Kent and Medway
NHS and Social Care Partnership Trust

Promoting Safe Services: Restrictive Practice Policy

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DOCUMENT TRACKING SHEET

Restrictive Practice Policy

Version	Status	Date	Issued to/approved by	Comments
1.0	Final	15 March 2022	Trust Wide Patient Safety and Mortality Review Group	Approved

REFERENCES

RELATED POLICIES/PROCEDURES/protocols/forms/leaflets

Seclusion Policy	
Long-term Segregation Policy	
Health & Safety Policy	
Safeguarding Adults?	
Resuscitation Policy	
CQC (2019)Brief guide: the use of 'blanket restrictions' in mental health wards	
Concerns and Complaints	
Use of mobile devices by patients in hospitals 9 December 2020	

SUMMARY OF CHANGES

Date	Author	Page	Changes (brief summary)

CONTENTS

1 INTRODUCTION

1.1 We believe that our patients and carers deserve to receive care and treatment that is safe, effective and is delivered by staff working in an environment free from harm.

1.2 Our commitment to reduce incidents of challenging and harmful behaviours that occur within our services, including the use of restrictive and coercive practices is highlighted in our Trustwide strategy, policies and training programmes; all founded with a Human Rights and person-centred approach to ensure that dignity and respect are central to the care we provide.

1.3 The use of restrictive practices can create further challenging and harmful behaviours, which have significant and diverse outcomes for all involved. A reduction in these practices will enhance patient experience, recovery and engagement with services, carers and families. This will also provide a safe and conducive place for our staff to work.

1.4 We will achieve this by continuing to embed evidence-based preventative initiatives and strategies, work collaboratively with service users, carers and families and other stakeholders; learn from incidents and further develop a culture of recovery through open and therapeutic relationships.

2 WHO DOES THIS POLICY APPLY TO?

2.1 This policy applies to all clinical/non-clinical staff employed by Kent and Medway NHS and Social Care Partnership Trust including agency and bank staff who, during the course of their work, are involved in the care of a patient.

2.2 This policy applies to all patients cared for at any time, whether they are detained under the Mental Health Act or not, both within inpatient and community settings.

3 PURPOSE

3.1 The aim of this policy is to encourage a culture across the organisation that is committed to enhance the therapeutic environment where the use of restrictive practices / interventions is minimised and used in a transparent, legal and ethical manner.

3.2 This procedural guidance will provide an overview of restrictive practices to all staff. It will also look at the process for managing behavioural disturbances using primary, secondary and tertiary approaches including reporting and evaluating the use of restrictive interventions/practices.

3.3 When episodes of challenging behaviour do occur, these guidelines provide clear and effective strategies as recommendations for actions staff may take to deescalate, manage or intervene to bring the episode to a safe and rapid conclusion.

3.4 This policy will cover all aspects of Promoting Safe Services (PSS)

3.5 The Trust will learn from Best Practice and is committed to reducing/eliminating prone/face down restraint and restrictive practices

4 DUTIES

4.1 The Trust Board

4.1.1 The Trust is committed to providing an environment which minimises risk and promotes the health, safety and well-being of all those who enter or use its premises whether as staff, patients, visitors and carers. It has overall responsibility to:

a) Ensure that appropriate training (PSS) is in place and effective throughout the Trust.

b) Work to ensure full compliance with all appropriate legislative and statutory requirements.

c) Ensure risk management becomes an integral part of the management processes and financial planning within the Trust.

d) Ensure that strategies, structures and processes are constantly reviewed and evaluated to ensure the continuing health, safety and well-being of staff, patients, visitors and carers.

4.1.2 They have delegated responsibility for monitoring and review through the Quality Committee.

4.1.3 A memorandum of understanding has been developed with the Association of Chief Police Officers (ACPO). The Trust will provide information to Kent County Constabulary through the Local Security Management Specialist (LSMS) where appropriate.

4.2 Executive Director of Nursing, Allied Professional and Quality

4.2.1 Takes the lead for delivering clinical governance and ensuring that PSS follows the

4.2.2 Department of Health and Security Management's Services (SMS) Guideline's and acts as effective risk management tool for all staff.

4.2.3 Executive boards must approve the increased behavioural support planning and restrictive intervention reduction programmes to be taught to their staff.

4.2.4 Executive Director of Nursing, Allied Professional and Quality is the designated course director for PSS training courses and they ensure that the training provided meets the required standards under Restraint Reduction Network Training Accreditation.

4.3 Quality Committee

4.3.1 Have responsibility and the authority to act on behalf of the trust board.

4.3.2 Ensure that a risk training strategy is in place and an annual review is undertaken.

4.3.3 Receive reports from trust wide health and safety group.

4.3.4 Responsible for providing assurance to the trust board.

4.3.5 Report to the board twice yearly.

4.4 Trust Wide Health and Safety Reporting Group

4.4.1 Ensure compliance with Health and Safety law, including (RIDDOR) 2013 specifically include those serious injuries sustained by staff as a result of violence.

