Restrictive Practice Policy

Including guidance on Restrictive Interventions and Physical Restraint and guidance on the application of hand control mittens

V4.2

March 2015
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1. **Introduction**

1.1. Restrictive practices definition:
"Making someone so something they don't want to do or stopping doing something they want to do" (A positive & proactive workforce, Skills for Care. April 2014)

1.2. Restrictive practice may involve the physical containment of a patient by care staff or security, with or without the use of mechanical aids. It may include the use of equipment (for example door locks) to ensure that the patient cannot move out of a prescribed area. More subtle forms of restrictive practices may also be used, for example removing a walking aid from the patient's reach or not supporting an immobile patient if they wish to move or leave. The use of electronic devices can alert staff to the movement of a patient and thus enable their apprehension. Chemical restraint of patients may be achieved by the use of sedative medication, on a short or long term basis.

1.3. While the emphasis should be on pre-emptive action, wherever possible, in order to prevent the need to restrain, there are some occasions in which the risks to the service user, or others, of inaction may outweigh those of taking action.

1.4. This version supersedes any previous versions of this document.

2. **Purpose of this Policy**

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

3. **Scope**

3.1. This policy sets out the best practice guidance for all staff working at the Royal Cornwall Hospital Trust (RCHT).

3.2. This policy applies to patients who require restrictive practice while receiving treatment; this would include those patients lacking the mental capacity to make specific decisions about their own health and personal safety needs.

3.3. This document is applicable only to individuals over 16 years of age. The RCHT Policy for Restrictive Physical Intervention and Therapeutic Holding of children and young people (June 2011), is available to guide practitioners to enable them to carry out Restrictive physical intervention or Therapeutic Holding in a safe manner which ensures minimal trauma and distress for the child/young person and family.

4. **Definitions**

4.1. Restrictive practice is defined as:
"Making someone so something they don't want to do or stopping doing something they want to do" (A positive & proactive workforce, Skills for Care. April 2014)

4.2. 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 is necessary"
(Positive & Proactive Care: reducing the need for restrictive interventions. DoH. April 2014)

4.3. Physical Restraint is defined:
"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"
(Positive & Proactive Care: reducing the need for restrictive interventions. DoH. April 2014)

4.4. Physical restraint must be reported on DATIX when there is: direct physical contact, with or without resistance, where the intention is to prevent, restrict or subdue movement of the body, or part of the body of another person, by two or more staff.

5. Ownership and Responsibilities

5.1. Chief Executive
The Chief Executive and wider Trust Board have key roles and responsibilities to ensure the Trust meets requirements set out by statutory and regulatory authorities such as the Department of Health, Commissioners and the Care Quality Commission. The Trust's Chief Executive has overall responsibility to have processes in place to:
- Ensure that clinical staff are aware of this policy and adhere to its requirements
- Ensure that appropriate resources exist to meet the requirements of this policy

5.2. Executive Directors
The Executive Directors are responsible for ensuring that all operational managers in their area are aware of this policy, understand its requirements and support its implementation with relevant staff.

5.3. Associate Medical Director/Consultants
The Associate Medical Director and Consultants are responsible for ensuring procedures are understood and carried out by medical staff involved in the implementation of this policy.

5.4. Departmental Managers
Departmental Managers are responsible for implementing the policy with their immediate staff and ensuring that they carry out the duties prescribed in this policy.

5.5. Members of Clinical Teams
Clinical team members have responsibility to comply with the requirements of this and associated policies and have a legal duty to have regard to it when working with, or caring for adults who may lack capacity to make decisions for themselves.

5.6. Quality, Safety and Compliance Team
The Quality, Safety and Compliance Team are responsible for informing the Care Quality Commission (CQC) of all DOLS applications and outcomes. This is a statutory requirement.

5.7. Mental Health and Wellbeing Specialist Nurse
The Mental Health and Wellbeing Specialist Nurse is responsible for:
- The day-to-day management of the Mental Health Act (MHA) in accordance with statutory legislation, Codes of Practice, national guidelines and local policies and procedures.
- Patient applications to Mental Health Review bodies, and MHA Managers.
- Provides of advice, support and training in relation to the Mental Health Act 1983 and 2007, the Mental Capacity Act 2005 (MCA), Deprivation of Liberty Safeguards 2007 (DOLS) and other associated statutory legislation, national guidance, policy or procedures.
- The development and review of Trust policies and procedures relating to the application and administration of the MHA 1983 the MCA 2005, DOLS 2007 and related Codes of Practice.
- To support and advice with regard to the application and administration of the MCA and DOLS within the Trust.

6. Standards and Practice

6.1 Types of Restrictions
6.1.1 Restrictive practice is not confined to physical restraint; it also refers to actions or inactions that contravene a person's rights. Listed below are some restrictive categories. It must be remembered that to apply any of these to an individual there must have a lawful and legitimate right and reason to do so. The following list is not exhaustive.

