching of Inpatients and their Property Policy

- Leicestershire Partnership NHS Trust, 2020. Rapid Tranquillisation Policy.
- Leicestershire Partnership Trust, 2020. Consent to Treatment Policy
- NICE, 2015. Violence and aggression: short-term management in mental health, health and community settings – NG10
- NICE, 2015. Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges – NG11.
- Restraint Reduction Network Training Standards (2022)
- Royal College of Psychiatrists (2022) Medical Emergencies in Eating Disorders: Guidance on Recognition and Management (Replacing MARSIPAN and Junior MARSIPAN). College Report CR233. Available here: https://bit.ly/3EPslEo
- Sherwood Forest Hospital NHS Foundation Trust, 2019. Restraint and Restrictive Practices Policy.
- Tees, Esk and Wear Valleys NHS Foundation Trust, 2020. Positive & Safe Care – Restrictive Interventions – Trustwide Information. Inpatient information about your care.

Appendix 1

Training Requirements

Training Needs Analysis

Training topic:	Safety Interventions, Foundation, Advanced & Emergency and Disengagement
Type of training: (See study leave policy)	✓ Mandatory (must be on mandatory training register) ✓ Role specific ☐ Personal development
Directorate (s) to which the training is applicable:	✓ Directorate of Mental Health ✓ Community Health Services ☐ Enabling Services ✓ Families Young People Children/ Learning Disabilities ☐ Hosted Services
Staff groups who require the training:	Clinical staff
Regularity of Update requirement:	Yearly (Foundation and Advanced & Emergency), 3 yearlies (Disengagement)
Who is responsible for delivery of this training?	Learning & Development Staff
Have resources been identified?	Yes
Has a training plan been agreed?	Yes
Where will completion of this training be recorded?	✓ ULearn ☐ Other (please specify)
How is this training going to be monitored?	Via ULearn Training records

Appendix 2

The NHS Constitution

The NHS will provide a universal service for all based on clinical need, not ability to pay.
The NHS will provide a comprehensive range of services.

Shape its services around the needs and preferences of individual patients, their families and their carers	✓
Respond to different needs of different sectors of the population	✓
Work continuously to improve quality services and to minimise errors	✓
Support and value its staff	✓
Work together with others to ensure a seamless service for patients	✓
Help keep people healthy and work to reduce health inequalities	✓
Respect the confidentiality of individual patients and provide open access to information about services, treatment and performance	✓

Appendix 3

Stakeholders and Consultation

Key individuals involved in developing the document

Designation
Least Restrictive Practice Practitioner

Circulated to the following individuals for comment

Designation
Least Restrictive Practice Practitioner
Head of Nursing, DMH
Clinical Directors for all Directorates
Heads of Nursing for all Directorates
Medical Director
Nursing Director
Heads of Service for all Directorates
Safeguarding Lead
Patient Experience Lead
Senior Health Safety & Security Advisor
Clinical Directors for all Directorates
Heads of Nursing for all Directorates

Appendix 4

Due Regard Screening Template

Section 1	
Name of activity/proposal	Reducing Restrictive Practices against our patient group
Date Screening commenced	17.9.21
Directorate / Service carrying out the assessment	DMH
Name and role of person undertaking. this Due Regard (Equality Analysis)	Rachael Shaw
Give an overview of the aims, objectives and purpose of the proposal:	
AIMS:	
OBJECTIVES:	

Section 2	
Protected Characteristic	**If the proposal/s have a positive or negative impact please give brief details**
Age	No
Disability	No
Gender reassignment	No
Marriage & Civil Partnership	No
Pregnancy & Maternity	No
Race	No – monitored via Least Restrictive Practice Group
Religion and Belief	No
Sex	No
Sexual Orientation	No
Other equality groups?	No

Section 3			
Does this activity propose major changes in terms of scale or significance for LPT? For example, is there a clear indication that, although the proposal is minor it is likely to have a major affect for people from an equality group/s? Please <u>tick</u> appropriate box below.			
Yes		No	
High risk: Complete a full EIA starting click here to proceed to Part B		Low risk: Go to Section 4.	**X**

