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

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

Purpose

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Methods of Restrictive Interventions / Practices

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Purpose

• The guideline is designed to define restrictive interventions and practices, identify some methods of restrictive interventions/practices and specify the ethical, legal and professional principles, to ensure the care, treatment and management offered by practitioners is lawful, necessary, proportionate and the least restrictive option reasonably available.

• While the emphasis is on anticipating risk behaviour and early intervention to prevent the need for restrictive intervention and restrictive practices 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.
Definition of Restrictive Interventions/Practices

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.

“Making someone do something they don't want to do or stopping them doing something they want to do". This can include more subtle forms of restrictive practice.

A Positive and Proactive Workforce, Skills for Care. DOH April 2014
Principles – Underpinning Values

- Care
- Well-being
- Safety
- Proactive Prevention to avoid use and misuse of RI/RP
- Security

Principles - Legal & Professional Framework
Main Menu
Proactive Prevention:

- 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.

- **Tertiary Intervention**: Only as a last resort when there is no safer alternative would the need for tertiary restrictive interventions or restrictive practices be considered.
treating people with high levels of compassion; respecting peoples uniqueness in the assessment and delivery of person centred care in a dignified manner
• promoting independence, including giving opportunities to take calculated risk and making choices; involving patients and their care’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.
• 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.
• 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.
Principles: Legal & Professional Framework

- 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) and the United Nations Convention on the Rights of the Child (1990) 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.
<table>
<thead>
<tr>
<th>Article</th>
<th>What it says</th>
<th>How might this right be breached in practice</th>
</tr>
</thead>
</table>
| 3       | **Prohibition of torture**  
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 | Measures used to control behaviours which in reality are shaming and humiliating, for example: not being allowed to have a meal, or being made to stand outside as a means of managing a perceived “bad behaviour”                                                                                       |
| 5       | **Right to liberty and security**  
A person has the right not to be deprived of their liberty- ‘arrested or detained’- except in limited cases specified in the article (e.g. where they are suspected or convicted of committing a crime or of unsound mind) and provided there is a proper legal basis in UK law | Measures used to prevent behaviours perceived to be a risk to self or others for example: improper or inappropriate admission/detention to psychiatric care; use of chairs with straps; use of ‘time-out’ or seclusion                                                                 |
| 8       | **Right to respect for private and family life**  
A person has the right to respect for their private and family life, their home and their correspondence. This right can be restricted only in specified circumstances | Measures which prevent participation in family, social and recreational activities, for example: structural adaptations to accommodation which separate/isolate the person from others they live with: preventing or limiting contact with family or friends; use of restrictive clothing to limit perceived self-harm or inappropriate touch |
| 14      | **Prohibition of discrimination**  
In the application of the Convention Rights, a person has the right not to be treated differently because of their race, religion, sex, political views or any other personal status, unless this can be justified objectively. Everyone must have equal access to convention rights whatever their status | Reducing access to services or opportunities available because of perception of risk or lack of resources to allow for suitable adaptation and support, for example: a reduced school day; exclusion from social clubs. |
• Detention under the Mental Health (Northern Ireland) Order 1986
Deprivation of Liberty (DoL)

• 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.
“Acid Test”:
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.
The Deprivation of Liberty Safeguards (DOLS)

- Interim Guidance 2010: 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 (see section 5.0 of the guideline).

- 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.
**Principles in Practice**

- **Lack of Capacity and Best Interests Safeguards**
- **Reasonable & Proportionate to Likelihood & Seriousness of Harm**
- **Failure to Use May Cause a Greater Risk of Harm**
- **Last Resort / Least Restrictive**
- **Shortest Time**
- **Must not Cause: pain, harm or abuse, restriction of airways**
- **Based on sound MDT judgement**

**Main Menu**
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**, 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.**
• All restrictive interventions and practices must be for the **shortest time possible**.
Use of restrictive interventions/practices must not intentionally cause pain, harm, abuse or restriction of the airway
• 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 & reviewed by a multi-disciplinary team (MDT) and communicated to all relevant staff.
Methods of Restrictive Interventions/Practices

- Mechanical Restraint
  - Physical/manual restraint
- Chemical restriction
- Psychological restrictions
- Observations
- Technological surveillance
- Low Stimulus
- Time Out
- Seclusion

Acceptable / Justified vs Unacceptable/Overuse
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. (click here) to refer to MOVA Strategy 7.
• 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.
• involves the use of equipment such as: **specially designed mittens** in intensive care settings to prevent essential tubes from being removed prematurely by the patient; everyday equipment such as a **heavy table** or **belt** to stop the person getting out of a chair or using **bed rails** ([click here](#)) 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.
• 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.
• 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.
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
Seclusion

• is “the forcible denial of the company of other people by constraint within a closed environment” (click here) to refer to MOVA Strategy 10

Mental Health Northern Ireland Order 1986
• a safe area considered quiet and calming (click here) to refer to MOVA Strategy 9
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

Use Planned Approach

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 utilizing:
- Manual/Physical Restraint
- Seclusion
- Rapid Tranquilisation

Post RI/RP Record, Review, Monitor
- Complete Datix RI Form (only if RI/P 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

Main Menu

Risk Assessment Checklist & Management Plan

Foreseeable Potential Risk of Harm / Injury

Emergency Restrictive Interventions/Practices used in Exceptional Circumstances

Unforeseeable Immediate Risk of Harm / Injury
APPENDIX 2 - 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.