- **Physical restraint (See Appendix 3)**
  "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" *(Positive & Proactive Care: reducing the need for restrictive interventions. DoH. April 2014)*

- **Mechanical restraint**
  A device used on a person to restrict free movement such as placing a person in a chair which they are unable to get up from.
• **Environmental restriction**
The design of the environment to limit people’s ability to move as they might wish, such as locking doors or sections of a building, using electronic key pads with numbers to open doors, complicated locking mechanisms and door handles.

• **Chemical restraint**
The use of drugs and prescriptions to modify a person’s behaviour. Medication that is prescribed to be taken ‘as and when required’ can be used as a form of restraint unless applied responsibly. For more information please refer to: Guideline for ‘Guideline for the use of medication to manage acutely disturbed or violent behaviour in adult patients of RCHT (Rapid Tranquillisation)’

• **Forced care**
Actions to coerce a person into acting against their will, for example having to be restrained in order to comply with the instruction or request.

• **Cultural restriction**
Preventing a person from the behaviours and beliefs characteristic of a particular social, religious or ethnic group

• **Decision making**
Making a decision on the persons behalf or not accepting or acting on a decision the person has made.

• **Contact with community**
Preventing the person from participating in community activities, including work, education, sports groups, community events or from spending time in the community such as parks, leisure centres, shopping centres

• **Contact with family and friends**
Preventing or limiting contact with the persons friends and family, for example not allowing the person to receive visitors, make phones calls or not allowing contact with a specific friend or family member.

### 6.2 Unacceptable Methods of Restriction

6.2.1 The following methods of restriction are unacceptable, however if the patient requests or is consenting to any of the following it may be considered and applied as appropriate. This must be clearly documented. Inappropriate use of restrictions may be viewed as abuse and a safeguarding concern. The following list is not exhaustive.

• **Inappropriate bed height.** This is an unacceptable form of restraint, one reason being that it increases the risk of injury resulting from a fall out of bed.

• **Inappropriate use of wheelchair safety straps.** The safety straps on wheelchairs should always be used, when provided for the safety of the user. However patients should only be seated in a wheelchair when this type of seating is required, not as a means of restraint.
• **Using low chairs for seating.** Low chairs should only be used when their height is appropriate for the user. Again they should not be used with the intention of restraining a person. Low chairs also pose risks to staff in relation to manual handling.

• **Chairs whose construction immobilises patients** eg, reclining chairs, bucket seats. Reclining chairs should be used for the comfort of the user and not as a method of restraint.

• **Locked doors.** On the occasion that doors are locked clear signage should be displayed informing patients and the public that doors are locked and who they should ask to have them unlocked to exit the ward. If a patient is asking to leave and being prevented by the locked door that patient is being restricted.

• **Arranging furniture to impede movement.** Other methods of dealing with behaviour such as wandering should be pursued. Any equipment, including furniture, should only be used for the purpose for which it is intended.

• **Inappropriate use of night clothes during waking hours.** This is demeaning and should not be used as a way of restraining people.

• **Removal of outdoor shoes and other walking aids and/or the withdrawal of sensory aids such as spectacles.** As with the above, these are not acceptable ways of restraining people in any care setting. Removal of sensory aids can cause confusion and disorientation.

• **Isolation**

  It is important to note that patients may be “isolated” for infection control reasons and if a patient is cared for in a side room, when he or she wishes to be on the main ward, this may be construed as restraint. This is a complex issue, which should be discussed on a case by case basis with the multidisciplinary team, including the Infection Control Team. For further information refer to the RCHT Seclusion Guidelines.

• **Planned prone physical restraint**

  The utilisation of a planned prone restraint should not be used other than exceptional circumstances eg medical reason. Utilisation of seated, supine or release of person to be considered as alternatives.

**6.3 Decision making and Assessment**

6.3.1 Individual assessment should be carried out that considers:

  • **The patient’s behaviour and underlying condition and treatment**

    Understanding a patient’s behaviour and responding to their individual needs should be at the centre of patient care. All patients should be thoroughly assessed to establish what therapeutic behaviour management interventions may be of benefit.
• **The patient’s mental capacity and/or mental health**
  It is necessary to consider a patient’s mental capacity as consent must be gained from patients to use any type of restriction unless they lack capacity to make this decision and the restrictive practice is sanctioned under the Mental Capacity Act or the Mental Health Act.

• **The environment**
  Every effort should be made to reduce the negative effects of the care environment. Examples of negative environmental factors include: High levels of noise or disruption, inappropriate temperature, inappropriate levels of stimulation, negative attitudes of care staff, poor communication skills.

• **The risks to the patient and to others**
  When using restrictive practice a balance must be achieved between minimising risk of harm or injury to the patient and others, and maintaining the dignity, personal freedom and choice of the patient.

6.3.2 Assessment should always place the individual at the centre of the process, involving them and those who are important to them in their lives, as is practical to do so. Evidence of a person centred approach to assessment and planning must be recorded.

