

Restrictive Interventions Policy

Version: 4

Summary:	<p>The aims of this policy are:</p> <ol style="list-style-type: none"> 1) To provide guidance on the recognition, prevention and management of aggression and violence. 2) To make for the provision of safe therapeutic environments for service users, staff and visitors. 3) To ensure that where in order to achieve a legitimate aim, restrictive interventions need to be used, that this is done in a safe, transparent and lawful manner with every effort (both systemic and operational) being made to ensure that it is a demonstrable and necessary last resort. 4) To ensure proper corporate oversight and monitoring of the use of restrictive interventions across the organisation. 	
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Version Control

Change Record

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Restrictive Interventions Policy

1. Introduction

- 1.1 This policy should be read in conjunction with the overarching Restrictive Practices Policy. That policy describes the expectations of the Trust with regard to the use of restrictive practices and interventions and describes the legal framework within which these practices and interventions must take place.
- 1.2 Under section 6 of the Human Rights Act 1998¹ Southern Health NHS Foundation Trust has a responsibility to uphold and promote the human rights of both its staff and service users. Similarly under Health and Safety at work legislation² and associated guidelines, it has statutory responsibilities to protect staff and service users alike from harm.
- 1.3 This policy describes specific restrictive interventions that may be employed in the Trust in specific circumstances, and associated policies, procedures and practice guidance. It also describes blanket restrictions and set the expectation of any reduction in the use of such restrictions.
- 1.4 The use of all restrictive practices and interventions must only take place in prescribed legal frameworks. The Trust is committed to reducing the need for restrictive interventions and this policy aims to promote the development of therapeutic environments in order to minimise all forms of restrictive interventions; and where of absolute necessity, to provide for their safe application.
- 1.5 In addition, in order to maintain the safety and wellbeing of the service users at all times, staff must ensure that those service users whose history, needs or current clinical presentation are predictive of behaviours that may lead to the use of restrictive interventions are identified on the basis of dynamic risk assessments, and care and support must be provided with the aim of reducing the likelihood of such behaviours in the first place. Staff must use de-escalation techniques where a person shows initial signs of distress or agitation, and minimizing the risk of physical and emotional harm both during and after any restrictive intervention.
- 1.6 The Trust will, without prejudice, support anybody to whom a duty of care is owed (staff, service users, or otherwise), who believes may they have been the victim of a crime, to seek lawful recompense and / or justice.
- 1.7 Safeguarding our services users is a key responsibility for the Trust .Any concern alleged by a service user as a result of a restrictive intervention will be managed using the appropriate safeguarding procedures as outlined in Trust policy SHCP 15 Safeguarding Adults and SHCP 202 Safeguarding Children.

2. Scope

- 2.1 This policy applies to all Southern Health NHS Foundation Trust clinical staff working in Adult Mental Health, Specialised Services, Older Persons' Mental Health and Learning Disability services. It has implications for the executive team, as well as direct care staff.
- 2.2 It covers the use of all forms of restrictive interventions. It does not include arrangements for forms of restrictive practice that fall outside of this definition; nor for

¹ *Human Rights Act 1998* HMSO

² *Health and Safety at Work Act 1974* London: The Stationery Office & *Management of Health and Safety at Work Regulations 1999* SI 1999 No 2051 London: HMSO

the immobilisation of service users in order to deliver essential care and treatment in situations where there is no immediate risk of harm (sometimes referred to as therapeutic or clinical holding). These practices in general are covered by either common law or the Mental Capacity Act 2005.

- 2.3 This policy equally applies to all staff working in community settings and therefore it should be considered in conjunction with the Trust Procedure on Lone Working (SH NCP 24).

3. Restrictive Interventions

- 3.1 The broader concept of restrictive practices refers to any form care practice that involves 'making someone do something they don't want to do, or stopping someone doing something that they do want to do'³. In essence such practices engage and risk breaching people's human rights and can therefore only ever be employed in accordance with in the context of an appropriate lawful justification.
- 3.2 The Trust recognises that occasionally some service users may behave in an aggressive or violent manner and that where all else fails, this may necessitate the use of restrictive interventions. The Trust also recognises the rights of staff to use such force as is reasonable to protect themselves from an attack, or to prevent an unlawful attack on bystanders.
- 3.3 Restrictive Interventions (such as restraint or seclusion) are amongst the most hazardous interventions that we use and can pose significant risks to both service user and staff wellbeing. If used injudiciously, or without proper procedural safeguards and lawful justification, such interventions risk breaching people's fundamental human rights.
- 3.4 Restrictive interventions are defined⁴ as deliberate acts on the part of other person(s) that restrict a service user'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 patient or others.

Any intervention that meets this definition falls within the scope of this policy.

- 3.5 The Mental Health Act 1983 Code of Practice⁵ is clear that restrictive interventions should not be used to punish, or for the sole intention of inflicting pain, suffering or humiliation. Also, that where a person restricts a service user's movement, or uses (or threatens to use) force then it should:
- be used for no longer than necessary to prevent harm to the person, or to others ; and
 - be a proportionate response to that harm; and
 - be the least restrictive option.

These principles are applicable to all in the receipt of Trust services, whether in hospital settings or community, young or old, regardless of clinical presentation.

