HEALTH & SAFETY ASSURANCE COMMITTEE
PWYLLGOR IECHYD A DIOGELWCH

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	08 September 2022
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Reducing Restrictive Practice Policy – for approval
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Mandy Rayani, Director of Nursing, Quality and Patient Experience
SWYDDOG ADRODD: **REPORTING OFFICER:**	Rachel Wood, Reducing Restrictive Practice Lead Tim Harrison, Head of Health, Safety and Security

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Health Board has not previously had an overarching policy on the use of restrictions in Healthcare settings. Whilst not statutory the Welsh Government (WG) Reducing Restrictive Practice Framework (RRP) 2021 conveys a weight of expectation on Health Boards to implement the principles, standards and structures it sets out. Aside from this, the Health board also has statutory responsibilities within the Mental Health Act and Mental Capacity Act, which determine how we practice when using restrictive interventions.

Cefndir / Background

Historically the Health Board have had a number of policies and procedures to address elements of restrictive practices within Health care settings.

This policy aims to set out and articulate Hywel Dda University Health Board's commitment to reducing restrictive practices and applying the least restrictive principles to all aspects of the Health Board's business and service delivery. This policy has been produced in accordance with the Department of Health Guidance - Positive and Proactive Care, Reducing the Need for Restrictive Practice (2014), the EHRC Human Rights Framework for Restraint (2019) and the Welsh Government Reducing Restrictive Practice Framework (2021). Least restrictive principles relate to applying as few limits as possible to a person's choices, personal rights and freedom while ensuring their support and care needs are being met.

With the current focus on reducing restrictive practices, it is timely that the health board outlines its commitment to reducing unnecessary restrictions for the people in our care.

Asesiad / Assessment

As a Health Board, we have participated in All Wales Expert reference groups, developed working relationships with Improvement Cymru key representatives and consulted on the WG Reducing Restrictive Practice Framework. We felt the need to develop a Health Board wide policy to provide an underpinning foundation from which to progress implementation of the guidance.

Acknowledging our obligations within the legal frameworks, the policy provides clear guidance to Health Board staff on the practical application and navigation of this complex arena.

Having undertaken a scoping exercise of what policies and procedures currently existed in this area, it was felt that an overarching policy that captured the principles of reducing restrictive practice was key. Hywel Dda UHB have already received recognition from Improvement Cymru for our approach towards reducing restrictive practices for the people we care for when using the principles set out in this policy.

Argymhelliad / Recommendation

The Health & Safety Committee is requested to approve Policy 843 – Reducing Restrictive Practice Policy.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	Provide assurance around the UHB arrangements for ensuring the health, safety, welfare and security of all patients and the workforce.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability 2. Safe Care 2.1 Managing Risk and Promoting Health and Safety
Nodau Gwella Ansawdd: Quality Improvement Goal(s):	No Avoidable Deaths Protect Patients From Avoidable Harm From Care Focus on What Matters to Patients, Service Users, Their Families and Carers, and Our Staff
Amcanion Strategol y BIP: UHB Strategic Objectives	3. Growing older well.
Amcanion Cynllunio Planning Objectives	Not Applicable
Amcanion Llesiant BIP: UHB Well-being Objectives:	2. Develop a skilled and flexible workforce to meet the changing needs of the modern NHS

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Not applicable- in the main body of the report

Rhestr Termau: Glossary of Terms:	Contained within the body of the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Iechyd a Diogelwch: Parties / Committees consulted prior to Health and Safety Committee:	Consent and Mental Capacity Deprivation of Liberty team Mental Health and Learning Disabilities directorate Nutrition and Hydration Group- appendix 5

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Not applicable.
Ansawdd / Gofal Claf: Quality / Patient Care:	Improvement in quality of patient care
Gweithlu: Workforce:	Improvement in knowledge, skills and confidence of the workforce on matters around restrictive practices
Risg: Risk:	Identifying and managing risk of restrictive interventions and the needs of our patients. Reducing risk to staff, patients and visitors
Cyfreithiol: Legal:	Identification of legal frameworks for use of restrictive practices. Improvement in awareness of the legal processes around applying restrictions
Enw Da: Reputational:	Positive impact- Health board acknowledgement of their requirement to recognise and reduce unnecessary restrictions in healthcare.
Gyfrinachedd: Privacy:	Not applicable.
Cydraddoldeb: Equality:	Has EqIA screening been undertaken? Yes

Hywel Dda University Health Board
Equality Impact Assessment (EqIA)

Please note:

Equality Impact Assessments (EqIA) are used to support the scrutiny process of procedures / proposals / projects by identifying the impacts of key areas of action before any final decisions or recommendations are made.

It is recognised that certain proposals or decisions will require a wider consideration of potential impacts, particularly those relating to service change or potential major investment. For large scale projects and strategic decisions please consult the Health Board's Equality and Health Impact Assessment Guidance Document and associated forms.

The completed Equality Impact Assessment (EqIA) must be:

- Included as an appendix with the cover report when the strategy, policy, plan, procedure and/or service change is submitted for approval.
- Published on the UHB intranet and internet pages as part of the consultation (if applicable) and once agreed.

For in-house advice and assistance with Assessing for Impact, please contact:-

Email: Inclusion.hdd@wales.nhs.uk
Tel: 01554 899055

Form 1: Overview

1.	**What are you equality impact assessing?**	Reducing Restrictive Practice Policy- how it will impact staff and patient populations within Hywel Dda UHB.
2.	**Brief Aims and Description**	This policy aims to set out and articulate Hywel Dda University Health Board's commitment to reducing restrictive practices and applying the least restrictive principles to all aspects of the Health Board's business and service delivery.
3.	**Who is involved in undertaking this EqIA?**	Reducing Restrictive Practice Team
4.	**Is the Policy related to other policies/areas of work?**	285 – Violence and Aggression Policy (*PDF, 756Kb*) 609 – Seclusion Policy 894 - 'Putting Things Right' Management and Resolution of Concerns Policy (Incidents, Complaints and Claims) (*PDF, 860Kb*) 177 – Engagement and Observation Procedure 654 – Management of Acutely Disturbed Adults & Older People Guideline 163 - Deprivation of Liberty Safeguards Policy 811 - Mental Capacity Act Practice Guideline 340 – Staff Psychological Well-being Policy (*PDF, 1.2Mb*) 203 - All Wales Capability Policy (*PDF, 375Kb*) 158 - Redeployment Policy (*PDF, 261Kb*) 767 - New and Expectant Mothers/Birthing Parents Procedure.
5.	**Who will be affected by the strategy / policy / plan / procedure / service?** (Consider staff as well as the population that the project / change may affect to different degrees)	This policy applies to all staff and clinical services involved with all patient groups in all areas covered by Hywel Dda University Health Board.
6.	**What might help/hinder the success of the Policy?**	Executive leadership and support will influence culture and reduce any resistance from the workforce. Staff not being aware that the policy applies to them may hinder the implementation.

Form 2: Human Rights

Human Rights: The Human Rights Act contains 15 Articles (or rights), all of which NHS organisations have a duty to act compatibly with and to respect, protect and fulfil. The 6 rights that are particularly relevant to healthcare are listed below.

Depending on the Policy you are considering, you may find the examples below helpful in relation to the Articles.

Consider, is the Policy relevant to:	Yes	No
Article 2 : The right to life **Example**: The protection and promotion of the safety and welfare of patients and staff; issues of patient restraint and control	✓	
Article 3 : The right not be tortured or treated in an inhuman or degrading way **Example**: Issues of dignity and privacy; the protection and promotion of the safety and welfare of patients and staff; the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travellers; Issues of patient restraint and control	✓	
Article 5 : The right to liberty **Example**: Issues of patient choice, control, empowerment and independence; issues of patient restraint and control	✓	
Article 6 : The right to a fair trial **Example**: issues of patient choice, control, empowerment and independence	✓	
Article 8 : The right to respect for private and family life, home and correspondence; Issues of patient restraint and control **Example**: Issues of dignity and privacy; the protection and promotion of the safety and welfare of patients and staff; the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travellers; the right of a patient or employee to enjoy their family and/or private life	✓	
Article 11 : The right to freedom of thought, conscience and religion **Example**: The protection and promotion of the safety and welfare of patients and staff; the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travellers	✓	

How will the strategy, policy, plan, procedure and/or service impact on:-	Positive	Negative	No impact	Potential positive and / or negative impacts Please include unintended consequences, opportunities or gaps. This section should also include evidence to support your view e.g. staff or population data.	Opportunities for improvement / mitigation If not complete by the time the project / decision/ strategy / policy or plan goes live, these should also been included within the action plan.
Age Is it likely to affect older and younger people in different ways or affect one age group and not another?	✓	✓		It is possible that as the workforce ages they may have age related health problems that could affect their ability to fulfil practical restrictive practice training requirements. Inability to complete the range of practical interventions may negatively impact their ability to fulfil their role, this could result in redeployment. Positive on the patient population. For any restrictive interventions age is taken into account and any plans factor in the person's age and how this may impact their presentation or the use of restrictive interventions. For examples, there are different types of physical restraint used for young people and older adults.	
Disability Those with a physical disability, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes	✓	✓		Positive impact for patient population as person centred plans take disabilities into consideration and reasonable adjustments are made wherever possible. Positive impact for staff with disabilities as a risk assessment and subsequent action can be taken to ensure the member of staff or others are not left at risk. Negative impact for staff who have disabilities that may impact their ability to fulfil the practical elements of their role.	

Gender Reassignment Consider the potential impact on individuals who either: •Have undergone, intend to undergo or are currently undergoing gender reassignment. •Do not intend to undergo medical treatment but wish to live in a different gender from their gender at birth.			✓	The patient's preferences with regards to gender should be taken into account as far as practicable. This does not have an impact upon gender reassignment but does honour the person's choice as to who supports them in a crisis situation. This may not always be possible but is taken into account. The policy outlines the importance of upholding a person's Human Rights and not discriminating against any person. It outlines the protected characteristics under the Equality Act 2010.	
Marriage and Civil Partnership This also covers those who are not married or in a civil partnership.			✓	The policy outlines the importance of upholding a person's Human Rights and not discriminating against any person. It outlines the protected characteristics under the Equality Act 2010.	

Form 3 Gathering of Evidence and Assessment of Potential Impact

Pregnancy and Maternity Maternity covers the period of 26 weeks after having a baby, whether or not they are on Maternity Leave.	✓			Special consideration by way of risk assessment is undertaken for pregnant staff and patient populations. The policy sets out considerations for the use of RPI with pregnant patients. Pregnant staff will have a risk assessment undertaken by their line manager and either have their role adapted or redeployment considered dependent on area of work.	
Race/Ethnicity or Nationality People of a different race, nationality, colour, culture or ethnic origin including non-English / Welsh speakers, gypsies/travellers, asylum seekers and migrant workers.	✓			Positive impact as the policy requires staff to take race/ethnicity or nationality into account. For example, if a patient required information presented in a specific language then this should be accommodated at the nearest opportunity. The policy outlines the importance of upholding a person's Human Rights and not discriminating against any person. It outlines the protected characteristics under the Equality Act 2010.	Staff are aware of how to access Health Board Approved translation services if required.
Religion or Belief (or non-belief) The term 'religion' includes a religious or philosophical belief.			✓	The policy outlines the importance of upholding a person's Human Rights and not discriminating against any person. It outlines the protected characteristics under the Equality Act 2010.	Staff are able to utilise Health Board libraries in order to update their knowledge around different religions or cultures if required. Cultural Awareness training can be provided for staff.
Sex Consider whether those affected are mostly male or female and where it applies to both equally does it affect one differently to the other?			✓	The policy outlines the importance of upholding a person's Human Rights and not discriminating against any person. It outlines the protected characteristics under the Equality Act 2010.	Pronoun usage within quotes taken directly from Mental Health Act legislation are beyond our control but we acknowledge their bias.
Sexual Orientation Whether a person's sexual attraction is towards their own			✓	The policy outlines the importance of upholding a person's Human Rights and not discriminating	

sex, the opposite sex or to both sexes.				against any person. It outlines the protected characteristics under the Equality Act 2010.	
Socio-economic Deprivation Consider those on low income, economically inactive, unemployed or unable to work due to ill-health. Also consider people living in areas known to exhibit poor economic and/or health indicators and individuals who are unable to access services and facilities. Food / fuel poverty and personal or household debt should also be considered. For a comprehensive guide to the Socio Economic Duty in Wales and supporting resource please see: https://gov.wales/more-equal-wales-socio-economic-duty			✓	A person's Socio-economic status has no bearing in the application of this policy.	
Welsh Language Please note opportunities for persons to use the Welsh language and treating the Welsh language no less favourably than the English language.	✓			The policy outlines that patient's should be able to communicate in Welsh. People using HDdUHB services should be engaged in all aspects of care and support planning. This should include identification of any trigger factors and early warning signs of behavioural disturbance and how staff should respond to them. ***Any individual cultural, spiritual and communication needs should be taken into account when facilitating this engagement including where applicable and practicable, meeting any language preference needs the patient may have.***	Person centred behaviour support plans and post incident forms need to be translated into Welsh.