6.3.3 If a restriction is deemed appropriate the following points must be considered;
  • The practice needs to have a legitimate aim. It must be necessary in order to protect the health and wellbeing of the individual or to protect the safety or human rights of others (patients, staff, visitors, public).
  • All individuals who may be affected by the practice must be involved in the decision making process to the fullest possible extent of their understanding.
  • The practice that is implemented must be proportional, i.e. the least restrictive practice required to achieve the aim.
  • Principles of dignity and respect should be observed during the implementation of any restrictive practice.
  • The effectiveness of the practice in meeting its aims should be continually reviewed and the practice should continue only for as long as it remains both necessary and effective.

6.3.4 If the patient has capacity to give valid consent and their agreement or consent can be gained, without undue pressure, from the person then the restriction can be put in place so long as it does not contravene the law. It must be remembered that the person has the right to withdraw their agreement or consent and they should be informed of this right at the outset.

6.3.5 If the person withdraws their consent but it is felt that the restriction should continue, this can only be achieved if the practice is sanctioned under law, examples include the Mental Capacity Act, Mental Health Act, Criminal Law, Public Health Act.
6.4 Restrictive practice decision making flowchart

Restrictive practice - guidance flowchart

Is the patient behaving in a way that is a risk to themselves or others?

Yes

Is this an emergency situation where immediate harm needs preventing?

No

Are there environmental factors which may be causing or contributing to this behaviour?

Yes

Adapt or modify the environment if possible

No

Are there underlying physiological, psychological, pharmacological or pathological reasons for the behaviour?

Yes

Address underlying causes

No

Does the patient have Mental Capacity with regards to their risk behaviours?

Yes

Have you obtained the persons consent to use the restrictive practice?

No

Is restriction in the patient's best interest?

Yes

Use restrictive practice

No

Do not use restrictive practice

No

Do not use restriction consider other measures to manage the risk behaviour

* Criminal Law Act Section 3 (1967)

Common law use 'reasonable force to protect, under the circumstances' to prevent harm. Document and Datix the incident

Note: Document and Datix the incident for any concerns related to restrictive practice.
6.5 Deprivation of Liberty

6.5.1 The Deprivation of Liberty Safeguards (DoLS) 2007 (came into force 2009) and the DoLS are an amendment to the Mental Capacity Act (2005). They provide a legal framework to protect those who may lack the capacity to consent to the arrangements for their treatment or care where levels of restriction or restraint used in delivering that care are so extensive as to be depriving the person of their liberty.

6.5.2 The safeguards apply to people in England and Wales who have a mental disorder and lack capacity to consent to the arrangements made for their care or treatment, but for whom receiving care or treatment in circumstances that amount to a deprivation of liberty may be necessary to protect them from harm and appears to be in their best interests. A large number of these people will be those with significant learning disabilities, or older people who have dementia or some similar disability, but they can also include those who have certain other neurological conditions (for example as a result of a brain injury).

6.5.3 For more information please see the RCHT Mental Capacity Act, Independent Mental Capacity Advocacy and Deprivation of Liberty Safeguards Policy

6.6 Duty of Care

6.6.1 The Government best practice guidance Independence Choice and Risk (2007), states 'Duty of Care' as, 'an obligation placed on an individual requiring that they exercise a reasonable standard of care while doing something (or possibly omitting to do something) that could cause harm to others. Exercising 'duty of care' to a person cannot be used to justify restrictive practices except where a person has capacity and gives consent to the practice or where the practice is sanctioned under the Mental Health Act or the Mental Capacity Act.

6.7 Care Planning

6.7.1 It is essential that any restriction is identified and justified in the care plan; this should include
- Rationale for the use of restraint.
- The frequency of re-assessment of the need for restraint. Review times should be specified in advance.
- All discussions that have taken place to allow the patient to give informed consent and to assess best interests.
- Discussions with relatives, carers and others with regard to the restraint.
- Details about the use of the restraint itself.
- Which legislative framework is being used to legitimise the restriction; eg. MCA, MA etc.

6.7.2 A Core Care Plan titled: Clinically Related Challenging Behaviours is available on the staff intranet at: Royal Cornwall Hospitals Trust > Our Services > A-Z Services > F > Forms > Forms To Print
6.7.3 Any person affected by the restriction needs to be involved in the decision to the fullest possible extent. Clear communication is essential.

6.7.4 Restrictions where possible must be a multi disciplinary decision, consulting family; un-befriended patients may require an Independent Mental Capacity Advocate (IMCA).

6.7.5 In cases where it is not possible to establish a persons view, e.g. due to mental incapacity, staff will need to consider if the restriction is likely to cause more harm than good.

6.8 Recording Restrictive Practice
6.8.1 This must be documented in the medical records, with a Mental Capacity assessment where appropriate. All documentation in relation to restraint should be clear, detailed and contemporaneous.

