GUIDELINES: WHEN CONSIDERING AND REVIEWING THE USE OF RESTRICTIVE INTERVENTIONS AND RESTRICTIVE PRACTICES

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1.0 Introduction and Purpose

The intention of this guideline is to raise staff awareness of what constitutes restrictive interventions and practices by defining and broadly identifying some of the methods of restrictive interventions/practices. This guideline is designed to specify the ethical, legal and professional principles to be applied in all circumstances when staff are considering the use, monitoring or reviewing the current use, of restrictive intervention and practices including by other health, education and social care areas.

To ensure the reduction in the use of and avoid the misuse of restrictive interventions and practices this guideline details the decision making, including monitoring and review processes and includes a method of recording these processes. This will enable staff to evidence the application of the legal ethical and professional principles and processes including measuring the impact on an individual’s human rights, future risk and the therapeutic relationship. Ultimately ensuring, where the use of restrictive intervention and or practices are used in the delivery of care, treatment and risk management, is lawful, necessary, proportionate, least restrictive and the last resort option reasonably available.

This guideline details the process to be considered when the risk is anticipated or foreseen and the use of restrictive intervention or restrictive practices is part of a pre agreed multi-disciplinary planned approach but also recognises that the use of restrictive intervention and practices may be necessary in exceptional circumstances in an emergency situation in response to unforeseen immediate risk. In all situations staff must be confident in their professional judgement that there is no safer alternative to keep people safe.

There are inherent risks especially in the prolonged use of certain types of restrictive interventions such as Physical Restraint, Seclusion and Rapid Tranquilisation and these are highlighted in this document. However it is recognised that there are some occasions in which the risk to the service user or others of inaction may outweigh those of taking action. Ultimately the benefits in the delivery of care, treatment and risk management must outweigh the risk of using restrictive interventions and /or practices.

The following definitions, methods and principles of restrictive interventions and practices applies to individuals being cared for in all types of settings for example acute and non-acute hospitals, mental health, learning disability and care in the community.

In order to assist staff in adhering to the principles and practices contained in this guideline a summary Restrictive Interventions/Practices Pathway has been developed. (see APPENDIX 1)

1.1 Responsibilities

This guideline is to be adopted by all SHSCT staff within the appropriate Directorates. All staff have responsibility to comply with the requirements of this guideline and associated policies and have a legal duty to have regard to it when working with, or caring for service users including those who may lack capacity to make decisions for themselves.
2.0 Definitions: - (in this document the use of the word ‘restrict’ and ‘restraint’ are used interchangeably).

Restrictive Interventions are defined as:
Deliberate acts on the part of other person(s) that restrict an individual's movement, liberty and/or freedom to act independently in order to:

- take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken; and
- end or reduce significantly the danger to the person or others; and
- contain or limit the person’s freedom for no longer than is necessary” ¹

Restrictive Practice is defined as:

“Making someone do something they don't want to do or stopping them doing something they want to do or doing it in the way they want to do it”². Or preventing a person from having something they want. This can include more subtle forms of restrictive practice. (see section 4.0).

NB: If an action fits the definition of restrictive intervention/practices it is not automatically unacceptable or wrong. A discussion of the ethical, legal, practical, and professional principles follows (Section 3.0), to help staff understand the difference between unacceptable or abusive use of restrictive intervention/practices and the rare circumstances in which restrictive intervention/practices may be justified or positively required, to help strike the right balance between independence and safety³.

3.0 Principles: the use of Restrictive Interventions/Practices needs to be ethically, legally and professionally justified based on the following principles to reduce the use and prevent the misuse of Restrictive Interventions/Practices

3.1 Proactive Prevention (see APPENDIX 2):
Every effort should be made to reduce the likelihood of challenging and serious risk behaviours. Having a greater understanding of the function of the behaviour i.e. “why does John run away” and the contributing factors which may increase risk, gives staff and the organisation the opportunity to facilitate primary and secondary preventative strategies where possible.

Primary Prevention: Creating a therapeutic environment to help support individuals to get their physical and psychological needs met may help avoid an escalation in behaviours. This might include managing trigger factors in the environment such as clear signage and reducing noise levels. Recognising the early warning signs of changes in individual behaviours including through the risk assessment process and treating any underlying health conditions may help mitigate the risk. Developing an educational approach to empower service users to strengthen their protective factors will also avoid and or limit the need for restrictions.

Secondary Intervention: To further create calm and avoid an escalation to risk behaviour, person centred secondary intervention strategies can be further developed as part of a therapeutic behavioural/risk/support/care crisis management plan.

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¹ Positive & Proactive Care: reducing the need for restrictive interventions. DoH. April 2014
² A Positive and Proactive Workforce, Skills for Care. DOH April 2014
³ Let’s Talk about Restraint: Rights, Risks and Responsibilities. RCN. March 2008
3.2 **Underpinning Values**

- **Care™**: treating people with high levels of compassion; respecting peoples uniqueness in the assessment and delivery of person centred care in a dignified manner

- **Wellbeing**: promoting independence, including giving opportunities to take calculated risk and making choices; involving patients and their carer's in the decision making process such as in wellbeing plans and through the process of consent. Demonstrating the best interest decision making process for those who lack capacity.

- **Safety™**: staff have a legal obligation to safeguard others from harm, abuse and injury that respect and protect the individual's human rights. A balance must be achieved between risk of harm or injury to patient and others and maintaining dignity, personal freedom and choice.

- **Security™**: ensure a multidisciplinary team and service user approach to assessment, care crisis management and communication of risk. This assessment process develops an understanding of the contributing factors and triggers to the crisis risk behaviour such as the underlying condition of the patient/service user e.g. physical/mental health condition; influence of substances; cognitive impairment and environmental factors such as inappropriate level of stimulation, staff attitude and approach, communication skills (see APPENDIX 2).