Form 4: Examine the Information Gathered So Far

1.	**Do you have adequate information to make a fully informed decision on any potential impact?**	Yes
2.	**Should you proceed with the Policy whilst the EqIA is ongoing?**	Yes
3.	**Does the information collected relate to all protected characteristics?**	Yes
4.	**What additional information (if any) is required?**	None
5.	**How are you going to collect the additional information needed? State which representative bodies you will be liaising with in order to achieve this (if applicable).**	N/A

Form 5: Assessment of Scale of Impact

This section requires you to assign a score to the evidence gathered and potential impact identified above. Once this score has been assigned the Decision column will assist in identifying the areas of highest risk, which will allow appropriate prioritisation of any mitigating action required.

Protected Characteristic	Evidence: Existing Information to suggest some groups affected. (See Scoring Chart A below)	Potential Impact: Nature, profile, scale, cost, numbers affected, significance. Insert one overall score (See Scoring Chart B below)	Decision: Multiply 'evidence' score by 'potential impact' score. (See Scoring Chart C below)
Age	3 3	-3 +3	-9 H (staff) +9 P (patients)
Disability	3	-3	-9 H
Sex	1	0	0
Gender Reassignment	1	0	0
Human Rights	3	+3	+9 P
Marriage and Civil Partnership	1	0	0
Pregnancy and Maternity	3	-1	-3 M
Race/Ethnicity or Nationality	1	0	0
Religion or Belief	1	0	0
Sexual Orientation	1	0	0
Socio-economic Deprivation	1	0	0
Welsh Language	3	+3	+9 P

Scoring Chart A: Evidence Available	
3	Existing data/research
2	Anecdotal/awareness data only
1	No evidence or suggestion

Scoring Chart B: Potential Impact	
-3	High negative
-2	Medium negative
-1	Low negative
0	No impact
+1	Low positive
+2	Medium positive
+3	High positive

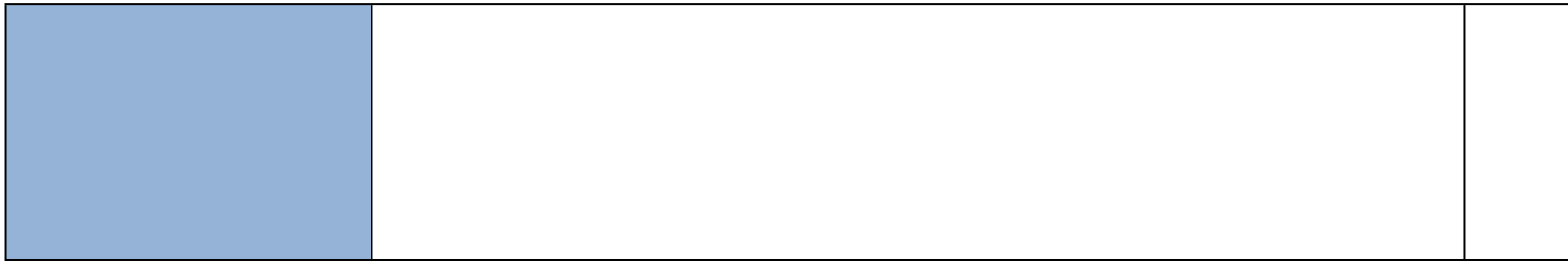
Scoring Chart C: Impact	
-6 to -9	High Impact (H)
-3 to -5	Medium Impact (M)
-1 to -2	Low Impact (L)
0	No Impact (N)
1 to 9	Positive Impact (P)

Form 6 Outcome

You are advised to use the template below to detail the outcome and any actions that are planned following the completion of EqIA. You should include any remedial changes that have been made to reduce or eliminate the effects of potential or actual negative impact, as well as any arrangements to collect data or undertake further research.

Will the Policy be adopted?	**Yes**	
If No please give reasons and any alternative action(s) agreed.		
Have any changes been made to the policy/ plan / proposal / project as a result of conducting this EqIA?	**YES Staff Pregnancy Risk Assessment Arrangements are now set out in the Policy & Welsh Language translation or support is clearly referenced in the policy**	

What monitoring data will be collected around the impact of the plan / policy / procedure once adopted? How will this be collected?	**Routine and targeted incident data relating to restrictive practice is collected continuously by scrutinising Datix electronic incident recording system.**	
When will the monitoring data be analysed? Who will be responsible for the analysis and subsequent update of the impact assessment as appropriate?	**The Reducing Restrictive Practice Team Lead will analyse and report on the data quarterly for the Quality & Safety Committee. Rachel Wood, RRP Lead Trainer will review and update the impact assessment should the data review suggest this necessary.**	
Where positive impact has been identified for one or more groups please explain how this will be maximised?	**The policy aims to promote and uphold patients' human rights and therefore the organisation prioritises this and actively pursues this value to ensure adherence.**	
Where the potential for negative impact on one of more group has been identified please explain what mitigating action has been planned to address this. **If negative impact cannot be mitigated and it is proposed that HDUHB move forward with the plan / project / proposal regardless, please provide suitable justification.**	**It is difficult to mitigate for the staff's physical health and/or disability which may result in their redeployment on capability grounds through not be able to fulfil their role and the responsibilities within it. Each staff member that experiences this will be fully supported by Occupational Health, Psychological Wellbeing Department and Human Resources to reach a satisfactory conclusion or solution.**	



Form 7 Action Plan

Actions (required to address any potential negative impact identified or any gaps in data)	**Assigned to**	**Target Review Date**	**Completion Date**	**Comments / Update**

EqIA Completed by:	**Name**	**Rachel Wood**
	Title	**Reducing Restrictive Lead Trainer**
	Team / Division	**Reducing Restrictive Practice Team**
	Contact details	**Rachel.Wood3@wales.nhs.uk**
	Date	**26.01.22**
EqIA Authorised by:	**Name**	**Tim Harrison**
	Title	**Head of Health & Safety**
	Team / Division	**Health, Safety &Security**
	Contact details	**Tim.Harrison@wales.nhs.uk**
	Date	**26.01.22**

Reducing Restrictive Practice Policy

THIS IS A DRAFT DOCUMENT FOR CONSULTATION PURPOSES ONLY
All comments on this document should be sent to the author by the consultation end date, using the comment form on the policy consultation pages.
Approved Hywel Dda HDdUHB policies can be found on the Policies and Procedures Approved section of the intranet

Policy Number:	843	Classification			Corporate/clinical
Supersedes					
LOCSSIP reference:		NATSSIPS Standards	List standard (NATSSIPS Standards)		

Version No	Date of EqIA:	Approved by:	Date of Approval:	Date made Active:	Review Date:
V1		Clinical Written Control Documentation Group			3 years

Brief Summary of Document:	This policy aims to set out and articulate Hywel Dda University Health Board's commitment to reducing restrictive practices and applying the least restrictive principles to all aspects of the Health Board's business and service delivery.
Scope:	This policy applies to all staff and clinical services involved with all patient groups in all areas covered by Hywel Dda University Health Board.
To be read in conjunction with	285 Violence and Aggression Policy (PDF, 756Kb) 609 Seclusion & Segregation Procedure 749 HDUHB Lockdown policy. 894 'Putting Things Right' Management and Resolution of Concerns Policy (Incidents, Complaints and Claims) (PDF, 860Kb) 177 – Engagement and Observation Procedure 654 – Management of Acutely Disturbed Adults & Older People Guideline 163 - Deprivation of Liberty Safeguards Policy 811 - Mental Capacity Act Practice Guideline 340 – Staff Psychological Well-being Policy (PDF, 1.2Mb) 203 - All Wales Capability Policy (PDF, 375Kb)

	158 - Redeployment Policy (PDF, 261Kb) 767 - New and Expectant Mothers/Birthing Parents Procedure.
Patient information:	Patient Information Library

Owning Committee	Task and finish group Health and Safety Committee

Executive Director:	Mandy Rayani	Job Title	Director of Nursing, Quality & Patient Experience

Reviews and updates		
Version no:	Summary of Amendments:	Date Approved:
1	New Policy	

Glossary of terms

Term	**Definition**
HDdUHB	Hywel Dda University Health Board
TNA	Training Needs Analysis
NIC	Nurse in Charge
MHA	Mental Health Act
MCA	Mental Capacity Act
DoLS	Deprivation of Liberty Safeguards
NEWS	National Early Warning Score
PAMOVA	Prevention & Management of Violence and Aggression
PBM (ABMU)	Positive Behaviour Management (ABMU)
RRPT	Reducing Restrictive Practice Team

Keywords	Restrictive Practice, Restrictive Physical Intervention, Behaviours that Challenge, Restraint

CONTENTS

Contents

1. Introduction

This policy aims to set out and articulate Hywel Dda University Health Board's commitment to reducing restrictive practices and applying the least restrictive principles to all aspects of the Health Board's business and service delivery. This policy has been produced in accordance with the Department of Health Guidance - Positive and Proactive Care, Reducing the Need for Restrictive Practice (2014), the EHRC Human Rights Framework for Restraint (2019) and the Welsh Government Reducing Restrictive Practice Framework (2021). Least restrictive principles relate to applying as few limits as possible to a person's choices, personal rights and freedom while ensuring their support and care needs are being met.

'Restrictive practices are a wide range of activities that stop individuals from doing things that they want to do or encourages them to do things that they don't want to do.
They can be very obvious or very subtle.' (Care Council for Wales, 2016)

This term covers a wide range of activities that restrict people. It includes:

- Physical restraint
- Chemical restraint
- Environmental restraint
- Mechanical restraint
- Seclusion or enforced isolation
- Long term segregation
- Coercion

Welsh Government: Reducing Restrictive Practice Framework (2021)

This policy will guide and demonstrate a clear position to staff to ensure that Hywel Dda University Health Board and its workforce provide compassionate, trauma-informed and recovery focused individual care to the people who use our services in the safest and least restrictive manner.

2. Policy Statement

In line with Local and National Guidance and aspirations of cultural change, Hywel Dda University Health Board is committed to reducing restrictive practices. The Health board will apply the least restrictive principles to all aspects of business and service delivery. It will uphold human rights and strive for the highest possible standards of care for those requiring and using our services.

3. Scope

This policy applies to all staff and clinical services involved with all patient groups in all areas covered by Hywel Dda University Health Board.

4. Aims

The policy sets out the expectations of Hywel Dda University Health Board with regard to the use of restrictive practices and interventions and describes the legal framework within which these practices and interventions must take place. HDdUHB is committed to reducing the need for restrictive interventions and this policy aims to promote the development of therapeutic environments in order to minimise all forms of restrictive interventions and where of absolute necessity, to provide for their safe application.

Under section 6 of the Human Rights Act (1998), HDdUHB has a responsibility to uphold and promote the human rights of both its staff and people using Health Board services. Similarly, under Health and Safety at work legislation and associated guidelines, it has statutory responsibilities to protect staff and people using HDdUHB services alike from harm.

HDdUHB will involve Experts by Experience in developing services and in working to reduce restrictive practice. People who use our services will be involved in all aspects of their clinical care and have individualised processes and plans to support them at times of crisis that are co-produced, collaborative, clearly documented and recorded for the service-user and staff team.

All existing and new developments and innovation in clinical care, service delivery and organisational transformation will be consistent with the commitment to reducing restrictions and promoting recovery based and person-centred care.