6.8.2 Physical restraint must be reported on DATIX when there is: direct physical contact, with or without resistance, where the intention is to prevent, restrict or subdue movement of the body, or part of the body of another person, by two or more staff.

6.8.3 Any injuries to a patient, member of staff or visitor to the Trust premises, involving the use of restraint, should be reported on DATIX. Incidents should also be documented in the nursing / multidisciplinary notes.

6.9 Advice on Restrictive Practice
6.9.1 For further support and advice on the use of restrictive practice please contact:
- Safeguarding Nurse for Adults on ext 2446 or 07825 904386
- Learning Disability Team on ext 2875 or by Net Page via RCHT switchboard.
- Mental Health and wellbeing Specialist Nurse on ext 2446 or 07789 876247
- DOLs Lead for Cornwall County Council, Paul Wilkins, on 07910800537
- Security team on 2147
- Complex Care and Dementia liaison psychiatry via ext 1300
- Psychiatric Liaison Service via ext 1300

6.10 Training and Advice on Physical Restraint
The Management of Aggression and Violence Practitioners manage all training in relation to physical restraint, for advice or details of the training available contact Learning and Development on ext: 5148

7 Dissemination and Implementation
7.1 This policy is to be implemented and disseminated through the organisation immediately following ratification and will be published on the organisations intranet site document library. Access to this document is open to all.

7.2 This policy document will be held in the public section of the Documents Library with unrestricted access, replacing the previous version which will be archived in accordance with the Trust Information Lifecycle and Corporate Records Management Policy.
7.3 This policy will be disseminated through the Safeguarding Adults Operation Group membership, the Senior Nurse, Midwifery and AHP Group, the Matron’s and Senior Matrons weekly briefing and the RCHT daily communication all user email

7.4 Reference to relevant sections from this Policy will be utilised at all RCHT Level 1 and 2 Safeguarding Adults mandatory training and at specific mental capacity training

8 Monitoring compliance and effectiveness

8.1 Auditing of the implementation of the restrictive practice policy across clinical areas will be undertaken to monitor the effectiveness and usage of this policy. The monitoring of compliance with this policy will be overseen by the RCHT Safeguarding Adults Operational Group.

<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>The use of restraint within RCHT Compliance with this policy The reporting and documentation of incidents The use of the clinically related challenging behaviours core care plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead</td>
<td>Management of Violence and aggression Lead Specialist Nurse for Mental Health and Wellbeing</td>
</tr>
<tr>
<td>Tool</td>
<td>The RCHT DATIX system Medical and Nursing Documentation</td>
</tr>
<tr>
<td>Frequency</td>
<td>Annually.</td>
</tr>
<tr>
<td>Reporting arrangements</td>
<td>The completed audit reports will be discussed at the Safeguarding Adult Operational Group.</td>
</tr>
<tr>
<td>Acting on recommendations and Lead(s)</td>
<td>Where the report indicates sub optimal performance the Chair of the SAOG will nominate a group member to produce an action plan. The SAOG will be responsible for monitoring progress and will undertake subsequent recommendations and further action planning for all deficiencies identified within agreed timetables.</td>
</tr>
<tr>
<td>Change in practice and lessons to be shared</td>
<td>Required changes to practice identified will be documented in the action plan outcomes. The membership of the SAOG will identify a lead to take each change forward across divisions as appropriate. Lessons will be shared with all relevant parties.</td>
</tr>
</tbody>
</table>

9 Updating and Review

9.1 This policy has been agreed by Trust management and the staff and management side of the Health and Safety committee. It has been viewed by Learning and Development.

9.2 This policy will be reviewed every 3 years or earlier in view of developments which may include legislative changes, national policy instruction (NHS or Department of Health) or Trust Board decision.

10 Equality and Diversity

10.1 This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the [Equality](#).
Diversity & Human Rights Policy or the Equality and Diversity website.

The Initial Equality Impact Assessment Screening Form is at Appendix 2.
### Appendix 1. Governance Information

<table>
<thead>
<tr>
<th>Document Title</th>
<th>Restrictive Practice Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Issued/Approved:</td>
<td>March 2015</td>
</tr>
<tr>
<td>Date Valid From:</td>
<td>March 2015</td>
</tr>
<tr>
<td>Date Valid To:</td>
<td>February 2018</td>
</tr>
</tbody>
</table>
| Directorate / Department responsible (author/owner): | Corporate Division  
Lerryn Hogg / Jon Wiggans |
| Contact details:       | 01872 252446 / 01872 256488 |
| Brief summary of contents | This policy is designed to define restrictive practice and to allow the practitioner to ensure that the care or treatment that they are offering is lawful, legitimate, proportionate, and the least restrictive reasonable option available. |
| Suggested Keywords:   | Restraint, Restrictive practice, Deprivation of Liberty Safeguards, DOLS, Mental Capacity, MCA, Physical restraint, Locked door, Mittens, Posey Mitts, Mitts, Hand restraints, Gloves. |
| Target Audience       | RCHT  
PCH  
CFT  
KCCG |
| Executive Director responsible for Policy: | Director of Nursing |
| Date revised:         | March 2015                  |
| This document replaces (exact title of previous version): | Restrictive Practice Policy |
| Approval route (names of committees)/consultation: | Steering Group RCHT Divisional Directors RCHT Nursing Midwifery and Allied Health Professionals Board Safeguarding Adults Operations group |
| Divisional Manager confirming approval processes | Corporate Division |
| Name and Post Title of additional signatories | Not Required |
| Signature of Executive Director giving approval | {Original Copy Signed} |
| Publication Location (refer to Policy on Policies – Approvals and Ratification): | Internet & Intranet  
✓ Intranet Only |
| Document Library Folder/Sub Folder | Clinical / Safeguarding Adults |
Links to key external standards