³ Skills for Care & Skills for Health (2014) *A Positive and Proactive Workforce* London: Skills for Care

⁴ DH (2014) *Positive and Proactive Care* London: DH

⁵ DG (2015) *The Mental Health Act 1983 Code of Practice* London: TSO

- 3.6 Restrictive interventions represent the very specific subset of ‘restrictive practices’ that are deliberately employed for the purposes of resolving or containing episodes of violent / disturbed behaviour where there is a real risk of harm to the person and / or others.
- 3.7 Interventions that meet the definition in para 1.5 (above).can be further categorised on the basis of the definitions below:

Type of restrictive intervention ⁶	Definition
Physical restraint⁷	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
Rapid tranquillisation	Use of medication to calm or lightly sedate an individual, to reduce the risk of harm to self or others and to reduce agitation and aggression. A form of chemical restraint where medication is prescribed and administered for the purpose of controlling or subduing disturbed / violent behaviour, rather than for the treatment of a formally identified physical or mental illness.
Seclusion⁸	The supervised confinement and isolation of a service user, away from other service users, in an area from which the service user is prevented from leaving, where it is of immediate necessity for the purpose of the containment of severe behavioural disturbance which is likely to cause harm to others.

- 3.8 There are specific policies and procedures in relation to each of these restrictive interventions. These are:
- Management of violence and aggression procedure
 - Rapid tranquillisation policy and procedure
 - Seclusion and long-term segregation policy
- 3.9 In addition, in specialised forensic mental health services within the Trust, other specified interventions may be used on occasion, including mechanical restraints. These will be on a named-patient basis only, in accordance with prescribed legal and policy frameworks.
- 3.10 No form of restrictive intervention that lies outside of the above definitions and their associated individual policies will be used in Trust services.
- 3.11 A restrictive intervention that effectively deprives a person of their liberty and which is implemented without their consent, where they have capacity to do so, is only likely to be lawful where the person is subject to detention under the Mental Health Act, and / or it is of therapeutic necessity.

⁶ Recent national policy (both the Mental Health Act 1983 Code of Practice and Positive and Proactive Care also deal with ‘mechanical restraint’ – such interventions are not however authorised for use in SHFT services with the exception of Bluebird House where a local procedure is in place for the use of Emergency Response Belts (ERB)

⁷ The planned use of physical holds to render a person, who is not presenting with disturbed behaviour, immobile for the purposes of delivering treatment (which may include a clinical procedure), is sometimes referred to as clinical (or therapeutic) holding. It is clearly a restrictive practice but falls outside of the definition of restrictive intervention – as such, provisions for its use falls outside of the scope of this policy.

⁸ It should be noted that long term segregation is defined in the Mental Health Act Code of Practice, is a grave and highly restrictive practice that requires many important safeguards. Typically it is not however, an immediate response to an episode of disturbed behaviour and therefore falls outside of the definition of restrictive intervention and consequently the scope of this policy.

- 3.12 Where a person lacks the capacity to consent to a restrictive intervention, sections 5 and 6 of the Mental Capacity Act may permit acts of restraint, in the person's best interests, in order to undertake acts in connection with care and treatment, so long as they do not amount to a deprivation of liberty. If the proposed intervention amounts to a deprivation of liberty, this should first be lawfully authorised either through detention under the Mental Health Act, or through a Deprivation of Liberty Safeguards (DoLS) authorisation.
- 3.13 The lawful and ethical use of all forms of restrictive interventions demands that:
- Restrictive interventions should never be used to punish or for the sole intention of inflicting pain, suffering or humiliation.
 - There must be a real possibility of harm to the person or to staff, the public or others if no action is undertaken.
 - The nature of techniques used to restrict a person must be reasonable in the circumstances and proportionate to the likelihood of harm and the seriousness of that harm.
 - Any action taken to restrict a person's freedom of movement must be the least restrictive option that will meet the need.
 - Any restriction should be imposed for no longer than absolutely necessary.
 - What restrictive interventions have been used, why and with what consequences must be subject to audit and monitoring and must be open and transparent.
 - Restrictive interventions should only ever be used as a last resort.
 - People who use services, carers and advocate involvement is essential when reviewing plans for restrictive interventions.
 - Any member of staff who has a concern that a restrictive intervention has been used unethically or in a disproportionate manner can raise their concerns with a senior manager and or utilise the whistleblowing procedure SH HR 12 Freedom to speak up

4. Reducing the need for restrictive interventions

- 4.1 It is the expectation that all mental health services in the Trust will actively work to reduce the use of restrictive practices. The responsible lead executive director for this plan is the medical director.
- 4.2 All mental health (including specialised) and Learning Disability inpatient governance teams must prepare and maintain a local procedure for least restrictive practice that includes annual plans and supporting protocols.
- 4.3 Key restrictive intervention reduction approaches include the use of the Safewards⁹ model; Positive Behavioural Support¹⁰ approaches; No Force First¹¹; and the 6 Core

⁹ Bowers, L., Alexander, J., Bilgin, H., Botha, M., Dack, C., James, K., Jarret, M., Jeffrey, D., Nijman, H., Owiti, J.A., Papadopoulos, C., Ross, J., Wright, S. and Stewart, D. (2014) Safewards: a new model of conflict and containment on psychiatric wards *Journal of Psychiatric and Mental Health Nursing*

¹⁰ Allen, D., Kaye, N., Horwood, S., Gray, D., Mines, S. (2012) The impact of a whole-organisation approach to positive behavioural support on the use of physical interventions *International Journal of Positive Behavioural Support* 2(1): 26-30

¹¹ Ashcroft, L., Bloss, M., Anthony, W.A. (2012) Best practices: The development and implementation of "no force first" as a best practice. *Psychiatric Services* 63(5) 415-417

Strategies for Restraint Reduction¹². It is useful for progress to be shared across services through shared learning events.

