Shropshire Community Health NHS Trust

Document Details	
Title	Restrictive Practice Policy
Trust Ref No	2523
Local Ref (optional)	
Main points the document covers	Restrictive interventions must be used as a last resort and decisions to use them should be based on the principle of using the least restrictive intervention necessary.
Who is the document aimed at?	All clinical staff
Owner	Ian Gingell Health and Safety Manager
Approval process	
Who has been consulted in the development of this policy?	Health and safety and security team, Medicines Management
Approved by (Committee/Director)	Patient Safety Committee
Approval Date	13th March 2025
Initial Equality Impact Screening	Completed
Full Equality Impact Assessment	
Lead Director	Director of Nursing
Category	
Subcategory	
Review date	March 2028
Distribution	
Who the policy will be distributed to	All staff
Method	Staff Zone, Public Website, Staff Newsletter, Local agenda item, all staff, Line Managers, Senior Managers
Keywords	Physical restraint, Chemical restraint, Clinical Holding, Mental Capacity, Deprivation of Liberty, Safe holding, Consent
Document Links	
Required by CQC	Yes
Other	NICE Guidance

Amendments History		
No	Date	Amendment
1		
2		
3		
4		
5		

Contents

1. Policy statement

Shropshire Community Health NHS Trust (SCHT) prides itself on delivering the highest standards of health, safety and welfare to its patients, visitors and employees.

In all cases, care must be person-centred. A positive culture which supports recovery, engendering trust between patients and staff, and protecting the safety and wellbeing of all patients and people using services must be a priority. All care providers must listen to and seek to understand people, including how people communicate their needs, emotions, or distress. This understanding must be used to support adjustments that remove the need to consider the use of any restrictive practice. The focus needs to shift to one which respects all patients' rights, provides skilled, trauma-informed therapy, follows the principle of least restriction, and promotes recovery.

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

2. Document Library

Trust policies will be published and made accessible on the Public Website and Staff Zone

3. Purpose

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

4. Scope

This policy sets out the best practice guidance for all staff working at SCHT. This policy applies to patients who require restrictive practice while receiving treatment; this would include those patients lacking the mental capacity to make specific decisions about their own health and personal safety needs.

5. Definitions

Definitions of the types of restraint are outlined below:

- Physical restraint: any direct physical contact where the intention of the person intervening is to prevent, restrict, or subdue movement of the body, or part of the body of another person.
- Prone restraint: (a type of physical restraint) holding a person chest down, whether the patient placed themselves in this position or not, is resistive or not and whether the person is face down or has their face to the side. It includes being placed on a mattress face down while in holds; administration of depot medication while in holds prone and being placed prone onto any surface.
- Chemical restraint the use of medication which is prescribed and administered for the purpose of controlling or subduing disturbed/violent behaviour, where it is not prescribed for the treatment of a formally identified physical or mental illness.
- Mechanical restraint: the use of a device (e.g. belt or cuff) to prevent, restrict or subdue movement of a person's body, or part of the body, for the primary purpose of behavioural control.
- Restrictive Practice is defined as: "Making someone do something they don't want to do or stopping doing something they want to do" (A Positive & Proactive Workforce, Skills for Care, April 2014)
- Violence: The use of physical force which has the potential to harm or injure another person.
- Aggression: A disposition, a willingness to inflict harm, regardless of whether this is behaviourally or verbally expressed and regardless of whether physical harm is sustained.
- Clinical / Safe Holding: is any intervention preventing a person from behaving in ways that threaten to cause harm to themselves, to others or to property. Under Section 6(4) of the Mental Capacity Act 2005, someone is using clinical / safe holding if they are over age 16 and:

    - Use force – or threaten to use force – to make someone do something they are resisting or;
    - Restrict a person's freedom of movement, whether they are resisting or not.

- Imminent danger: Any situation or practices in a place of employment which are such that a danger exists which could reasonably be expected to cause death or serious injury.
- Mental Capacity: Is the ability to make a decision. The Mental Capacity Act (2005) promotes the principle of least restriction when restrictive or restraint procedures are being considered. The Act introduced the role of the Lasting Power of Attorney. A Lasting Power of Attorney (LPA) allows the appointment of someone (the "attorney") to make decisions on the patient's behalf if mental capacity is lost, either for health and welfare or property and financial affairs
- If the vulnerable adult has this type of Attorney, they must always be consulted when restrictions or restraint procedures are being considered, unless restriction is required urgently e.g. cases of

violence and aggression. Under this law it is now a criminal offence to wilfully neglect or ill-treat a person who lacks capacity, which includes ill treatment through the inappropriate use of restraint.