HDdUHB has in its care, people whose needs and histories mean that individuals can reasonably be predicted to present with behaviours that challenge. In order to maintain the safety and wellbeing of the people using HDdUHB services at all times, staff must ensure that those people whose history, needs or current clinical presentation are predictive of behaviours that may lead to the use of restrictive interventions are identified on the basis of dynamic risk assessments. Care and support should be provided with the aim of reducing the likelihood of such behaviours in the first place. This policy will explain the process for supporting patient groups who may display behaviours that challenge.

Appropriate training for staff is provided in the use of restrictive practices and the principles of least restriction to ensure the workforce have the knowledge, skills and competencies to prevent and manage conflict in a safe and collaborative manner. The focus of the training will be on non-restrictive approaches, person-centred therapeutic interactions, recovery and social inclusion.

Our wards and where appropriate, community teams will ensure they provide care that is based on the needs of the people who use services. All policies, rules, practices and procedures that are restrictive to personal freedoms and choices require a rationale in place to justify their use.

HDdUHB, will collect and report data to its relevant governance structure on the use of any restrictive practice.

5. Objectives

HDdUHB is committed to delivering care in accordance with the 6 Key Restraint Reduction Strategies:

- **Leadership** in organisational culture change.
- **Using data** to inform practice.
- **Workforce** development.
- **Inclusion** of families and peers.
- **Specific reduction** interventions (using risk assessment, trauma assessment, implementation of primary strategies, secondary interventions and crisis planning).
- **Rigorous** debriefing and post incident reviews.

(Huckshorn 2004)

Individuals who may be subject to restrictive practices should be given clear information about the range of restrictive approaches approved and authorised within the service, the circumstances which govern their use and with whom to raise concerns if there is any conflict over how these measures are implemented.

Any restrictive interventions that are used will be and only be, used as a last resort where non-restrictive alternatives cannot be used or have failed.

All interventions should be proportionate, reasonable and necessary. They should be the least restrictive option for the circumstance and used for the shortest possible time.

The use of restrictive interventions will be assessed and planned to meet the specific needs of the individual. They should take account of the individual's history, physical, psychosocial needs and preferences in order to minimise distress, trauma or risk of harm.

No individuals in receipt of HDdUHB care will be subjected to the use of any restrictive practice that could be considered degrading or abusive.

Restrictive practices will not be used as a consequence to enforce rules, to punish or coerce, or as a substitute for a lack of resources.

Staff performance regarding outcomes relating to restraint, medication led restraint, seclusion and segregation and supportive observations are robustly monitored and will form the basis for learning and development across the clinical divisions.

6. Procedures

6.1 Definitions

Restrictive Practice is something which stops a person from doing what they want to do, or encourages them to do things that they don't want to do. This does not have to include the use of force.

Prevention and Management of Violence and Aggression (PAMOVA) is a multi-component model to reduce the use of restrictive interventions in the care and support of people with mental health problems. This includes, pro-active prevention theory, self-protective and tiered restrictive physical intervention training with an ethos of restrictive practice reduction.

Positive Behaviour Management (PBM ABMU) is a multi-component action plan to reduce the use of restrictive interventions in the care and support of people with learning disabilities. This includes, pro-active prevention theory, self-protective and restrictive physical intervention training with an ethos of restrictive practice reduction.

The All Wales Violence and Aggression Passport is a standardised, layered approach to meeting the training needs of all Health Board staff consisting of:

Module A - Induction and awareness raising
Module B - Theory of personal safety and de-escalation
Module C - Breakaway
Module D - Restrictive physical intervention (RPI) techniques

In Mental Health Services, the standards for Module D are met via the PAMOVA approach and in Learning Disability Services, they are met via Positive Behaviour Management (PBM ABMU).
The Health Board also offers provision of training for staff who support Older Adults who may be subjected to restrictive practices.

Restrictive Interventions are deliberate acts on the part of other person(s) that restrict a patient'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
- Or reduce significantly, the danger to the patient or others.

(Positive and Proactive Care DoH) (2014)

It is never lawful to use restraint to humiliate, degrade or punish people.

These principles are applicable to all in the receipt of HDdUHB services, whether in hospital settings or community, young or old, regardless of clinical presentation.

Breakaway techniques constitute a set of physical skills used to disengage or break away from an aggressor in a proportionate manner. They do not involve the use of restraint but can be restrictive and do include emergency responses that may be required for either escape or rescue.

Physical Restraint refers to any direct physical contact where the intention is to prevent, restrict, or subdue movement of the body (or part of the body) of another person.

(Mental Health Act Code of Practice 2016 26.69)

Mechanical Restraint is the use of a device to prevent, restrict or subdue movement of a person's body or part of the body for the purposes of behavioural control.

(Mental Health Act Code of Practice 2016)

Clinical Holding involves holding a part or parts of the body while a necessary procedure or treatment is undertaken.

Psycho-Social Restraints are the deliberate use of any negative actions and/or language to control or to deprive a person of lifestyle choices and are prohibited.

(RRN Training Standards 2020)

Use of technological surveillance such as tagging, pressure pads, closed circuit television, or door alarms are often used to alert staff that the person is trying to leave or monitor their movement.

(RRN Training Standards 2020)

Rapid tranquillisation refers to the use of medication to calm or lightly sedate an individual to reduce the risk of harm to self or others and to reduce agitation and aggression.

(Mental Health Act Code of Practice 2016 26.91)

Seclusion, Longer-Term Seclusion, the use of Extra Care Areas (ECA) and Long-Term Segregation broadly refer to the supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving, where it is of immediate necessity for the purpose of the containment of severe behavioural disturbance which is likely to cause harm to others.

(Mental Health Act Code of Practice 2016 26.103)

- For the definition of each of the following terms: Seclusion, Longer-Term Seclusion, the use of Extra Care Areas (ECA) and Long-Term Segregation please see the HDhUHB Seclusion and Long-Term Segregation procedure.

- Seclusion and segregation may only be used in accordance with the HDdUHB procedure for Seclusion & Long-Term Segregation as this describes the legal framework within which these restrictive interventions may be used and establishes important safeguards by which to protect the well-being and human rights of the people using HDdUHB services.

Planned restrictive interventions are procedures which have been devised as a result of a risk assessment, have been pre-agreed (where possible with the individual's agreement) as being essential for their care and have been recorded in their person-centred support plan.

Unplanned restrictive interventions are used in response to unforeseen circumstances to prevent harm to the individual or others.

Prohibited Interventions: Patients should not be deliberately restrained in a way that impacts their airway, breathing or circulation. The mouth and/or nose should never be covered and there should be no pressure applied to the neck region, chest, rib cage, abdomen or back. **Prone restraint is only used in exceptional circumstances and where is it essential to maintain the safety of the patient and others.**

(Mental Health Act Code of Practice 2016 26.70)

6.2 Restrictive Intervention Reduction Programmes

Restrictive intervention reduction programmes are overarching, multi-component action plans which aim to reduce the use of restrictive interventions. They should demonstrate organisational commitment to restrictive intervention reduction at a senior level. The use of data relating to restrictive interventions will inform service developments, continuing professional development for staff and how models of service that are known to be effective in reducing restrictive interventions are embedded into care pathways, how people using HDdUHB services are engaged in service planning and evaluation and how lessons are learned following the use of restrictive interventions. They should ensure accountability for continual improvements in service quality through the delivery of positive and proactive care. They should also include improvement goals and identify who is responsible for progressing the different parts of the plan. A key indicator that a plan is being delivered well will be a reduction in the use of restrictive

interventions. Other indicators include reduction of injuries as a result of restrictive interventions, improved patient satisfaction and reduced complaints.

It is the expectation that all HDdUHB staff will pro-actively work to reduce the use of restrictive practices.

Key restrictive intervention reduction approaches include the use of the 6 Key Restraint Reduction Strategies (Huckshorn 2004), Positive Behavioural Support and/or Person-Centred Support Plans. Any progress will be shared across services through shared learning events.

Primary Prevention Strategies

These aim to reduce behavioural disturbance by ensuring that people's needs are fully and appropriately assessed, well understood, formulated and met. It will be recognised that people are central to their own recovery plans; that risks are recognised and mitigated; and that care and support minimises the potential for conflict.

Assessment and the management of risk is key to minimising the use of all forms of restrictive interventions. They are essential elements of the care and treatment provided to people using HDdUHB services and are an integral component of the Wales Mental Health Measure. Accordingly, it is essential that on admission / referral, a risk assessment is carried out and a risk management plan is put into place. This should be undertaken in collaboration with the person using health services and their carer / family wherever possible.

Risk assessments and risk management plans must be regularly reviewed with people using HDdUHB services and their carers whenever possible. Plans should record known triggers for risk behaviours based on current observations, previous history and discussion with the person and their carers / families. Changes in levels of risk should be recorded, communicated and risk management plans revised accordingly.

Assessments of behavioural presentation are important in understanding an individual's needs. These should take account of the individual's social and physical environment and the broader context against which behavioural disturbance occurs. There may be times where an individual feels angry for reasons not associated with their mental disorder and this may be expressed as behavioural disturbance. Assessments should seek to understand behaviour in its broader context and not presume it to be a manifestation of a mental disorder.

Staff should wherever possible, proactively support people using HDdUHB services to make advance decisions or advance statements about the use of restrictive interventions.

The approach to risk assessment must be multi-disciplinary and reflect the care setting in which it is undertaken. Any risk factors relating to a person using HDdUHB services must be communicated appropriately across care settings.

The physical and therapeutic environment within which services are delivered can have a strong mitigating effect on the levels of agitation, frustration and boredom that can be experienced by people using HDdUHB services.

Subject to any individually required security measures, care environments must make provision for people using HDdUHB services to have predictable and routine access to preferred items and a range of appropriate occupational, social and recreational activities (including evening and weekend activities), taking into account people's abilities, level of functioning and the resources

available. Care environments should also be organised to provide for different needs, for example, quiet rooms, recreation rooms and access to open spaces and fresh air.

People using HDdUHB services should be engaged in all aspects of care and support planning. This should include identification of any trigger factors and early warning signs of behavioural disturbance and how staff should respond to them. Any individual cultural, spiritual and communication needs should be taken into account when facilitating this engagement including where applicable and practicable, meeting any language preference needs the person may have.

Meetings to discuss an individual's care must occur in a format, location and at a time of day that promotes engagement of people using HDdUHB services, families, carers and advocates.

All staff must demonstrate a positive attitude when communicating with people using HDdUHB services. Staff must never use language that could be construed as supporting negative stereotypes. This would include verbal or non-verbal responses that could be interpreted as carrying aggressive, threatening, sarcastic or disrespectful intent and this would also include the use of microaggressions.

Individualised, person-centred support plans or care plans must take account of each person's unique circumstances, their background (including any trauma history), priorities, aspirations and preferences. Care plans should be formatted in a manner that renders them accessible and understandable for those who will implement them. Care plan summaries in a suitably accessible format, should be available to people using HDdUHB services and their families.

Secondary Preventative Strategies

These aim to guide and inform the actions of staff, in response to a person beginning to show signs of agitation and / or emotional arousal that may indicate an impending behavioural disturbance and risk behaviour.

De-escalation strategies refers to 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.

An individualised account of bespoke de-escalation strategies should be contained within the person's Person-Centred Support Plan or Positive Behaviour Support Plan. This should be prepared with them and in consultation with families / carers. This element of the care plan should be regularly reviewed and forms an essential component of the risk management plan.

There may be occasions where enhanced observation may temporarily act either as a primary or secondary preventative strategy and this should always be undertaken in line with the HDdUHB's Engagement and Observation Policy. A careful judgement will be required however, as for some individuals; increasing observation may escalate the risks. The key consideration is that enhanced observation is about support and engagement, rather than mere observation.

Tertiary Reactive Strategies

Whilst the overarching aim is always to reduce the need for the use of restrictive interventions, it is recognised that there may be times when a person's behaviour places themselves or others at imminent risk of significant harm and that where de-escalation strategies have not been enough to prevent a crisis, a restrictive intervention may be necessary as a proportionate and reasonable response to the risk posed.

There are non-restrictive interventions that could be an approach response to crisis e.g., evasion, these should always be considered as the least restrictive option if it is possible to maintain the safety of the person and others.