- 4.4 The first concern in minimising the use of restrictive interventions for any service user is the use of appropriate primary preventative strategies. These aim to ensure that people's needs are fully and appropriately assessed, well understood, formulated and met; that people are central to their own recovery plans; that risks are recognised and mitigated; and that care and support minimises the potential for conflict.
- 4.5 Assessment and the management of risk is key to minimizing the use of all forms of restrictive interventions, they are essential elements of the care and treatment provided to service users and is an integral components of the Care Programme Approach (CPA). Accordingly, it is essential that on admission / referral, a risk assessment is carried out and a risk management plan is put into place. This should be undertaken in collaboration with the service user and their carer / family wherever possible.
- 4.6 Risk assessments and risk management plans must be regularly reviewed with the service user and their carer whenever possible. Plans should record known triggers for aggressive / violent behaviour based on current observations, previous history and discussion with service users and their carers / families. Changes in levels of risk should be recorded, communicated and risk management plans changed accordingly.
- 4.7 Staff should, wherever possible, proactively support service users to make advance decisions or advance statements about the use of restrictive interventions.
- 4.8 The approach to risk assessment must be multi-disciplinary and reflect the care setting in which it is undertaken. Any risk factors relating to a service user must be communicated appropriately across care settings.
- 4.9 The physical and therapeutic environment within which services are delivered can have a strong mitigating effect on the levels of agitation, frustration and boredom that can be experienced by service users.
- 4.10 Subject to any individually required security measures, care environments must make provision for service users to have predictable and routine access to preferred items and a range of appropriate occupational, social and recreational activities (including evening and weekend activities), taking into account people's abilities, level of functioning and the resources available. Care environments should also be organized to provide for different needs, for example, quiet rooms, recreation rooms, single-sex areas and access to open spaces and fresh air.
- 4.11 Service users should be engaged in all aspects of care and support planning, including the identification of their own trigger factors and early warning signs of behavioural disturbance and in how staff should respond to them.
- 4.12 Meetings to discuss an individual's care must occur in a format, location and at a time of day that promotes engagement of service users, families, carers and advocates
- 4.13 All staff must demonstrate a positive attitude when communicating with service users. Staff must never use language that could be construed as supporting negative stereotypes. This would include verbal or non-verbal responses that could be interpreted as carrying aggressive, threatening, sarcastic or disrespectful intent.

¹² Huckshorn, K.A. (2004) *Reducing the use of seclusion and restraint@ A national initiative for culture change and transformation* Lincoln, Nebraska: Roman Hruska Law Centre

- 4.14 Individualised, person centred care plans must take account of each person's unique circumstances, their background (including any trauma history), priorities, aspirations and preferences. Care plans should be formatted in a manner that renders them accessible and understandable for those who will implement them. Care plan summaries in a suitably accessible format, should be available to service users and their families.
- 4.15 Physical and mental health needs must be holistically assessed and service users must be supported to access appropriate, evidence based treatments according to their preference. Care plans should specifically support service users to develop alternative coping strategies in response to known predictors of behavioural disturbance.
- 4.16 Access to leave, food and drink, fresh air, shelter, warmth, a comfortable environment, exercise, confidentiality or reasonable privacy should never be restricted, or used as a 'reward' or 'privilege' dependant on 'desired' behaviours.
- 4.17 Planned secondary preventative strategies (de-escalation) aim guide and inform the actions of care and support staff in response to service users beginning to show signs of agitation and / or arousal that may indicate an impending behavioural disturbance.
- 4.18 De-escalation strategies promote relaxation, e.g. through the use of verbal and physical expressions of empathy and alliance. They should be tailored to individual needs and should typically involve establishing rapport and the need for mutual co-operation, demonstrating compassion, negotiating realistic options, asking open questions, demonstrating concern and attentiveness, using empathic and non-judgemental listening, distracting, redirecting the individual into alternate pleasurable activities, removing sources of excessive environmental stimulation and being sensitive to non-verbal communication.
- 4.19 An individualised record of bespoke de-escalation strategies should be contained within the service user's care plan. This should be prepared with them and in consultation with families / carers. This element of the care plan should be regularly reviewed and forms an essential component of the risk management plan.
- 4.20 Staff should ensure that they do not exacerbate behavioural disturbance, e.g. by dismissing genuine concerns or failing to act as agreed in response to requests, or through the individual experiencing unreasonable or repeated delays in having their needs met. Where such failures are unavoidable, every effort should be made to explain the circumstances of the failure to the individual and to involve them in any plans to redress the failure.
- 4.21 There may be occasions where enhanced observation may temporarily act either as a primary or secondary preventative strategy and this should always be undertaken in line with the Trust's Observation and Engagement Policy (SH CP 37). A careful judgment will be required however as for some individuals, increasing observation may actually escalate the risks. The key consideration is that enhanced observation is actually about support and engagement, rather than mere observation.
- 4.22 Whilst the overarching aim is always to reduce the need for the use of restrictive interventions, it is recognised that there may none the less, be times when a person's behaviour places themselves or others at imminent risk of significant harm and that where de-escalation strategies have failed to prevent a crisis, a restrictive intervention may be necessary as a proportionate and reasonable response to the risk posed.