Section 4			
If this proposal is low risk please give evidence or justification for how you reached this decision:			
Signed by reviewer/assessor	Rachael Shaw	**Date**	01/05/22
Sign off that this proposal is low risk and does not require a full Equality Analysis			
Head of Service Signed	Michelle Churchard-Smith	**Date**	26/09/22

Appendix 5

DATA PRIVACY IMPACT ASSESSMENT SCREENING

Data Privacy impact assessment (DPIAs) are a tool which can help organisations identify the most effective way to comply with their data protection obligations and meet Individual's expectations of privacy. **The following screening questions will help the Trust determine if there are any privacy issues associated with the implementation of the Policy. Answering 'yes' to any of these questions is an indication that a DPIA may be a useful exercise. An explanation for the answers will assist with the determination as to whether a full DPIA is required which will require senior management support, at this stage the Head of Data Privacy must be involved.**			
Name of Document:			
Completed by:	**Michelle Churchard-Smith**		
Job title	**Head of Nursing**		**Date 26/09/22**
Screening Questions		**Yes / No**	**Explanatory Note**
1. Will the process described in the document involve the collection of new information about individuals? This is information in excess of what is required to carry out the process described within the document.		No	
2. Will the process described in the document compel individuals to provide information about them? This is information in excess of what is required to carry out the process described within the document.		No	
3. Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information as part of the process described in this document?		No	
4. Are you using information about individuals for a purpose it is not currently used for, or in a way it is not currently used?		No	
5. Does the process outlined in this document involve the use of new technology which might be perceived as being privacy intrusive? For example, the use of biometrics.		No	
6. Will the process outlined in this document result in decisions being made or action taken against individuals in ways which can have a significant impact on them?		No	
7. As part of the process outlined in this document, is the information about individuals of a kind particularly likely to raise privacy concerns or expectations? For examples, health records, criminal records or other information that people would consider to be particularly private.		No	
8. Will the process require you to contact individuals in ways which they may find intrusive?		**N/A**	
If the answer to any of these questions is 'Yes', please contact the Data Privacy Team via Lpt-dataprivacy@leicspart.secure.nhs.uk **In this case, ratification of a procedural document will not take place until review by the Head of Data Privacy.**			
Data Privacy approval name:			
Date of approval			

Acknowledgement: This is based on the work of Princess Alexandra Hospital NHS Trust

Data Privacy Impact Screening Guidance Notes

The following guidance notes should provide an explanation of the context for the screening questions and therefore assist you in determining your responses.

Question 1: Some policies will support underpinning processes and procedures. This question asks the policy author to consider whether through the implementation of the policy/procedure, will introduce the need to collect information that would not have previously been collected.

Question 2: This question asks the policy author if as part of the implementation of the policy/procedure**,** the process involves service users/staff providing information about them, over and above what we would normally collect.

Question 3: This question asks the policy author if the process or procedure underpinning the policy includes the need to share information with other organisations or groups of staff, who would not previously have received or had access to this information.

Question 4: This question asks the author to consider whether the underpinning processes and procedures involve using information that is collected and used, in ways that changes the purpose for the collection e.g., not for direct care purposes, but for research or planning

Question 5: This question asks the author to consider whether the underpinning processes or procedures involve the use of technology to either collect or use the information. This does not need to be a new technology, but whether a particular technology is being used to process the information e.g., use of email for communicating with service users as a primary means of contact

Question 6: This question asks the author to consider whether any underpinning processes or procedures outlined in the document support a decision-making process that may lead to certain actions being taken in relation to the service user/staff member, which may have a significant privacy impact on them

Question 7: This question asks the author to consider whether any of the underpinning processes set out how information about service users/staff members may intrude on their privacy rights e.g., does the process involve the using specific types of special category data (previously known as sensitive personal data)

Question 8: This question asks the author to consider whether any part of the underpinning process(es) involves the need to contact service users/staff in ways that they may find intrusive e.g., using an application based communication such as WhatsApp

If you have any further questions about how to answer any specific questions on the screening tool, please contact the Data Privacy Team via
LPT-DataPrivacy@leicspart.secure.nhs.uk

Appendix 6

Brøset Violence Checklist (BVC)

Instructions

Score the patient at agreed time on every shift. Absence of behaviour gives a score of 0. Presence of behaviour gives a score of 1. Maximum score (SUM) is 6. If behaviour is normal for a well known client, only an increase in behaviour scores 1, e.g. if a well known client normally is confused (has been so for a long time) this will give a score of 0. If an increase in confusion is observed this gives a score of 1.