Where risk assessments identify that restrictive interventions could potentially be needed, their implementation should so far as possible, be planned in advance and recorded as **tertiary reactive strategies** within the care / risk management plan. Here, the choice of restrictive intervention will be informed by the preference of the people using HDdUHB services; any particular risks associated with their general health (e.g., musculoskeletal problems, or poor cardiovascular health); any known trauma history; and an appraisal of the immediate environment. Staff must always ensure that they utilise the least restrictive option for the least amount of time required to ensure safety of the person and others. The type of restriction/s should also be recorded along with any preferences of the person. For any planned restrictive intervention identification of the legal framework and justification for use of the intervention must be documented and regularly reviewed.

6.3 Consent and Capacity

Consent is the principle that a person must give permission before they receive any type of medical care, treatment, test or examination. This must be carried out on the basis of an explanation by a clinician. Consent from a patient is needed regardless of the procedure.

For consent to be valid, it must be voluntary and informed, and the person consenting must have the capacity to make the decision. These terms are explained below:

Voluntary – the decision to either consent or not to consent to treatment must be made by the person them self and must not be influenced by pressure from medical staff, friends or family.

Informed – the patient must be given all of the information in terms of what the treatment involves, including the benefits and risks, whether there are reasonable alternative treatments and any consequences if treatment does not go ahead.

Capacity – the patient must be capable of giving consent, which means they understand the information given to them, they can consider and weigh up that information (are aware of the pros and cons of the decision being discussed) and they can retain and use that understanding to make an informed decision.

Any unauthorised or unjustified use of restrictive interventions could be considered legally, to be trespass or assault and it is therefore imperative that all practice is carefully considered and justified. Under certain circumstances, it may be necessary to provide treatment to an individual against their expressed wishes. Further guidance regarding this is available in the Mental Health Act Code of Practice and/or the Mental Capacity Code of Practice.

6.4 Use of Restrictive Interventions

In this policy, the use of the term **Restrictive Interventions** refers to all restrictive practice including restraint and breakaway techniques. **De-escalation Interventions** are referred to separately.

Restrictive interventions must only be used as a last resort and when all other measures have been unsuccessful and the situation is deteriorating. Consideration must be given to the overall context of care; therefore, staff must take into account the detrimental effect the use of Restrictive Interventions may have to all involved individuals.

In exceptional circumstances, a Restrictive Intervention may form part of a Person-Centred Support Plan, Care Plan or Positive Behaviour Support plan that has been agreed by the multidisciplinary team.

The most common reasons for needing to consider the use of restrictive interventions are:

- Physical assault
- Dangerously destructive behaviour
- Non-compliance with lawful treatment
- Likely or actual self-harm
- Sexually inappropriate behaviour
- Absconding or risk of absconding
- Extreme and prolonged over-activity that is likely to lead to physical exhaustion

(Mental Health Act Code of Practice 2016)

Any restraint used should:

- Be reasonable, justifiable and proportionate to the risk posed by the patient
- Apply the minimum, justifiable level of restriction or force necessary to prevent harm to the patient or others
- Be used for only as long as is absolutely necessary
- Be carried out in a way that demonstrates respect for the patient's gender and cultural sensitivities.

(Mental Health Act Code of Practice 2016)

Where a restrictive intervention has been deemed necessary in a person's care plan. The team must ensure that any methods aimed at reducing and eliminating behaviours that challenge should take account of the:

- Patient's preference, if known
- Patient's needs

- Patient's physical condition
- Environment of care
- Staff's duty to protect all those under their care.

(Mental Health Act Code of Practice 2016)

6.5 Clinical Holding Interventions

Clinical holding is concerned with the application of safe restrictive interventions in order to deliver essential care and treatment to people who are unable or unwilling to comply where there is an appropriate legal framework in place. Staff involved in the essential care and treatment must act in the best interests of the person in order to maintain the person's health, safety and welfare. The use of clinical holding should be proportionate to the aims of the procedure to be carried out.

It involves proactively holding a part or parts of the body to which a procedure is carried out such as an arm from which blood is being taken to prevent reflexive withdrawal. On other occasions, clinical holding may be necessary to restrict free movement that might otherwise interfere or prevent the safe and necessary implementation of care or treatment. For guidance specific to enteral tube feeding a patient under restraint please see appendix 5.

Clinical holding should only be considered where a risk assessment accompanied by a Clinical Holding assessment determines that a person's care or treatment cannot be carried out effectively and/ or safely due to the behaviour that is predicted to occur. Clinical holding should be clearly recorded in a patient's digital care record. The intervention may require an incident report please see **appendix 2** for guidance on reporting incidents. Where it is used as a one off in order to facilitate a medical procedure in an emergency, an incident report must be completed and the need for any future intervention should be subsequently reviewed by the appropriate Clinician e.g., Responsible Clinician.

Where clinical holding is necessary as part of a routine care plan, its use should be expressly indicated along with the legal justification for its application. Such care plans should be subject to regular review by the multi-disciplinary team. All clinical holding interventions must be recorded on the patient's digital care record. Not all care planned interventions will require incident reporting, however there will be circumstances where this is required, please refer to the reporting guide **appendix 2.**

Restrictive Physical Intervention techniques for Clinical Holding will not be taught routinely during Physical Intervention training but can be taught upon consultation with the Reducing Restrictive Practice Team. You will be asked by the team to complete a Training Needs Analysis so requirements and justification of use can be established. This is to ensure that staff are taught what they need to avoid a blanket approach to Physical Intervention training.

6.6 Physical Interventions and Pregnancy

Special provision should be made for pregnant patients in the event that a physical intervention has to be used. Physical interventions should be adapted to avoid possible harm to the unborn child. Best practice procedures should include:

- Proactive use of holding pregnant patients in a semi-recumbent position
- Staff awareness of the symptoms of Supine Hypotension syndrome how to respond
- Staff releasing holds if the patient moves to prone position

- Pregnant patients being medically assessed at the earliest opportunity after a physical intervention. The medical assessment should be recorded in the patient's digital care record.
- Pregnant patients involved in a physical intervention should be physically/ psychologically monitored during a restrictive intervention, immediately following the intervention and hourly post intervention for a period of 24 hours. Signs and symptoms to observe should be discussed with the multi-disciplinary team and where advised, the local midwifery services

Specific techniques to aid this process will not be taught routinely during physical intervention training,but will form part of a bespoke training package for services.

7. Basic Principles

There must be a legal framework governing the use of restraint that complies with the following principles:

1. The legal framework must include a legal power authorising the use of restraint:

a) in the individual's circumstances, and
b) for the intended purpose of the restraint.

The legal power to restrain may be contained in primary or secondary legislation, or derived from the common law.

(Equality and Human Rights Commission: Human Rights Framework for Restraint (2019))

Patients should not be deliberately restrained in a way that impacts their airway, breathing or circulation. The mouth and/or nose should never be covered and there should be no pressure to the neck region, rib cage and/or abdomen.

Full account should be taken of the individual's age, physical and emotional maturity, health status, cognitive functioning and any disability or sensory impairment, which may confer additional risks to the individual's health, safety and wellbeing in the face of exposure to physical restraint.

Throughout any period of physical restraint:

- A member of staff should be identified to lead the intervention but **all** staff involved should monitor the individual's airway and physical condition to minimise the potential of harm or injury (so monitoring is not reliant upon any one individual). Observations, including vital clinical indicators such as pulse, respiration and complexion (with special attention for pallor/discolouration), should be conducted and recorded. Staff should be trained so that they are competent to interpret these vital signs.

- If at any time, the nurse in charge believes the individual is showing signs of cardiovascular event or respiratory distress then staff should terminate the intervention and summon medical assistance immediately.

- Emergency resuscitation devices should be readily available in the area where restraint is taking place and someone trained in Immediate Life Support should always be available on the unit/ward or via a resuscitation team.

- A member of staff should take the lead in any care required for other patients, moving them away from the area of disturbance if necessary.

Where physical restraint has been used, staff should record the decision and the reasons for it, including details about how the intervention was implemented and the patient's response. Please see further guidance on this later in the policy (from 7.4).

Any individual subject to restraint should be medically assessed at the earliest opportunity. The nurse in charge should inform the relevant medical staff that a restraint has taken place, clearly indicating:

- How the person was held and how long for
- Whether their airway/breathing was restricted at any time
- The individual's pre-existing medical conditions
- The individual's medication (regular & as required)
- The results of physical health monitoring
- A recommendation as to whether medical staff should attend

Following any incident of restraint, staff should use the least intrusive level of observation necessary, balancing the safety, dignity and privacy with the need of the people using HDdUHB services to maintain the safety of those around them. See HDdUHB's Engagement and Observation Policy.

(NICE Guideline NG10)

7.1 Training

Training in relation to this policy is part of the core training requirements for HDdUHB staff. More information can be found in directorate training needs analyses and training plans. All staff identified to complete this training (including bank staff) should complete a relevant course and subsequent refresher course to update their skills and maintain compliance.

Restrictive Intervention training does not rely upon physical strength but managing movement safely by maximising the use of biomechanics. Therefore, the training is suitable for a wide range of staff in healthcare settings. Staff attending this training should expect that the fitness level and range of movement required is no more than required in a busy care environment.

Prior to each training event, staff are required to declare any injuries and any medical or physical exclusions they may have by completing a Physical Activity Readiness Questionnaire (PARQ) **appendix 4**. This should ascertain their appropriateness to attend a Physical Intervention training course. Individuals and/or line managers are to seek advice from their GP or Occupational Health Department if they have any concerns.

On the day of training, participants must also declare to the Trainers any injury, medical, physical or other condition, which may prevent them from participating fully in the training. These exclusions will be reported back to line managers.

Those staff that are not trained in Restrictive Physical Interventions (including those staff who are out of date for this training, have been referred or are awaiting training) should not be involved in planned restrictive interventions in the care environment. If an emergency and dangerous situation occurs, individual staff members are expected to assess the situation and exercise any

duty of care to ensure their own safety as well as the safety of the individual, others accessing care and the staff team.

New employees joining HDdUHB will complete training relevant to their work area and this will be determined by a Training Needs Analysis (TNA) of each work area. Appointing managers will be responsible for completing this and booking the relevant training.

Any member of staff using Restrictive Intervention techniques must be in-date with their relevant training for each type of intervention unless they have been afforded a grace period by the training team due to unforeseen circumstances. Staff should only implement Restrictive Physical Intervention Techniques that are taught to them by recognised HDdUHB Reducing Restrictive Practice Trainers and any deviation from these techniques necessitated should be recorded on the electronic incident and care record with a justification for why this was done.

All staff employed in inpatient settings must complete NEWS – (National Early Warning Score) physical health monitoring training within two weeks of commencing employment. This is to ensure they are skilled in carrying out accurate physical health monitoring tasks for people using HDdUHB services in ward environments, who may be subject to restrictive interventions or for whom there may be concern over their physical health deterioration or status. This training should be organised through the HDdUHB Induction programme. Staff trained in RPI must also be trained and annually updated in ILS (for inpatient ward areas).

7.2 Inpatient Ward Requirements

Inpatient services are required to provide safe, high-quality care which requires all rostered staff who work within these services to be physically able and appropriately trained to undertake TNA identified Restrictive Physical Interventions in line with this policy.
It is up to ward managers to establish whether the practical element of the training is a requirement for their inpatient setting. This can be established through completion of a TNA for their area.

If, due to ill health or injury, a member of staff is temporarily unable to undertake some or all aspects of Restrictive Physical Interventions (RPI) in line with policy requirements, or if a member of staff does not successfully complete all aspects of the Restrictive Physical Interventions Training course, the ward manager is required to make a prompt occupational health referral to seek advice and establish how long this is likely to last. The ward manager must also complete a risk assessment to evaluate if the staff member can safely remain an active member of ward staff. The overall safety of the ward environment is paramount. Any inability to complete or take part in restrictive intervention or complete the full restrictive Interventions training such as Physical Restraint or Breakaway training should be an interim position and reviewed frequently and circumstantially. If risk assessment identifies that it is unsafe for the member of staff to actively remain on the ward, temporary re-deployment may apply.

If the injury or illness is likely to result in a member of staff becoming long term or physically or emotionally unable to complete all aspects of the RPI Training, they will be unable to remain as a rostered inpatient member of staff. This is due to the risks posed to themselves, patients and other members of staff.

In these circumstances, the following process must be followed:

- Where a member of staff is temporarily unable to complete RPI training, a formal risk assessment to be completed giving consideration to any reasonable adjustments that could

be made to allow them to safely remain in the workplace and the potential risks posed to staff or patients on that ward.