4.4.2 Violence, Restraint and Seclusion Monitoring group.

4.4.3 Ensure that there are suitable arrangements in place within directorates/care groups to meet their training in Promoting Safe Service (PSS) requirements and demonstrate compliance with 5 CQC domains of Safe, Effective, Caring, Responsive and Well-led'.

4.5 Promoting Safe Service Monitoring Group

4.5.1 Will undertake regular and systematic audit of all activities clinical and non-clinical to identify, and where possible eliminate or minimise risk.

4.5.2 This Group will have a senior representative from PSS, Corporate Nursing, Health and Safety, Care Groups and Safeguarding.

4.5.3 The Group will consider themes and trends and ensure these are taken to the Learning from Experience Group and picked up in supervision if needed in the Care Groups.

4.6 Ward Manager and Matrons

4.6.1 Ward managers will ensure that staff are trained in the use of restrictive interventions, and rosters are constructed is a safe manager that consider skill and gender mix.

4.6.2 Ward manager and Matrons will ensure to review incidents of restrictive interventions, challenging behaviours, violence and aggression on their wards and ensure lessons are learnt to prevent further incidents

4.6.3 Managers and matron will monitor the use of blanket rules on their wards and ensure that if the blanket restrictions are required and used they are recorded, regularly reviewed and reported.

4.6.4 Ward managers with the Multi-Disciplinary Team will maintain Restrictive Practice Logs on the wards and ensure that they are kept up to date.

4.6.5 Managers, Matrons and the multi-disciplinary team to ensure that are engagement in therapeutic activities and they are reviewed regularly with the patients.

4.7 Head of Learning and Development

4.7.1 Ensure staff induction and training programmes take full account of all hazards and risks, clinical and non-clinical, likely to be encountered in the workplace and provide safe systems of work based upon evidence-based practice where available.

4.7.2 Reviews corporate, directorate and care group mandatory and statutory training requirements, and reports on compliance.

4.7.3 Provides sufficient courses to train all staff in PSS as stated in training matrix.

4.7.4 Provide regular updates to Quality Committee on PSS training compliance

4.8 **Promoting Safe Services Manager**

4.8.1 Ensures that training is fit for purpose and available to all staff.

4.8.2 Designs and delivers packages tailor-made for services or challenging individuals via team teaches.

4.8.3 Works with Risk Manager to review incidents regarding (aggression, violence, seclusions, SIs and blanket restrictions)

4.8.4 Monitors and audits restrictive intervention skills (Trust wide).

4.8.5 Develops safe systems of working and best practice.

4.8.6 Provides Clinical Support to wards and provides the link between clinical area's and training teams.

4.8.7 Assists in complaints process on issues of physical interventions.

4.8.8 Provides advice to Trust on lessons to be learnt from incidents.

4.8.9 Provides a monthly report to care groups and bi-monthly reports to the Trust wide Health and Safety Group.

4.8.10 Follow up with Service Managers incomplete reporting forms to ensure complete

4.8.11 learning is picked up.

4.9 **Complaints Manager**

4.9.1 Ensures that the PSS Training Manager or Clinical Practice Lead is involved in reviewing complaints regarding the use of physical intervention skills, restrictive interventions or any issues of conflict management.

4.9.2 Feeds back outcomes from complaints to ensure lessons can be learnt.

5 EMPLOYEE'S DUTIES

5.1 All staff have a responsibility to keep up to date with training and practice on restrictive interventions. Staff should not engage in restrictive interventions such as restraints unless trained to do so.

5.2 Those registered nurses who are involved in administration of rapid tranquilisation must undertake Immediate Life Support training yearly.

5.3 All other nursing staff who are trained in physical interventions must undertake Basic Life Support training yearly.

5.4 All employees will identify potential / actual risks within their own work area and bring these to the attention of their designated manager at the earliest opportunity.

5.5 All staff must be aware of the systems and procedures in place for summoning assistance when required.

5.6 All employees will report all incidents / near misses of violence and aggression in accordance with Trust policy and procedures, to their Line Manager and complete the necessary documentation at the earliest opportunity, whether directly or indirectly involved in an untoward incident or as a witness to a violent or potentially violent

incident, in accordance with the Trust's Incident/Accident/Near Miss Reporting Policy.

5.7 All employees should utilise the least restrictive intervention and always seek to patient engagement in resolving challenging behaviour incidents

5.8 All employees should utilise patient centred interventions and avoid the use of blanket rules, where they are deemed necessary staff will engage with patients and carers to ensure all are kept informed and they should be under regular reviews.

