Name of Policy: Restrictive Interventions Policy
(previously Physical Control and Restraint Policy)

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This policy supersedes all previous issues
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Restrictive Interventions Policy

1. Introduction

This policy is aimed at promoting the development of therapeutic environments and minimising all forms of restrictive practices so they are only used as a last resort. Restrictive interventions can delay recovery, and cause both physical and psychological trauma to people who use services and staff.

Reducing the need for restrictive interventions sets out mechanisms to ensure accountability to reduce the use of restrictive practices, including effective governance, transparent reporting and monitoring.

The guidance says recovery-based approaches are essential. It introduces positive behavioural support, an approach rooted in learning disability services, which promotes understanding the context and meaning of behaviour to inform the development of supportive environments and skills that can enhance a person’s quality of life.

It is the Trust’s position that physical control and restraint techniques will only be used as a last resort. Staff should exhaust all appropriate therapeutic interventions in the first instance to prevent untoward incidents occurring.

In the event that physical skills are used then they should be the minimum necessary to deal with the situation. Thoughtful consideration should be given to the self-respect; dignity and cultural values of the patient at all time.

Control and restraint is the systematic use of approved physical techniques aimed at restraining or breaking away from an individual who is likely to, or is acting in, a manner likely to result in harm to themselves or others. The actual physical skills are taught by qualified instructors authorised by the Trust and should be used only under the supervision of staff who have attended an approved course.

2. Policy Scope

The policy covers the safe use of restrictive practices to ensure the safety of patients and staff is maintained when all therapeutic interventions have been exhausted and trained staff are considering restrictive interventions, the use of the Police may also be considered.

3. Aim of the Policy

To provide a framework for carrying out restrictive interventions in line with national guidance therefore minimising the risk of injury or ill-health to staff, patients and others resulting from violence, aggression and challenging behaviours.

4. Duties - Roles & Responsibilities

The governance framework for the Physical Control and Restraint Policy is as follows:

- Trust Board is responsible for implementing a robust system of corporate governance across the organisation.
- The Chief Executive is ultimately responsible for ensuring effective corporate governance within the organisation and therefore supports the Trust-wide implementation of this policy.
Associate Directors, Heads of Service, Ward/Departmental Managers and Matrons are responsible for ensuring that systems are in place to support the implementation of this policy.

Ward Managers are responsible for ensuring that local systems are in place to support the implementation of this policy.

All Staff
All identified staff within Gateshead Health NHS Foundation Trust are responsible for ensuring that the principles outlined in this policy are universally applied.

Trust Board
The Trust Board is committed to ensuring safe and effective patient care, and therefore supports the process for assessing capacity and acting in the patient’s best interest. The Trust Board have responsibility for ensuring compliance with the Act.

Chief Executive
The Chief Executive is ultimately accountable for the delivery of safe and effective patient care. They are responsible for ensuring appropriate systems are in place to enable employees adhere to the principles of the Act, and the Code of Practice.

Mental Health Act Managers Committee
The Mental Health Act Managers Committee is responsible for ratifying the Policy and monitoring the training.

Ward Managers/Team Leaders
Ward Managers and Team Leaders are responsible for ensuring a copy of the Code of Practice is available to staff. They are responsible for ensuring their staff are aware of the policy and principles, and promote best practice. The must ensure their staff receive appropriate training.

All Staff
All staff are responsible for being aware of the Act and the Trust policy. They should follow the Code of Practice when assessing capacity and acting in the patient’s best interests.

5. Definitions

The DH guidance defines restrictive interventions as:

“Deliberate acts on the part of other person(s) that restrict an individual’s movements, liberty and/or freedom to act independently in order to take control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken, end or reduce significantly the danger to person and others, and contain or limit the patient’s freedom for no longer than is necessary.

Restrictive practices refer to physical, mechanical and chemical restraint and seclusion.

Physical restraint refers to: any direct physical contact where the intervener’s intention is to prevent, restrict, or subdue movement of the body, or part of the body of another person.

Mechanical restraint refers to: the use of a device to prevent, restrict or subdue movement of a person’s body, or part of the body, for the primary purpose of behavioural control.

Chemical restraint refers to: the use of medication which is prescribed, and administered for the purpose of controlling or subduing disturbed/violent behaviour, where it is not prescribed for the treatment of a formally identified physical or mental illness.
Seclusion refers to: the supervised confinement and isolation of a person, away from other users of services, in an area from which the person is prevented from leaving. Its sole aim is the containment of severely disturbed behaviour which is likely to cause harm to others.