- 2005 Mental Capacity Act
- Mental Health Act 1983 & 2007
- CQC outcome 7

Related Documents:

- Positive & Proactive Care: reducing the need for restrictive interventions. DoH. April 2014
- A positive & proactive workforce, Skills for Care. April 2014
- RCHT Mental Capacity Act, Independent Mental Capacity Advocacy and Deprivation of Liberty Safeguards Policy (2011)
- Guideline for the use of medication to manage acutely disturbed or violent behaviour in adult patients of RCHT (Rapid Tranquillisation Policy)

Training Need Identified?

Yes. Training is required for physical restraint. Please contact Jon Wiggins in the Learning and Development department.

Version Control Table

<table>
<thead>
<tr>
<th>Date</th>
<th>Version No</th>
<th>Summary of Changes</th>
<th>Changes Made by (Name and Job Title)</th>
</tr>
</thead>
<tbody>
<tr>
<td>03.09</td>
<td>V1.0</td>
<td>Date first published</td>
<td>Zoe Mclean, Liaison Nurse for Learning Disabilities</td>
</tr>
<tr>
<td>12.08.10</td>
<td>V2.0</td>
<td>Care plan removed</td>
<td>Zoe Mclean, Liaison Nurse for Learning Disabilities</td>
</tr>
<tr>
<td>23.01.09</td>
<td>V3.0</td>
<td>Reformat in line with Trust “Policy on Policies”</td>
<td>Karen Powell, Security Management Administrator</td>
</tr>
<tr>
<td>Date</td>
<td>Version</td>
<td>Changes</td>
<td>Authors</td>
</tr>
<tr>
<td>------------</td>
<td>---------</td>
<td>------------------------------------------------------------------------------------------------------------------</td>
<td>----------------------------------------------</td>
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</tbody>
</table>
| 09.07.12   | V4.0    | Reviewed and updated  
• Expanded on types of restriction  
• Included unacceptable methods of restriction  
• Included restrictive practice guidance flowchart  
• Leg strap protocol removed                  | Lerryn Hogg  
Mental Health and Wellbeing Nurse  
Jon Wiggans  
Management of Aggression & Violence - Lead |
| 21.02.14   | V4.1    |  
• Amendment to 5.6 changed DOLS administrator to Quality, Safety and Compliance Team.  
• Change to title of the ‘rapid tranquillisation policy’  
• Updated definitions of restrictive practice and physical interventions.  
• Defined reportable incidents of restraint.            | Lerryn Hogg  
Mental Health and Wellbeing Nurse  
Jon Wiggans  
Management of Aggression & Violence - Lead |
| 03.03.15   | V4.2    |  
• Definitions update in line with Department of Health guidance.  
• Inclusion of Mittens guidance                      | Lerryn Hogg  
Mental Health and Wellbeing Nurse  
Jon Wiggans  
Management of Aggression & Violence – Lead  
Tracy Lee - Nutrition Nurse Specialist |

All or part of this document can be released under the Freedom of Information Act 2000

This document is to be retained for 10 years from the date of expiry.

This document is only valid on the day of printing

Controlled Document
This document has been created following the Royal Cornwall Hospitals NHS Trust Policy on Document Production. It should not be altered in any way without the express permission of the author or their Line Manager.
Appendix 2. Initial Equality Impact Assessment Form