<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 History unknown</td>
</tr>
<tr>
<td>Uncooperative</td>
<td></td>
<td>Easily annoyed or angered. Unable to tolerate the presence of others.</td>
</tr>
<tr>
<td>Verbal abuse</td>
<td></td>
<td>Appears obviously confused and disoriented. May be unaware of time place or</td>
</tr>
<tr>
<td>Threatening</td>
<td></td>
<td>May be 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</td>
</tr>
<tr>
<td>Assulative</td>
<td></td>
<td>An application of force or attack directed at an individual, i.e. kick,</td>
</tr>
</tbody>
</table>

Type of Behaviour exhibited by:
- Patient
- Others Please specify (e.g. parent, spouse, etc)

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>Sample Interventions</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>
<td></td>
</tr>
<tr>
<td>History of Uncooperative or Verbal Abuse (Secondary Intervention) May trigger necessity of Tertiary Restrictive Interventions/Practices</td>
<td>Medium</td>
<td>Intervention required: Verbal and Non-Verbal de-escalation Reduce stimulation Reorientate Diversational activities/topics of conversation Person centred (e.g. PRN oral medication) Observation: Controlled egress locked door</td>
<td></td>
</tr>
<tr>
<td>Any ONE(S) or more in SHADeD area or TWO(S) or more in NON-SHADED area (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 low stimulus area Supportive stance Team approach Seek assistance Directive statement (e.g. Rapid Tranz physical)</td>
<td></td>
</tr>
</tbody>
</table>

Signature  Date  Review date

(Adapted from the Broset Violence Checklist (R. Almvik & P. Woods, 2000) and Ontarian VAAC (PSHSA 2010)
APPENDIX 4

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

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

OR

<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>
</table>

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

Multidisciplinary Team Member (PRINT NAME) | Designation | Signature | Date | Time

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

Assessment & Management Plan
Page 2
## 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 Welbeing 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>
<tr>
<td></td>
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<td></td>
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</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>Date</td>
<td>Time</td>
</tr>
</tbody>
</table>
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>
Post Restrictive Interventions/Practices

**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.

**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;
- 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.
Children's and Young Peoples (CYP) Services.

- Children's services will be guided by the SHSCT guidelines for the use of restrictive interventions and restrictive practices and Three Steps to Positive Practice (RCN).

- As a general rule, the younger the person is, the greater the level of restraint they would typically be subject to. For example, a 5 year old, 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. (Reference: “The law society – identifying a deprivation of liberty: a practical guide Under 18’s”).

CYPS Examples

Main Menu
Example 1 – this practice was used for a short amount of time, and was viewed as helping the child. It was however not the least restrictive option.

Lucy is seven years old, has a diagnosis of autism and attends a special school. Lucy often ran about the classroom, climbed on furniture and was disruptive. For short periods during the day Lucy’s teacher used a chair with high sides and a lap strap to keep Lucy in one place. The teacher says this helped Lucy to concentrate and focus on curriculum-based activities and believed Lucy liked the chair.

When this practice was identified, a multi-disciplinary meeting was arranged to review the risk assessment in relation to the use of the chair and to discuss what other types of calming activities and classroom based activities might help Lucy co-operate. The meeting reached the decision that the use of mechanical restraint was not the least restrictive, most effective way of approaching her behavioural difficulties, and not in her best interests.

Lucy was diagnosed with ADHD. Treatment for this, alongside regular advice from the CAMHs practitioner and occupational therapist for her teacher on how to adapt the environment (pro-active prevention) led to marked improvements in her concentration for specific activities. Lucy was more relaxed and focused during the day and able to learn a range of new skills over the months ahead.
Example 2 – this practice was used as a last resort and it was felt it was reasonable and in the best interests of the child. It was however not the least restrictive option.

Francis is a 10 year old child with a diagnosis of autism. To prevent him smearing faeces during the night, he wore a “wet suit” in bed. This practice not only restricted him but placed him at risk of overheating during the night.

An assessment of Francis behaviour concluded the function of smearing was sensory and attention maintained. A multi-disciplinary meeting was arranged to review the risk assessment in relation to Francis wearing the wet suit. The meeting reached the decision that the use of the wet suit was not the least restrictive, most effective way of approaching his behavioural difficulties, and not in his best interests.

