Trust Policy		Worcestershire Acute Hospitals NHS Trust

Restrictive Interventions Policy - Adults

Department / Service:	Trustwide
Originator:	Deborah Narburgh Head of Safeguarding
Accountable Director:	Sarah Shingler, Chief Nursing Officer
Approved by:	Integrated Safeguarding Committee Clinical Governance Group
Date of approval:	1st August 2023
First Revision Due:	7th January 2027
Target Organisation(s)	Worcestershire Acute Hospitals NHS Trust
Target Departments	Trustwide
Target staff categories	All staff

Policy Overview:

This Policy provides information and guidance on the use of restrictive interventions for adult patients within Worcestershire Acute Hospitals NHS Trust. The key principles within this document are:

- Compliance with the Human Rights Act 1998
- Compliance with the Mental Capacity Act (2005)
- Compliance with the Mental Health Act Code of Practice (2015)
- Compliance with Department of Health best practice guidance – Positive & Proactive Care (2014)
- Compliance with Common Law principles
- Any restrictive intervention must be necessary, reasonable, proportionate to the risk of harm, the least restrictive intervention and used for the least time possible
- Involvement and participation of people with care and support needs and their representatives is essential, wherever practicable and subject to the person's wishes and confidentiality obligations
- People must be treated with dignity, compassion and kindness
- Staff must support people to balance safety from harm and freedom of choice
- Positive relationships between people who deliver services and the people they serve must be protected and preserved
- Understanding people's behaviour allows their unique needs, aspirations, experiences and strengths to be recognised and their quality of life to be enhanced

Key Amendments

Date	Amendment	Approved by
Feb 2020	Document extended whilst new legislation is expected	Debbie Narburgh
November 2020	Document extended for 3 months whilst review process is currently ongoing	Debbie Narburgh

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February 2023	Document extended for 6 months whilst review in process	Deborah Narburgh
July 2023	Full policy review and rewrite	Deborah Narburgh
8th July 2026	Document extended for 6 months due to vacancy and current workload	Deborah Narburgh

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Meanings of Terms Associated with the Use of Restrictive Interventions