3.3 **Legal and Professional Frameworks**

Use of restrictive interventions/practices must be undertaken within the appropriate legal and professional frameworks including:

- A human rights based approach to decision making. The Human Rights Act (1998)\(^4\) and the United Nations Convention on the Rights of the Child (1990)\(^5\) is based on the presumption that every adult and child are entitled to these core rights to meet our basic needs as human beings so that we may develop our potential and live our lives in dignity and respect. The following table shows the Articles most frequently considered in relation to health and social care provision and includes, how these rights may be breached in practice\(^6\)

<table>
<thead>
<tr>
<th>Article</th>
<th>What it says</th>
<th>How might this right be breached in practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Prohibition of torture&lt;br&gt;A person has the absolute right not to be tortured or subjected to treatment or punishment which is inhumane or degrading and cannot be interfered with under any circumstances</td>
<td>Measures used to control behaviours which reality are shaming and humiliating, for example: not being allowed to have a meal, being made to stand outside as a means of managing a perceived “bad behaviour”</td>
</tr>
<tr>
<td>5</td>
<td>Right to liberty and security&lt;br&gt;A person has the right not to be deprived of their liberty- ‘arrested or detained’- except in limited cases</td>
<td>Measures used to prevent behaviours perceived to be a risk to self or others for example: improper or inappropriate admission/detention to psychiatric care;</td>
</tr>
</tbody>
</table>

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6. Three Steps to Positive Practice: Royal College of Nursing Northern Ireland (2017):
Detention under the Mental Health (Northern Ireland) Order 1986 7
The use of restrictive interventions and restrictive practices can amount to a Deprivation of Liberty (DoL) based on the degree and intensity of the restraint, the duration and frequency and setting and the level of planning before the restraint was done. An act that is short, time-bound and reactive to an immediate event is likely not to be a DoL but restraint. When considering if the service user is subject to DoL’s the following ‘acid test’ should be considered.8

A person who lacks capacity and
a. is under continuous supervision and control (e.g. control over contacts, control over activities or supervision over health and actions),
b. is not free to leave whether they are compliant or not making any objection (e.g. locked doors that are not unlocked on request; physically preventing service user from leaving; not being able to leave without supervision and not free to permanently move residence)
c. the state is involved in the care or treatment directly (e.g. hospital; foster home; care home) or indirectly e.g. direct payments

For young persons the acid test should be considered in the context of the liberty restricting measures that are universally applied to those of the same age and maturity who are free from disability. As a general rule the younger the person is the greater the level of constraint to which they would be subject. A 5 year old, for example regardless of their disability would be under continuous or complete supervision and control wherever they are and not free to leave. The fact they are under such control, whether in the care of their family or State, does not mean they are deprived of their liberty. However, if the level of constraint typically afforded to a non-disabled 5 year old is provided to a disabled 16 year old, then those constraints must be taken into account in determining whether the acid test is satisfied 9.

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7 Mental Health Northern Ireland Order 1986
8 Mental Capacity Act 2016 Northern Ireland (MCA 2016)
- The Deprivation of Liberty Safeguards (DOLS) -Interim Guidance 2010 ¹⁰ aim to ensure that additional safeguards are applied by those involved in taking decisions about an individual's care or treatment that may result in a deprivation of the individual's liberty. The safeguards aim to ensure that individuals are only deprived of their liberty in a necessary and proportionate way and that there is also protection from criminal liability for those who are required to provide care or treatment which involves limiting the freedom of an individual ¹¹ (see section 5.0)

- It is a criminal offence to use physical force or threaten to use force unless the circumstances give rise to a ‘lawful excuse’ or justification for the use of force.

### 3.4 Principles in practice
- In circumstances where staff reasonably believe an individual lacks capacity to independently make decisions about their care treatment and/ or support, health and social care professionals have a duty to ensure that any use of restrictive intervention/practices is in the ‘best interests’ of or to ‘benefit’ the person.
- The degree of restrictive interventions/practices must be a reasonable and proportionate response to the likelihood and seriousness of imminent or immediate harm to the service user or others.
- **Failure to use a restrictive intervention** and practices in connection with the care treatment or personal welfare of a person would create a greater risk of harm to self or others.
- Restrictive interventions/practices will always be viewed as a **last resort and the least restrictive option** where other, less restrictive, strategies have been tried and found to be unsuccessful. However, “where there is clear documented evidence that particular sequences of behaviour rapidly escalate into serious harm the use of restrictive interventions/practices at an earlier stage in the sequence may potentially be justified” ¹²

- All restrictive interventions and practices must be for the **shortest time possible**.
- Damage to property does not warrant the use of restrictions unless the act in itself is going to cause danger to the service user or others.
- Use of restrictive interventions/practices must not intentionally cause pain, harm, abuse or restriction of the airway.

### 4.0 Methods of Restrictive Interventions/Practices: As it would be impossible to list every type of restrictive intervention or practice the following are examples, some of which are detailed under Management of Violence and Aggression (MOVA) Strategies

- Physical/manual restraint refers to any direct physical contact by one or more members of staff holding an individual to prevent, restrict, or subdue movement of the body or part of the body ¹³. [click here](#) to refer to MOVA Strategy 7.
- Mechanical restraint involves the use of equipment such as: specially designed mittens in intensive care settings to prevent essential tubes from being removed.

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¹⁰ Department of Health and Social Services and Public Safety: Circular MHU 1/10 – Deprivation of Liberty Safeguards Interim Guidance (DHSSPS October 2010)
¹¹ Mental Capacity (draft) Bill: DOLS Briefing Paper 96/15 to Northern Ireland Assembly NIAR 360-15 Jane Campbell
¹² Department of Health Social Services and Public Safety: Guidance on Restraint and Seclusion in Health and Personal Social Services (DHSSPS NI August 2005)
¹³ Positive & Proactive Care: reducing the need for restrictive interventions. DoH. April 2014
prematurely by the patient; everyday equipment such as a heavy table or belt to stop the person getting out of a chair\textsuperscript{14} or using bed rails (click here\textsuperscript{15}) to stop an older person getting out of bed for example in exceptional emergency circumstances to avoid injury or harm due to mobilising too soon following a fractured hip; controls on freedom of movement such as locks and other door access controls for example to prevent a confused patient from leaving the facility onto a dangerous road.