4.23 Where risk assessments identify that restrictive interventions could potentially be needed, their implementation should so far as possible, be planned in advance¹³ and recorded as tertiary strategies within the care / risk management plan. Here the choice of restrictive intervention will be informed by the service user's preference; any particular risks associated with their general health (e.g. musculoskeletal problems, or poor cardiovascular health); any known trauma history; and an appraisal of the immediate environment.

5. Physical Restraint

5.1 Physical restraint must always be undertaken in a manner consistent with the Trust's physical restraint policy.

5.2 Physical restraint should not be undertaken in a manner that interferes with the service user's airway, breathing or circulation, for example by applying pressure to the rib cage, neck or abdomen, or obstructing the mouth or nose¹⁴.

5.3 Physical restraint should not be carried out in a way that interferes with the service user's ability to communicate, for example by obstructing the eyes, ears or mouth.

5.4 Staff must not cause deliberate pain to a person in an attempt to force compliance with their instructions.

5.5 Staff must not use physical restraint or breakaway techniques that involve the use of pain, including holds where movement by the individual induces pain. If exceptionally a member of staff encounters a situation that they felt ill-prepared to deal with, the incident should be promptly drawn to the attention of the senior management team and an urgent review of training requirements should be undertaken.

5.6 Unless there are cogent reasons for doing so, there must be no planned or intentional restraint of a person in a prone position (whereby they are forcibly laid on their front) on any surface, not just the floor. This means that across SHFT services, by default there should be no pre-planned use of prone restraint. The exceptions to this are detailed below.

5.7 In some cases, there may be a reasonable, convincing and compelling rationale for the use of prone restraint. The patient may express a preference to be restrained in the prone position, in which case, an advance statement must be recorded in the patient's electronic records. This should be accompanied by a care plan which is approved by the patient's Multi-Disciplinary Team (MDT).

5.8 It may be necessary to employ prone restraint for patients who are admitted as emergency, whose preferences are not known to the staff team. In such cases, teams must ascertain, as soon as is practicable, the preferences of the patient and have appropriate advance statements and care plans in place.

5.9 It may be necessary to employ prone restraint in patients with particular physical conditions, including obesity. Other reasons may include the need to administer certain intramuscular medications, past trauma or physical limitations. In such cases, there must be appropriate care plans in place.

5.10 It may also be necessary to use prone restraint in some parts of the trust due to environmental restrictions, such as the design of seclusion rooms. This will be reported as exception-reporting.

¹³ However, it should be noted that the advance planning of seclusion is discouraged by the Mental Health Act Code of Practice which states it should not form part of a treatment programme.

¹⁴ Department of Health (2015) *Mental Health Act 1983: Code of Practice* London: TSO Chapter 26

- 5.11 People should not routinely be restrained for more than 10 minutes. It is vital that staff ensure that they take accurate recordings of the duration of restraint as this is a key factor increasing the risk of death in restraint. In some circumstances, in accordance with NICE guidance¹⁵ and having taken full account of the person's preferences (if known) and their physical health, degree of frailty and developmental age, it may be appropriate to consider whether rapid tranquillisation or seclusion may represent a less restrictive, proportionate response than prolonged physical restraint (more than 10 minutes).
- 5.12 One member of staff should lead throughout the restraint procedure. This person should ensure that others are: protecting the service user's head and neck; checking that airways and breathing are not compromised; monitoring vital signs and ensuring that the duration of the restraint is timed and recorded.
- 5.13 In accordance with Trust policy¹⁶, appropriately maintained emergency resuscitation equipment should be available within three minutes, in any area / unit where restraint is likely to be necessary and staff, trained in immediate life support techniques, should be immediately available to attend in an emergency.

6. Seclusion & Long Term Segregation

- 6.1 Seclusion and long term segregation may only be used in accordance with the Trust policy on seclusion and long term segregation (SH CP 107), as this describes the legal framework within which these restrictive interventions may be used and establishes important safeguards by which to protect the well-being and human rights of the service users.
- 6.2 Seclusion should only be used in hospitals and in relation to service users detained under the Mental Health Act. If an emergency situation arises involving an informal service user and, as a last resort, seclusion is necessary to prevent harm to others, then an assessment for an emergency application for detention under the Act should be undertaken immediately.
- 6.3 Seclusion should not be used as a punishment or a threat, or because of a shortage of staff. It should not form part of a treatment programme.
- 6.4 Seclusion should **never** be used solely as a means of managing self-harming behaviour.