- This risk assessment must be reviewed and authorised by the Ward Manager.

- If the risk assessment identifies that no reasonable adjustments can be made that would ensure it is safe for the employee to remain on the ward, or a member of staff is permanently unable to complete RPI then redeployment on medical grounds procedures may apply.

- If a member of staff is permanently unable to undertake RPI a risk assessment will also need to be completed to identify whether it is safe for them to remain on the ward as a non-rostered (supernumerary) member of staff whilst redeployment opportunities are explored.

If it is not possible to secure suitable alternative employment for the employee in line with the HDdUHB's Redeployment Policy (*PDF, 261Kb*) then consideration will be given to progressing the matter through the All Wales Capability Policy (*PDF, 375Kb*).

If an employee does not complete and successfully pass all aspects of the RPI Training for any other reason, the Ward Manager must complete a risk assessment to evaluate if the staff member can safely remain an active member of Ward Staff. The overall safety of the ward environment is paramount. The staff member will be given the opportunity to retake the course at the nearest practicable opportunity. If the employee remains unable to successfully complete the all required elements of the course again, consideration will be given to progressing that matter through HDdUHB's All Wales Capability Policy (*PDF, 375Kb*).

When assessing the risks for any pregnant staff, the line manager should follow the procedures set out in the New and Expectant Mothers/Birthing Parents Procedure.

7.3 Police Assistance

Staff should follow the process for safe management of a person displaying behaviours that challenge that may cause harm to self or others. This may include the attendance of suitably trained staff from the ward area, putting out a security call for assistance from the hospital porters (where applicable). Staff will need to familiarise themselves with the process for the area they are working in.

At no time will staff put themselves at risk if the individual is armed with a weapon or if the risk to staff and others is deemed too high for staff to safely manage the incident. The Police should be summoned immediately by dialling for the emergency services. All those within the area should keep a safe distance from the armed/violent aggressor and, where possible, lock the area off, please consider the use of HDUHB Lockdown policy.

The Nurse in Charge and/or the senior manager on site will brief the Police on their arrival. The Police must be given the relevant information on the incident and the risk and physical health history of the aggressor. This is to ensure that the intervention adopted is a proportionate and reasonable response. Following this handover, the Police will (working in conjunction with the staff from the hospital) assume control of the incident. The Police will make a judgement as to which intervention they will employ bearing in mind the safety and risks to all involved.

7.4 Reporting and Recording Of Incidents

The Doctor or On-Call Doctor must be informed of Restrictive Interventions that have resulted in injury, harm or use of seclusion, as soon as possible after the event. All incidents involving physical interventions must be recorded in accordance with HDdUHB policy. For specific guidance on the recording and reporting of the use of seclusion or long term segregation please see the HDUHB Seclusion and Segregation procedure (609).

A Datix must be completed in line with the PRRICE reporting guidance. **(See appendix 2)**

As a minimum standard the record should clearly indicate:

- What has the reason for use of the restrictive intervention
- What primary/secondary interventions were tried
- How the person was held / in what position?
- How long were they held?
- Who was holding them and which parts of the person's anatomy were held.
- Who was monitoring physical health during intervention
- What legal framework was applicable or what was the course of action taken if the person was informal? (i.e., review of legal status)
- Has a post incident debrief/questionnaire been completed

The statistics from these incident reports will be included on quarterly reports sent to teams and Directorate Governance Boards and the Quality, Safety & Experience Committee. The ward managers within Mental Health and Learning Disabilities also conduct thematic reviews of the use of restraint.

Digital Care Partner or equivalent electronic notes should also record the restrictive intervention. These will include:

- A medical review- clearly indicating the time that this was carried out and any decisions reached about management
- Review of risk assessments
- Review of relevant Care plans
- Justification for use of restrictive intervention
- Identification of legal framework or the need to review legal status
- How long the person was held
- In what position
- Who was involved
- Who led the intervention including monitoring of physical health
- Post incident debrief conducted with the patient and with the staff team involved or the reason why this has not taken place
- Any views of the person- if expressed or observed
- Whether family/carers/ Next of Kin have been informed
- Post incident review date scheduled
- Seclusion forms (if appropriate)
- Incident report number

7.5 De-brief and review following Interventions

Debrief

Following all incidents of restrictive intervention techniques, a debrief and review should take place at the earliest opportunity. All members of staff involved in the incident should attend.

(NICE Guideline NG10 – 1.4.55 – 1.4.61)

The aim of the 'debrief' is to ensure that all involved parties, including subjects of the incident, have appropriate support and that there is opportunity for organisational learning. The person should always be given the opportunity to complete a Restrictive Intervention Feedback Form (**Appendix 1**). Where applicable and practicable, every effort should be made to conduct the debrief in a language of the patient's choice.

A member of staff should endeavour to spend time on a one-to-one basis with the person and if they are willing, assist them to complete a Restrictive Intervention Feedback Form (**Appendix 1** when the timing is appropriate.

Where the subject of the incident is not able, or declines, to participate in a post-incident de-brief or complete a Restrictive Intervention Feedback Form, methods for assessing the effects of any intervention on their behaviour, emotions and clinical presentation should be fully explored and they should be closely monitored. Any observations should be recorded on a Restrictive Intervention Feedback form. If the subject of the incident is able and agrees to discuss the incident which led to the use of a restrictive intervention, their understanding and experience of the incident should be explored and recorded and plans updated accordingly.

In accordance with HDdUHB's 'Putting Things Right' framework, person's account of the incident and their feelings, anxieties or concerns following restrictive intervention **must** also be recorded in their notes. Patients should be reminded of their right to Advocacy support and that they can use advance statements to record future wishes and feelings about restrictive interventions, or indeed any other element of care that they would, or would not like to be used. Staff should take all reasonable steps to honour the person's wishes.

If any member of staff is injured or assaulted prior to or during an incident, a Datix incident form must be completed with 'perpetrator's' details clearly included. The form must be made available to the Senior Nurse/ Manager at the earliest opportunity in accordance with HDdUHB policies and Health and Safety at Work Act 1974. Staff should be reminded of and directed toward the facilities for staff support such as the Psychological Well-Being Service and the Violence and Aggression Case Manager.

People who use our services will be involved in all aspects of their clinical care and should have individualised processes and plans to support them at times of crisis that are co-produced, collaborative, clearly documented and recorded for the person's and staff team.

7.6 Physical Health Monitoring

Any individual subject to restrictive intervention must be physically monitored continuously during the intervention and periodically following restraint. This should be continued for as long as considered necessary by the clinical team, or for a period of 24 hours. This checklist includes**:**

During restrictive physical intervention

One staff member should lead throughout the use of manual restraint. This person should ensure that other staff members are:

- able to protect and support the service user's head and neck, if needed
- able to check that the service user's airway and breathing are not compromised
- able to monitor vital signs (Pallor, respiration and level of alertness/responsiveness)
- supported throughout the process.

*NICE NG10:*Violence and aggression: short-term management in mental health, health and community settings (2015)

Following restrictive physical Intervention

NICE NG10 (2015) advises that staff monitor the service user's physical and psychological health for as long as clinically necessary after using manual restraint.

If at any time physical health monitoring results breach NEWS escalation thresholds, then medical advice or assistance should be sought immediately.

If consent and co-operation for these observations is not forthcoming from the person subject to the intervention, then staff should monitor what can be observed and clearly document in the person's digital care record why certain checks could not be performed and what alternative actions had been taken.

In the event of, the restrictive physical intervention being necessitated for rapid tranquillisation then the monitoring should be in accordance with that outlined in HDdUHB's Management of Acutely Disturbed Adults & Older People Guideline (654)

8. Responsibilities

8.1The Chief Executive

The Chief Executive as overall and final responsibility for reducing restrictive practice within HDdUHB. The Chief Executive is also responsible for:

- Ensuring that this policy is implemented.
- Ensuring that the policy is reviewed every three years or when deemed appropriate by the board.
- Appointing an Executive Director to lead on reducing restrictive practice.
- The Chief Executive will be supported in the decision-making process in applying these responsibilities by a Senior Management Team.
- Ensuring values of the organisation promote the recognition of individual needs and rights.

8.2 The Director of Nursing, Quality & Patient Experience (Executive Lead)

- Advise the Health Board on matters of Reducing Restrictive Practice.
- Ensure that Reducing Restrictive Practice is appropriately considered at county, departmental and committee level with regular reports submitted.
- Ensuring that suitable and sufficient arrangements are in place to protect both staff and patients as far as reasonably practical from restrictive practice.
- Ensure effective monitoring arrangements are in place.
- Champion Reducing Restrictive Practice at Health Board level.

8.3 The Director of Workforce and Organisational Development
is responsible for:

- Ensuring that the Health Board and Partnership Forum are informed as required on restrictive practice matters.
- Ensuring that regular progress reports are presented to the Board and Partnership Forum
- Supporting mandatory training and the continuous development of staff.
- Ensuring that clear Reducing Restrictive Practice responsibilities are included in job descriptions, training programmes and induction procedures.
- Ensuring that Reducing Restrictive Practice information, procedures and action plans are communicated effectively throughout HDdUHB.
- Ensuring that appropriate risk assessments and control measures are co-ordinated throughout the Health Board area.
- Ensuring that there is effective support for staff through the Occupational Health Service.
- Ensuring that manager's annual performance appraisal includes their effectiveness in Reducing Restrictive Practice.

8.4 Senior Managers
(including departmental and line managers) have responsibility for:

- Ensuring effective arrangements are in place for the co-ordination of risk,
- Ensuring health and safety arrangements are in place and effective.
- Ensuring organisational arrangements, policies and procedures and compliance with legislation and guidelines regarding restrictive practices are followed.
- Ensuring that they have knowledge of the range and extent of restrictive practices that are used within the organisation.
- For the development and implementation of this policy and the WG RRP Framework (2021) within their directorate.
- Ensuring safe systems of work are adopted.
- Monitor staff compliance with training.
- Organisations should recognise that workplace stress can have an adverse impact on the quality of practice. Appropriate measures to support the wellbeing of the workforce should be in place.
- That the monitoring and review of individual personal plans includes consideration of planned restrictive practices and reduction guidelines. Particular attention should be paid to the language that is used to describe individuals and incidents; it should be objective, accurate and respectful.
- Ensure that incident reports are investigated.
- Model excellent communication and practice regarding the reduction of restrictive practices.

8.5 Service / Line Managers and/or Heads of Department
have overall responsibility for making sure that arrangements are in place:

- To access specialist advice by liaising with the relevant Violence and Aggression Case / Security Manager, RRP Trainer or the Head of Health, Safety & Security.
- To ensure that individuals are aware of their responsibilities for health and safety in relation to restrictive interventions.
- For the development and implementation of this policy and the WG RRP Framework (2021) within their Service/Department
- For identifying hazards and carrying out appropriate risk assessments in line with current legislation including the risk assessment and risk register procedure.

- To consult and involve staff and safety representatives to identify issues and develop appropriate working practices and control measures.
- For staff to have relevant information about the risks they face and preventative measures.
- To prepare and implement safe systems of work.
- Service managers should ensure that there are regular audits and reviews of restrictions within their services
- To ensure the right level of expertise exists and for individuals to be properly trained on recruitment **and** when they may be exposed to increased or new risks due to changes in responsibility, the environment or working practices.
- To complete an annual training needs analysis ensuring that training is pertinent and repeated at suitable intervals. This may need to be reviewed sooner if risk indicates.
- To ensure as far as reasonably practicable that sufficient information, training, instruction and supervision is in place to protect the health safety and welfare of staff within the Service / Department.
- To organise the distribution of HDdUHB instructions and guidance to staff with the Service / Locality / Department.
- To ensure that those individuals who may display behaviours that challenge are identified so that appropriate holistic therapeutic input is made available to them
- Managers should be watchful for signs of restrictive cultures developing. They should facilitate regular discussion about restrictive practices and create a non-blaming environment where practice can be discussed and questioned
- Supervision and team meetings should include restrictive practices as a standing agenda item to allow for the identification of any issues, to ensure practitioners are clear on the organisational position on reducing restrictive practices and to identify any learning and/or support needs.