<table>
<thead>
<tr>
<th>Name of the strategy / policy / proposal / service function to be assessed (hereafter referred to as policy) (Provide brief description): Restrictive Practice policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Directorate and service area: Corporate</td>
</tr>
<tr>
<td>Name of individual completing assessment: Lerryn Hogg</td>
</tr>
<tr>
<td>1. Policy Aim*</td>
</tr>
<tr>
<td>Who is the strategy / policy / proposal / service function aimed at?</td>
</tr>
<tr>
<td>2. Policy Objectives*</td>
</tr>
<tr>
<td>3. Policy – intended Outcomes*</td>
</tr>
<tr>
<td>4. *How will you measure the outcome?</td>
</tr>
<tr>
<td>5. Who is intended to benefit from the policy?</td>
</tr>
<tr>
<td>6a) Is consultation required with the workforce, equality groups, local interest groups etc. around this policy?</td>
</tr>
<tr>
<td>b) If yes, have these *groups been consulted?</td>
</tr>
<tr>
<td>C). Please list any groups who have been consulted about this procedure.</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>7. The Impact</td>
</tr>
<tr>
<td>Please complete the following table.</td>
</tr>
</tbody>
</table>

| Are there concerns that the policy could have differential impact on: |
|---|---|---|
| Equality Strands: | Yes | No |
| **Age** | | √ |
| **Sex** (male, female, transgender / gender reassignment) | √ |

Restrictive Practice Policy
| Race / Ethnic communities /groups | √ | in conjunction with principles of dignity, equality, respect, fairness and autonomy. |
| Disability - Learning disability, physical disability, sensory impairment and mental health problems | √ |
| Religion / other beliefs | √ |
| Marriage and civil partnership | √ |
| Pregnancy and maternity | √ |
| Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian | √ |

You will need to continue to a full Equality Impact Assessment if the following have been highlighted:
- You have ticked “Yes” in any column above and
- No consultation or evidence of there being consultation- this excludes any policies which have been identified as not requiring consultation. or
- Major service redesign or development

8. Please indicate if a full equality analysis is recommended. | Yes | No √ |

9. If you are not recommending a Full Impact assessment please explain why.

Not required

Signature of policy developer / lead manager / director | Date of completion and submission
Lerryn Hogg | March 2015

Names and signatures of members carrying out the Screening Assessment
1. 
2.

Keep one copy and send a copy to the Human Rights, Equality and Inclusion Lead, c/o Royal Cornwall Hospitals NHS Trust, Human Resources Department, Knowledge Spa, Truro, Cornwall, TR1 3HD

A summary of the results will be published on the Trust’s web site.

Signed ________________

Date ________________
Appendix 3. Restrictive Interventions / Physical Restraint

1. Restrictive Interventions (including use of Physical Restraint) definition:
"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 is necessary"

Positive & Proactive Care: reducing the need for restrictive interventions. DoH. April 2014

Physical Restraint definition:
"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"

Positive & Proactive Care: reducing the need for restrictive interventions. DoH. April 2014

2. Training

Physical restraint training to be provided by those identified within the Trust, as qualified to do so.

“Staff in NHS hospitals….. should have completed an appropriate course taught by a qualified trainer”


All new employees will attend Trust Induction, which will outline basic health & safety responsibilities and provide an awareness of violence & aggression risks.

Conflict Resolution Training for all frontline staff within the Trust is mandatory. This training will forms part of Trust induction program. All training will meet the aims and outcomes as laid out in – Conflict Resolution Training: Implementing the learning aims & outcomes. NHS Protect. 2013. Frontline staff being those staff who ordinarily deal with members of the public or patients, as part of their job role.

Personal Safety Training: based upon localised Violence & aggression risk assessment, staff working in ‘high risk’ areas, will receive Personal Safety Training as mandatory, in addition to CRT.
Managing Clinically Related challenging Behaviour Restraint Training: based upon localised risk assessment, and reported incidents of clinically related challenging behaviour, staff to receive bespoke restraint training.

Trust Learning & Development Department provide all of the above training, along with other bespoke training packages.

It is the responsibility of department/ward manager to determine what training is required by their staff according to job role. Staff must be made available to attend the training they require and ensure they remain in date.

Management of Violence & Aggression Policy 2014

3. Use of Physical Restraint:

Where possible staff implementing Physical Restraint should be trained to do so, as identified

Violence, Aggression & Challenging behaviour Risk Assessment Matrix
[for determining Mandatory / Training Requirements]
Management of Violence & Aggression Policy 2014. Appendix

Planned prone physical restraint
The utilisation of a planned prone restraint should not be used other than exceptional circumstances eg medical reason. Utilisation of seated, supine or release of person to be considered as alternatives.

4. Planned Interventions
Persons implementing Physical Restraint must reasonably believe that restraint is necessary to prevent harm and the level of restraint used is proportionate in response to the likelihood and seriousness of harm.

“The level must be justifiable, appropriate, reasonable and proportionate to a specific situation and should be applied for the minimum amount of time”.

“ Other than to mitigate significant risk of immediate harm or danger under criminal / common law, any physical interventions or physical restraint are not to include the use of pain, pain compliance or techniques likely to cause pain.

(Positive & Proactive Care: reducing the need for restrictive interventions. DoH. April 2014)
Staff applying physical restraint should be made aware of physical and emotional risks to the person being restrained, in particular including risk of positional asphyxia. Staff should also be trained in Basic Life Support (BLS – Resuscitation Council UK), along with having immediate access to Immediate Life Support (ILS – Resuscitation Council UK) and medical cover.