7. Rapid Tranquillisation

- 7.1 Rapid tranquillisation should only be used where a service user is highly aroused, agitated, overactive and aggressive, or is making serious threats or gestures towards others, or is being destructive to their surroundings, when other therapeutic interventions have failed to contain the behaviour. It may only be undertaken in accordance with the Trust policy on Rapid Tranquillisation (SH CP 48).
- 7.2 Rapid tranquillisation includes the use of both intra-muscular injections and oral medication. Oral medication should always be considered before any injections.
- 7.3 Rapid tranquillisation should be prescribed in accordance with evidence-based practice guidelines.

¹⁵ NICE (2015) *Violence and aggression: short-term management in mental health, health and community settings*
London: NICE

¹⁶ Medical Emergencies and Resuscitation Policy (SH CP 30)

- 7.4 Where rapid tranquilisation in the form of an intramuscular injection is needed, the person prescribing the injection should state the preferred injection site within their care plan, having taken full account of the need to avoid prone restraint.
- 7.5 Staff prescribing rapid tranquilisation must, in accordance with Trust policy, note any physical observations and monitoring requirements following administration and ensure that these are clear to staff caring for the service user. Associated monitoring paperwork should be completed in full.

8. Procedure following restrictive interventions

8.1 As soon as is practicable, following any use of restrictive interventions in response to behavioural disturbance, staff should:

8.1.1 Complete a Ulysses Incident Report Form which includes:

- Details of the service user subjected to a restrictive intervention
- Details of any other service users and all staff involved in the incident in the form
- The incident type (i.e. the nature of the incident which resulted in the restraint or de-escalation)
- The reason for the intervention (including whether de-escalation was attempted)
- In the case of physical restraint, entries should also include:
 - position(s) of restraint used
 - details of staff and their position during restraint
 - the start time and end time of each position of restraint
 - details of any medication given

8.1.2 Review / amend the person's risk assessments and immediate management plans

8.1.3 Make a progress note entry (RiO) which includes:

- The Ulysses Incident number.
- The circumstances which warranted the use of a restrictive intervention.
- Attempts to de-escalate the situation and the service user's response to them.
- Anonymised details of other service users involved in the incident.
- The nature of the restrictive intervention used, including the role of any / all staff involved in the associated procedures (including holding positions in the case of physical restraint).
- The start and end time of the intervention.
- Details of any injuries sustained.
- Any measurements taken of vital signs both during and after the intervention.
- Post incident support for the service user.
- The service user's perspective of what happened and why.
- Summary of any resulting changes to care plans, risk management plans etc.
- Updates to risk assessments

8.1.4 Make arrangements for a post incident review / debrief in accordance with Trust Policy.

- 8.1.5 Consider whether any wider parties need to be informed of the incident (as stated in the person's plan of care - this could include family members or relatives, advocates and / or managers).

9. Post incident review / debrief

- 9.1 It is good practice for a member of staff who was not part of the incident to spend time on a one to one basis with the service user and if the person is willing to assist them to record their account of the events.
- 9.2 Following any application of a restrictive intervention, a post incident review or debrief should take place in accordance with trust policy. The aim of the 'debrief' is to ensure that all involved parties, including service users, have appropriate support and that there is opportunity for organisational learning.
- 9.3 Where a service user is not able, or declines, to participate in a debrief, methods for assessing the effects of any intervention on their behaviour, emotions and clinical presentation should be fully explored and they should be closely monitored.
- 9.4 If the service user is able and agrees to discuss the incident which led to the use of a restrictive intervention, their understanding and experience of the incident should be explored. Service users' accounts of the incident and their feelings, anxieties or concerns following the restrictive intervention should be recorded in their notes. Service users should be reminded that they can use advance statements to record future wishes and feelings about restrictive interventions, or indeed any other element of care, that they would or would not like to be used.
- 9.5 All staff involved in any incident should be reminded of Trust facilities for support.

10. Blanket Restrictions

- 10.1 The term 'blanket restriction' refers to rules or policies that restrict a service user's liberty and other rights, which are routinely applied to all service users, or to classes of service user, within a service, without an individual risk assessment to justify their application to every service user. Further guidance can be found in the Blanket restrictions policy.

11. Training

- 11.1 All staff who may be exposed to aggression or violence in their work or who may need to become involved in the application of restrictive interventions must receive appropriate training.
- 11.2 Training should be delivered to all staff during the induction period or as soon as is practicably possible. Any new member of staff who has not received the appropriate training should play no part in the use of restrictive interventions until they have completed the training.
- 11.3 All clinical staff that undertake training in the recognition, prevention and management of violence and aggression and associated physical restraint should attend periodic refresher or update education and training programmes.
- 11.4 All staff that support people who are liable to present with behavioural disturbance should be competent in moving and handling, physical monitoring and either immediate or basic life support (depending upon role and in accordance with Trust policy on Medical Emergencies

and Resuscitation) to ensure the safety of service users, especially following administration of rapid tranquillisation and during periods of physical restraint or seclusion.

- 11.5 Appendix 1 specifies who will receive what level of training and how often they will be re-trained.