- Chemical restriction involves the use of medication. This could be regularly prescribed medication, including that to be used as required. (click here) to refer to Rapid Tranquilisation Guidelines
- Psychological/Institutional restrictions can include attempting to exert control or force compliance by what is said or how it is said and or use of body language for example: constantly telling the person not to do something or that doing what they want to do is not allowed or is too dangerous; rigid application of rules routines. Restricting family/visitors. In a communal living facility restrictions placed on one person may have a negative impact on others living in the same place. It may include depriving a person of life style choices by, for example, telling them what time to go to bed or get up. Only allowing a person a certain amount of time watching T.V. Psychological restrictions might also include depriving individuals of equipment or possessions they consider necessary to do what they want to do, for example taking away walking aids, glasses, outdoor clothing or keeping the person in night wear with the intention of stopping them from leaving. Restrictive practice may also involve control and/or abuse of a person's financial matters
- Technological surveillance, such as tagging, pressure pads, closed circuit television or door alarms, to alert staff that the person is trying to leave or to monitor their movement. Whilst not a restriction in themselves they could be used to trigger restrictive intervention/practices, for example through physically restraining a person trying to leave when the door alarm sounds.
- Observations: Service users will automatically be observed by staff who see, hear and positively engage with the service user at various times of the day and night. The level of observation may be general or continuous.
- Time Out: a service user is separated temporarily from their current environment as part of a planned and recorded therapeutic programme to modify behaviour (click here) to refer to MOVA Strategy 8
- Low Stimulus: a safe area considered quiet and calming (click here) to refer to MOVA Strategy 9
- Seclusion which is “the forcible denial of the company of other people by constraint within a closed environment”\textsuperscript{16} (click here) to refer to MOVA Strategy 10

5.0 Planned use of Restrictive Interventions/Restrictive Practice (RI/RP)
In addition to clinical judgement use the Risk Assessment Checklist (APPENDIX 3) * to evaluate level of risk of potential harm/injury to self or others as a triage tool and complete the Risk Assessment/Management plan (APPENDIX 4) * if indicated.

*where the programme of care has no other RI/RP documents in use

The planned use of restrictive interventions/practices can only be considered if deemed an essential component of a broader therapeutic behavioural or risk/crisis management plan. The plan should include proactive preventative person centred strategies (see section 3.1) to ensure individual needs are met and a functional based resolution intervention plan is created to avoid where possible the use of any

\textsuperscript{14} MDA/2015/DO18 Posture and Safety belts fitted to supportive seating, wheelchairs, hoists and bathroom equipment
\textsuperscript{15} Bed Rails policy for adult service users within the inpatient and community setting: SHSCT 2013
\textsuperscript{16} Mental Health Northern Ireland Order 1986
restrictive interventions or practices. However where restrictive interventions/practices are considered necessary including for the provision of essential treatment or care they must be based on professional accountability and the aforementioned legal frameworks and principles including the following best practice safeguards to avoid arbitrary deprivation of liberty

- ensure all decisions are taken, documented and reviewed in a structured way. The decision making process should be based on sound multidisciplinary advice and judgement, agreed and reviewed by a multi-disciplinary team (MDT) and communicated to all relevant staff

- when designing/agreeing or delivering care, treatment or support which may be potentially restrictive each health and social care professional must consider the individual’s capacity to make decisions about care, treatment and support and it is a general legal and ethical requirement that informed consent must be obtained before commencing an examination, starting treatment or physical investigation or providing care. The requirement to presume that an adult is capable of independently making decisions about any aspect of their care treatment and/or support has been protected within relevant UK laws. If an adult makes a voluntary and appropriately informed decision to consent or withhold consent then this decision must be respected (click here) to refer to Trust Policy on Gaining Consent

- Best Interests: there are circumstances where a person who despite being provided with all practicable help and support is unable to independently make decisions about his/her care treatment and /or support and are therefore regarded as “lacking capacity”. In these circumstances health and social care professionals have a duty to ensure that any decision taken is in the ‘best interests’ of or to ‘benefit’ the person.

- In order to inform decisions regarding an assessment of capacity please refer to the Guidance for the Assessment of Capacity (click here) for Capacity/Screening Guidance/Tool

- In applying the principles of best interests determination the person must have special regard to ( so far as reasonably ascertainable) the past and present wishes and feelings of how the service user would like staff to respond which may be recorded in an advance decision or written statement. If this has not been made encourage them to do so as soon as possible; the beliefs and values that would be likely to influence the service users decision if he/she had capacity

- Consult and involve the relevant people about what would be in the service user’s best interest especially in relation to above to ensure their views are considered and appropriate information is given to service users, family member, carer and or advocates such as mental health advocate and in the case of children, any person with parental responsibility. This should include purpose and reasons for the care/intervention, review plans, outcomes of reviews and ways to challenge the decisions such as through the relevant complaints procedure. Document process of involvement of the above.

- Clearly explain in detail in the treatment or care plan or alternatively in the Planned Restrictive Interventions/Practices Assessment and Management Plan (APPENDIX 4):

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17 Department of Health and Social Services and Public Safety: Circular MHU 1/10 – Deprivation of Liberty Safeguards Interim Guidance (DHSSPS October 2010)
18 Principles of Consent :Royal College of Nursing (2017)
19 Violence and Aggression: Short-term management in mental health, health and community settings NICE NG10 (May 2015)
- any physical/medical/psychological conditions or triggers to be aware of including circumstances when restrictive interventions should be avoided due to a greater risk posed;
- the risks of harm/injury identified which necessitates the use of restrictive intervention
- include any potential risks of delaying the intervention versus proceeding with the intervention sooner;
- preventative/proactive de-escalation strategies include adjustments to environment and or procedure
- the agreed method/s of restrictive intervention/practices evidencing the least restrictive intervention option; including the circumstances of use such as duration, position, monitoring of vital signs where appropriate, review arrangements and desired outcomes/goals including impact on Human Rights and how the individuals integrity is being promoted.