Judgements as to the acceptability and legitimacy of restrictive interventions will always be based on all presenting circumstances. Without a clear ethical basis and appropriate safeguards such acts may be unlawful.

6. Safe use of Restrictive Intervention

6.1 Purpose of Restrictive Interventions

The purpose of a restrictive intervention is to take control of a dangerous situation and secondly to limit the service user’s freedom for no longer than is necessary to end or reduce significantly the threat to self or others. Restrictive interventions must only be used when all other less intrusive methods have been explored and are considered not suitable or have failed.

The Human Rights Act 1998 sets out important principles regarding the protection of individuals from abuse by state organisations or people working for those institutions. 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.

Adults who may be at risk can be justifiably restrained in some cases, in the following circumstances:

- Displaying behaviour that is putting themselves at risk of harm
- Displaying behaviour that is putting others at risk of harm
- Requiring treatment by a legal order, for example under the Mental Health Act 2007 requiring urgent lifesaving treatment
- Needing to be maintained in secure settings

6.2 When to consider restraint

Before any restraint is applied, a full risk assessment must be undertaken. The risk assessment is to be undertaken by the decision maker with the Nurse in Charge of the patient’s care and other members of the multi-disciplinary team. Specific risks requiring the consideration of restraint must be clearly documented, along with previous attempts at managing risk.

If a decision to apply restraint is made then the recorded assessment must be capable of demonstrating that:

- there are objective reasons to justify the restraint which demonstrate that the patient is likely to suffer harm if not restrained
- the patient has challenging behaviour which may cause harm to others
- consideration has been given to whether the purpose for which the restraint is needed can be effectively achieved in a way that is less restrictive to the patient’s rights and freedom of action
- there has been consultation with others involved in the care of the patient, including carers (if any), as to what action they think is in the patient’s best interests
The application of restraint should be time limited and subject to regular review and must be for the shortest time possible. It is essential that during the review process it will be important to consider the circumstances as a whole and any change in circumstances in order to determine whether any continuing use of restraint may amount to a deprivation of liberty.

6.3 Alternatives to restraint

Primary Preventative Strategies

Behavioural disturbance can be minimised by promoting a supportive and therapeutic culture within the care environment. Unless an individual is subject to specific justifiable restrictions (e.g. for security reasons), primary preventative strategies should typically include the following, depending on the individual’s assessed needs:

- providing predictable access to preferred items and activities
- avoiding excessive levels of environmental stimulation
- organising environments to provide for different needs, for example, quiet rooms, recreation rooms, single-sex areas and access to open spaces and fresh air
- giving each patient a defined personal space and a safe place to keep their possessions
- ensuring an appropriate number and mix of staff to meet the needs of the patient population
- ensuring that reasonable adjustments can be made to the care environment to support people whose needs are not routinely catered for, for example, sensory impairments
- avoiding demands associated with compliance with service-based routines and adherence to ‘blanket rules’
- opportunity for individuals to be involved in decisions about an activity that is relevant to their identified needs
- delivering individualised patient-centred care which takes account of each person’s unique circumstances, their background, priorities, aspirations and preferences
- developing a therapeutic relationship between each patient and worker or nurse identified as the patient’s primary contact
- providing training for staff in the management of behavioural disturbance, including alternatives to restrictive interventions, desirable staff attitudes and values, and training in the implementation of models of care including positive behavioural support plans
- ensuring that individuals’ complaints procedures are accessible and available and that concerns are dealt with quickly and fairly
- ensuring that physical and mental health needs are holistically assessed and that the person is supported to access the appropriate treatments
- developing alternative coping strategies in response to known predictors of behavioural disturbance.

Secondary preventative strategies

De-escalation is a secondary preventative strategy. It involves the gradual resolution of a potentially violent or aggressive situation where an individual begins to show signs of agitation and/or arousal that may indicate an impending episode of behavioural disturbance.

De-escalation strategies promote relaxation, e.g. through the use of verbal and physical expressions of empathy and alliance. They should be tailored to individual needs and
should typically involve establishing rapport and the need for mutual co-operation, demonstrating compassion, negotiating realistic options, asking open questions, demonstrating concern and attentiveness, using empathic and non-judgemental listening, distracting, redirecting the individual into alternate pleasurable activities, removing sources of excessive environmental stimulation and being sensitive to non-verbal communication.