12. Monitoring compliance

- 12.1 The effectiveness of this policy and aligned policies will be reviewed on an annual basis.
- 12.2 The Trust's Forum leading on the Minimising Restrictive Practice Programme (the SAFER forum) will commission an annual audit programme. They will receive audit data and identify key issues warranting action.
- 12.3 The SAFER forum chair will provide the executive director responsible for leading on restrictive practice reduction, with an annual report (including recommendations).
- 12.4 The SAFER forum chair will feedback to unit managers regarding their performance at audit.
- 12.5 Unit managers and the executive director for leading on restrictive practice reduction will update local and corporate plans.

Appendix 1: Training Needs Analysis

If there are any training implications in your policy, please make an appointment with the LEaD department (Louise Hartland, Quality, Governance and Compliance Manager on 02380 874091) to complete the TNA **before** the policy goes through the Trust policy approval process

Topic/Subject		Frequency	Course Length	Delivery Method	Facilitators	Recording Attendance	Strategic & Operational Responsibility
Conflict Resolution Training		Once followed by refresher every 3 years	Initial and Refresher – 3.5 hours	Face to face	LEaD	LEaD	Strategic - Medical Director Operational - Head of Nursing, AHP and Quality for MH.
Service		Target Audience					
MH/LD	Adult Mental Health	All staff who are not required to complete Supporting Safer Services (sSs) training					
	Specialised Services						
	Learning Disability Services						
	Older Persons Mental Health						
ISD	Adults	All Staff					
	Childrens Services & Quit for Life						
Corporate	Director of Nursing						
	Medical Director						
	Chief Executive						
	Chief Financial Officer						
	Development Director						
	People of Communications						
Property and Estates							

Topic/Subject		Frequency	Course Length	Delivery Method	Facilitators	Recording Attendance	Strategic & Operational Responsibility
Supporting Safer Services (sSs)		Full programme once only followed by annual Refresher	Full programme – 30 hours Refresher – 15 hours	Face to face	LEaD	LEaD	Strategic - Medical Director Operational - Head of Nursing, AHP and Quality for MH.
Service		Target Audience					
MH/LD	Adult Mental Health	All registered nurses, mental health practitioners, trainee practitioners and health care support workers who work in the following services; Elmleigh (Elmleigh Inpatients, Elmleigh FM); Antelope House (Hamton, Trinity & Saxon wards); Parklands Hospital (Hawthorns Inpatients, Hawthorns MOD & Hawthorns PICU); Melbury Lodge (Kingsley Ward & Mother & Baby Unit).					
	Specialised Services	All registered nurses, mental health practitioners, trainee practitioners and health care support workers who work in the following services; Leigh House All registered nurses, mental health practitioners, occupational therapists, OT technicians, trainee practitioners and health care support workers who work in the following services; Ashford Unit, Ravenswood House (RSU Clinical Management, RSU Ashurst, RSU Lyndhurst, RSU Malcolm Faulk Ward, RSU Mary Graham Ward, Meon Valley Ward, RSU Therapies, RSU Clinical Risk & Security Liaison, RSU Support Services); Southfield (Cedar, Oak and Beech wards, Southfield OT & Southfield Reception and Security); Bluebird House (Bluebird Nursing & Security, Hill Ward, Moss Ward & Stewart wards, Bluebird House Site Services, Bluebird House OT, Bluebird Staff Dummy) and Specialised Services Management.					
	Learning Disability Services	All registered nurses, assistant/associate practitioners, and health care support workers who work in the following services; Willow Assessment & Treatment Unit;					
	Older Persons Mental Health	All registered nurses, mental health practitioners, trainee practitioners and health care support workers who work in the following services; Gosport War Memorial Hospital (Dryad & Daedalus wards); Melbury Lodge (Stefano Oliveri ward); Parklands Hospital (Beechwood & Elmwood wards) and Western Community Hospital (Beaulieu & Berrywood). All inpatient modern matrons (OPMH Western Management).					
ISD	Adults	Not Applicable					
	Childrens Services & Quit for Life						
Corporate	Director of Nursing						
	Medical Director						
	Chief Executive						
	Chief Financial Officer						
	Development Director						
	People and Communications						
	Property and Estates						
	Strategy Director						

Appendix 2

Southern Health NHS Foundation Trust: Equality Impact Analysis Screening Tool

Equality Impact Assessment (or 'Equality Analysis') is a process of systematically analysing a new or existing policy/practice or service to identify what impact or likely impact it will have on protected groups.

It involves using equality information, and the results of engagement with protected groups and others, to understand the actual effect or the potential effect of your functions, policies or decisions. The form is a written record that demonstrates that you have shown *due regard* to the need to **eliminate unlawful discrimination, advance equality of opportunity and foster good relations** with respect to the characteristics protected by equality law.

For guidance and support in completing this form please contact a member of the Equality and Diversity team.