8.6 The Reducing Restrictive Practice Team

- Provide needs based training to HDdUHB staff. This training will comply with the All Wales Violence & Aggression Passport scheme ensuring that adequate and appropriate training is provided in consultation with managers, the Learning and Development Department and the Health, Safety & Security Department.
- Provide consultation on complex case management and the use of restrictive interventions in such situations.
- Maintain a Service Level Agreement (SLA) between HDdUHB and Swansea Bay University Health Board (SBUHB) that facilitates the training of PBM (ABMU) for HDdUHB staff working with people in Learning Disabilities Services.
- Assist in co-ordinating the provision of advice and monitor implementation of policies related to restrictive practice, risk assessments and safe working practices.
- Produce quarterly audits of Restrictive Interventions, including the use of seclusion in the MHLD Directorate.
- Facilitate debrief/review of any critical incidents involving the use of restrictive interventions.
- Provide support to patients subject to high levels of restrictive interventions within HDdUHB.
- Provide accredited competence-based training. Practitioners should receive training in prevention approaches and de-escalation before they receive training in the use of restrictive practices. Measures should be in place to ensure any new starters have timely access to training.
- Ensure the training should also cover the trauma that can be experienced both by people who are subject to restrictive practices and those who carry out restrictive practices. Any

training should also include perspectives from people who have lived experience of being subject to restrictive practices.

8.7 The Occupational Health Department / Staff Psychological Well Being Service

- Ensure that, where referral to Occupational Health is necessary, access is expedited. The recommendations of the Occupational Health team must be delivered swiftly and monitored.
- Ensure that victims are offered access to appropriate psychological intervention quickly and effectively.
- Ensure that confidential and independent counselling services are available.

8.8 Individual Employees

- Have a moral and statutory duty of care, both for their own personal safety and that of others who may be affected by their acts or omissions.
- Are required to co-operate with their manager/supervisor to enable HDdUHB to meet its legal duties and obligations.
- Are expected, in the course of their employment, to report to their Manager/Supervisor any hazardous situations or defective equipment.
- Where issued with personal protective equipment or personal safety equipment employees will ensure that they have adequate training to use the equipment correctly.
- Where locally accepted safety practices exist such as the use of personal safety alarms or call bells, it is the duty of the individual to adhere to those practices to assist in the personal safety.
- Must report incidents via the incident reporting system as soon as practicable where increased risks are evident to any other persons.
- To ensure that those individuals who may display behaviours that challenge are identified so that appropriate holistic therapeutic input is made available to them

9. References

NG10 Nice Guideline (2015) Violence and Aggression: *Short-term management in mental health and community settings. NG10*

NG11 Nice Guideline (2015) Challenging Behaviour and Learning Disabilities: *Prevention and Interventions for people with learning disabilities whose behaviour challenges.* NG11

Welsh Government (2016) Mental Health Act Code of Practice for Wales

Department of Health and Social Care (2007) Mental Capacity Act Code of Practice

Restraint Reduction Network Training Standards (2021)

All Wales Violence & Aggression Training Passport & Information Scheme

Department of Health (2014) - *Positive & Proactive Care: Reducing the Need for Restrictive Practice*

European Human Rights Commission (2019) - *Human Rights Framework for Restraint*

Welsh Government (2021) - *Reducing Restrictive Practice Framework*

Human Rights Act (1998)

Deprivation of Liberty Safeguards (2016)

Huckshorn, K A (2004) – *Reducing Seclusion & Restraint Use in Mental Health Settings: Core Strategies for Prevention*

NEWS2 – *(National Early Warning Score)*

10. Appendix 1 - Reducing Physical Intervention Feedback Form

Online form available here.

Reducing Physical Intervention Feedback Form

This form has been created for anyone in Hywel Dda UHB to complete if they have experienced physical restraint whilst in hospital.

The information you provide will go to the Reducing Restrictive Practice Team, this team train Health Board staff in ensuring that restraint is always a last resort and always done safely, in a way that does not cause pain.

The information may also be shared with ward staff where there are opportunities for learning. If any concerns are raised then safeguarding procedures will be followed.

If you recently experienced a restrictive physical intervention (physical restraint) please read the following.

Restrictive physical intervention is a way of holding someone safely. Staff will not do this unless it is absolutely necessary.

To ensure we continue to offer the highest standards of care, we would value your comments on how you feel about your experience.

DO YOU WISH TO COMMENT? YES ☐ NO ☐

If yes, please feel free to answer the following questions. A member of staff can support you with this form if you wish.

Name: **Incident Date:**

1. Please use this space to describe in your words what happened

2. How are you feeling now about what happened?

3. Could anything have been done differently?

4. Do you think there was any aspect that was positive?

5. What can we do together to possibly prevent this happening again?

6. Would you like to discuss your experience with any of the following; (Please tick)

A member of ward staff	☐
Ward Management	☐
Independent Mental Health Advocacy Service	☐
The Reducing Restrictive Practice Trainers	☐

SIGNATURE: **WARD:** **DATE:**

If you need assistance to complete this form you may wish to ask an advocate or member of the ward staff.
Thank you for your comments, please return this form in the enclosed envelope.

Rachel Wood / Caroline Heath / Jodelle Jones / Ben Smith
Reducing Restrictive Practice Trainers
Reducing Restrictive Practice/PAMOVA Department
Hafan Derwen

11. Appendix 2 PRRICE - Physical Restraint Reporting Guide

Clinical Indicators		Clinical Examples (A)	Clinical Examples (B)
Immediate risk present. Positions of increased risk used (e.g. prone position). Extreme resistance or dangerous behaviour present. First time event. Injuries sustained. Weapons involved. Property damaged. Patient has medical complications which may be affected by intervention. External agencies involved. Incident is not care-planned or extends beyond confines of care-plan. Rapid tranquilisation administered.	**Complete DATIX & Record in Clinical Notes**	A patient is angry after having their medication changed. A nurse spends time with them and tries to explain the reasons and offer reassurance. The patient suddenly attempts to punch the nurse in the face and they activate their alarm. A team of nurses arrive at the scene and intervene by restraining the patient's arms and supporting their head. The patient struggles violently and is trying to kick staff. The restraint team transfer the patient to the floor in the supine position and administer rapid tranquilisation by briefly rolling them on their side. The patient eventually settles and agrees to go to their room accompanied by staff. There is a care plan in place and a nurse was injured during the incident.	A patient with a history of targeting vulnerable patients moves very quickly towards another patient with their arms stretched out in an attempt to assault. Two staff members intervene to prevent injury by using a standing escort technique to move them to another room where the patient quickly settles. The restraint lasts approximately a minute. The other patient is visibly distressed and requires support and reassurance from staff. Whilst engaging with the patient, a red mark is noted on the left side of their face although it is unclear whether this was caused during the incident.
Unidentified risk is immediate or likely. Patient uncooperative and resistive to intervention. Rapid tranquilisation administered. Total duration of restraint(s) exceeds 10 minutes. First time restraint used within context of care-plan. Incident unforeseen and not care-planned.		A detained patient attempts to abscond and staff are concerned for their safety. The incident was unforeseen and there was no care plan in place for such behaviour. Nurses intervene and restrain the patient by the arms and support their head. They continue to struggle and they are moved to a chair where they are restrained in the sitting position. The patient accepts oral medication and begins to calm – holds are released.	A patient is being supported by staff to access the community – whilst walking along the pavement the patient sees a family member and impulsively attempts to run across the busy road to greet the family member, putting themselves and others at risk due to the oncoming traffic. As the patient is stepping off the kerb a member of staff pulls them back from the road by taking hold of their arm. Staff considered there to be an immediate risk and the event was unforeseen.
Clinical judgement may be needed – if in doubt, report!			
Some resistance offered – stops if intervention stops. No positions of increased risk used. Care-planned event which is foreseeable. Not the first time restraint used within context of care-plan. Intervention may have a minor impact on vital signs e.g. raised pulse. Amenable to vital signs being taken. No injuries occurred.	**Record in Clinical Notes**	A non-ambulant patient is incontinent of faeces. Nurses follow the care plan and encourage the patient to allow the nurses to clean them. The patient refuses and concerned about the possibility of infection developing, staff decide to intervene. Whilst care is being given, it is necessary to hold the patient's arms to prevent them from scratching staff. Once care has been given the patient begins to calm down and the holds are released.	A patient who uses a wheelchair becomes agitated in response to the sound of a fire alarm sounding. They proceed to clench both fists and staff are concerned that they will start hitting themselves as has previously been the case. As part of the individual's care plan, the application of a helmet has been endorsed by a multidisciplinary team as a best interest intervention and two members of staff proceed to hold the patient's arms whilst a third puts the helmet on – staff then disengage and withdraw within 30 seconds.

Patient cooperates or offers little or no resistance. Resistance stops if intervention stops. Guiding gestures or arm holds only used. Risk not immediate but could increase without intervention. Intervention used for minimal duration. No injuries occurred. Intervention would have no impact on vital signs.	**Only record if judged necessary**	A confused patient is headed in the direction of a wet floor surface – two nurses intervene and take hold of the patient's arms in order to turn them away from the risk. The patient resists slightly but cooperates once nurses explain that the floor is slippery and they are worried they may fall. Holds are released and the patient heads away from the hazard.	A patient with mobility problems needs to be move from their bed to a chair safely. Due to the known risk of the patient falling, two members of staff stand either side of them and support their arms whilst they walk them to the chair with the cooperation of the patient.

12. Appendix 3 Person Centred Support Plan

These are the early signs that my behaviour is escalating	These are the behaviours that other people may find challenging or risky
Slow Triggers for my behaviour (These are the events that build up slowly and may affect my behaviour over time) **Fast Triggers for my behaviour (These are the events that may immediately affect my behaviour)**	
What do I believe is the function for the behaviour?	
Primary Prevention: What can reduce the risk of challenging behaviour ?(prevent triggers from occurring)	
Secondary Prevention: What can be done to reduce the impact of triggers?	

Crisis Management: How to support me in a crisis

13. Appendix 4 Physical Activity Readiness Questionnaire (PAR-Q)

Online form available here.

This form must be completed and returned to the Reducing Restrictive Practice Team prior to the commencement of any physical training activities.
If you have any doubts about your fitness to participate in the physical activities you should seek qualified medical advice.

In Strictest Confidence

1. Have you ever been told that you have problems with your heart? Yes/No

If yes please give details……
……
……

2. Have you ever had pain in your chest? Yes/No

If yes please give details……
……
……

3. Have you ever experienced feeling faint or dizziness? Yes/No

If yes please give details……
……
……

4. Have you been told that you have high blood pressure? Yes/No

5. Do you have any bone/joint problems or arthritis that is aggravated by exercise? Yes/No

If yes please give details……
……
……

6. Have you been to hospital for admission or treatment in the last 3 years? Yes/No

If yes please give details……
……
……

7. Are you currently taking medication? Yes/No

If yes please give details……
……
……

8. Do you have asthma or any other breathing problems? Yes/No

If yes please give details……
……
……

9. Do you have diabetes or epilepsy? Yes/No

If yes please give details……
……
……

10. Are you pregnant or have you recently been pregnant? Yes/No

If yes please give details……
……
……

11. Do you have any allergies? Yes/No

If yes please give details……
……
……

12. Is there any other reason that you are aware of that would prevent you from completing Physical Intervention Training? Yes/No

If yes please give details……
……
……

If you have answered Yes to any of the above then please ensure you speak to an RRP Trainer prior to attending the training.
By signing this form you agree that the information you have provided above it accurate and that you will inform the trainer of any changes.

Name …….. (Please Print)
Signature ……
Date …….