6 RESTRICTIVE PRACTICES

6.1 Restrictive practices' is an umbrella term to describe a range of interventions and practices that in some way restrict a person's liberty. The Skills for Care and Skills for Health, a Positive and Practice Workforce (2014) provide a simple definition:

"Making someone do something they don't want to do or stopping someone doing something they want to do."

6.2 The Mental Health Act Code of Practice (2017) 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".***

6.3 Restrictive practices encompass a variety of activities that are governed by law, guidance and best practice to ensure that any restriction is legal, ethical and adheres to the 'least restrictive principle'.

6.4 Such acts risk engaging or possibly breaching a person's human rights. In particular, the following rights are at risk of being breached where restrictive practices (of any form) are implemented outside of a robust policy framework based on human rights:

- Article 3: The right to freedom from torture, inhuman and degrading treatment (Article 3)
- Article 5: The right to liberty and security
- Article 8: The right to respect for private and family life, home and correspondence

6.5 The following restrictive practices are more commonly seen within mental health services and each is defined for clarity.

6.5.1 **Physical Interventions** - This is also known as physical or manual restraint and is a type of restrictive intervention which refers to any direct physical contact where the intention is to prevent, restrict, or subdue movement of the body (or part of the body) of another person. (MHA, Code of Practice 2015)

6.5.2 **Seclusion** - Seclusion refers to the supervised confinement and isolation of a patient, away from other patients, in an area from which the patient 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. (MHA, Code of Practice 2015)

6.5.3 **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, 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. (MHA, Code of Practice 2015)

6.5.4 **Mechanical Restraint** - Mechanical restraint is a form of restrictive intervention which involves the use of a device to prevent, restrict or subdue movement of a person's body, or part of the body, for the primary purpose of behavioural control. (MHA, Code of Practice 2015)

6.5.5 **Chemical Restraint** - the use of medication which is prescribed and administered for the purpose of controlling or subduing disturbed/violent behaviour, where it is not prescribed for the treatment of a formally identified physical or mental illness. (CQC briefing; restraint, 2016)

6.5.6 **Blanket Restrictions** - defined 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. (MHA, Code of Practice 2015)

There needs to be justification for the implementation of blanket restrictions. They should be avoided unless there are specific justifications which are deemed appropriate and necessary to address the risk or risks identified for particular individuals, the impact of a blanket restriction on each patient / resident should be considered and documented in their records.

The care team should consult the PSS Team before introducing blanket restrictions and ensure that least restrictive options are considered first

Blanket restrictions should be recorded on the Blanket Restrictions Log, (**Appendix 1**) that is kept on the ward and reviewed regularly by the care team. All restrictions must be reported to the care group safety meetings, that will maintain a care group log.

Care group restrictive practice logs will be reported to the PSS meeting as standing agenda of the meeting

6.5.7 **Forced Care** - Actions to encourage / coerce an individual into acting against their will, for example having to be restrained in order to comply with instruction or request, or non-application of Section 5/4 following advising an individual you will use it if they attempt to leave.

6.5.8 **Cultural Restrictions** -Preventing an individual from following the behaviours and beliefs characteristic of a particular social, religious or ethnic group chosen by them.

6.5.9 **Decision making** - Deciding on the person's behalf or not accepting or acting on a decision the person has made.

6.5.10 **Community contact** - Preventing an individual from participating in community activities, including working, education, sports and community events or from spending time in the community such as parks, leisure centres and shopping centres.

6.5.11 **Contact with family and friends** - Preventing or limiting contact with the individual's peer groups, friends or family. For example, not allowing the

person to receive visitors, make phone calls or allowing them contact with specific friends or family member.

6.5.12 **Restricted access to mobile phones and mobile devices** - Patients should not be prevented from using their phones or other mobile devices without justification which should be informed by their needs and risk assessment. See Section 18 below.

6.6 The remainder of the policy will provide legal justification and guidance on each on the aforementioned restrictive interventions.

7 UNACCEPTABLE METHODS OF RESTRAINT/RESTRICTVE PRACTICES

7.1 The following methods of restriction are unacceptable, especially if the individual requests or is consenting to any of the following. It may be considered and applied as appropriate, this must be clearly documented. Inappropriate use of restrictions may be viewed as abuse and a safeguarding concern. The following is not an exhaustive list:

7.1.1 **Inappropriate use of wheelchair safety straps**

Straps supplied with wheelchairs should always be used when provided for the safety of the user. Although patient / residents should only be seated in a wheelchair when this type of seating is required and not as a means of restraint or to restrict the individual's movement when there are lesser options available.

7.1.2 **Inappropriate bed height**

This is unacceptable form of restraint as it could also lead to an increased risk of falls to the patient and risks to staff.

7.1.3 **Using low chairs for seating**

Low chairs should only be used when their height is appropriate - they should not be used with the intention of restraining a person; low chairs also pose a risk to staff in relation to manual handling.