Staff should liaise with individuals and those who know them well, and take into account clinical assessments, to identify individualised de-escalation approaches which should be recorded as secondary preventative strategies in the patient’s care plan. In some instances it may be feasible for families to contribute to de-escalation approaches, e.g., by speaking to their relative on the telephone.

Staff should ensure that they do not exacerbate behavioural disturbance, eg by dismissing genuine concerns or failing to act as agreed in response to requests, or through the individual experiencing unreasonable or repeated delays in having their needs met. Where such failures are unavoidable, every effort should be made to explain the circumstances of the failure to the individual and to involve them in any plans to redress the failure.

**Tertiary preventative strategies**

When a patient’s level of agitation escalates to a crisis point where they place either themselves or others at significant risk of harm. This may result in the need for restrictive interventions.

Interventions now required are identified as tertiary strategies, which may include details of planned restrictive interventions to be used in the safest possible manner, for the shortest time and which should only be used as an absolute last resort.

Where incidents of any restrictive practice occur and tertiary strategies are implemented, there should always follow retrospective recording, including an entry within DATIX to ensure learning and continuous safety improvements.

On occasion, where the risks far outweigh the benefits and in order to maintain patient safety, it may be necessary, to immediately instigate the tertiary strategy. Omission of the need to follow through without the use of primary and secondary strategies must always follow retrospective recording, including an entry within DATIX outlining the reason for this decision.

**6.4 Dangers of Physical Restraint**

**Positional Asphyxia**

Any situation that requires the use of a physical intervention constitutes a medical emergency and must be treated as such. Staff taking part in any physical intervention must be:

- Able to recognise conditions of physical and respiratory distress
- Trained in basic life support
- Aware of emergency equipment and where it is located
- Aware of how to summon assistance and secure medical and ambulance support

In all wards/units where the use of restraint is foreseeable there must be immediate access to basic life support equipment that is checked weekly.
In all instances when a physical intervention takes place, there must be one team member who is responsible for leading the team through the intervention and protecting and supporting the head and neck. They must ensure that the airway and breathing are not compromised and that the patients’ vital signs are monitored throughout the whole process.

Throughout physical intervention staff must continue to employ de-escalation techniques and continually explain the reason for the action to the patient. Physical restraint must be brought to an end at the earliest opportunity.

Under no circumstances should:
- Pain be inflicted deliberately
- Direct pressure be applied to the neck, thorax, abdomen, back or pelvis
- Choke or strangle neck holds be used
- Seated or kneeling holds be used if the person is bent forward at the waist (hyperflexion)
- Restrict airways by obstructing nose or mouth

It is considered unsafe for anybody to restrain another person on their own. If you are alone in a difficult situation, break away and summon assistance.

Where possible staff must remove name badges, pens and other items that may constitute risk prior to any physical intervention. This will help to reduce the risk of damage and injury occurring.

Staff not trained in physical intervention techniques still have a duty of care for their patients and must act in a manner reasonable to the situation and in good faith, bearing in mind the principles within this policy.

**Post-physical intervention care of Patient**

It is especially important to monitor the patient after a physical intervention if:
- There has been a prolonged and violent struggle
- The patient has been subject to rapid tranquillisation
- The patient is under the influence of drugs or alcohol
- The risk assessment has identified that the patient has a physical condition that may inhibit cardio-pulmonary function

The doctor must physically assess the patient at the earliest opportunity, but no longer than 2 hours after the commencement of a physical intervention.

All patients subject to physical intervention must be monitored every 2 hours post restraint for up to 24 hours or as directed by the doctor, this should include:
- Blood pressure
- Pulse
- Temperature
- Respirations
- Fluid and food input and output

If the patient will not co-operate in these routine observation, this should be clearly documented in the patients notes and the doctor informed.
6.5 Communication, Record Keeping and Reporting

Clear communication is essential in relation to the use restrictive interventions. Written information should be used to supplement verbal information wherever possible and offered to patient and carer.

The rationale for use of restrictive intervention should be explicit and clearly documented on the care plan and held within the patient notes.

Staff implementing the use of restrictive interventions should always enter a DATIX; staff will be reassured that the entry on the database is not for action or investigation but for patient safety reasons. This will ensure compliance with CQC regulations for effective recording and monitoring.