To be completed by RRPT
Fit to participate in Physical Intervention based on the information provide above:
Yes/No/Further assessment required
Action plan from RRP Trainer:
……
……
……
……
……
……
……
……
……
……
Discussed with Participant:
Discussed with Line Manager:

Senior Trainer Name:
Signature of Senior Trainer:

14. Appendix 5- Enteral Tube Feeding a Patient Under Restraint Procedure

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Enteral Tube Feeding a Patient Under Restraint Procedure

THIS IS A DRAFT DOCUMENT FOR CONSULTATION PURPOSES ONLY
All comments on this document should be sent to the author by the consultation end date, using the comment form on the policy consultation pages.
Approved Hywel Dda University Health Board policies can be found on the Policies and Procedures Approved section of the intranet

Procedure Number:	Issued following approval	Supersedes:	List document Numbers	Classification	Select Clinical/ Corporate/Employment
LOCCSIP Reference:		NATSSIP standard:	List standard (NATSSIPS Standards)		

Version No:	Date of EqIA:	Approved by:	Date Approved:	Date made active:	Review Date:
1					

Brief Summary of Document:	Decisions about feeding under restraint are not easy or straightforward. Restraint is defined as 'An act carried out with the purpose of restricting an individual's movement, liberty and/or freedom to act independently' (Welsh Government, 2016a). This procedure sets out the process to follow if a patient *under the care of the adult mental health team* is being considered for enteral tube feeding under restraint.
Scope	The procedure is to inform the care of adult and paediatric patients under mental health services who are detained under the Mental Health Act 1983 and are being considered for enteral tube feeding under restraint due to them suffering from Mental Illness (MI) including an Eating Disorder (ED) preventing them from eating.

To be read in conjunction with:	• Mental Health Act (1983) • Mental Capacity Act Practice Guideline • Human Rights Act 1998 • Policy 008: Consent to Examination and Treatment Policy • Policy 331: Enteral Feeding Policy for Adults including Operational Guideline • Policy 209: Adult Refeeding Guideline • The National Institute of Clinical Excellence (NICE) Eating Disorders Recognition and Treatment guidance (NG69) • Marsipan Guidelines 2014 • NICE CG32: Nutrition support for adults: oral nutrition support, enteral tube feeding and parenteral nutrition, 2017
Patient information:	Include links to Patient Information Library

Owning committee/ group	

Reviews and updates		
Version no:	Summary of Amendments:	Date Approved:
1	New Procedure	

Glossary of terms

Term	Definition
NG	Nasogastric
ED	Eating Disorder
MI	Mental Illness
HCP	Health Care Professional
MHA	Mental Health Act
MCA	Mental Capacity Act
NICE	National Institute of Clinical Excellence
RRN	Restraint Reduction Network
WCD	Working Control Document
MDT	Multi-Disciplinary Team

Keywords	Nasogastric tube Mental Health Act Enteral feeding/nutrition Restraint Refeeding Safeholding

CONTENTS

1. Introduction

Restraint is a deprivation or restriction of personal liberty or freedom of movement. It can be referred to using many different terms, some may include; “safe-holding, safe-handling, clinical-holding, manual intervention, physical intervention, RPI, PBM, PAMOVA.” to name a few. The definition of restraint "An act carried out with the purpose of restricting an individual’s movement, liberty and/or freedom to act independently” (Welsh Government 2016a). Restraint of any kind is used only when the patient's behaviour presents a danger to them self or another person. It is never used for the convenience of staff or as a substitute for conscientious nursing care.

The procedure aims to inform Health Care Professionals (HCP) working in adult mental health, specialist child and adolescent mental health (SpCAMHS), and acute hospital inpatient settings. It will outline the process to follow in a situation when the use of enteral tube feeding under restraint is being considered for a patient who is detained under a relevant section of the Mental Health Act 1983 (MHA). The food/fluid refusal must be intrinsically linked to the mental illness, this may include but is not limited to an eating disorder.

Food and fluid refusal and the resultant starvation (malnutrition) and/ or dehydration as a result of serious mental illness is potentially life threatening risk to a patient’s physical and mental well-being and can lead to serious harm or death.

When a patient is refusing oral nutrition and hydration every effort should be made to encourage and support oral intake whether via food and / or fluids, and careful monitoring of both food and fluid intake and nutritional status is essential to support an accurate assessment, timely intervention and appropriate treatment planning. Patients, and as appropriate their parents / guardians, should be informed of the clinical risks associated with poor food and fluid intake as part of the process.

Enteral feeding under restraint is an invasive intervention that should only be considered as a last resort and subsequent to encouraging voluntary enteral nutrition. Restraint should only be considered when the MDT assessment considers that the risks to a patient’s physical and mental health as a result of prolonged starvation and/ or dehydration are significant and greater than the risks associated with the placement and use of a feeding tube under restraint.

The re-establishment of nutrition and or hydration following a period of starvation requires careful planning and monitoring to avoid both refeeding syndrome and under feeding syndrome.

This procedure is required to inform Health Care Professionals (working as a team, referred to as 'the team') of the process to follow when considering feeding an inpatient under restraint, identifies the legal framework that must be adhered to, considerations to ensure the process is undertaken as safely as possible and reviewed. This is recognised as part of inpatient treatment in NG69.

2. Procedure Statement

This procedure provides the Health Board with a clear governance framework to operate within when providing care for patients under section who refuse either food or fluids in a mental health unit or acute inpatient setting.

3. Scope

- The procedure informs the care of adult and paediatric inpatients detained under the MHA in mental health or acute inpatient settings Health Board wide
- It is intended for use by Health Care Professionals: psychiatrists, medical teams, nursing including clinical nurse specialists in nutrition, dietitians and reducing restrictive practice practitioners.
- The procedure informs the care of adult and paediatric patients who are detained under the MHA where feeding under restraint is being considered

4. Aim

- This procedure aims to inform all Health Care professionals involved in the care of an individual who may require NG feeding with restraint.
- It aims to provide information and the necessary tools to ensure robust decision making and that health and safety and risk management arrangements are in place.
- It aims to improve the effectiveness of the processes involved when feeding under restraint needs to take place.

5. Objectives

- To provide a prompt and effective response when a patient's physical health is compromised by fluid and/or food refusal.
- To take account of the legal and medical factors in deciding whether or not to provide nutrition or rehydrate patients against their will and the legal and ethical issues for staff justifying the use of restraint.
- To provide practical advice on caring for patients in these circumstances.
- To address fluid refusal (see fluid refusal flowchart) and food refusal (see food refusal flowchart) separately. Fluid refusal for more than 24 hours becomes a medical emergency whereas food refusal only may be tolerated for some weeks - the procedure for fluid refusal should be followed when a patient is assessed as being clinically compromised secondary to dehydration.

- To highlight the dangers arising from re-feeding syndrome when re-introducing food to patients who have not eaten for 7-10 days with evidence of stress and depletion and direct the team to safely managing refeeding risk.
- To recognise the need to identify and implement the least restrictive intervention to provide the person with the care they require.
- To consider the steps required post incident to address the physical and psychological wellbeing of the person.

6. Detention under the Mental Health Act (MHA) 1983

Restraint and compulsory treatment can only be applied under the MHA (1983) for a physical disorder (rather than a mental disorder) in very specific situations where the physical condition is inextricably linked with the mental disorder.

The MHA allows for detention in order to assess or treat a person for a psychiatric condition where admission is considered necessary in the interests of the person's health and safety or for the protection of others and where the person concerned does not consent to admission.

7. Legal, ethical and professional issues - when to Act and if Action is Appropriate - Guidelines for Responsible Clinician

7a. In terms of the decision as to whether one has the right to intervene against a patient's will, there is no real difference between the refusal of food and the refusal of fluids so they will be addressed together in this section.

7b. throughout, two overarching principles apply, namely the doctor's (responsible clinician) obligation to respect the sanctity of human life and the autonomy which a patient has over their personal choices (provided the patient has capacity for the particular choice being made).

7c. However, if the patient is detained under the MHA they cede a range of autonomies that may include the autonomy to refuse food or fluid.

7d. as stated in the Guidelines Statement above, the Health Board has both a statutory and a common law duty to care for the wellbeing of its patients and act according to their best interests. Consequently, the Responsible Clinician (RC) or the Approved Clinician in charge of the treatment may decide that it is appropriate to intervene and ensure that the patient is nourished.

8. Mental Health Act Sections

8a. where patients are detained under the MHA, intervention against their will may be authorised under section 63 of that Act. This section states: The consent of a patient shall not be required for any medical treatment given to him for the mental disorder from which he is suffering, if the treatment is given by or under the direction of the Approved Clinician in charge of treatment (Note, however, that this ONLY applies to treatments that do NOT require authorisation under sections 57, 58, 58A or 62 of the Act).

8b. Medical treatment is very broadly defined in the following terms in Section 145 of the MHA. Medical treatment includes nursing, psychological intervention and specialist mental health rehabilitation and care the purpose of which is to alleviate, or prevent a worsening of, the disorder or one or more of its symptoms or manifestations.

8c. the courts have given a wide interpretation to the type of medical treatment that can be given under Section 63 of the Act to patients with a Mental Disorder. The case of B -v- Croydon Health Authority established that feeding could, in certain circumstances, be seen as a type of medical treatment under Section 63, on the basis that relieving symptoms of a Mental Disorder was as much a part of the treatment as relieving the underlying cause of the Mental Disorder. If, therefore, the food refusal is seen as a symptom of the Mental Disorder, then the RC may authorise the feeding of the patient against their will under Section 63 without having regard to the patient's capacity.

8d. Similarly, if food/fluid refusal prevents necessary treatment of a mental disorder (even though it may not be a symptom of that mental disorder) then, again, this may be prescribed and administered under Section 63 of the MHA.

8e. NOTE: Part IV of the MHA in which Section 63 falls, does NOT apply to patients detained under Sections 5(2), 5(4), 4, 35, 135, 136, (place of safety directions), or to conditionally discharged patients not recalled to hospital.

8f. if a patient detained under Section 3 refuses food/fluid there should be plenty of time to review their Section. If the fluid refusal is a symptom of the patient's Mental Disorder then Section 62 would give similar powers to the RC, in this circumstance, as described for Section 63 above.

9. Responsibilities

9.1. Chief Executive

As Accountable Officer, the Chief Executive has overall responsibility for ensuring the Health Board complies with the policy and provides services that are safe, evidenced-based and sustainable.

9.2. Nominated Director

The Nominated Director is responsible for ensuring there is a robust and clear governance framework provided to inform staff and for ensuring mechanisms are in place to assure of compliance with this procedure.

9.3. Senior Management

Senior management are responsible for:

- Ensuring that the procedure is followed by staff within their area of responsibility.
- Ensuring all staff have access to the procedure and associated WCDs.
- Ensuring that all the procedure is cascaded appropriately within their area of responsibility and that training needs are identified and addressed.

9.4. Department/Service/Ward Management

Department/Service/Ward Managers, through their line/supervisory structure, are responsible for:-

- Ensuring that the procedure is adhered to by staff within their area of responsibility
- Ensuring there is a robust documentation control system in place locally to ensure the procedure is readily available and accessible to staff and that staff are working to the most up to date version.
- Ensuring their staff are competent to implement the procedure.
- Ensuring adequate and appropriately skilled staffing to safely undertake the procedure.

9.5 Psychiatrist and Medical Consultant (the RC may depend on the location of the patient), b Both a Psychiatrist and a Physician should be involved with the MDT care of a patient being considered for feeding under restraint.

The Responsible Consultant (RC) is responsible, working in conjunction with other members of the healthcare team, for the early identification of patients refusing food and/or fluid intake and ensuring a prompt referral to specialist mental health Dietetic team.

The RC is responsible for convening an MDT and leading the MDT decision making process in relation to consideration of NG feeding and the use of restraint and for ensuring the relevant risk assessments are completed and appropriate monitoring review undertaken.
It is the responsibility of the RC following discussion with the patient and if appropriate, their care coordinator, and MDT to ensure that the rationale for the decision made is clearly documented.

9.6 Dietitian

The dietitian must be involved in the care of a patient refusing food and fluid from the onset and is responsible for undertaking a nutrition assessment and to work collaboratively with the MDT to ensure all practical efforts are made to persuade and negotiate food and fluid intake with the patient. The dietitian is responsible for advising the MDT on a suitable enteral feeding plan to meet the needs of the patient considering both refeeding syndrome, underfeeding, patient tolerance and the practical use of restraint whilst NG feeding. The dietitian is responsible for referring the patient to the CNS Nutrition nurse for assessment and consultation in relation to enteral tube management.
The dietitian is responsible for clearly documenting the nutrition and hydration plan to inform the patient's overall care plan.

9.7 Clinical Nurse Specialist (CNS) Nutrition

The role of the CNS Nutrition nurse is to provide expert advice and guidance to staff who are managing patients who require an NG feeding tube. In the case of NG feeding under restraint it is the responsibility of the CNS Nutrition to support the team to safely plan placement of the NG tube which, for adult patients, may involve the CNS Nutrition placing the tube, and training other staff to safely undertake the procedure. Only a registered nurse or doctor competent to place NG tubes and who has undergone training in relation to placement under restraint should place an NG tube in a patient under restraint.