Name of policy:	Restrictive Interventions Policy
Policy Number:	SH NCP 23
Department:	Quality and Governance
Lead officer for assessment:	Tim Coupland, Head of Nursing, AHP and Quality
Date Assessment Carried Out:	31.03.2015

1. Identify the aims of the policy and how it is implemented.	
Key questions	Answers / Notes
<p>Briefly describe purpose of the policy including</p> <p>How the policy is delivered and by whom</p> <p>Intended outcomes</p>	<p>Creating and maintaining a safe and secure environment for the staff it employs, the health and safety of the service users, which is patients, visitors, contractors and all persons who visit Trust premises or premises on which the Trust operates. Tackling violence and aggression and protecting lone workers.</p> <p>This policy has been written to ensure to support the organisational framework for promoting equality and eliminating discrimination (Equality Delivery System): Service users and their carers should be made aware of the policy and its procedures Service users and their carers should be involved in shared decision-making about the management of violent/aggressive behaviour through the use of their care plans</p> <p>Person-centred care In order to create a genuinely patient-centred service several processes should be created to enable users to contribute to the design and delivery of care. The aim is to promote a non-judgemental, non-patronising, collaborative approach to care (Department of Health, Mental health policy implementation guide 2002, p14).</p>

	<p>United Kingdom Central Council for Nursing, Midwifery and Health Visiting</p> <p>Violence directed to staff, patients or visitors is completely unacceptable. We should start from a position of Zero Tolerance, but then recognise that some patients, because of their illness, may behave in a violent (physical and non-physical manner) and that this condition may need special consideration. Organisations must support their staff fully when it comes to prosecution of perpetrators and develop and use strong links with the police and criminal justice system to ensure that mental illness or personality disorder per se or simply being a “patient in care”, does not absolve perpetrators from the legal consequences of their actions.</p>
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2. Consideration of available data, research and information

Monitoring data and other information involves using equality information, and the results of engagement with protected groups and others, to understand the actual effect or the potential effect of your functions, policies or decisions. It can help you to identify practical steps to tackle any negative effects or discrimination, to advance equality and to foster good relations.

Please consider the availability of the following as potential sources:

- Demographic** data and other statistics, including census findings
- Recent **research** findings (local and national)
- Results from **consultation or engagement** you have undertaken
- Service user **monitoring data**
- Information from **relevant groups** or agencies, for example trade unions and voluntary/community organisations
- Analysis of records of enquiries about your service, or **complaints** or **compliments** about them
- Recommendations of **external inspections** or audit reports

	Key questions	Data, research and information that you can refer to
2.1	<i>What is the equalities profile of the team delivering the service/policy?</i>	<i>The policy is relevant to all Trust staff. The Equality and Diversity team will report on Workforce data on an annual basis.</i>
2.2	<i>What equalities training have staff received?</i>	<i>All Trust staff undertake Equality and Diversity training as part of Corporate Induction (Respect and Values) and E-Learning</i>

		LEaD Training programmes in the management of violence
2.3	What is the equalities profile of service users?	The Equality and Diversity team will report on patient data on an annual basis.
2.4	<p>What other data do you have in terms of service users or staff? (e.g results of customer satisfaction surveys, consultation findings). Are there any gaps?</p> <p>The effectiveness of this policy will be reviewed on an annual basis and assessed by reviewing its implementation and application across the organisation in line with the requirements of the NHSLA minimum data set for Standard 4 – Safe Environment review will be led by the LSMS and approved by the MOVA and Health & Safety Committee.</p> <p>The Trust is aware and acknowledges the following resources:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Department of Health (1999) Homicides and Suicides Inquiry <input type="checkbox"/> Department of Health (1999) Zero Tolerance <input type="checkbox"/> Mental Health Act (1983) Code of Practice <input type="checkbox"/> Royal college of Psychiatrists (1997) Guidelines on the Management of Imminent violence <input type="checkbox"/> United Kingdom Central Council (2002) The recognition, prevention and therapeutic management of violence and aggression <input type="checkbox"/> NICE (2005) Short term management of violent behaviour 	<p>The Trust is preparing to implement the Equality Delivery System which will allow a robust examination of Trust performance on Equality, Diversity and Human Rights. This will be based on 4 key objectives that include:</p> <ol style="list-style-type: none"> 1. Better health outcomes for all 2. Improved patient access and experience 3. Empowered, engaged and included staff 4. Inclusive leadership
2.5	What internal engagement or consultation has been undertaken as part of this EIA and with whom? What were the results? Service users/carers/Staff	<ul style="list-style-type: none"> <input type="checkbox"/> Management of Violence and aggression Committee (MOVA) <input type="checkbox"/> Health & Safety Committee <input type="checkbox"/> Quality & Safety Committee <input type="checkbox"/> Trust Equality and Diversity Lead
2.6	What external engagement or consultation has been undertaken as part of this EIA and with whom? What were the results? General Public/Commissioners/Local Authority/Voluntary Organisations	

Equality Impact Assessment – Screening Tool

	Positive impact (including examples of what the policy/service has done to promote equality)	Negative Impact	Action Plan to address negative impact			
			Actions to overcome problem/barrier	Resources required	Responsibility	Target date
Age	<p>Applied to all Protected Characteristics: Everyone has a duty to behave in an acceptable and appropriate manner. Staff have a right to work, as patients have a right to be treated, free from fear of assault and abuse in an environment that is safe and secure.</p>	<p>Unqualified and junior staff are at greater risk than more senior, experienced staff (United Kingdom Central Council (2002)</p> <p>(Gournay et al, 2000) shows that the most vulnerable members of nursing staff are those in the lower grades and that staff aged between 21 and 32 are almost twice as likely to be assaulted than staff over the age of 46.</p> <p>Incidents not considered serious enough (Beale et al 1999) - although serious incidents are not always reported (Owen et al 1998)</p>	<p>Applied to all Protected Characteristics: Monitoring</p> <ul style="list-style-type: none"> <input type="checkbox"/> Number of incidents being reported; <input type="checkbox"/> Number of incidents passed onward to the Security Management team; <input type="checkbox"/> The uptake of training programmes; <input type="checkbox"/> Information staff exit interviews; <p>Employees can expect that the Trust will: Uphold the principles of the</p>		Local Security Management Specialist	On-going: EqIA will be reviewed at Policy Review stage and monitoring data will be used to inform any changes