Monday / /	Day	Evening	Night
Confused			
Irritable			
Boisterous			
Verbal threats			
Physical threats			
Attacking objects			
SUM			

Tuesday / /	Day	Evening	Night
Confused			
Irritable			
Boisterous			
Verbal threats			
Physical threats			
Attacking objects			
SUM			

Wednesday / /	Day	Evening	Night
Confused			
Irritable			
Boisterous			
Verbal threats			
Physical threats			
Attacking objects			
SUM			

Thursday / /	Day	Evening	Night
Confused			
Irritable			
Boisterous			
Verbal threats			
Physical threats			
Attacking objects			
SUM			

Friday / /	Day	Evening	Night
Confused			
Irritable			
Boisterous			
Verbal threats			
Physical threats			
Attacking objects			
SUM			

Saturday / /	Day	Evening	Night
Confused			
Irritable			
Boisterous			
Verbal threats			
Physical threats			
Attacking objects			
SUM			

Sunday / /	Day	Evening	Night
Confused			
Irritable			
Boisterous			
Verbal threats			
Physical threats			
Attacking objects			
SUM			

Brøset Violence Checklist Behavioural Criteria

Risk Rating and Score Sheet

Behavioural Criteria	Descriptor	Score
Confused	Appears obviously confused and disorientated (e.g., may be unaware of time, place or person).	
Irritable	Easily annoyed or angered (e.g., unable to tolerate the presence of others).	
Boisterous	Behaviour is overtly 'loud' or noisy (e.g., slamming doors, shouting out when others are talking etc.).	
Verbal Threats	A verbal outburst which is more than just a raised voice; and where there is a definite intent to intimidate or threaten another person (e.g., verbal abuse, sexually or racially offensive abuse, name calling, open or veiled threats).	
Physical Threats	A definite intent to physically threaten or harm. (e.g., adopting an aggressive stance, raising a hand/arm as if to strike out, raising a foot or posturing as if to kick out, modelling or imitating a head-butt, raising an object as if to throw or smash it).	
Attacking Objects	An attack directed at an object and not an individual (e.g., indiscriminate throwing, smashing or breaking of objects or furniture, punching, kicking or headbutting walls or doors).	
	Total Behaviour Criteria Observed	

Scoring the BVC
Score 0 if behaviour is not present, and score 1 if behaviour is present (only score 1 if the behaviour is present regardless of how many times the behaviour is repeated).

Risk Rating

Total = 0	The risk of violence is small.
Total = 1-2	The risk of violence is moderate. Preventive measures should be taken.
Total = 3-6	The risk of violence is high. Preventive measures should be taken. In addition, plans should be developed to manage the potential violence.

Appendix 7

Post Incident Review for Patients

Type of Incident (Please Circle)	Seclusion	Long Term Segregation
	Rapid Tranquilisation	High Risk Restraint

Patient Label

What happened in the incident?

How do you feel about the incident

In your mind, what led to the incident?

Can you think of other ways this could have been resolved?

What other coping strategies/distraction/calm down methods/activities could we have helped you engage in to prevent this in future?

How do you feel about the way staff involved you during the incident? Is there anything else they could have done differently?

Care Plan Reviewed? Yes ☐ No ☐

Risk Assessment updated? Yes No If not complete, explain why?