Chairs by way of construction immobilise an individual e.g. Reclining chairs, bucket seats. This type of chair should be used for the comfort of the individual and not for the purpose to restrict movement.

7.1.4 **Locked doors**

Where units have locked doors for identified risks, there should be clear signage displayed informing individuals and visitors that the doors are locked and who they need to speak to gain exit from the area. If an individual wished to leave and is being prevented by the locked door that patient / resident is being restricted.

7.1.5 **Arranging furniture to impede movement**

Furniture should only be used for its intended purpose. Furniture must not be used to prevent a patient from a room e.g. bedroom

7.1.6 **Removal of outdoor shoes and other walking aids or the withdrawal of sensory aids e.g. glasses**

As with the above they should be enabled to prevent confusion and disorientation.

7.1.7 **Planned prone physical restraint**

Planned prone restraint should not be used other than in exceptional circumstances, e.g. medical reasons, or administration of prescribed medication, when the medical lead has prescribed medication following consideration of site. Utilisation of supine, seated de-escalation or the release of the patient in a controlled manner if it is deemed appropriate and safe to so enabling them to move of their own volition to an area mutually agreed with them and staff as alternatives.

8 PREVENTATIVE INTERVENTIONS

8.1 The effective nursing of aggressive or severely disturbed patients is one of the most challenging aspects of working in a mental health inpatient setting. It is an area where good interaction and communication skills are required.

8.2 KMPT places emphasis on recognising early warning signs and knowing individual triggers in attempts to prevent situations escalating into aggressive and violent incidents.

8.3 A patient's anger and frustration need to be treated with an appropriate, measured and reasonable response. Use de-escalation techniques before other interventions.

8.4 De-escalation can be defined as the gradual resolution of a potentially violent or aggressive situation through the use of verbal and physical expressions of empathy and alliance. It should be tailored to individual needs and typically involves 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 patient into alternate enjoyable activities, removing sources of excessive environmental stimulation and being sensitive to non-verbal communication.

8.5 If other interventions are necessary, e.g. physical interventions, then staff must continue to use verbal de-escalation throughout.

8.6 Staff should also consider the use of PRN medication to help calm the patient and alleviate any psychological distress, where appropriate.

8.7 All staff should learn to recognise what generally and specifically upsets and calms the patient. This should be noted in their care plans/Positive Behaviour Support plans and a copy should be given to the patient.

8.8 Trauma Informed Care

8.8.1 Trauma can be defined in many ways. The concept of trauma encompasses experiences of interpersonal violence, such as rape or domestic violence; complex childhood and developmental traumas including community violence (e.g. bullying, gang culture, sexual assault, homicide, war), abuse, neglect, abandonment and family separation. Lesser understood, but equally important, forms of trauma include social trauma, such as inequality, marginalisation, racism and poverty.

8.8.2 Experiencing trauma can lead to emotional and physiological responses which can result in feelings of despair, hopelessness and helplessness and behaviours associated with harm to self and others.

8.8.3 Staff should be aware of the concept of trauma and the potential risks of re-traumatisation within mental health systems. These include the use of restrictive practices, such as restraint, seclusion and long-term segregation which can all trigger the original event and cause mental distress to the patient.

8.8.4 Staff must consider any previous trauma and the potential impact the use of restrictive practices could have in their decision-making process.

9 DE-ESCALATING A VIOLENT SITUATION

9.1 De-escalation primarily concerns the actions staff undertake to manage potentially untoward situations.

9.2 The aim of de-escalation is to defuse the situation and avoid the need for physical intervention. The purpose of de-escalation is to:

Alter the course of the aggression cycle	Re-direct the patient to a calmer state
Reduce their level of anxiety / arousal	Restore control to the health care environment
Avoid violent responses and the need for physical intervention	
Staff should not at any time during the interaction exceed their personal capabilities or professional responsibilities or place unrealistic expectations on the potential aggressor; this could cause the situation to rapidly deteriorate	

9.3 In approaching the situation staff will need to demonstrate through their verbal and non-verbal behaviours that they are:

Calm	Caring	Open and non-judgmental
Controlled	Non-threatening	

9.4 De-escalation in principle is only effective under certain circumstances where the level of risk is relatively low.

9.5 Where the motivational circumstances and the presenting behaviors of the potential attacker(s) indicate increased risk, then staff will need to seek immediate help and assistance as opposed to trying to engage the patient in de-escalation strategies.

9.6 Staff must at all times adhere to planned responses in order to ensure that potentially violent episodes are properly managed. Any ad hoc actions taken by staff must comply with local / Trust policy and procedures.

9.7 All incidents involving staff action should be reported and recorded on the PSTS section on the Datix electronic reporting system as soon, as is practically possible after the event, but no later than 24 hours.