- The Deprivation of Liberty Safeguards (2009) DOLS provides a legal framework for lawfully detaining someone against their will. This law only applies to those over age 18 years without capacity and living in a registered nursing or care home or being cared for in hospital. The difference between deprivation of liberty and restriction upon liberty is one of degree or intensity. It may therefore be helpful to envisage a scale, which moves from "„safe holding" or "restriction" to "deprivation of liberty". Where an individual is on the scale will depend on the concrete circumstances of the individual and may change over time.

What does restrictive practice look like?

Most people know and accept that restraint, seclusion, and segregation are more extreme forms of restrictive practice. But there are more subtle forms of restrictive practice that easily become day-to-day normal responses to perceived risk or lack of time.

Examples of more subtle types of restrictive practice include:

- making people use incontinence products to manage their toilet needs because it's easier for staff
- keeping walking frames out of reach, which restrict a person's movements or keep them in a specific area
- making people use bibs or feeding cups
- making someone use a wheelchair when they're willing and able to walk
- denying people access to visitors, friends, or food due to a lack of staff or time.

Many of these examples make it quicker or easier for staff to manage people in their care, rather than providing person-centred trauma-informed care.

These types of restrictive practices have been used as a form of punishment in response to the way in which people communicate or express their distress. **This is completely unacceptable.**

6. Applicability

All staff that are required to work within the organisation, employed and non-employed, must adhere to this policy.

7. Responsibilities

Trust Board	Strategic	Strategic overview and final responsibility for setting the direction of this policy. Ensure that it fulfils its statutory responsibilities.
Chief Executive	Executive Lead	The Chief Executive has overall responsibility for all Trust polices and ensuring an appropriate process for the production, management and monitoring of polices is in place
Director of Nursing	Executive Lead	The Director of Nursing is responsible for the Trust strategic direction for this policy. Agree action plans to address issues relating to this policy. Updating the Trust Board where necessary
Medical Director	Executive Lead	Medical Director is responsible for ensuring that there is an up to date-policy that meets both legal and best practice guidance and that professional conduct relating to consent is maintained.
Operational Managers	Operational	Will be responsible for implementing this policy at local level.
Locality/Service Managers	Operational	The /Service Manager across the Trust will support the Directors in the operational implementation of this policy and support the process of risk management and incident reviews as required. They will ensure that any restraint is recorded via the DATIX process.
The Security Manager and Health and Safety Manager	Operational	Review all DATIX raised around restraint or restrictive interventions, provide overview and learning from all incidents involving restraint. Liaise with relevant external agencies as appropriate. Be involved in de-brief and any subsequent follow up activity. Provide regular updates to the Patient Safety Committee Ensure security involvement in planning the Trust response to an expected situation where the need for restraint is considered probable. Advise the Trust and its employees on any change in security legislation or guidance around restraint. Ensure the Patient Safety Committee are kept fully informed of any incidents, the outcome and any learning that needs to take place.
The Person in Control	Operational	The person leading the implementation of any restrictive intervention will: (this is usually the ward sister/ charge nurse)

		• If they consider restraint is likely, request (without delay) that: the Police attend. • Assume the lead role for any restraint that does take place, which is informed by an assessment of risk and clinical judgement. • Have a sufficient understanding of restraint processes, of the law, and of this policy to ensure a satisfactory outcome for all involved. • Ensure that wherever possible de-escalation techniques are used throughout a restraint process. • Arrange for the family, friends or carer to be contacted / be involved if they may have a calming influence on the patient. • Ensure the intervention is reported via DATIX.
All clinical staff	Operational	All clinical staff will ensure that they have read and adhere to this policy as and when required. The member of staff identifying the violent or aggressive behaviour or intent will: • Attempt to de-escalate by reassurance and other means. If de-escalation is failing then notify Nurse in Charge at once and take reasonable steps to ensure safety of patients, visitor and staff is protected. • Wherever possible and if it is safe do to so move other patients away from the vicinity.

8. De-escalation

8.1 Managing Challenging Behaviour

Successful management of challenging behaviour is underpinned by having an understanding of the reasons for the behaviour and the identification of appropriate interventions which staff can use when interacting with the patient. The use of de-escalation techniques must be the first strategy when faced with an escalating situation. De-escalation or diffusion refers to talking with an angry or agitated patient in such a way that violence is averted, and the person regains sense of calm (NICE 2015).