- Ensure both the assessment of capacity and management plan are kept under review. Capacity should be reviewed at appropriate intervals, for example, if it appears that the persons understanding of their situation has changed or there are changes in the restrictions.

- Independent Review: It may be helpful to include an independent element in the review. Depending on the circumstances, this might be achieved by involvement of social work or community health staff, or by seeking a second medical (or other appropriate clinical) opinion either from within the HSC Body/independent organisation, or elsewhere. Such a second opinion will be particularly important where family members, carers or friends do not agree with the organisation’s decisions. But, even where there is no dispute, an Organisation must ensure its decision making stands up to scrutiny.\(^{20}\) There are complex situations where it will be appropriate to seek legal opinion.

6.0 Unplanned (emergency) response (which cannot reasonably be anticipated)

The Trust acknowledges that there may be exceptional circumstances when unplanned or emergency restrictive intervention/practices may be necessary when an individual behaves in an unexpected way.

As in all circumstances of use of restrictive interventions/practices, members of staff retain their duty to care for the individual and restrictive intervention/practices will only be permitted, without the relevant safeguards in place as at point 5.0 above, if the person using it reasonably believes the person lacks capacity and it is in the best interest of the individual where any delay in acting would create an unacceptable likelihood of serious harm.

Any subsequent potential for use of planned restrictive interventions/practices must be immediately reflected and reviewed in the care plan, including the risk assessment.

\[^{20}\text{Department of Health and Social Services and Public Safety: Circular MHU 1/10 – Deprivation of Liberty Safeguards Interim Guidance (DHSSPS October 2010)}\]
7.0 **Risk of Death**

Restrictive interventions can cause psychological and physical harm. The greatest risk of death from positional asphyxia has been increasingly recognised during manual restraint, and harm can occur in the period following restraint from the effects of illicit substances, alcohol, prescribed medications including rapid tranquillisation and co-existing medical conditions. People with diagnoses of severe and enduring mental illness are at increased risk of coronary heart disease, cerebrovascular disease, diabetes, infections, epilepsy and respiratory disease, all of which can potentially be exacerbated by the psychological and physical effects of restrictive interventions. The risk of death is also greatest in other conditions such as delirious behaviour that require manual restraint or rapid tranquillisation which may indicate a life threatening underlying medical cause or head injury.

The risk of death following restraint may be increased if the service user is also in seclusion.

**Life Support**

Any situation that requires the use of Restrictive Intervention may constitute a medical emergency and must be treated as such. Staff taking part in any Restrictive Intervention must be:

- able to recognise conditions of physical and respiratory distress;
- trained in immediate life support or as a minimum taught how to observe for vital signs so that medical emergencies can be responded to quickly and safely. (For specific guidance (click here) for Rapid Tranquilisation; (click here) for Seclusion; (click here) for Physical/Manual Restraint)
- where there is emergency resuscitation equipment available, including defibrillators these must be maintained and checked as per local protocol/procedures.
- aware of how to summon assistance and secure medical and ambulance support.

8.0. **Post Restrictive Interventions/Practices**

8.1 **Recording**

Where the use of Restrictive Interventions/Practices is associated with a reportable Incident, the DATIX Restrictive Interventions/Practices form (APPENDIX 5) must be completed.

Where the use of Restrictive Interventions/Practices is NOT associated with an Incident the ‘Restrictive Interventions/Practices Register of Use Form’ (APPENDIX 6) should be completed to facilitate audit purposes.

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8.2 Review: Post-Incident Debrief (see APPENDIX 7)

Where the use of Restrictive Interventions/Practices involving physical manual restraint; rapid tranquilisation or seclusion is associated with a reportable incident of aggression and or violence, conduct an immediate post restrictive intervention check debrief to ensure everyone’s safety and provide emotional first aid when the risks of harm have been contained. The completed Debrief template should be uploaded to the incident record on Datix.

Discuss the incident with the services user involved, advocate, carer, witnesses as appropriate and staff involved only after they have recovered their composure and aim to repair the therapeutic relationship

Ensure that everyone involved in the service users care, including their carers has been informed of the event if the service user agrees.

During the debrief/incident review process, consider contributing factors (see APPENDIX 2) to identify any elements that can be addressed quickly to reduce the likelihood of further incidents. Consider what went well and didn’t go so well and what could be done differently including less restrictive interventions and amend risk and care plans accordingly.

Share any learning with other units as appropriate and address any training needs identified.

Any concerns or complaints expressed by the service user must be dealt with at the point of service delivery in the first instance immediately and directly in an attempt to resolve the matter informally, speedily and appropriately in accordance with the Trust’s Policy for The Management of Complaints. (click here)

The provision of post incident management including support, reporting/documentation and analysis is detailed in the Trust’s Management of Violence and Aggression Procedure (click here)

8.3 Monitoring & Auditing

It is the ward/team/departments’ manager’s responsibility to ensure the level of use of restrictive interventions/practices are monitored/audited. Operational should agree their monitoring/auditing arrangements and the resources/support for same.