10 THE DE-ESCALATION PROCESS

Staff must:

10.1 Be aware of personal space and keep a safe distance.

10.2 Remain calm and in control of their own level of arousal.

10.3 Adopt non-confrontational verbal and non-verbal behaviors – Keep own personal threat level low.

10.4 Remain open and non-judgmental – be cautious of demonstrating negative feelings through unguarded comments or facial expressions.

10.5 Assess the potential aggressor's verbal and non-verbal behavior.

10.6 Determine their grasp on reality, psychosis / substance abuse.

10.7 Assess the degree of dangerousness (potential harm) associated with their behaviour and their willingness / ability to co-operate.

10.8 Consider the impact staff presence is having upon the situation.

10.9 Conduct an environmental assessment, exit routes, door locking mechanisms, lighting, floor surface, potential barriers, proximity to unsafe areas i.e. tops of stairs, large glass areas, corners of a room, etc. Avoid all vulnerable areas do not compromise personal safety.

10.10 Adopt non-confrontational behaviours, seek and maintain non-threatening eye contact – observe and listen - give them your full attention.

10.11 Encourage them to talk and ask questions, ensure honest responses are given, do not make promises that you or others cannot deliver on, use non-provocative language avoiding jargon.

10.12 Throughout your interactions continually monitor and assess the patient's behavior, how are they responding is their behavior becoming less or more aggressive.

10.13 Clarify the problem, search for an acceptable solution; agree a course of action and act.

10.14 Report and record the incident in detail, document the antecedents and the behaviours exhibited by the potential aggressor and the de-escalation process you undertook and the outcome of your intervention.

11 PHYSICAL RESTRAINT (SOMETIMES REFERRED TO AS MANUAL RESTRAINT)

This revised dataset seeks to record incidents that meet:

(1) The MHA code of practice (2015, DH) definition of 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.

(2) Meets all parts of the above definition of restrictive interventions.

Position	Definition
Prone	A physical restraint in a chest down position, regardless of whether the person's face is down or to the side.
Supine	A physical restraint where the patient is held on their back.
Side	A physical restraint where the patient is held on their side
Standing	Where the patient is restrained in a standing position.
Seated	Where the patient is held in a seated position.
Kneeling	Where the patient is held in a kneeling position.
Restricted escort	Any restrictive hold where an individual is moved/ re-located from one area of a unit to another or between units regardless of level of hold.

11.1 The Trust recognises that staff who are likely to find themselves in aggressive or violent situations, where intervention might be necessary, must attend an appropriate course run by qualified instructors.

11.2 Patients (either detained or informal), visitors or others may behave in such a way as to disturb others around them and their behaviour may present a risk to themselves or others.

11.3 These problems may occur anywhere and it is important to distinguish the needs of the patient, visitors and others who pose an immediate threat to themselves or others around them and where Physical interventions are used must be to:

a) 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

b) end or reduce significantly the danger to the patient or others. (Mental Health Act 1983 s.26.36)

11.4 The Trust seeks to highlight the legal and statutory requirements that Trust employees must observe when managing difficult patients or members of the public. This Policy should be read in conjunction with the policies guidance and references above.

11.5 The most important legal principle underpinning the valid use of Physical Interventions is that of `least restrictive alternative' (Mental Health Act 1983) or `least necessary use of force' (Criminal Law Act 1967) must be used.

11.6 The principles of understanding cultural sensitivity and awareness underpins the principles of this policy and procedures therein.

Non-resistive physical interventions, which do not involve the use of force, may the DoH suggests, include such measures as assisting a person walking.

11.7 A restrictive physical intervention is defined as involving the use of force to control a person's behaviour and can be employed using bodily contact, mechanical devices or changes to the persons environment (Mental Health Act 1983 Code of Practice s.26) (The idea is that there may be some kind of resistance exercised by the person to whom the force is applied.

11.8 All such interventions may constitute the offences of assault, assault and battery, or false imprisonment.

11.9 In more serious cases it may constitute the offences of inflicting grievous bodily harm (GBH), causing harm with intent, and where death occurs manslaughter.

11.10 A duty of care exists when duties and responsibilities are imposed upon professionals or paid carers. In general terms, this means taking reasonable care to avoid acts or omissions that are likely to cause harm to another person. Judgement about what is or is not a 'reasonable' course of action may be made with reference to the following:

11.10.1 The conduct of other practitioners with similar skills and responsibilities

11.10.2 An appropriate body of expert opinion

11.10.3 What is reasonable in the circumstances

11.10.4 The foreseeable risks associated with a course of action

11.10.5 KMPT is aiming to reduce the number of restrictive interventions (i.e.

11.10.6 Restraint, Seclusion and Rapid Tranquilisation, blanket rules, long-term segregation) alongside significant reductions in the use of prone restraint:

a) Full account should be taken of the individual's age, physical and emotional maturity, health status, cognitive functioning and any disability or sensory impairment, which may confer additional risks to the individual's health, safety and well-being in the face of exposure to physical restraint.

