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**Restraint Policy**

**[Date of Issue]**

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| Policy Lead: | [Policy Lead] |
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**This policy should only be used by companies that have approved the use of accredited breakaway and/or restraint training providers. This should match with the paragraph on restraint provided in the Mental Capacity Act and DoLS policy. Companies not using an accredited breakaway and/or restraint training should document their policy towards restraint in the Mental Capacity Act and DoLS policy.**

This policy should be read in conjunction with the Positive Behaviour Support Policy and Mental Capacity Act and DoLS Policy.

**[Name of breakaway training provider]** will be providing breakaway training to[Company Name]

**[Name of restraint training provider]** will be providing restraint training to [Company Name]

# Introduction

[Company Name] is committed to delivering the highest standards of health and social care, and ensuring the safety and welfare of its clients, relatives, and staff. [Company Name] recognises that violence and aggressive behaviour can escalate to the point where restraint may be needed to protect the person or staff member(s) from significant injury or harm, even if all best practice to prevent such an escalation is deployed. Physical intervention must only be considered once de-escalation and other strategies have failed to calm the situation. These interventions are management strategies and are not regarded as primary treatment techniques.

This policy refers to restraint meaning a reactive physical intervention to stop someone harming themselves, those around them or damaging property. Restraint referring to a pre-planned deprivation of liberty such as a bed rail or wheelchair belt is covered by the Mental Capacity Act and DoLS Policy.

This policy is intended to provide guidance in relation to the nature, circumstance and use of approved restraint techniques currently adopted across [Company Name]. Its aim is to help all involved to act appropriately in a safe manner, thus ensuring effective responses in potential or actual difficult situations. It sets out a framework of good practice, recognising the need to ensure that all legal, ethical, and professional issues have been taken into consideration.

# Policy Statement

The aim of this policy is to provide staff with the guidance needed to practice in accordance with the law, professional standards and in line with [Company Name]’s policies. The policy outlines the general principles that must be applied to practice including the legal position where appropriate.

Decisions about physical interventions or restraint are not easy or straightforward. It is acknowledged that decisions in urgent and emergency situations may have to be made quickly and without consultation with colleagues. Sometimes such interventions may lead to complaints by clients or their relatives. Unlawful restraint may give rise to criminal or civil liability.

It is self-evident that staff may be required to account for their actions in such circumstances. However, [Company Name] will always support staff who act in a way that is deemed reasonable, measured and the least restrictive option at the time of the incident and in accordance with professional standards and training.

# Scope

The policy applies to all staff within [Company Name].

# Legal Framework

The legal framework underpinning the lawful use of restraint is complex and supported by the Human Rights Act 1998, with various statutes and common law, making restraint lawful in certain situations, as follows:

* Mental Capacity Act 2005 (MCA) – this particularly includes the Deprivation of Liberty Safeguards (DOLS) which were added in 2009. The requirements of the legislation can pose challenges to the provision of client care, support, and treatment in health care.
* Mental Health Act 1983 (MHA) – applicable to those who fulfil the criteria for detention, largely sections 2, 3, 4 and 5(2). Where applicable restraint is only lawful to further the management of the underlying mental health disorder.
* Common law - the doctrine of necessity where there is a general power to take steps that are reasonably necessary and proportionate to protect people from the immediate risk of significant harm, whether or not the client lacks capacity to make decisions for themself.

# Training

[Company Name]’s emphasis on training and education will be on dealing effectively with situations to obviate the need for restraint. Conflict Resolution training is mandatory for all front-line staff and renewed every 3 years.

Breakaway training is mandatory for the following staff groups:

* Staff group A
* Staff group B
* Staff group C

It is renewed on a [insert timeframe] basis and is offered by [insert training provider name and URL]

Restraint training is mandatory for the following staff groups:

* Staff group A
* Staff group B
* Staff group C

It is renewed on a [insert timeframe] basis and is offered by [insert training provider name and URL]

# Behaviour

Successful management of challenging behaviour is underpinned by understanding the reasons for the behaviour and the identification of appropriate interventions which staff can use when interacting with the client. [Company Name] adopts the principles of positive behaviour support as laid out in the Positive Behaviour Support policy. The identification and elimination of the cause and triggers of challenging behaviour is always the preferred and optimal outcome.

The use of de-escalation techniques must be the first strategy when faced with an escalating situation. De-escalation or diffusion refers to talking with an angry or distressed client in such a way that violence is averted, and the person regains a sense of calm.

Understanding a client’s behaviour and responding to individual needs must be at the centre of client care. All clients must be assessed comprehensively to establish which type of therapeutic behaviour management might be of benefit. This will involve identifying the underlying cause of the behaviour (distress, walking without purpose, absconding etc.) and deciding whether the behaviour needs to be prevented. Possible causes to consider include:

* the need to empty their bladder or bowel
* anxiety or distress
* mental illness (e.g., dementia, schizophrenia)
* delirium (acute confusion) due to:
  + infection/ pyrexia
  + hypoxia
  + electrolyte or metabolic imbalance
  + pain or discomfort
  + constipation/dehydration
  + hypotension
  + other form of memory impairment
  + drug dependency or withdrawal (including alcohol, nicotine, sleeping tablets and illicit drugs)
  + brain insult/injury or cerebral irritation
  + reaction/side effect of medication
  + intoxication (due to alcohol, drug overdose or drugs of abuse)
  + pregnancy and postnatal conditions
  + communication, religious or cultural issues
  + impact of Disability, Learning Difficulties.