It is the ward/team/departments’ manager’s responsibility to:

- ensure compliance with human rights and legal requirements;
- ensure compliance with the ‘last resort’ principle;
- ensure the intervention/practice was reasonable and proportionate to the level of risk
- ensure that the least restrictive option was used for the shortest possible time;
- ensure compliance with Management of Violence and Aggression (MOVA) Policies and Procedures where applicable;
- determine that staff involved were appropriately trained and updated within Trust guidelines;
- determine what lessons can be extracted to inform future practice, training or staff support.
Restrictive Interventions are defined as:
Deliberate acts that restrict an individual’s movement, liberty and/or freedom
to act independently to prevent harm to self or others (Positive & Proactive Care,
reducing the need for restrictive intervention (DoH April 2014)
Restrictive practice is defined as:
“Making someone do something they don’t want to do or stopping them
doing something they want to do” (A Positive & Proactive Workforce, Skills for Care. April 2014)

Use of Restrictive Interventions/Practice needs to be ethically, legally and professionally justified based on the following:

**PRINCIPLES TO REDUCE THE USE AND MISUSE OF RESTRICTIVE INTERVENTIONS/PRACTICE**

### Underpinning Values

- **Care**
  - Compassion
  - Respect
  - Dignity
  - Person Centred

- **Wellbeing**
  - Best Interests
  - Choice
  - Independence

- **Safety**
  - Duty of Care
  - Protecting Human rights
  - Minimise Harm_Injury

- **Proactive Prevention to Avoid use and misuse of RI/RP**

- **Security**
  - Team Approach
  - Therapeutic Relationships
  - Communicate Risk
Principles in Practice

EXAMPLES of METHODS OF RESTRICTIVE INTERVENTIONS

RESTRICITVE PRACTICES

Reasonable belief of Lack of Capacity & Best Interest Safeguards

Reasonable & Proportionate to Likelihood & Seriousness of Harm

Failure to Use May Cause a Greater Risk of Harm

• Last Resort
• Least Restrictive
• Shortest Time

Planned Approach Based on Sound MDT Judgement

Taking account of patients
• preferences,
• characteristics
• physical/mental health

Must not cause:
• Pain, harm, abuse
• Restriction of airway

PSYCHOLOGICAL/INSTITUTIONAL: DEPRIVATION OF LIFESTYLE CHOICES; RIGID RULES/ROUTINES; REMOVING AIDS E.G. MOBILITY AIDS

TECHNOLOGICAL/ENVIRONMENTAL: DOOR ALARMS; PRESSURE PADS; TAGGING

MECHANICAL: BED RAILS; TABLE; MITTENS; LAP BELTS;

MANUAL/PHYSICAL: HOLDING BY STAFF including assessing/delivering essential care and treatment to patients who lack capacity

CHEMICAL: RAPID TRANQUILISATION; PRN

SECLUSION: LOCKED DOORS

TIME OUT; LOW STIMULUS

OBSERVATION: GENERAL; CONTINUOUS
RESTRICTIVE INTERVENTIONS/PRACTICES PATHWAY
Refer to MOVA Policy Procedures and Strategies

Risk Assessment and/or Checklist (as used by each programme of care)
Indicates High Risk of Harm/Injury to self or others Requiring Restrictive Interventions/Practices

Foreseeable Potential Risk of Harm / Injury

Emergency Restrictive Interventions/Practices used in Exceptional Circumstances

Unforeseeable Immediate Risk of Harm / Injury

Assessment & Management Plan
Developed by Multidisciplinary Team which should include:
- Consideration of areas of capacity, consent and ‘best interests’ decision making.
- Involvement of carers/advocates (where appropriate)
- Description of underlying conditions, triggers
- Include circumstances when RI/RP should not be used due to greater risk posed
- Description of risks
- Preventative de-escalation strategies
- Method (s) of Least Restrictive Practices detailing duration, monitoring/review arrangements etc.

Monitoring of Vital Signs (as a minimum)
Airway Breathing Circulation

NB: only to be used when utilising:
- Manual/Physical Restraint
- Seclusion
- Rapid Tranquilisation

Post RI/RP
Record, Review, Monitor
- Complete Datix RI Form (only if RI/RP is related to an incident)
- If not associated with an incident record on ‘Register of Use Form’ (Appendix 6)
- Informal/Formal Debrief
- Review Risk: use planned approach
- Monitor/Audit

Use Planned Approach
Appendix 2
Contributing Factors to Crisis /Challenging Risk Behaviour and Proactive Prevention

Primary Prevention

Address contributing factors known to increase triggers to crisis/challenging risk behaviour for example:

<table>
<thead>
<tr>
<th>Physical</th>
<th>Cognitive</th>
<th>Psychological</th>
<th>Environmental/Social</th>
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</thead>
<tbody>
<tr>
<td>Hypoxia</td>
<td>Confusion: delirium; Dementia</td>
<td>Fear and or anxiety;</td>
<td>Noise; Light; Temperature</td>
</tr>
<tr>
<td>Blood Sugars:</td>
<td>Communication problems</td>
<td>Trauma</td>
<td>Inappropriate signage</td>
</tr>
<tr>
<td>Hypo/Hyper</td>
<td>(expression and understanding)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dehydration</td>
<td>Learning Disability</td>
<td>Anger</td>
<td>Change: routine; staff</td>
</tr>
<tr>
<td>Constipation</td>
<td>Disorientation</td>
<td>Depression</td>
<td>Under/over stimulation</td>
</tr>
<tr>
<td>Infection</td>
<td>Autism</td>
<td>Social Isolation; learned behaviour</td>
<td>Inconsistency</td>
</tr>
<tr>
<td>Pain</td>
<td>Loss of insight</td>
<td>Hallucinations/delusions</td>
<td>Negative staff attitude/approach</td>
</tr>
<tr>
<td>Substance misuse</td>
<td>Poor reasoning ability</td>
<td>Unmet emotional needs</td>
<td>Imposed boundaries/limitations</td>
</tr>
</tbody>
</table>

Include learning from Post Incident Reviews

Sample Interventions

Provision of Therapeutic Environment; team work: staff support; positive staff attitude and approach; self-regulation Communication/information

Clear signage e.g. waiting times; facilities; appropriate lighting; address noise levels; consider décor attention to colours