Patient Signature:_____ Date:_____

Staff Name:_____ Staff Signature:_____

Charge Nurse/Sister Review:

Name_____ Signature_____ Date:_____

Appendix 8

Body Map:

Patient Label

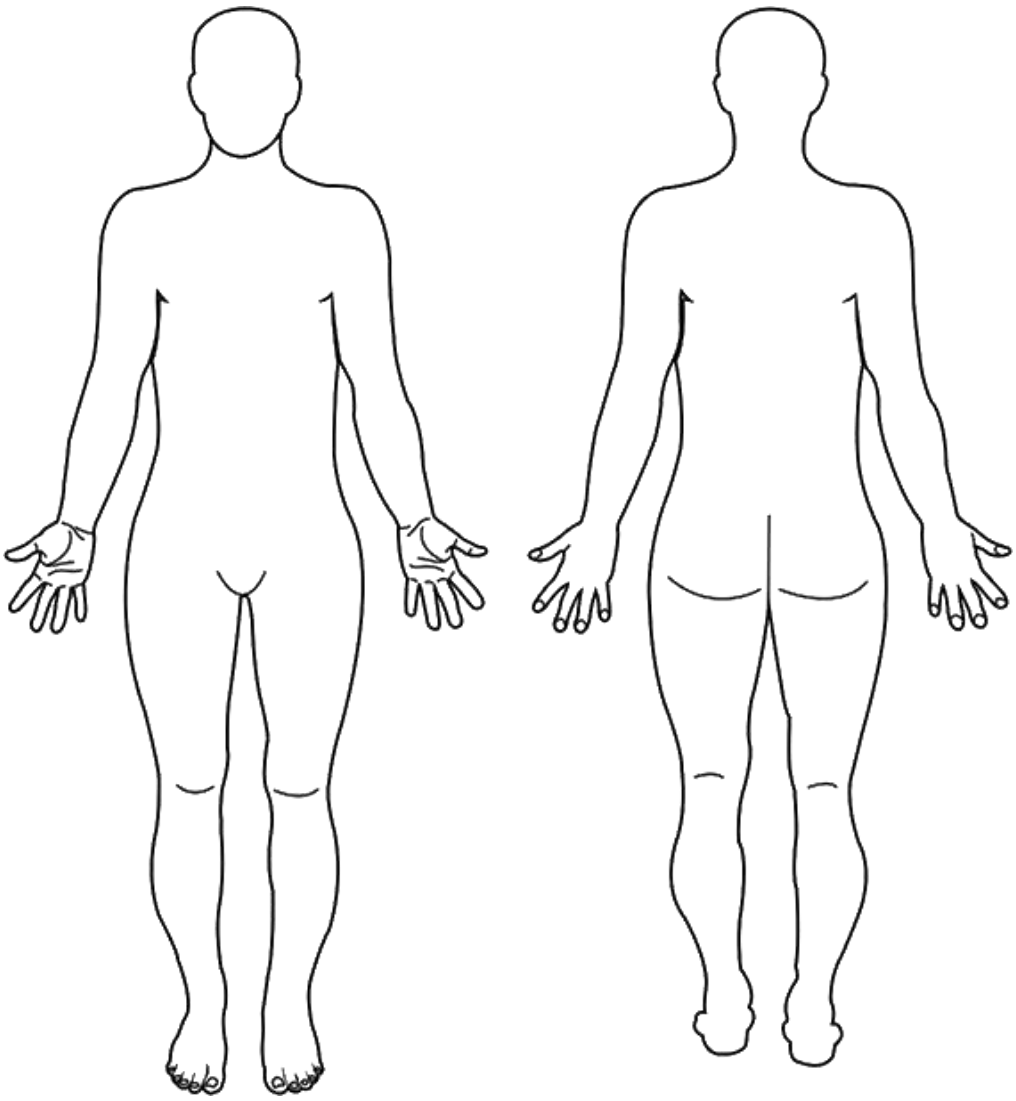
Draw on image and add a description of the marks/ injuries.

Circle below the purpose of the Body Map.

(Must circle 2)

Seclusion Commencement

Long Term Segregation Termination



FRONT BACK

Date:

Time

Completed by [Print name]:

Appendix 9

Debrief Flow Chart following an incident- staff members

Incident occurs and is escalated to senior member of staff/ Team Lead/NIC on duty

Out of Hours- Inform Clinical Duty Manager/ report to On Call Manager (serious incidents)

complete EIRF within 24 hours

Refer to Incident Reporting and Management Policy

Senior member of staff/ NIC/ Team Lead responds to incident and ensures safety of patients and staff

Serious incident to be reported to senior manager for service

Immediate (or as soon as practically possible) debrief convened by senior member of staff (not directly involved in incident) with all staff involved (within 24hrs)