		<p>Some community staff workplace may be patient's home: This Policy should be read in conjunction with the Trust Lone Working Policy</p>	<p>Human Rights Act that all individuals should be treated with fairness, respect, equality, dignity and autonomy</p> <p>Investigate all reported incidents of violence and aggression</p> <p>Undertake continual monitoring and evaluation of such incidents</p> <p>Provide advice, support and counselling to any employee involved in a violent or aggressive incident</p> <p>Provide appropriate training to employees in dealing with potentially violent or aggressive situations</p>			
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<p>Disability</p>	<p>The Trust will ensure that all its facilities and estates are accessible and safe through: Disability Access Audits and the design of service areas and personal alarms</p>	<p>Patients with a dual diagnosis (co-existing mental illness and substance misuse) are much more likely to perpetrate a violent act than people with mental illness alone (United Kingdom Central Council (2002)</p> <p>Effects of sensory Impairment: It has been noted that service users with sensory impairments are particularly vulnerable when managing violence and aggression. One such example is the restraining of a deaf service user's hands, thereby preventing them from communicating.</p>			<p>Estates and Facilities Management</p> <p>Local Security Management Specialist</p>	<p>On-going: EqIA will be reviewed at Policy Review stage and monitoring data will be used to inform any changes</p>
<p>Gender Reassignment</p>		<p>Transgender people may experience violence and aggression</p>	<p>Appropriate management of single sex accommodation</p>		<p>Local Security Management Specialist</p>	<p>On-going: EqIA will be reviewed at Policy Review stage and monitoring data will be used to inform any changes</p>

Marriage and Civil Partnership						On-going: EqIA will be reviewed at Policy Review stage and monitoring data will be used to inform any changes
Pregnancy and Maternity		Some community staff workplace may be patient's home	Trust Lone Worker and individual staff risk assessments	Conflict Resolution Training	Local Security Management Specialist	On-going: EqIA will be reviewed at Policy Review stage and monitoring data will be used to inform any changes
Race	The David Bennett Inquiry (2004) highlighted the importance of considering the needs of black and minority ethnic groups when managing disturbed/violent behaviour in the short-term.	Discrimination based upon race affecting staff and service users The effects of violence and aggression are wide-ranging and include not only physical injury, sometimes necessitating medical treatment, but also the emotional consequences which	Policy and procedure will support staff in dealing with racist incidents		Local Security Management Specialist	On-going: EqIA will be reviewed at Policy Review stage and monitoring data will be used to inform any changes

		sometimes amount to post traumatic stress disorder				
Religion or Belief		The Trust needs to be aware that abusers often target people because they are different and sometimes an individual's religion, belief or non-belief may be a trigger. Multi-faith concerns: <input type="checkbox"/> Possession of Kirpan.			Local Security Management Specialist	On-going: EqIA will be reviewed at Policy Review stage and monitoring data will be used to inform any changes
Sex	In terms of managing violent/aggressive behaviour in psychiatric in-patient settings, the main concern raised in <i>The women and mental health strategy</i> has been to identify gender specific needs, such as single-sex facilities, and to ensure that both male and female service users feel safe, listened to and involved in identifying and meeting gender related needs	Although no direct adverse impact has been found directly relating to this policy, the organisation needs to be aware that women are disproportionately victims of abuse. Research by Women's Aid in October 2007: While 1 in 4 adult women and 1 in 13 adult men will experience domestic violence during				On-going: EqIA will be reviewed at Policy Review stage and monitoring data will be used to inform any changes

	<p><i>(Mainstreaming gender and women's mental health implementation guide 2003).</i></p>	<p>their lifetimes findings from the research found that vulnerable women and men are at increased risk of abuse; 1 in 2 disabled women have experienced domestic abuse compared with 1 in 4 of non-disabled women.</p> <p>A potentially serious degree of harm can be inflicted without physical contact being made has now been recognised in law. For example, there have now been a number of successful prosecutions for grievous bodily harm brought against stalkers.</p> <p>In-Patient settings: Service Users Body Building through weight training and/or consumption of supplements to increase strength and body weight</p>				
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Sexual Orientation		<p>Gay, lesbian and bisexual individuals are likely to face additional concerns around homophobia and gender discrimination.</p>	<p>It is important that staff are trained to be aware of the specific requirements of the Equality Act 2010 and Human Rights Act. Human rights will therefore be reflected where it is appropriate to do so in general training within SHFT. This includes Corporate Induction Training, Respect and Values and E- Learning.</p>		<p>Equality and Diversity Lead</p>	<p>On-going: EqIA will be reviewed at Policy Review stage and monitoring data will be used to inform any changes</p>
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