9.10 Reducing Restrictive Practice Team (RRPT).

The Reducing Restrictive Practice team will need to be involved in discussions with ward staff on safe holding/restraint techniques required to place the NG tube and to administer fluids and / or the NG feed where practicable. All safe holding/restraint techniques will be clearly documented in the patient's support plan. There may be times where bespoke techniques will be required due to medical/physiological need or the patient's preferences. These will be devised and signed off by the RRPT. The RRPT may in some circumstances meet with patient to support person centred care planning and development of a bespoke intervention plan. The RRPT may also be required to support training of staff teams. There may be circumstances where due to the level of risk involved the RRPT may provide direct clinical support with an intervention, this will require discussion with a senior member of the RRPT.

9.11 Pharmacy

If required medications administered via the NG tube should be in a suitable formulation and prescription charts should be written to reflect this. Further advice is available in the Adult Enteral Feeding Policy and Guidelines, and when necessary, further advice should be sought from a pharmacist before administering medication via a feeding tube.

9.12 All Staff

All Staff involved with the care of a patient where feeding under restraint is being considered or undertaken are responsible for:-

- Complying with the procedure
- Ensuring their practice is in line with the procedure, pertinent to their area of work and that they are trained and competent to undertake their part in the procedure
- Identifying barriers to compliance with the procedure for example in relation to training needs, competence, equipment, and report this through the appropriate structure
- Identifying any changes in practice, guidance or legislation
- Identify and report any concerns with regards to practice through appropriate channels as appropriate e.g. All Wales Safeguarding processes or HDUHB Raising Concerns & Whistleblowing process.

10. Considerations for the use of Restrictive Physical Interventions

The patient will have an individual care and treatment plan and a risk assessment will be undertaken prior to the commencement of any NG feeding with restraint. Where possible this will be developed in collaboration with the patient and if appropriate, carers. In an emergency situation this may involve a dynamic risk assessment by the RC with the team responsible for carrying out the intervention.

Where NG under restraint is taking place the ward area should inform the RRPT at the nearest opportunity.

The appropriately trained personnel to support each episode of feeding under restraint will be identified as part of the plan. If the patient is in a general ward and requires safe holding, the mental health team will support identification of suitably trained staff.

In the event that there is a particular ward undertaking frequent safe holding, training may be sought for the ward team from the RRPT.

Specific measures needed:

- There must be risk assessments on the types of restrictive interventions/physical restraint techniques authorised in recognition of under-developed anatomy/physiology and psychological/emotional abilities to cope with such experiences
- Physical health monitoring in restraint in line with training. Minimum requirement; respiratory rate/function, pallor, signs of cyanosis, level of alertness/responsiveness. Dependent on risk the person may require more invasive monitoring (e.g. use of Sp02 device)
- The availability of resuscitation equipment and ILS trained staff to respond in the event of a medical emergency
- Procedures need to account for the space, time and understanding required to justify and support prolonged restraint due to the natural delivery time of NG feed
- Consideration must always be given to the least restrictive option i.e., bolus feeds rather an infusion devices
- Additional staff may be required in order to safely manage an incident involving treatment resistance
- Physical adjuncts may be required to maintain safety and reduce prolonged restraint. These would need to be discussed and agreed with RRPT.
- Items used in the management of NG feed restraint may be required, such as cushions, appropriate seating or sofa, these would need to be detailed in the person-centred support plan. Any use of an item to restrict a person would need to be discussed and agreed with RRPT.

- Support structures should be in place in order to help staff manage their emotions, anxieties and trauma related concerns when dealing with individuals in psychological and emotional distress that they may experience when involved in NG feeding. (RRN Training Standards 2019)
- NG feeding under restraint must be carried out in line with other HDUHB policies and procedures relating to restraint.

11. Training and Support

It is important that health care staff involved in implementing this procedure have the necessary skills, competence and support to deliver safe, high quality care and work within their respective professional codes of conduct. All healthcare staff who are directly involved in inpatient care will have the appropriate skills and competencies needed to ensure that the person's nutritional and hydration needs are safely met. This should include:

- PAMOVA/PBM (ABMU) Training
- Mental Capacity Act: mandatory training
- Documentation of food and fluid charts: e-learning
- Nutritional screening
- Skills to Care- physical health monitoring

Following restraint staff involved should be offered debrief and be able to access support as required.

12. Refeeding Syndrome and underfeeding syndrome

Inappropriate feeding after a period of starvation can lead to serious complications including death. Refer to the NICE 2006 Guidelines Nutrition support in adults: oral nutrition support, enteral tube feeding and parenteral nutrition for guidance and the Health Board's Adult Refeeding Guideline (policy 209).

Too over cautious refeeding in the malnourished patient can lead to further weight loss and physical compromise and thus must also be taken into consideration.

Good refeeding practice requires close monitoring of biochemistry. There may be further difficulties undertaking phlebotomy to enable this level of monitoring and additional decisions would then be required regarding use of restraint to take bloods please see Reducing Restrictive Practice Policy for clinical holding.

13. References

NICE CG32: Nutrition support for adults: oral nutrition support, enteral tube feeding and parenteral nutrition, 2017

NICE NG10: Violence and Aggression: Short term management in mental health, health and community settings (2015)

Welsh Government (2016) Mental Health Act Code of Practice for Wales

Restraint Reduction Network Training Standards (2021)

Mental Health Act 1983

B -v- Croydon Health Authority [(1995) 2 WLR 294]

In Re T (adult: refusal of treatment) (1993) Fam 95

Bland -v- Airedale NHS Trust, 1993 AC789.16

Fox -v- Riverside Health NHS Trust

Nursing & Midwifery Council (2015) Code of Professional Standards of Practice and Behaviour for Nurses and Midwives

Further reading

American Psychiatric Association (2000) Practice Guideline for the Treatment of Patients with Eating Disorders (Revision): Supplement to the American Journal of Psychiatry

BMA/Law Society Assessment of Mental Capacity: Guidance for Doctors and Lawyers (available from the BMA)

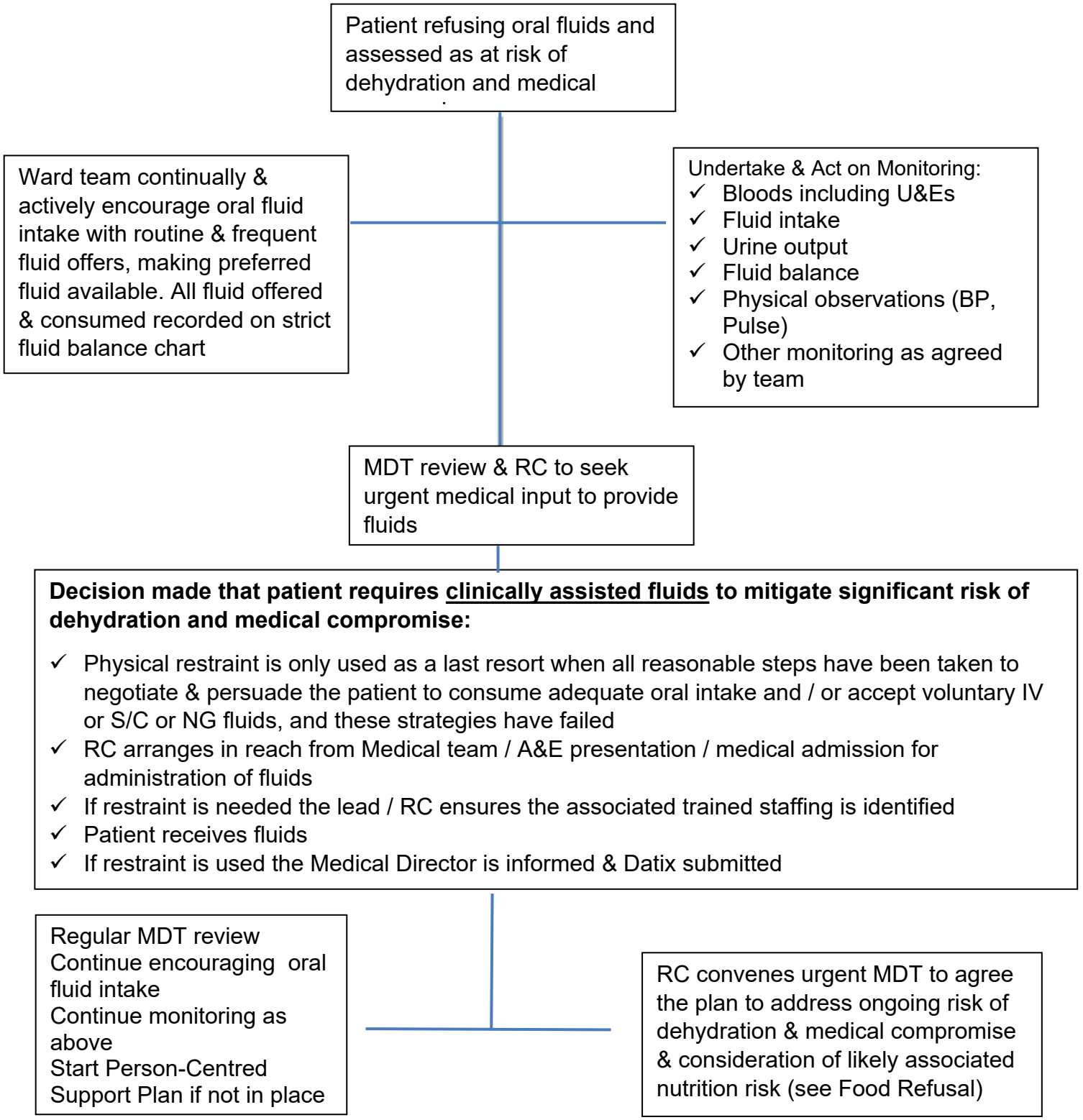
Department of Health (2001) A Reference Guide to Consent for Examination or Treatment

Foster.S. 2000. Force-feeding, self-determination and the right to die. New Law Journal. June, 857 - 858.

Garner DM & Garfinkel PE (eds) 1997 Handbook of Treatment for Eating Disorders 2nd edition The Guildford Press, New York

14. Appendices

Enteral Tube Feeding a Patient Under Restraint Procedure Appendix 2: Flowchart for the management of fluid refusal in a patient detained under the Mental Health Act when giving fluids under restraint is being considered



Enteral Tube Feeding a Patient Under Restraint Procedure - Appendix 3: Flowchart for the management of food refusal in a patient detained under the Mental Health Act when restraint feeding is being considered

Patient refuses food (but may be taking fluids) and is assessed as medically and psychiatrically compromised

- ✓ Actively encourage oral intake
- ✓ Frequent food & fluid offers
- ✓ Undertake routine nutrition risk screening & associated actions
- ✓ Refer to dietetics
- ✓ Contact RRPT
- ✓ Commence Person-centred support plan

RC convenes an urgent MDT to agree plan

Undertake & Act on Monitoring:

- ✓ Bloods: biochemistry as advised by team
- ✓ Strict food intake chart (document offered & consumed)
- ✓ Strict fluid balance
- ✓ Weight: frequency as advised by team
- ✓ Any other monitoring as agreed by team

MDT decision made to NG feed to mitigate significant risk to medical compromise:

- ✓ Physical restraint is only used as a last resort when all reasonable steps have been taken to negotiate & persuade the patient to consume adequate oral intake and / or accept a voluntary NG feeding tube, and these strategies have failed
- ✓ MDT undertakes & documents an individual patient risk assessment in relation to feeding with restraint
- ✓ MDT agree & document the plan for NG feeding with restraint including the aim of NG feeding, the refeeding plan, responsibilities for interventions and monitoring, and review is scheduled
- ✓ A person-centred support & care plan is agreed in collaboration with the patient and family, as appropriate
- ✓ The associated staffing and training needs are identified and a plan agreed
- ✓ The Medical Director is informed

Each occasion NG feeding with restraint is required / undertaken:

- Risk assess the patient's current clinical condition in relation to the potential stress associated with NG feeding with restraint, this is a continuous process during feeding
- Datix each occasion restraint is used
- Document in clinical notes
- Team and patient debrief

Regular MDT review
Review after each incident of restraint