# Use of Breakaway and Restraint

**Staff should always refer to training provided by their training provider**

**Staff**

Wherever possible use de-escalation techniques irrespective of the stage of the restraint. Restraint is an intervention that prevents a person from behaving in ways that threaten to cause harm to themselves, to others or to property.

The use of physical restraint must be reported on the incident reporting system when there is:

* direct physical contact, with or without resistance
* where the intention is to prevent, restrict or subdue movement of the body, or part of the body of another person, by two or more staff.

Careful deliberation must precede the application of this practice and an assessment of mental capacity must be undertaken. The use of physical restraints does not ensure safety and staff must be always aware of the need for vigilance and constant supervision of these clients.

The Mental Capacity Act (2005) Section 6(4) of the Act states that someone is using restraint if they: use force, or threaten to use force, to make someone do something that they are resisting, or restrict a person’s freedom of movement, whether they are resisting or not. It adds that restraint is only permitted if the person using it reasonably believes it is necessary to prevent harm to the person who lacks capacity and if the restraint used is a proportionate response to the likelihood and seriousness of the harm.

Any staff using physical restraint must ensure that one staff member leads the team and assumes control of the person being restrained throughout the process (person in control). They must ensure that (it is advisable the person leading the intervention does not become part of the restraint intervention):

* the restrained person’s head and neck is appropriately supported and protected
* the restrained person’s airway and breathing are not compromised
* monitor the restrained person’s overall physical and psychological well-being throughout
* for safety reasons, staff should only hold/apply pressure to the person’s limbs. Under no circumstances must direct pressure be applied to the neck, thorax, abdomen, back or pelvic area
* every effort is made to use skills and techniques that do not use the deliberate application of pain
* the level of force applied is reasonable and necessary and proportionate to a specific situation, and being applied for the minimum possible amount of time
* the person subject to restraint is physically monitored throughout the incident.

Post-restraint, the person who has been restrained will be reviewed as to whether they require additional observation. During this time, physical observations must be recorded, and the observer must be fully aware of the possibility of restraint/positional asphyxia.

Face down/prone restraint must never be used. However, if the floor is used then this must be used for the shortest period of time and only for the purpose of gaining reasonable control.

**Physical Monitoring**

Physical monitoring is important during and after restraint. This must be documented as part of the risk assessment and in the client’s records. Monitoring must be undertaken by an appropriately trained and competent staff member and must include physical observations (e.g., pulse, blood pressure, respiration, SPO2, GCS etc.). This is especially important:

* following a prolonged or violent struggle
* if the person has been subject to enforced medication or rapid tranquilisation
* if the person is suspected to be under the influence of alcohol or elicit substances
* if the person has a known medical condition which may inhibit cardio-pulmonary function (e.g., obesity (when face down), asthma, heart disease etc.).

**Post Restraint Arrangements**

The aim of a post-incident review must be to seek to learn lessons, support staff and clients and encourage the therapeutic relationship between staff, clients and their carers. A de-brief must take place as soon as practicably possible post-incident unless there are exceptional circumstances which prevent this. The review must address:

* what happened during the incident
* any trigger factors
* each person’s role in the incident
* their feelings at the time of the incident, at the review and how they may feel in the near future
* what can be done to address their concerns.

As soon as practicably possible, following the use of physical interventions, the staff involved will meet. The time will be used to discuss any issues anyone may have, as well as reviewing the details of the incident itself. Any significant points raised must be documented and discussed with the Registered Manager. All persons involved in the use of physical interventions must be offered post-incident support and be involved in any support or feedback process. The person leading the team must ensure that an incident report is submitted.

# Restrictive Practice in the Care of Children and Young People

**[Delete this section if the company does not provide services to children and young people]**

**General principles**

Good decision making about restrictive physical interventions and therapeutic holding requires:

* An ethos of caring and respect for the child’s/young person’s rights, where the use of restrictive physical interventions or therapeutic holding without the child’s/young person’s consent are used as a last resort and are not in the first line of intervention.
* A consideration of the legal implications of using restrictive physical intervention. Where necessary, application must be made through the Family Courts for a specific issue order clearly outlining the appropriate restraint techniques to be used.
* Openness about who decides what is in the child’s/young person’s best interests. Where possible, these decisions must be made with the full agreement and involvement of the parent or guardian.
* A clear mechanism for staff to be heard if they disagree with a decision.
* A sufficient number of staff available who are trained and confident in safe and appropriate techniques and in alternatives to restrictive physical interventions and therapeutic holding of children and young people.
* A record of events. This must include why the intervention was necessary, who held the child/young person, where the intervention took place, the method used, the length of time and any techniques needed to reduce the future need for restrictive physical interventions or therapeutic holding.
* Where any restrictive interventions are utilised as part of a behavioural management plan, a positive behavioural support approach is to be implemented. Here staff will utilise primary preventative strategies where possible, identify patterns of behaviour and secondary preventative strategies used to de-escalate situations and review the effectiveness of any interventions. Tertiary strategies, such as restrictive interventions, must be reviewed and documented (guidance may be required by specialists (e.g., learning disabilities, autism, and epilepsy).