8.2 Behaviour and Underlying Condition

Understanding a patient's behaviour and responding to individual needs must be at the centre of patient care. All patients must be assessed

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

Possible causes to consider are:

- Need to empty bladder or bowel
- Anxiety or distress
- Mental illness – (e.g. dementia, schizophrenia)
- Delirium (acute confusion) due to:
    - Infection/ Pyrexia
    - Hypoxia
    - Electrolyte or metabolic imbalance
- Pain or discomfort
- Constipation/dehydration
- Hypoglycaemia
- Hypotension
- Other form of memory impairment
- Drug dependency or withdrawal (including alcohol, nicotine, sleeping tablets and illicit drugs)
- Brain insult/injury or cerebral irritation
- Reaction/side effect of medication
- Intoxication (due to alcohol, drug overdose or drugs of abuse)
- Pregnancy and postnatal conditions
- Communication issues
- Impact of Disability

8.3 Implementation of Physical interventions / safe holding

Conflict Resolution Training (CRT) and de-escalation techniques must be attempted irrespective of the stage of restraint. This may enable rapid and safer resolution.

Ensure that one member of staff leads the team and assumes control of the person being restrained throughout the process (person in control). The person in control must manage and control the event to ensure the patient‟s best interests are maintained. This control must continue throughout the period of clinical / safe holding and must pay attention to the following:

- Appropriate support / protection of head / neck
- Monitoring of airway and breathing at all times
- Regular monitoring of vital signs depending on extent of chemical / safe holding used.

To maintain optimum safety during the period the patients is being safely held

- Pressure must only be applied to limbs.
- Direct pressure must not be applied to neck, back, chest, abdomen or pelvis.

There must be no application of pain during safe holding. The use of safe holding must be reasonable, necessary and proportionate. Following the

period of safe holding the person who has been safely held must be physically assessed and monitored for a period of at least 24 hours, paying attention to neuro–observations.

In assessing the reasonableness of the force consider two questions:

- Was the use of force necessary in the circumstances, i.e. was there a need for any force at all? and;
- Was the force used reasonable in the circumstances?

Face down (prone) restraint of persons must be avoided at all times.

Please see Appendix One

8.4 Mechanical restraint

The use of mechanical restraints is prohibited by Trust staff or any employed contractor. This prohibition does not apply to the Police, Prison service or other approved agency.

8.5 Physical monitoring

Appropriate monitoring is essential during and after periods of safe holding and **MUST** be fully documented. If significant safe holding is used, vital signs must be taken and recorded.

Following the period of safe holding the person who has been safely held must be physically assessed and monitored for a period of at least 24 hours, paying attention to neuro–observations.

8.6 Rapid Tranquilisation

Rapid tranquilisation by means of medication is not approved for use in SCHT.

9. Safe holding de-brief

The aim of a post incident review / de-brief is to seek to learn lessons, support staff and patients.

A de-brief must take place as soon as practicably possible post incident unless exceptional circumstances prevent this. Ideally facilitated by a senior nurse and include all staff involved.

Reflective reviews and root cause analysis are essential after a patient hold or rapid tranquilisation event. Reviews must consider:

- What happened during the incident?
- Any trigger factors.
- Each person’s role in the incident, their feelings at the time of the incident and how they
- may feel in the near future.

- Addressing concerns raised by staff.

Staff must also be offered support by their line manager and the incident reported on Datix.

10. Documentation

Clear documentation of the decision to safely hold or not must be made within the notes including:

- Reason for the safe hold.
- Names of those consulted.
- Procedure to be followed, this must contain:
    1. Mental Capacity assessment.
    2. Best interests' assessment where required.
    3. Type of behaviour displayed.
    4. Reasons as to why the patient may be behaving in this way.
    5. Clinical / Safe holding risk assessment.
    6. Discussion (where possible/appropriate) with the patient regarding the use of Clinical / Safe holding.
    7. Reporting via Datix

In addition, where Clinical / Safe holding is used the following must be documented:

- Type of Clinical / Safe holding used.
- Rationale for the use of that type of Clinical / Safe holding.
- Patient consent / non consent.

11. Governance and Compliance

The effectiveness of this policy will be routinely monitored through channels including incident reporting (DATIX), Governance meetings and through the Trust Committees.

Any cases where legal action is considered or taken will be reported to the Trust Quality and Safety Committee.

12. Equality Impact Assessment

All public bodies have a statutory duty under The Equality Act 2010 (Statutory Duties) Regulations 2011 to consider the impact of policies on "protected characteristics". The Trust will comply with the legislation and will have a process in place to evidence that an equality screening and assessment has been completed, documented, and published for all policies. An Equality Impact Assessment Screening will be completed, and the outcome recorded on the front sheet of the document.