b) A member of staff should monitor the individual's airway and physical condition to minimise the potential of harm or injury. Observation, including vital clinical indicators such as pulse, respiration and complexion (with special attention for pallor/discolouration), should be conducted and recorded.

c) People should not be deliberately restrained in a way that impacts on their airway, breathing or circulation. The mouth and/or nose must never be covered and techniques should not incur pressure to the neck region, rib cage and/or abdomen.

d) There must be no planned or intentional restraint of a person in a prone/face down position on any surface, not just the floor. (Prone is any position that the person's chest is in contact with a solid surface). Only exception high level seclusion method as taught on PSS training.

e) If exceptionally a person is restrained unintentionally in the prone/face down position (i.e. they over power the team due body mass, strength or skills) staff should reposition into a safer alternative as soon as possible (i.e. immediate turn) if the environment allows.

f) Where unplanned or unintentional incidents of any restrictive practice occur there should always be recording and debrief to ensure learning and continuous safety improvements.

g) There may be the odd occurrence where it maybe the patient's preference due to some past trauma, if this is the case it must be documented in the notes, care plan and behaviour therapy put in place to deal with the past trauma and to move away from this preference.

h) When restraint is used on a pregnant woman, restraint in the prone (chest on floor)/supine (back on floor) position should be avoided if possible (as these positions can put the mother and unborn child at risk). There may be times that the person may force themselves into one of the above positions. The

restraining team should be mindful of the actual restraint position utilised that it follows the least restrictive holds for the shortest possible time and this should be reflected in the Proactive use of holding pregnant women in the seated position – ideally on the safety pod/chair/bed is preferred option. This should always be of priority in the third trimester of pregnancy

i) Staff must not deliberately use techniques where a person is allowed to fall unsupported, other than where there is a need to escape from a life-threatening situation

11.11 Whilst deployment of personal safety techniques generally occurs in a one to one situation or with a member of staff rescuing someone else, physical intervention must be employed using a team approach.

11.12 A minimum of one team per site must be available (which must be noted in the designated nurse in-charge folder).

11.13 A physical intervention team consists of three members of staff a team leader and two support members.

12 MECHANICAL RESTRAINT (HAND/SOFT CUFFS)

12.1 Mechanical restraint is a form of restrictive intervention that refers to the use of a device to prevent, restrict or subdue movement of a person's body, or part of the body, for the primary purpose of behavioral. (Section 26.75, Mental Health Act Code of Practice 2015):

12.1.1 Hand/Soft cuffs are only in use in Forensic services following Ministry of Justice Guidelines, and will only be applied to co-operative/compliant individuals. If the individual does not wish to co-operate other arrangements will be made for their movement to court/hospital (see separate policy).

12.1.1 As mechanical restraint (hand/soft cuffs) is a form of restrictive practice. All relevant paperwork must be completed this includes (appendix b of the forensic services hand cuff procedure) and Datix.

12.1.2 Staff applying soft /handcuffs devices must have undergone an appropriate training:

a) In their application of use.

b) Maintenance of the equipment.

c) All successful staff names will be kept on the learning and development training data base.

12.2 All training will be delivered internal by the recognised train the trainer who must be updated annually by a recognised and accredited tutor/company.

12.3 All staff attending their mandatory use of handcuffs training must firstly be in date with their PSS training prior to attendance. Use of soft/handcuffs must only be applied if staff have successfully completed that aspect of training.

12.4 Mechanical restraint which involves tying an individual (using tape or a part of the individual's garments) to some part of a building or its fixtures should never be used.

13 OLDER ADULTS – MECHANICAL RESTRAINT (SEE RELEVANT POLICY)

13.1 Mechanical restraint also includes the following:

a) Bed rails. (The use of these needs to be risk assessed and should include the patient (if possible) and their next of kin in the decision making) (refer to Use of Bed Rails Policy)

b) Lap belts on wheel chairs. (These should only be used for the transportation of patient from A to B and not for any other reason).

c) Lap belts on hoists free standing. (Must be used as per training and manufactures guidelines)

d) Lap belts on bath hoists fixed ((Must be used as per training and manufactures guidelines or lowering in and out of the bath). Unless risk assessment states otherwise i.e. risk of sliding of seat.

e) Arm Splints. (These are generally used to limit self-injurious frequent and intense behaviour of the patient)

14 USING ORAL PRN (PRO RE NATA) MEDICATION (REFER TO MEDICINES MANAGEMENT POLICY)

14.1 PRN in this policy refers to the use of oral medication as part of a strategy to de-escalate or prevent situations that may lead to violence or aggression. It does not refer to PRN medication used on its own for rapid tranquillisation during an episode of violence or aggression

15 RAPID TRANQUILLISATION (SEE RELEVANT POLICY)

15.1 Please refer to the separate Rapid Tranquillisation Policy.

16 MONITORING OF PHYSICAL INTERVENTION/ RAPID TRANQUILISATION

16.1 Following any physical intervention or rapid tranquilisation the monitoring forms **MUST** be completed via Datix electronic reporting system.