Following any occasion where a restrictive intervention is used, whether planned or unplanned, a full record should be made and DATIX completed. The record should allow aggregated data to be reviewed and should indicate:

- the names of the staff and people involved
- the reason for using the specific type of restrictive intervention (rather than an alternative less restrictive strategy)
- the type of intervention employed
- Details of events leading up to the incident and de-escalation techniques used.
- Details of the incident
- the date and the duration of the intervention
- whether the person or anyone else experienced injury or distress
- Any further actions taken i.e. first aid/debrief
- Whether rapid tranquillisation was administered

Following restrictive intervention the DATIX and the patient notes should provide details on the communication and information offered to the patient and their family/carer in line with the Trusts ‘Being Open and Duty Of Candour Policy’.

Wherever possible, people who use services, family carers, advocates and other relevant representatives should be engaged in all aspects of planning their care including how to respond to crisis situations, post-incident debriefings, rigorous reporting arrangements for staff and collation of data regarding the use of restrictive interventions.

Any injury sustained to a patient; member of staff; visitor as a result of the use of restrictive intervention should be reported according to Trust policy and documented in patient notes and DATIX completed.

The use of tertiary restrictive interventions may be needed on a patient in an emergency situation without staff implementing primary and secondary interventions as the first protocol will require an incident form - DATIX being completed in line with Trust policy and the rationale documented in patient notes.

When completing a DATIX, the different types of restrictive interventions are identified within a mandatory field. To offer further clarity to Staff when recording a DATIX, a drop down box is included to ensure the correct definition is used consistently.
6.6 Use of the Police

There may be times that it’s more appropriate for the Police to provide help and support:
- In the rare event that a patient is displaying such behaviour that places the safety of staff, patients or others at risk. Police should be contacted to provide support until the patients behaviour has sufficiently de-escalated. In such circumstances the Police have a duty in law to assist.
- If the patient has absconded from the department and hospital site, against the advice of clinical staff and is displaying suicidal ideology or threatening to harm themselves or others. In these cases the Police have powers under the Mental Health Act to detain the person and take them to a place of safety such as a Section 136 suite or the A&E Department.
- If a patient has left the ward or hospital site, contrary to the advice of medical or nursing staff and you have serious concerns about the welfare or safety of that individual and deem them to be at risk. It may be necessary to contact the Police to assist in returning the patient to the hospital.

6.7 The legal context

Current legislation, policy and accepted good practice are consistent that any restrictive practice should only be carried out where it is legally and ethically justified. This means it must be essential to prevent serious harm to a person and it must be the least restrictive option. Staff will draw on a number of legislative frameworks to work within, including:
- The Mental Health Act 1983 as amended by the Mental Health Act 2007 and Code of Practice 2015
- The Mental Capacity Act 2005, including the Deprivation of Liberty Safeguards.

Staff must always judge whether restrictive interventions are acceptable and legitimate based on all presenting circumstances. The guidance recommends that concerns about the misuse of restrictive interventions should always be escalated through local safeguarding procedures and protocols.

6.8 Mental Health Act 1983

Mental Health Act 1983 Code of Practice (2015) chapter 26, states:-

Providers who treat people who are liable to present with behavioural disturbances should focus primarily on providing a positive and therapeutic culture. This culture should aim at preventing behavioural disturbances, early recognition, and de-escalation.

All mental health providers therefore should have in place a regularly reviewed and updated restrictive intervention reduction programme.

Staff should ensure that patients who are assessed as being liable to present with behavioural disturbance have a care or treatment plan which includes primary preventative strategies, secondary preventative strategies and tertiary strategies. In some services such a care or treatment plan is referred to as a positive behaviour support plan. These individualised care plans, should be available and kept up to date, and include the following elements:
- primary preventative strategies aim to enhance a patient’s quality of life and meet their unique needs, thereby reducing the likelihood of behavioural disturbances
secondary preventative strategies focus on recognition of early signs of impending behavioural disturbance and how to respond to them in order to encourage the patient to be calm

tertiary strategies guide the responses of staff and carers when there is a behavioural disturbance. Responses should be individualised and wide ranging, if appropriate, possibly including continued attempts to de-escalate the situation, summoning assistance, removing sources of environmental stress or removing potential targets for aggression from the area. Where it can reasonably be predicted on the basis of risk assessment, that the use of restrictive interventions may be a necessary and proportionate response to behavioural disturbance, there should be clear instruction on their pre-planned use. Instructions should ensure that any proposed restrictive interventions are used in such a way as to minimise distress and risk of harm to the patient.