Where an individual is ‘restrained’ in a supine position whilst resisting, or at length in a seated position, staff implementing the Physical restraint are to ensure a third staff member is present to monitor the physical health and wellbeing of the person until the situation has de-escalated to a more minimal level of interventions.
This will involve communication with the individual, observation and possibly protection of the persons head.

There must be no planned or intentional prone / face down restraint as part of utilisation of planned intervention. “If exceptionally a person is restrained unintentionally in a prone / face down position, staff should either release their holds or reposition into a safer alternative as soon as possible”.

*(Positive & Proactive Care: reducing the need for restrictive interventions. DoH. April 2014)*

All measures are to be made to monitor the person during such transition (and record details on incident report eg reason for, duration)

In the case of Security Officers implementing the above, they do not carry medical responsibility for a patient and therefore may request nursing or medical staff to be in attendance throughout the implementation of physical interventions.

Good practice Core care plan – clinically related challenging behaviour:

Core care planning being integral part of Positive Behavioural Support process. (Where staff identify causes / antecedents, behaviours likely and consequences / ways to resolve the challenging behaviours). Whether based around known behaviours or responding to crisis.

(This may include guidance from external care organisations on specific approaches to the management of challenging behaviours).

Assessment of Mental Capacity should be demonstrated as per Trust Policy. (Refer to RCHT Mental Capacity Act, Independent Mental Capacity Advocacy and Deprivation of Liberty Safeguards Policy)

### 5. Emergency Interventions

As above. However, due to the very nature of ‘emergency’ situation, staff may be required to implement the Physical restraint as part of ‘use of reasonable force’ – Section 3 Criminal Law Act Sec. 3 1967 / Common Law, use of reasonable force. (If in the event of preventing immediate harm to a person).

Appropriate action to restrain or remove a person, in order to prevent harm to self or others may be conducted under this basis or under ‘common law’. (This in itself may impose a duty of care on healthcare and social care staff to whom they provide services).

This should be to resolve emergency situations only, there after for repeated or prolonged incidents of Physical Restraint, the use of the Mental Health Act should be considered. (Or removal where appropriate by Security Officers / Police).

Use of rapid tranquillisation (ref rapid Tranquillisation policy 2013) for the control of acutely disturbed, violent (or Deliriums) behaviour.

### 6. Security Team response
Whether a ‘planned’ intervention, or emergency call (as per Trust procedure for summonsing response team ext 2999); those staff requesting response team assistance are to -

- Ensure adequate hand over of information is given to the team (this may include issues around capacity, MHA sections or medical complications). In clinical areas, response team may seek clarification from nursing / medical staff over capacity (see policy MCA), in order to act.
- Be available to handover information on attendance.
- In clinical areas provide staff member to provide medical responsibility if required. (See above).
- Be available for response team to ‘stand down’ and leave.

7. Incident reporter

Physical restraint must be reported on DATIX when there is: direct physical contact, with or without resistance, where the intention is to prevent, restrict or subdue movement of the body, or part of the body of another person, by two or more staff.

DATIX reports identifying physical restraint activity will be reviewed by the Trust ‘specialist’ Violence and Aggression trainers, to monitor activity and provide support and guidance to staff involved, along with quality assured training in terms of appropriateness.

In clinical areas, the application of physical interventions should also be documented within medical notes, as a record of activity relating to patients.

8. References:

A positive & proactive workforce, Skills for Care. April 2014

Positive & Proactive Care: reducing the need for restrictive interventions. DoH. April 2014


Mental Health 1983 Act Code of Practice.

9. **Additional advice:**

- **Mental Health Act 1983 (revised 2007)**

The Mental Health Act code of practice revised 2008 can be found on the department of health website.

- **Mental Capacity Act 2005**

The Mental Capacity Act code of practice 2007 can be found on the department of health website.

- **Deprivation of liberty Safeguards**

The Deprivation of liberty Safeguards code of practice 2008 can be found on the department of health website.

- **Human rights, human lives**

The Human Rights, Human Lives hand book for public authorities can be found on the Ministry of Justice Website

- **Human rights in healthcare**

The Human Rights in Action framework for local action can be found on the department of health website.
Appendix 4. Restrictive Practices – Clinical Guideline for the use and application of hand control mittens in adults only.

1. Aim/Purpose of this Guideline

This guideline relates to the use and application of hand control mittens in adult patients where it is felt their safety is compromised and medical treatment can not be delivered effectively and safely. The guideline applies to all health care practitioners involved in the recommendation and/or use of hand control mittens.

Ward managers are responsible for ensuring the implementation of this guideline, associated guidelines and for monitoring compliance. They should ensure health care professionals access appropriate training. This policy is to be read in conjunction with RCHT Mental Capacity Act and RCHT Deprivation on Liberty Safeguards Guidance and Procedure.