Consider virtual debrief via teams or conference call where face to face not possible

Debrief for patients/ service users by senior member of staff- flow chart for service users to be developed

Senior member of staff/NIC/Team Lead assesses need for immediate medical or psychological support

Consider other professionals to be involved in debrief, dependent on the incident type ie resus team

Debrief Tool used and 6'Cs methodology followed

Include:

Debrief 6 C's.docx

- Support for staff
- Check in's for staff
- Record of who attended and documentation
- Actions to take forward
- Reflection and opportunities for additional debrief/ reflection
- Opportunity for One to one's
- Follow up calls to staff member

Senior staff member leading debrief completes debrief tool documentation and retains on secure service hard drive for future reference

Louise Evans: 17/05/21 Version 1.3

Appendix 10

Leicestershire Partnership NHS
NHS Trust

Provision of Staff Welfare and Support

Debrief Tool

Introduction

A debrief can be described as an opportunity for staff who have been involved in an incident to reflect on what has happened, identify a way forward and be offered support. Following an incident, there is often a pull to 'do something', however, the evidence for debriefing is mixed and, in some cases, a debrief can be harmful. Staff often ask for a debrief session, but it must be acknowledged that not everyone will feel comfortable with this and the debrief must be optional. This tool has been developed as part of the Trust's Guidelines for the Provision of Staff Welfare and Support following an incident. It is designed to help team members to facilitate a debrief for colleagues after an incident. The tool is based on the 6Cs - values which all NHS staff are encouraged to embrace.

How to use this tool

This tool aims to provide a structure for the debrief process and some ideas for discussion points (you may wish to add your own ideas). The document will also provide a record of the debrief and highlight ongoing actions you have identified.

	Discussion Points	Notes and Actions
1. Care *Care is our core business and that of our organisations and the care we deliver helps the individual. person and improves the health of the whole community. Caring defines us and our work. People receiving care expect it to be right for them consistently throughout every stage of their life.*	• How is everyone feeling? (physically/emotionally?) • What did that experience feel like? • What do you think will help you now?	
2. Compassion *Compassion is how care is given through relationships based on empathy, respect and dignity. It can also be described as intelligent kindness and is central to how people perceive their care.*	• Did you feel supported following the incident? • How has the team supported each other? • How have patients and carers been supported? • How can we understand this from the involved patient's perspective?	
3. Competence *Competence means all those in caring roles must have the ability to understand an individual's.*	• What went well and not so well? • Was everyone's training up to date i.e., MAPA, safeguarding etc.?	

	Discussion Points	Notes and Actions
health and social needs. It is also about having the expertise, clinical and technical knowledge to deliver effective care and treatments based on research and evidence.	• Was there anything that you feel may have contributed to the incident i.e., staffing shortage etc.?	
4. Communication *Communication is central to successful caring relationships and to effective team working. Listening is as important as what we say and do. It is essential for "no decision about me without me". Communication is the key to a good workplace with benefits for those in our care and staff alike.*	• What was handed over to you regarding this patient? • Were you aware of the care plan or risk assessment that was in place? • What was your role in the incident?	
5. Courage *Courage enables us to do the right thing for the people we care for, to speak up when we have. concerns. It means we have the personal strength and vision to innovate and to embrace new ways of working.*	• Did you feel you had the courage to say if you didn't agree with the approach taken? • Did you feel safe at the time? • Did you feel confident in your role at the time?	
6. Commitment *A commitment to our patients and populations is a cornerstone of what we do. We need to build on our commitment to improve the care and experience of our patients.*	• Reflecting on the incident, is there anything that you think could have been done differently? • What are our learning points? • What do we need to do to prevent or manage these types of incidents in the future?	

Next steps - checklist

☑ Let participants know that their emotional response is an expected part of the adjustment process to the experience of trauma, and mild symptoms are likely to subside over the coming weeks. After four weeks, anyone still experiencing symptoms should seek further support, for example your GP, occupational health or Amica.

☑ Identify any follow up actions.

☑ Identify support needs of other staff, patients, witnesses or relatives who may have been affected by the incident.

☑ Ensure all documentation is completed, including an eIRF.