Engage meaningful activity

Identifying and meeting needs: such as

- Attention: Respect/Dignity; Compassion;
- Control/Choice Person Centred Care; Collaboration
- Trust: Safe and Secure; Best Interest
- Status/Valued: Equality of Care; justice; sensitive to individual cultural and religious beliefs

Trauma informed care; education approach to develop new skills to get needs met

Training; staffing levels; skill mix

Specialist staff to meet individual needs

Positive Customer Service

Promotion of:

- Care :High Level of Tolerance
- Wellbeing: Meeting physical and emotional Needs
- Safety: Protecting Human Rights through Safeguarding: prevent and reduce risk of harm
- Security: Team work; Communicating and managing risk

Secondary Intervention  (Immediate Psychological Care)

Sample Interventions to De-escalate resolve conflict

**Build Rapport:** Introduce self; Use first or preferred name

Re-orientate/redirect

Avoid unnecessary moves

Identify and meet needs: ask self “what does this person feel need or want”? ‘Step into their world’ How would you feel?

Involve family as appropriate

Give time to process instruction/information

- “ 30 second rule”

Wait and see

Consistent but flexible approach when required

**Non- verbal de-escalation:**

Staff adopt positive respectful, non-threatening body language:

- Create space/distance
- Position side on at eye level (alert to safety)
- Open friendly body language ☺; intermittent eye contact; hands waist level

**Verbal and para verbal de-escalation:**

Maintain professional calm controlled tone, volume, rate and rhythm of speech

Offer choice and control

Allow individual to speak freely if safe to do so (consider privacy and safety)
Actively listen
Acknowledge upsets
Apologise and empathise
Role with challenge focus on creating calm
Explain individual benefit of intervention
Use of Verbal Scripts in a Calm Respectful and as appropriate Assertive manner; demonstrating empathy and caring
Diversional topics of conversation or activity: meaningful Person Centred and or safe topics e.g. favourite pet; hobby; life story (This is Me); memory/rummage box
Appropriate use of humour
PRN oral medication

Preventative Interventions to avoid risk of harm to self or others
Sample Interventions

PRN Medication
Staff adopt positive respectful, non-threatening body language:
- Create space/distance
- Position side on at eye level (alert to safety)
- Open friendly body language 😊; intermittent eye contact; hands waist level
Remain vigilant
Use item of furniture as barrier
Use Exit Strategy
Directive statement “Please stop we’re here to help”
Seek assistance (MOVA Strategy 5): wait and see
Disengage (MOVA Stratgey 4)

Tertiary Restrictive Interventions/Practices where there is Immediate or Imminent Serious Risk of Harm/Injury
- Unforeseen risk: Emergency Response
- Foreseen Risk: Planned MDT Risk Assessment and Management Plan
### APPENDIX 3 - Risk Assessment Checklist

The completion of this checklist can assist in determining the need to complete the planned restrictive intervention/practice assessment and management plan. This tool should only be used in areas where no other such checklist exists.  
(Adapted from the Brosset Violence Checklist (R. Almvik & P. Woods, 2000) and Ontarian VAAC (PSHSA 2010)

<table>
<thead>
<tr>
<th>Type of Behaviour</th>
<th>Yes/No</th>
<th>Descriptors</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of Violence</td>
<td></td>
<td>History of being physically violent towards self or others</td>
</tr>
<tr>
<td>History unknown</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uncooperative</td>
<td></td>
<td>Easily annoyed or angered. Unable to tolerate the presence of others. Appears obviously confused and disorientated. May be unaware of time place or person Unwilling or unable to follow instructions.</td>
</tr>
<tr>
<td>Verbal abuse</td>
<td></td>
<td>Verbal attacks. For example abuse, name calling. Verbally neutral comments uttered in a snarling aggressive manner</td>
</tr>
<tr>
<td>Threatening</td>
<td></td>
<td>A verbal outburst which is more than just a raised voice and where there is definite intent to intimidate or threaten another person. For example, taking an aggressive stance; raising of arm/ leg, making a fist etc</td>
</tr>
<tr>
<td>Attacking Objects</td>
<td></td>
<td>An attack directed at an object and not an individual. For example the indiscriminate throwing of an object; banging or smashing windows; kicking banging or head butting an object or the smashing of furniture</td>
</tr>
<tr>
<td>Assaulitive</td>
<td></td>
<td>An application of force or attack directed at an individual, i.e. kick, punch, spit, grabbing clothes, use of a weapon or weapon of opportunity</td>
</tr>
</tbody>
</table>

**Type of Behaviour exhibited by:**
- **Patient**
- **Others**

**Known Risk factors**
- Individual: i.e. Health status; Pain; Fear
- Environmental: i.e. waiting times; time of day
- Service provision: i.e. Intimate care needs

<table>
<thead>
<tr>
<th>Behaviour</th>
<th>Level of Risk</th>
<th>List INTERVENTIONS for Care Welfare Safety &amp; Security of patient and others. Refer to MOVA Policy Procedure &amp; Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Observed Behaviour (Primary Prevention)</td>
<td>Low</td>
<td>Therapeutic Environment; Team work; Communication Information e.g. clear signage Staffing Levels: specialist staff Positive Customer Service</td>
</tr>
<tr>
<td>History or Uncooperative or Verbal Abuse (Secondary Intervention)</td>
<td>Medium</td>
<td>Intervention required Verbal and Non - verbal de-escalation Reduce stimulation Re-orientate Diversional activities/topics of conversation; Person centred (RI e.g. PRN oral medication) Observation; Controlled egress locked door</td>
</tr>
<tr>
<td>May trigger necessity of Tertiary Restrictive Interventions/Practices</td>
<td>High</td>
<td>Preventative Interventions Manage environment Remove others to safety Redirect person in crisis to quieter area Supportive stance Team approach Seek assistance Directive statement (RI e.g. Rapid Tranq; physical)</td>
</tr>
</tbody>
</table>

**Signature**

**Date**

**Review date**
PLANNED RESTRICTIVE INTERVENTIONS/PRACTICES ASSESSMENT AND MANAGEMENT PLAN - ADULT SERVICES*

Assessment and Management plan must be completed by a minimum of two MDT members.