6.9 Mental Capacity Act: Restraint of patients who lack capacity

Restraint can only be used where a patient lacks mental capacity to consent to it if:-

- The staff member using it reasonably believes that it is necessary to prevent harm to the patient and
- Its use is proportionate both to the likelihood and seriousness of harm and
- The restraint must be in the patient’s best interests and
- The restraint is the least restrictive means by which to keep the patient safe from harm.

If these conditions are met, then S5 of the Mental Capacity Act (MCA) 2005 offers protection to staff against civil or criminal liability for certain acts done in the care or treatment of the patient which would normally require the patient’s consent.

The decision to use restraint and the reasons why the four criteria are met, in accordance with MCA 2005, must be thoroughly recorded in the patient’s notes

The meaning of ‘proportionate’

If restraint is assessed as being required then the response should be proportionate. The restraint should be the minimal necessary to achieve effective risk reduction and used for the minimal possible time.

The meaning of ‘best interests’

Whilst this is not defined in MCA 2005, the guidance given in the MCA Code of Practice suggests that a determination of “best interests” must include (if it can be ascertained) what the person themselves would have consented to if they had the capacity to do so.

“When working out what is in the best interests of the person who lacks capacity to make a decision or act for themselves, decision-makers must take into account all relevant factors that it would be reasonable to consider, not just those that they think are important. They must not act or make a decision based on what they would want to do if they were the person who lacked capacity.” (MCA Code of Practice, page 68, para 5.7)

The decision to use restraint in the patient’s best interests must be based on reasonable grounds and objective reasons, following consideration of:
The patient’s feelings and wishes: His/her past and present wishes and feelings, as far as they are reasonably ascertainable; the beliefs and values that would be likely to influence their decision if they had capacity, and the other factors that he/she would be likely to consider if he/she were able to.

The views of other people: The person making the decision must take into account, if it is practicable and appropriate to consult with them, the views of anyone named by the person as someone to be consulted with; anyone engaged in caring for the person or interested in his welfare; any donee of a Lasting Power of Attorney, and any Deputy appointed for the person by the Court.

It has to be recognised that the use of restraint in and of itself can cause significant harm. For instance, patients forced to sit for long periods are subject to increased risk of pressure ulcer development, loss of dignity resulting from iatrogenic incontinence, loss of mobility resulting from muscle wasting, etc. The use of bed rails may actually increase the risk of serious injury if the person attempts to climb over them, and the use of harnesses introduces the risk of limb dislocation, fracture or asphyxiation.

Restraint can therefore only be used after a detailed risk assessment is undertaken and the risk of using restraint is considered less than the risk it aims to reduce. The effects of restraint will need to be closely evaluated and its application reviewed on an ongoing basis.

In determining best interests, staff must take into account the detailed guidance contained within the MCA Code of Practice. An incapacitated person’s best interests, including the consultations that occurred with others in order to arrive at best interests, must be recorded in the patient’s notes.

Staff must never use restraint for other purposes – e.g. to compensate for inadequate staffing levels or just so they can do something more easily.

The meaning of “least restrictive”

Staff need to respond to the requirement to act in a way that would interfere least with the patient’s rights and freedom in order to be assured of the legal protection accorded by the MCA in relation to an act of restraint.

Staff must consider whether there is a need to use restraint at all, or if the patient’s safety could be assured by other means.

If restraint is used which cannot be justified then the protection from prosecution or being sued afforded by the MCA will fall away.

See Appendix 1

7. Training

The Trust will ensure that the appropriate training and education is available. All identified staff determined by the organisational training needs analysis and identified by their role will be expected to participate in the trust training programme for Control and Restraint. Appropriate training records will be stored in staff’s personal files as well as centrally maintained via OD & Training Dept.