As the smearing was a sensory issue, it was decided to introduce sensory based activities such as messy play in the evenings. This alongside a structured sleep programme and planned positive interaction between parents and Francis prior to bed, led to a positive outcome. Francis no longer wears the wet suit, no longer smearing faeces and his sleep pattern has improved.
Example 3 – The importance of review: a parent’s perspective.

The mother of Jack, who is a fully mobile child with autism, raised concerns to social services about a restrictive practice in the school setting.

Staff put Jack in a buggy to move him from one room to another. Staff stated this was for health and safety reasons as Jack may hit out at other children or run away.

A multi-disciplinary meeting was held and it was found the use of the buggy had never been reviewed. Staff agreed to use a schedule to prepare Jack before moving him from room to room which he now does without any concerns.
Review: Post-Incident Debrief (see Appendix 7)

• Where the use of Restrictive Interventions/Practices involving physical manual restraint; rapid tranquillisation 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.

• 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.
### 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></td>
</tr>
<tr>
<td>Signature / Designation:</td>
<td></td>
</tr>
</tbody>
</table>

#### Names of Staff Involved in the Incident Debrief and Designation.

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. Scan this form and add it to the incident as a document in Datix.

<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>
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>
</tr>
</thead>
<tbody>
<tr>
<td>Hypoxia</td>
<td>Confusion: delirium; Dementia</td>
<td>Fear and anxiety: Noise; Light; Temperature</td>
<td>Inappropriate signage</td>
</tr>
<tr>
<td>Blood Suggs: Hype/Hypo</td>
<td>Communication problems: (expression and understanding)</td>
<td>Trauma</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. walking times; facilities; appropriate lighting; address noise levels; consider decor 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/Value; Equality of Care; Justice: sensitive to individual cultural and religious beliefs

Traumas 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?
Involves 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: heads 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)
### DATIX

**Register of Use**

**Main Menu**

---

**APPENDIX 5**

**DATIX Restrictive Interventions/Practices Incident Form**

<table>
<thead>
<tr>
<th>Lesson</th>
<th>Service User Name</th>
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<tbody>
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</table>

<table>
<thead>
<tr>
<th>Date</th>
<th>Overall Duration of Restrictive Physical Intervention</th>
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</tbody>
</table>

**Immediate Action:**

- De-escalation, techniques used, verification of verbal responses

**Method of RI:**

- Physical
  - Mechanical (Restrain, PPV, etc.)
  - Chemical (Rasp, PPV, etc.)

**Reason for Restrictive Intervention:**

- Agitation/Aggression Behavior
- Amount/Amount of Touch
- Altered Cognition
- Ambulation
- Communication

**Level of Observation:**

- Continuous Observation
- General Observation

**Details of Event:**

- Yes
  - No
  - Other:
    - Description:

**Check Persons Affected Section in DATIX to be Best Fit for Those Involved**

**Table:**

<table>
<thead>
<tr>
<th>Description</th>
<th>Yes</th>
<th>No</th>
<th>Not Applicable</th>
</tr>
</thead>
</table>

**Advocate:**

- Yes
  - No
  - Other Information:
    - Description:

**Situations:**

- De-escalation
  - Yes
  - No

**Extra Care Suite:**

- Yes
  - No

**Sedation:**

- Yes
  - No

**Situation:**

- Extra Care Suite: Yes
- If yes, was ECS Monitoring Form Completed? Yes
- If yes, was Sedation Monitoring Form Completed? Yes

**KEY LEARNING POINTS:**

- If yes, what was the service user informed? Yes
- Outcome:
- Conclusion:

---
# 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>
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</table>
Drivers & Relevant Literature

- Mental Health Northern Ireland Order (1986)
- Let’s Talk about Restraint: Rights, Risks and Responsibilities. RCN. March 2008
- Bed Rails policy for adult service users within the inpatient and community setting: SHSCT 2013
- MDA/2015/DO18 Posture and Safety belts fitted to supportive seating, wheelchairs, hoists and bathroom equipment
- Circular MHU 1/10 – Deprivation of Liberty Safeguards Interim Guidance (DoH Oct 2010 )
- Mental Capacity (draft )Bill: DOLS Briefing Paper 96/15 to Northern Ireland Assembly NIAR 360-15 Jane Campbell
- SHSCT Policy on Gaining Consent (2009)
- Positive & Proactive Care: reducing the need for restrictive interventions. DoH. April 2014
- A Positive and Proactive Workforce, Skills for Care. DOH April 2014
- Violence and Aggression: Short-term management in mental health, health and community settings NICE NG10 (May 2015)
- DHSSPSNI: Safety Alert - The importance of vital signs during and after restrictive interventions/manual restraint (Dec 2015)
- Three Steps to Positive Practice: Royal College of Nursing Northern Ireland (2017)
- Mental Capacity Act 2016 Northern Ireland (MCA 2016)
- Department of Health Social Services and Public Safety :Guidance on Restraint and Seclusion in Health and Personal Social Services (DHSSPS NI August 2005)
- Principles of Consent :Royal College of Nursing (2017)