Addressograph

OR

<table>
<thead>
<tr>
<th>Name</th>
<th>DOB</th>
<th>H&amp;C No.</th>
<th>Location</th>
<th>Consultant or GP</th>
<th>Gender</th>
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</thead>
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<td></td>
<td>Eg ward / community</td>
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</table>

Name and Designations of people involved in decision making and management plan:

<table>
<thead>
<tr>
<th>Multidisciplinary Team Member (PRINT NAME)</th>
<th>Designation</th>
<th>Signature</th>
<th>Date</th>
<th>Time</th>
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</tbody>
</table>

SECTION 1 - ASSESSMENT

DATE:__/__/____

Mental Health Order Status (if applicable)

SERVICE USER CAPACITY:
Is the Service User Capable of Consenting to Treatment, Care and Intervention: YES / NO
(Please refer to Guidance for the Assessment of Capacity)

Outcome of discussion with Service User / Relative / Carer / Advocate regarding the use of restriction. Consider the services users preferences including advance statements.
Physical/medical/psychological conditions or triggers to be aware of; include any circumstances to avoid RI/RP due to a greater risk posed

Describe the risks identified which necessitate the use of restrictions (e.g. describe what the service user is doing/actions or likely to do which is causing or likely to cause harm to self or others; Include nature and outcomes of the treatment/care: what it involves and prospects of success/benefits; include any potential risk of delay versus intervening sooner
# PLANNED RESTRICTIVE INTERVENTIONS/PRACTICES - MANAGEMENT PLAN

**Addressograph**

<table>
<thead>
<tr>
<th>Name</th>
<th>DOB</th>
<th>H&amp;C No.</th>
<th>Location Eg ward / community</th>
<th>Consultant or GP</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
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</tr>
</tbody>
</table>

**Preventative/Proactive De-escalation Strategies; e.g.** Reassurance, Diversion, Personal comfort
### PLANNED RESTRICTIVE INTERVENTIONS/PRACTICES

**AGREED:**

<table>
<thead>
<tr>
<th>State RI/RP Method/ Disengagement Skills</th>
<th>Details as applicable such as: Duration, &amp; Frequency; Where e.g. Bed; Chair Position Of Patient Level of Restriction of arms; No. of Staff Required</th>
<th>Monitoring/Review Required (including Vital Signs* / Review Requirements: how often to be monitored.)</th>
<th>Outcomes/Goals Include which Human Right is impacted and how the legal/ethical principles including Care, Wellbeing, Safety and Security is promoted e.g. least restricted; shortest time; dignified approach; person centred</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example Lap Strap</td>
<td>Use for 30mins in chair.</td>
<td>Monitor/Review continuously and review decision re use of lap strap after 30 mins.</td>
<td>DoL. least restricted; shortest time;</td>
</tr>
</tbody>
</table>

**Intervention has been explained to and discussed with Patient/Client / N.O.K /Carer /Advocate**

Signatures (as appropriate)

<table>
<thead>
<tr>
<th>Patient</th>
<th>Date</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>NOK</td>
<td>Date</td>
<td>Time</td>
</tr>
<tr>
<td>Advocate</td>
<td>Date</td>
<td>Time</td>
</tr>
<tr>
<td>Staff Member completing this section</td>
<td>Date</td>
<td>Time</td>
</tr>
<tr>
<td>Staff Designation</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### MONITORING/REVIEW Multi-disciplinary (MDT) Meeting

**Summary of current position**

Example: rationale for use of lap strap reviewed at 30 mins. Rationale remains, decision taken to continue use of lap strap for further 15 mins then review decision.

<table>
<thead>
<tr>
<th>Name (PRINT &amp; SIGN)</th>
<th>Designation</th>
<th>Date of Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>A N Other</td>
<td>Ward Sister</td>
<td>02/10/17</td>
</tr>
</tbody>
</table>

---

### MONITORING/REVIEW MDT Meeting

**Summary of current position**

<table>
<thead>
<tr>
<th>Name (PRINT &amp; SIGN)</th>
<th>Designation</th>
<th>Date of Review</th>
</tr>
</thead>
</table>

---

### MONITORING/REVIEW MDT Meeting

**Summary of current position**

<table>
<thead>
<tr>
<th>Name (PRINT &amp; SIGN)</th>
<th>Designation</th>
<th>Date of Review</th>
</tr>
</thead>
</table>

---

### MONITORING/REVIEW MDT Meeting

**Summary of current position**

<table>
<thead>
<tr>
<th>Name (PRINT &amp; SIGN)</th>
<th>Designation</th>
<th>Date of Review</th>
</tr>
</thead>
</table>

### APPENDIX 5

**DATIX Restrictive Interventions/Practices Incident Form**

<table>
<thead>
<tr>
<th>Location</th>
<th>Service User Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exact Date:</td>
<td>Overall Duration of Restrictive Intervention</td>
</tr>
</tbody>
</table>

**Service User Status:** Detained (MHO) / Voluntary / Children Order / N/A

**Immediate Action:** De-escalation methods used verbal/non-verbal responses

<table>
<thead>
<tr>
<th>Method of RI</th>
<th>□ Physical</th>
<th>□ Chemical (Rapid Tranq or PRN or Other)</th>
<th>□ Mechanical (if mechanical free text)</th>
<th>□ Observation</th>
</tr>
</thead>
<tbody>
<tr>
<td>(multiple selection)</td>
<td>□ Seclusion</td>
<td>□ Disengagement Skills.(text box)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Low Stimulus</td>
<td>Environment (LSE)</td>
<td>□ Extra Care Suite</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Positions of Restraint if Physical RI used only.**

- Face Down (prone) □
- Face Up (supine) □
- Seated □
- Standing □
- Walking □
- Kneeling □
- Small child □