13. Communication and Dissemination

The policy will be published on the staff intranet and communicated to staff via the regular corporate communication channels.

14. Advice and Guidance

See references below, professional codes of conduct, Safeguarding Team and Health and Safety Team.

15.Training and Awareness

Training programmes to be accessed at team level in order to give staff skills to avoid escalation of aggressive behaviour.

16. Contact

Any queries with regards to this document should be directed to the author.

17. Review and Maintenance

This Policy will be reviewed every three years or in response to significant changes due to security incidents, variations of law and/or changes to organisational or technical infrastructure.

18. References

Restrictive practices - Care Quality Commission (cqc.org.uk)

Quality statement 10: Review of restrictive interventions | Learning disability: behaviour that challenges | Quality standards | NICE

Violence and aggression: short-term management in mental health, health and community settings NICE guideline [NG10]

Mental Capacity Act 2005

Deprivation of Liberties Safeguards 2009

Positive and proactive care reducing the need for restrictive interventions (DoH) 2014

Appendix 1- Standard Operating Procedure for use when Safe Holding

Affix patient name label here.

Rationale for Safe Holding:

Is the patient becoming a risk to themselves? ☐

Is the patient a risk to others? ☐

Has Patient been assessed for:
(De-escalation- check and tick each one)

Pain	☐	Boredom	☐
Hunger /Thirst	☐	Passing Urine	☐
Hot/cold	☐	Bowel Movement	☐

Actions taken to de-escalate:

Communication:
Discussion has taken place with the patient about need for sedation.

Yes ☐
No ☐

Consent

Mental Capacity Assessed and Form completed. ☐

Best interest Form completed. ☐

Discussion has taken place with: (Please tick)

Drs	☐	Name….
Nurse	☐	Name….
Family	☐	Name….
Security (if applicable)	☐	Name….

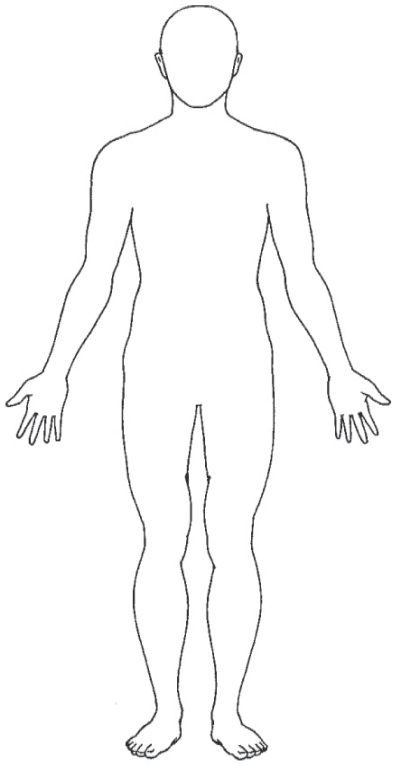
Body Map documentation
Complete before administration of safe holding, if possible (Please circle), Yes /No

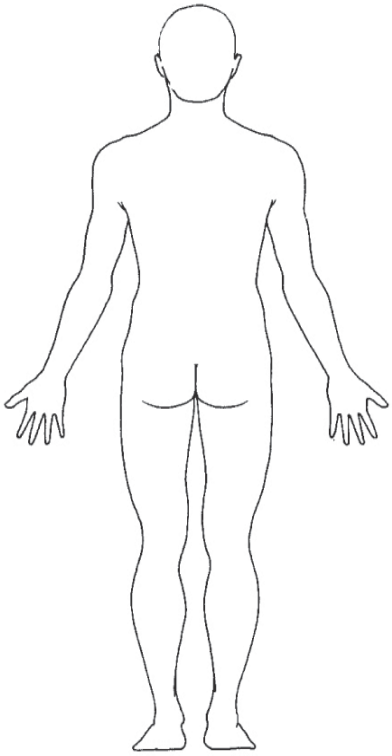
Body map documentation Complete after administrated of safe holding (Tick)	☐
DoLS completed if not already in place (Tick)	☐
Type of hold being used. **Duration of hold**	
Medication Tick: Consider oral medication before considering giving IM medication. Prescribed ☐ Administered ☐ Dose ☐ Route ☐ Signed ☐	
Observations recorded post holding – to include respiratory rate. (These should be recorded every 15 minutes for the first hour)	☐
Datix recorded for incident (record under violence and aggression category) Datix number:	☐
Family Informed	☐

Completed by …… signature
Designation PIN
Ward/Department
Date
Time

Appendix 2-Body map

Before Restraint





After Restraint