16.2 Failure to report can leave the staff and or patients, visitors and carers at risk.

17 STAFF AND PATIENT SUPPORT (SEE RELEVANT POLICY)

17.1 Following an incident of violence appropriate after-care will be provided for affected staff and patients, visitors and carers through the immediate line management who will involve other personnel as appropriate.

17.2 It is important to consider informing next of kin, family member or carer of staff or patient who have been involved in the incident before any press involvement.

17.3 Staff should work with the Patient to review and amend their Positive Behaviour Support Care Plans

18 LONE WORKING

18.1 **Definition:** Lone working is defined as - Staff who work by themselves in areas without direct supervision and away from Trust staff or other persons who would be able to provide immediate assistance if required. This includes staff working in the

community as well as in isolated parts of any non-domestic building or premises used as a workplace by Trust staff.

18.2 All staff have a responsibility to ensure they comply with their local lone working protocol which should be created in line with the Trust Lone Working Policy, available from http://i-connect.kmpt.nhs.uk/document-library/lone-working-policy/224

19 USE OF MOBILE PHONES

19.1 This guidance specifically considers the use of mobile devices by patients and visitors. The same principles apply to staff using a personal mobile device but the purpose of this guidance is to help you support patients' use of mobile devices.

19.2 There are many benefits for patients that arise from encouraging them to use mobile devices:

a) Communication with family and friends - often an essential element of support and comfort for a patient admitted to hospital.

b) Accessing helpful information about their conditions – apps and digital services can support greater patient participation, inform joint decision-making, and allow patients to provide feedback on their outcomes and experiences.

19.3 Mobile devices can be used safely in hospitals. You can support patients to use their mobile devices appropriately as follows:

a) Ask patients to respect people's privacy if they look like they are taking photos without permission, e.g. of staff or other patients in the background.

b) Speak to patients if the use of their mobile device is disturbing others e.g. if it is interrupting care provision, creating unacceptable working conditions for colleagues or undermining patient comfort and recuperation.

c) Staff to discuss with line manager and hospital security if you see anyone suspiciously taking photos of children or vulnerable adults.

19.4 Decisions to take away mobile devices or phones should be informed by risk assessment and the patient should be involved in the decision and a care plan should be in place to support the patient detailing alternatives offered

19.5 For further information, please refer to the Use of Mobile Phones Within Inpatient Settings Policy

20 IMPLEMENTATION INCLUDING TRAINING AND AWARENESS

20.1 PSS training provided will according to the training standards under Restraint Reduction Network Training Accreditation. The training will ensure all staff are aware of their duties/roles and responsibilities to enable them to implement the policy.

20.2 Set out below is the training needs analysis for all staff groups identifying which members of staff require training and the level they require:

PACKAGE	WHO AIMED AT	CONTENT'S	DURATION	UPDATES
A Inpatient Services	Forensic/learning Disabilities Younger/ Older Adults/ Rehab Units- on Trust Sites Occupational Therapists Ward	Theory Personal Safety Physical Interventions	5 DAYS	Yearly 3 Days
B Inpatient Services	(Standalone) Older Adult Wards	Theory Personal Safety Physical Interventions	2 DAYS	Yearly 2 Days
B Patient Contact	Community Teams Doctor's Domestic/Porter's/Kitchen Physiologist's Clerk/Receptionists Any person on an inpatient site (according to Risk Assessment) Rehab Units- off site*	Theory Personal; Safety	1 Day	Yearly ½ Day
C Non-Patient Contact	All Other Staff	Theory	e-Learning or ½ Day	Every 3 years

21 STAKEHOLDER, CARER AND USER INVOLVEMENT

- Promoting Safe Services Team
- Promoting Safe Services Group
- Patient Safety Group
- Local Faith Groups
- Trust Security Management

Carers/Users and Associated groups:

a) a) Via consultation and monitoring group

b) b) Via Clinical Governance Group

c) c) Experts by experience

Stakeholders will be informed of any changes via consultation, PSS Group and Trust wide Patient Safety and Mortality Review Group.

22 EQUALITY IMPACT ASSESSMENT SUMMARY

22.1 The Equality Act 2010 places a statutory duty on public bodies to have due regard in the exercise of their functions. The duty also requires public bodies to consider how the decisions they make, and the services they deliver, affect people who share

equality protected characteristics and those who do not. In KMPT the culture of Equality Impact Assessment will be pursued in order to provide assurance that the Trust has carefully considered any potential negative outcomes that can occur before implementation. The Trust will monitor the implementation of the various functions/policies and refresh them in a timely manner in order to incorporate any positive changes.