**Therapeutic holding**

**[Delete this section if the company does not supply services to children or young people]**

Therapeutic holding for a particular clinical procedure also requires practitioners to:

* Give careful consideration of whether the procedure is necessary and whether urgency in an emergency prohibits the exploration of alternatives.
* Anticipate and prevent the need for holding, by giving the child/young person information, encouragement, distraction and, if necessary, sedation. In considering the use of sedation, one must recognise that the risks associated with sedation need to be outweighed by the harm caused by therapeutic holding in the absence of sedation. Involve a play specialist from an early stage. Introduce them to the child/young person and family as soon as possible and liaise with the play specialist re appropriate techniques following their assessment of the child/young person.
* An attempt must be made to obtain consent/assent from all but the youngest of children. For any situation which is not a real emergency, seek the parent(s)/carer(s) consent or the consent of an independent advocate.
* Make an agreement beforehand with the parent(s)/guardian(s) and the child/young person about what methods will be used, when they will be used and for how long. This agreement must be clearly documented in the client’s records and any event fully documented.
* Ensure parental presence and involvement if they wish to be present and involved. Parent(s)/guardian(s) must not be made to feel guilty if they do not wish to be present during procedures. Staff must explain the parents’/guardians’ roles in supporting the child/young person and provide support for them during and after the procedure.
* Make skilled use of minimum pressure and other age-appropriate techniques, such as wrapping and splinting, explaining, and preparing the child/young person and their parent(s)/carer(s) beforehand as to what will happen.
* Comfort the child or young person where it has not been possible to obtain their consent and explain clearly to them why immobilisation is necessary.

# Action During Procedure

Action During Procedure (core principles) (this applies to all ages):

* All staff that carry out restrictive physical intervention or therapeutic holding must be trained by nominated trainers.
* A lead person must be identified to coordinate the process. Identify a person to communicate and reassure the child/young person and family throughout.
* Consider the child/young person’s age and adapt procedure in accordance with training received.
* Supportively hold the limb or body in a natural position. Avoid pressure over the face, neck, chest, abdomen, genitalia, and soft tissue. Use the whole hand to support around a limb.
* Physical restraint must never be used in a way that might be considered indecent, or that could arouse sexual feelings or expectations.
* Apply a firm but even pressure when holding ensuring circulation and breathing is not compromised.
* Other than in exceptional circumstances (e.g., due to a medical procedure) a person is not to be restrained or held face down. Should a child/young person require physical interventions, they are to be turned, if required, to be held face up (supine) or in a seated position.
* Methods used, and the circumstances in which they are used, must be agreed with the parent(s)/carer(s) and/or the child/young person and clearly documented in their record. For example, two unsuccessful attempts at bloods/cannulation must be followed by a rest and change in practitioner.
* Incidents resulting from the use of restrictive physical intervention and therapeutic holding are to be reported on the incident reporting system.

# Monitoring

To ensure this policy remains both practical and current, regular auditing processes will take place. Individual incidents will be monitored via the incident reporting system and themes and trends reported to the management team.

Any adverse issues or poor client outcomes related to this policy will be investigated.

# Related Policies

* Bedrails Policy
* Care Planning Policy
* Complaints Policy
* Conflict Resolution Policy
* Consent Policy
* Duty of Candour Policy
* Enteral and Parenteral Feeding Policy
* Governance and Risk Policy
* Incident Management Policy
* Information Governance and Record Keeping Policy
* Mental Capacity Act and DoLS Policy
* Person-Centred Care Policy
* Positive Behaviour Support Policy
* Quality Assurance Policy
* Safeguarding Policy
* Training and Induction Policy

# Legislation and Guidance

**Relevant Legislation**

* Mental Capacity Act 2005/2009
* Positive and proactive care reducing the need for restrictive interventions (DoH) 2014
* Human Rights Act 1998
* Mental Health Act 1983

**Guidance**

* Reducing the Need for Restraint and Restrictive Intervention
* Children and Young People with Learning Disabilities, Autistic Spectrum Disorder and Mental Health Difficulties (DofE) 2017
* NICE Guidance 2015 NICE NG10 [https://www.nice.org.uk/guidance/ng10#](https://www.nice.org.uk/guidance/ng10)
* Care Quality Commission [20160422\_briefguide-Restraint\_physical\_mechanical.pdf.pdf (cqc.org.uk)](https://www.cqc.org.uk/sites/default/files/20160422_briefguide-Restraint_physical_mechanical.pdf.pdf)

# Summary of Review

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| --- | --- |
| Version | 1 |
| Last amended | [Date of Issue] |
| Reason for Review |  |
| Were changes made? |  |
| Summary of changes |  |
| Target audience | Care staff, Managers |
| Next Review Date | [Date of Review] |