Debrief date …… Incident Reference……

Facilitator ……

Participants ……

Appendix 11

Leicestershire Partnership NHS
NHS Trust

Risk Assessment for the use of physical interventions

The following table can be used to:

- Assess and capture the patients pre-existing known health conditions that increase the risk of short and long term injury.
- Support staff in evidencing the legal framework underpinning the use of the physical intervention (s) that have been identified as required to manage risk whilst supporting the individual patient when distressed.
- Support the lead clinician in auditing the frequency of physical interventions and providing governance that the intervention is part of a wider patient risk prevention and risk reduction framework

Does the patient have any of the following Physical Health pre-existing conditions or contraindications associated with increased risk in relation to physical interventions?	**YES**	**NO**	**Where was this information obtained from? (Discussion with the pt, family, GP, Pt records)**	**Detail how this increases the risk to the use physical interventions**	**UNKNOWN- please record date and attempts to clarify information**	**Detail plan to monitor**
Learning Disability or cognitive impairment				Note physical health issues associated with Syndromes/ chromosomal disorders. Note how communication needs will affect how the pt will communicate if they are in pain/ distress whilst being held		
Sight, Hearing or Sensory deficits				Note if the pt wears hearing aids/ glasses or has known sensory needs		

Ethnic Minority groups (most vulnerable individuals- CPI 2021)						
Male (most vulnerable individuals- CPI 2021) aged 30-40						
Pt is under 20 years old						
Sickle cell anaemia				Causes blood cells to stick together which can block blood vessels and reduce oxygen and blood flow.		
Stress related cardiomyopathy- weakening of the heart muscle triggered by distress resulting in high circulating levels of adrenaline and epinephrine				Note risk of cardiac and peripheral vascular compromise		
Intoxication- alcohol illicit drug consumption				Note risk of further airway compromise		
Excited delirium- severe agitation/ anxiety associated with raised temp				Note risk of co-morbid acute physical condition such as infection, sepsis, NMS or serotonin syndrome		
Respiratory disorders/ restrictions/diseases i.e. asthma, acidosis (decrease in ventilation resulting in increase in carbon dioxide in the blood				Note risk of airways compromise		

and acidity in the blood and tissues						
Mobility Disorders/needs for example Cerebral Palsy, Joint replacements				Risk of articular or bony injury		
Degenerative Disorders e.g. Dementia, Multiple Sclerosis, Huntington's				Note risk related to frailty and soft tissue/bone and articular injury and co-morbid health conditions		
Cardiovascular diseases/ disorders i.e. thromboembolic diseases, heart disease,				Note risk of cardiac and peripheral vascular compromise		
Epilepsy				Note risk of seizures		
Obesity/ high BMI				Note increased risk of airways compromise and co-morbid conditions		
<u>Low BMI</u>						
Skin disorders				Note risk of soft-tissue Injury Including injury to skin, muscles, ligaments, and tendons.		
Muscle/ ligament and tendon disorders/ diseases				Risk of articular or bony injury		
Articular or bone injuries, previous fractures, breaks				Risk of articular or bony injury		
Polypharmacy- psychotropic medication associated with side				Note risk of airway/ cardiovascular compromise in side-effected patients		

effects resulting in hypotension, respiratory compromise, neuroleptic malignant syndrome						
Does the patient have a history of Trauma/ post-traumatic stress disorder?				Note risk of psychological injury including post-traumatic stress disorder and damage to therapeutic relationships		

Legal Framework

What is the legal framework that underpins the use of the physical intervention?	**Yes**	**No**	**Next/ due review date**
Mental Health Act			
Mental Capacity Act- Best interest Decision	**Capacity to keep self safe - has been assessed as lacking capacity**		
Common Law			
Gillick Competency (children's services only/ under 16)			

Summary of the MDT assessment and discussions

MDT **Date:**	**Present:**
Summary of discussion	

Chart listing type of interventions/ risks/ legal framework/ Rationale

Identified known physical health needs increasing risk	Physical Interventions likely to be required during periods of crisis/ distress	Why is the physical intervention required?	Legal Framework	Risk Reduction plan (discussed and agreed in MDT) please list actions agreed	Steps to be taken following use of physical intervention