2. The Guidance

Its aim is to guide decision-making when treating agitated or cognitively impaired patients and who often lack mental capacity. The guideline and the mittens assessment tool (see document) aims to support practitioners to ensure that the application of mittens is lawful, legitimate, proportionate, and the least restrictive reasonable option available. These issues should be applied in conjunction with principles of dignity, equality, respect, fairness and autonomy.

The use of Mittens is recognised as a form of restraint although they are not considered to be a deprivation of liberty (DOL). There are various forms of restraint e.g. Nasal bridle to secure NG feeding tubes, however mittens may be regarded in this situation as the least restrictive and safer alternative. The use of Mittens is ethically sensitive and this needs to be managed whilst providing optimal treatment. Mittens may be used in patients considered to lack capacity to recognise and manage risks and harm associated with removal of a medical device i.e. rigid cervical collar, NG feeding tube but only if use of mittens is considered proportionate to the likelihood and seriousness of harm and all other non restrictive and innovative alternatives has failed.

Mittens are designed to restrict the movement of one or both hands and are used with patients who are acutely ill (a number of these may be agitated or restless) have long term illness or have a cognitive impairment due to head injury, dementia or other conditions. This frequently often leads to the patients attempting to remove essential medical devices
e.g. rigid cervical and soft collars, NasoGastric feeding tubes, nasal bridles, urinary catheters, vascular access device and other appliances which then may need to be reinserted.

- **NasoGastric feeding tubes** Patient removal of NG tubes can lead to aspiration of feed, chest infection and irregular administration or omission of feed, water and/or medication resulting in inadequate nutrition, fluid and electrolyte imbalance.
- **Nasal Bridle** If a nasal bridle is forcibly pulled out of the nose trauma to nasopharynx could ensue. For this reason bridles should not be inserted in acutely confused patients, or those who have repeatedly pulled out NasoGastric tubes (see nasal bridle policy). Mittens may be considered as an alternative, safer and lesser restraint than a nasal bridle.
- **Hard cervical collar** Risk of removal of hard collar may lead to pain, ligament damage, neuropathy, delayed union or malunion of fracture site and/or paralysis.

The decision for the use of mittens should only be undertaken by a registered health professional who understands the risks and benefits associated with their application. Who is personally regulated and have professional accountability under their code of conduct, to ensure that while caring for clients they are assured they have been given/ sought information about the patient's condition and understand the risks and implications of any proposed restraint. Mittens must be applied by a registered nurse, allied Health care professional i.e. Occupational Therapist, physiotherapist and Doctor’s who have had appropriate training.

This guideline outlines the steps and safeguards required to enable practitioners to follow an agreed decision making, assessment and review process using the mittens assessment tool form thus ensuring appropriate use and management of hand control mittens in adult patients within the Trust. The assessment tool aims to ensure that the patient’s mental capacity is assessed and that if a patient does not have mental capacity (this is likely to be the case in the patient group concerned) to make a decision then the healthcare professional has an obligation to act in the patient’s best interest. This is likely to involve discussion amongst the multidisciplinary team caring for the patient and with their next of kin. A consent form 4 should be completed and a mittens care plan commenced. The assessment tool, mittens care plan and consent form 4 are available on the RCHT intranet.

**The following people may be considered for the use of mittens:**

- Disorientated patients/patients with delirium
- Restless and agitated patients
- Confused patients for clinical or functional reasons

**Contraindications:**

- Highly aggressive, combative or suicidal.
- Have wound site or abrasions on the affected hand or wrist
- Have sever arthritis of the wrist or hand
- Have a renal fistula
- Have a dislocation or fracture of the affected limb or shoulder
- Have an intravenous cannula inserted on the affected hand
- Have monitoring devices attached to the affected hand
• Caution should be used if a patient has a musculo-skeletal or neurological impairment of the hand or wrist

ONLY the recommended and branded product of hand mittens are to be used (see mittens care plan and assessment tool). Alternatives such as bandaging patients hands MUST NOT be used and is not condoned. Hand control mittens CANNOT be used when a patient has full mental capacity and has refused their use. Mittens should not be applied until the mittens assessment tool has been completed and documented clearly in the medical notes.

3. Monitoring compliance and effectiveness

<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>The use of Mittens</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead</td>
<td>Tracy Lee, Merion Grimshaw</td>
</tr>
<tr>
<td>Tool</td>
<td>Retrospective notes audit of patients who have received mittens</td>
</tr>
<tr>
<td>Frequency</td>
<td>Annual Audit of case notes</td>
</tr>
<tr>
<td>Reporting arrangements</td>
<td>Elder care clinical governance meeting documented by minutes of meeting Strategic Nutrition Steering group</td>
</tr>
<tr>
<td>Acting on recommendations and Lead(s)</td>
<td>The Audit will be presented to the Safeguarding Adults Operational Group. Where the report indicates sub optimal performance an action plan will be produced.</td>
</tr>
<tr>
<td>Change in practice and lessons to be shared</td>
<td>Re-audit annually</td>
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