The minimum standards recognised by the Trust for Trainers are an active GSA Tutors status and the teaching of GSA techniques.
Training Levels include
• Corporate induction
• Basic Life Support Training including positional asphyxia
• Violence and Aggression Level 1 and 2
• Violence and Aggression Level 3
• eLearning

8. **Equality & Diversity**

This policy seeks to apply the principles of the Human Rights Act 1998 of fairness, respect, equality, dignity and autonomy for all (DH 2007) The Trust recognises that placing someone under physical control or restraint requires consideration of an individual’s rights under Articles 3, 5, 7 and 8 of the Act. However the necessity and reasons for physical control and restraint being used, provided this policy is followed, should comply with the legislation.

**Article 3 (Prohibition of Torture).** Care will be taken to ensure that patients, because of need for physical control or restraint, are not subjected to inhumane or degrading treatment.

**Article 5 (Right to Liberty) is a limited right, exception includes the detention of a person of “unsound mind”**. European Case Law has established that there must be three minimum conditions for detention to be lawful under Article 5.

- A true mental disorder must be established before a competent authority on the basis of objective medical expertise.
- The mental disorder must be of a kind or degree warranting compulsory confinement.
- The validity of the continued confinement depends upon the persistence of the mental disorder.

As the patient’s condition improves, under Article 5, we are required to demonstrate that there had been no undue delay in ending an episode of restraint/detention.

**Article 7 (No punishment without law)** It should be clear to all that control and restraint is not to be regarded as a treatment method or is it used as a means of punishment.

**Article 8 (Right to Respect for Family and Private Life).** Infringement can be justified if it is in accordance with the law, is necessary in a democratic society, to ensure public safety, for the prevention of disorder or crime, for the protection of health or morals or for the protection of rights and freedoms of others.

The Trust is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds. This policy has been appropriately assessed.

This policy takes into consideration the need to make reasonable adjustments to ensure that patients with disabilities are not discriminated against. It promotes respect for cultural, religious and gender diversities, and aims to prevent discrimination on the grounds of age, disability, gender (including transgender), race, religion or belief, and sexual orientation.

In accordance with the NHS Constitution for England, patients have the right not to be unlawfully discriminated against in the provision of NHS services including on grounds of gender, race, religion or belief, sexual orientation, disability (including learning disability or mental illness) or age.
9. Monitoring the Compliance of this Policy

Monitoring the compliance of this policy will be the responsibility of the Trust Mental Health Committee via.

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10. Consultation & Review

The policy will be reviewed by the Mental Health Committee, which has both clinical and non-clinical representation. It also takes into consideration feedback from post incident review reports.

11. Implementation of the Policy

The policy will be implemented in accordance with local induction protocols for those staff identified as requiring control and restraint training.

12. References

Positive and Proactive Care: Reducing the need for restrictive interventions. DH (2014)

Transforming Care: A National response to Winterbourne View hospital London. DH (2012)


13. **Associated Policies**

This policy should be read in conjunction with:

- **RM04** Incident Reporting & Investigation
- **RM10** Violence at Work Policy
- **RM01** Risk Management
- **RM80** Policy for the Rapid Tranquilisation of Adult Patients Displaying Acutely Disturbed or Violent Behaviour
- **RM32** Policy and Procedure for the Care of Individuals who are Violent or Abusive
- **RM49** Being Open and Duty of Candour Policy
Restrictive Interventions Policy v5

Appendix 1

RESTRAINT FLOW CHART FOR PATIENTS AGED 16 YEARS AND OVER
(Policy on the use of Restraint in the Care Management of Patients who lack Mental Capacity to Consent to Treatment and Care)

- Does the patient lack capacity to consent to the proposed restraint?
  - Yes: Is restraint necessary to prevent harm to the patient?
    - Yes: Cannot use restraint without the patient's consent unless, under common law, it is used to protect others.
    - No: Restraint cannot be used unless it is to protect others from harm.
  - No: Is the patient under an LPA or a Court Appointed Deputy?
    - Yes: Restraint cannot be used.
    - No: Restraint cannot be used.

- If the LPA or Court Appointed Deputy has the authority does he/she consent to the use of restraint?
  - Yes: Is the restraint proportionate to the likelihood and seriousness of harm?
    - Yes: Restraint cannot be used.
    - No: Is the restraint the least restrictive means by which the patient can be protected from harm?
      - No: Use prescribed restraint & review.

NOTES
1) References to MCA 2005 are to the Mental Capacity Act 2005 and its accompanying Code of Practice.
2) Where restraint forms an aspect of treatment, consideration must be given to the completion of Consent Form 4.
3) Please ensure that all documentation supports dementia/bulldoc decision making.