23 HUMAN RIGHTS ACT

23.1 ARTICLE 2 (Right to Life) and ARTICLE 3 (Prohibition of Torture):

23.1.1 Under Articles 2 and 3, the following needs to be taken into consideration if handcuffs/soft cuffs are to be authorised for use by the KMPT and applied by its staff.

23.1.2 Article 2 provides for us the positive obligation for public authorities to promote the right to life giving high value to everyone's right to life.

23.1.3 Article 3 prohibits the use of torture, inhumane treatment, and degrading treatment. These are defined as:

a) **Torture:** Deliberate inhumane treatment causing very serious and cruel suffering.

b) **Inhumane Treatment:** Treatment that causes intense physical and mental suffering.

c) **Degrading Treatment:** treatment that arouses in the person a feeling of fear, anguish and inferiority capable of humiliating and debasing the person and possible breaking his/her physical or moral resistance.

23.2 ARTICLE 5 (Liberty and Security of Person):

23.2.1 Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law.

23.2.2 Everyone who is arrested or detained shall be informed promptly, in a language which he understands, of the reasons for his detention and of any charge against.

23.3 ARTICLE 8 (The Right to Respect for Private and Family Life, Home and Correspondence)

23.3.1 This article is very broad and holds a wide range of implications. Public authorities may only interfere with someone's private life where they have legal authority to do so, the interference is necessary in a democratic society for one of the aims stated in the article and is proportionate to that aim. For example, to maintain the safety of others.

24 MONITORING COMPLIANCE WITH AND EFFECTIVENESS OF THIS DOCUMENT

What will be monitored	How will it be monitored	Who will monitor	Frequency	Evidence to demonstrate monitoring	Action to be taken in event of non-compliance
Effectiveness of the policy and ability of staff to apply it in practice.	Observation of trends and review of incidents - data to service managers every 4 weeks to enable them to produce reports every 8 weeks to PSS Group	Promoting Safe Services monitoring Group Chaired by Deputy Director of Nursing and Practice	Bi-monthly meetings and reporting to Trustwide H&S group, Quality Digest H&S group to report to IARC quarterly. Board to sign off annually.	Minutes and reports from VRS group, Trust wide H&S group, IARC and board	A lead member of the clinical team will be identified to take each change forward where appropriate and lessons will be shared with all the relevant stakeholders through the PSS training team. Audits will be undertaken by the PSS Manager and identify if any patients were subject to DOLS or any safeguarding alerts have been raised.
Processes and duties for undertaking prevention & management of violence and aggression risk assessments are adhered to.	Review of PSS incidents via Datix	PSS Manager and PSS Senior Instructors	1. Bi-monthly 2. Bimonthly 3. Monthly	1. Reports to Promoting Safe Services monitoring group 2. Reports to Trust wide H&S group 3. Monthly reports to care groups. 4. Annual reports to commissioners made publicly available.	Required changes to practice will be identified and actioned within a specific time frame. A lead member of the clinical team will be identified to take each change forward where appropriate and lessons will be shared with all the relevant stakeholders through the PSS training team.
Risk assessments are shared to protect staff and patients from violence and aggression	Review of PSS monitoring forms	PSS Manager and Clinical Practice Lead	Monthly	Reports to care groups	A lead member of the clinical team will work with the PSS training team to share learning with relevant stakeholders.
Blanket Restrictions	Ward manager, MDT, matron, Patient Safety	PSS Group Care Group Patient Safety Meeting	Bi Monthly Monthly	Completed Log on the ward. Agenda item on PPS Group meeting	Datix will be completed for non-compliance and investigations conducted to ensure learning and mitigate the identified risks.

25 EXCEPTIONS

25.1 Exceptions to the various parts of the section will be guided by clinical need and law governing the notion under consideration.

APPENDIX 1: BLANKET RESTRICTIONS ASSESSMENT AND LOG

Blanket Restrictions Assessment and Log

WARD NAME: **Service/Care Group:**

Date of Assessment: `
Name of Staff completing:

Date of Review:

	No Blanket rule in place	Applies to all patients	Applies to identified patients	Rationale for use	Review Date
Limited or no access to the intranet					
Limited access to certain rooms (not bedroom) e.g. kitchen, quiet room					
Rigid visiting times					
Limited access to money or ability to make personal purchases					
Restrictions on the use of ward telephone					
Limited access to drinks (including hot drinks)					
Set time to get up in the morning					
Limited access or ban on mobile phones and chargers					
Limited access to secure outdoor space or access at only set times					
Night (or day) time of confinement or set bed times					
Food: No control over food portion size Takeaways, food storage, access to special requirements					
Routine searches of persons/possessions					
No access to mobile phone					