**Team Lead During the Restrictive Intervention** (free text)

- □ Emergency Response
- □ Planned Response (ie RI/RP is in line with service users care plan)

**Reason for Restrictive Intervention**

- Aggressive/Violent Behaviour □
- Actual/Attempted Self-Harm □
- Actual/Attempted to Abscond □
- Substance Abuse □

**Level of Observation**

- Continuous Observation □
- General Observation □

Did PSNI attend?  Yes □  No □
If YES did the PSNI Tactical Support Group attend?  yes/no/not required
What assistance was provided by PSNI?  (FREE TEXT BOX)

Did security staff attend?  Yes □  No □  Not Applicable □

CHECK PERSON AFFECTED SECTION on DATIX TO SEE BEST FIT FOR THOSE INVOLVED

<table>
<thead>
<tr>
<th>Staff involved in RI</th>
<th>Staff position during RPI</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>(DROPDOWN LIST OPTION)</td>
</tr>
<tr>
<td></td>
<td>• Head</td>
</tr>
<tr>
<td></td>
<td>• Left Arm</td>
</tr>
<tr>
<td></td>
<td>• Right Arm</td>
</tr>
<tr>
<td></td>
<td>• Legs</td>
</tr>
<tr>
<td></td>
<td>• Feet</td>
</tr>
<tr>
<td></td>
<td>• Assistance/Supportive Role</td>
</tr>
<tr>
<td></td>
<td>• Head Takeover</td>
</tr>
</tbody>
</table>
• Left Arm Takeover
• Right Arm Takeover
• Legs Takeover
• Feet Takeover
• Assistance/Supportive Role Takeover

2. as per above dropdown list for each person listed.
3. as per above dropdown list for each person listed.
4. as per above dropdown list for each person listed.

Were Vital Signs Monitored and Recorded during and post physical intervention/rapid tranquillisation / seclusion?  Yes / NO

If no, were there general observations ie ABC, level of consciousness.  YES / NO

<table>
<thead>
<tr>
<th>Post Restrictive Intervention Check</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient seen by MO / GP? Yes □ No □</td>
</tr>
<tr>
<td>Did patient sustain an injury? Yes □ No □</td>
</tr>
<tr>
<td>If yes detail below:</td>
</tr>
<tr>
<td>Did staff sustain an injury? Yes □ No □</td>
</tr>
<tr>
<td>If yes detail below:</td>
</tr>
<tr>
<td>Did others/relatives/visitors sustain an injury? Y / N</td>
</tr>
<tr>
<td>If yes detail below:</td>
</tr>
</tbody>
</table>

DEBRIEF:
Did a post incident debrief take place? Yes □ No □
Was CCTV footage reviewed? Yes □ No □ Not Available □

Advocacy Service
- Was the advocacy service informed? Yes □ No □ Not Available □
  If No give reason:________________________________________________________
  Date Informed:____/____/____
- If Yes, was the service user advised the advocacy service were informed? Yes □ No □
  Date Informed:____/____/____
  If No give details:________________________________________________________
- Was an advocacy appointment arranged? Yes □ No □

Family
Was the service user’s NoK/other informed? Yes □ No □ Not Available □
If No give reason:________________________________________________________

OUTCOME:
Outcome free text:
SITUATION DEESCALATED □
Extra Care suite □ - If yes was ECS Monitoring Form Completed? Yes □ No □
Seclusion □ - If yes was Seclusion Monitoring Form Completed? Yes □ No □

KEY LEARNING POINTS:
APPENDIX 6 RESTRICTIVE INTERVENTIONS/PRACTICES REGISTER OF USE

Where the use of Restrictive Interventions/Practices is NOT associated with an Incident this Register of Use Form should be completed to facilitate audit purposes

Ward/Dept/Location: ______________________

<table>
<thead>
<tr>
<th>Date</th>
<th>HSC Number</th>
<th>Type of restrictive interventions/practices used</th>
<th>Staff Name</th>
<th>Designation</th>
</tr>
</thead>
<tbody>
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</table>
# Post Incident Debrief Template

<table>
<thead>
<tr>
<th>Ward / Location:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>DATIX Ref :</td>
<td>Time:</td>
</tr>
<tr>
<td>Name of person holding post incident debrief:</td>
<td>Signature / Designation:</td>
</tr>
</tbody>
</table>

Discuss the incident with the services user involved, advocate, carer, witnesses as appropriate and staff involved only after they have recovered their composure and aim to repair the therapeutic relationship.

<table>
<thead>
<tr>
<th>Individual</th>
<th>Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Where there any injuries to patients / visitors? If so what action was taken?</td>
<td>Where there any injuries to staff? If so, What action was taken?</td>
</tr>
<tr>
<td>Find out from patient point of view what happened including their experience of restraint</td>
<td>Consider facts of the event from everyone’s point of view</td>
</tr>
<tr>
<td>What where the contributing factors patterns/triggers</td>
<td>Patterns in staff responses. What worked well /what didn’t work so well (e.g. team approach; timing; consistency of approach)</td>
</tr>
<tr>
<td>Consider with the service user what might help prevent this happening again but if it did how they would like to be managed. (Advanced decision/statement)</td>
<td>What can we do to strengthen the things that worked well or improve things that didn’t work so well? (Include training needs; review of safe systems; risk assessment; individual and team approach)</td>
</tr>
<tr>
<td>Negotiate and agree a proactive plan of action that will work for you and staff including ways to avoid use of restraint</td>
<td>Agree to changes that will improve interventions and gain commitment from everyone for improvement to be implemented. Include sharing of any learning with other teams or wider unit/Trust</td>
</tr>
<tr>
<td>What help and support do you need to nurture recovery and restore your dignity and respect to make these changes?</td>
<td>What help and support do you need to nurture recovery restore confidence and trust in making these improvements? (e.g. OH; GP; supervision; peer support)</td>
</tr>
</tbody>
</table>