Supporting Documents

Supporting Document 1 Equality Impact Assessment

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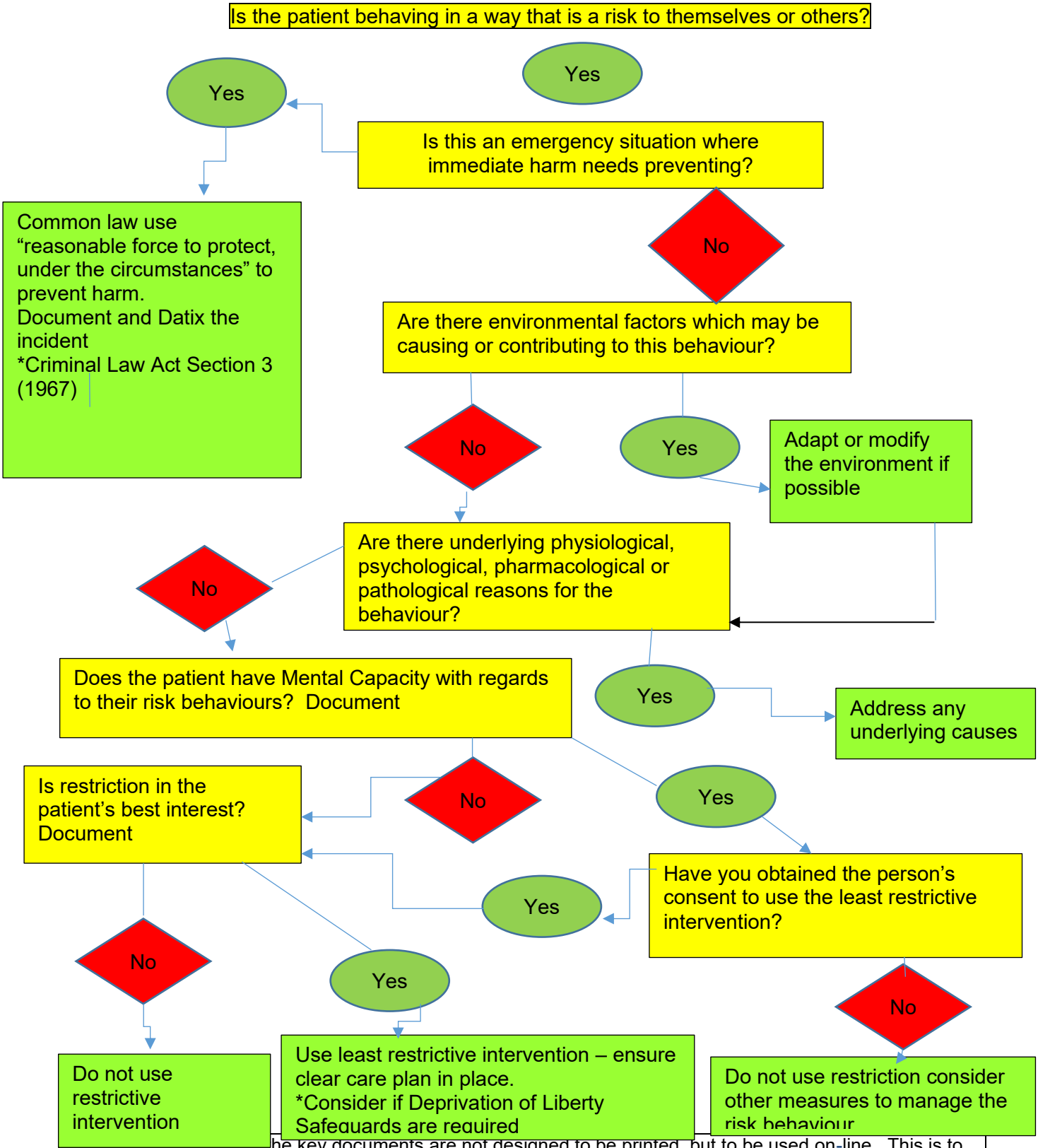
Trust Policy

Worcestershire Acute Hospitals NHS Trust

Supporting Document 2 Financial Risk Assessment

Quick Reference Guide



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1. Introduction

The Trust is committed to providing a safe environment for its patients, staff and others, as well as recognising the needs and respecting the dignity of the individuals for whom it provides care.
In the event staff need to implement restrictive interventions for those in their care, they must have a lawful basis for doing so.

There is a considerable amount of concern and controversy surrounding the potential harm to individuals as a result of the use of restrictive interventions; in some instances, resulting in serious physical and psychological trauma, and in some instances even death. All restrictive interventions can pose risks. It is important that those who use restrictive interventions understand the associated risks of the intervention intended. **Close attention should be paid to pre-existing conditions that may be exacerbated by the use of restrictive interventions e.g. cardiac, respiratory etc and therefore the monitoring of physical health during and after any restrictive intervention use is paramount for ensuring the person's safety and wellbeing.**

The legal and ethical basis for organisations to allow staff to use restrictive interventions ***as a last resort*** is founded on 8 overarching principles:

- Restrictive interventions should only ever be used as a last resort
- There must be a real possibility of harm to the person or to staff, the public or others if no action is undertaken
- Any action taken to restrict a person's freedom of movement must be the least restrictive option that will meet the need
- The nature of techniques used to restrict must be proportionate to the risk of harm and the seriousness of that harm
- People who use services, carers and advocate involvement is essential when reviewing plans for restrictive interventions
- Any restriction should be imposed for no longer than is necessary
- Restrictive interventions should never be used to punish or for the sole intention of inflicting pain, suffering or humiliation
- What is done to people, why and with what consequences must be subject to audit and monitoring and must be open and transparent

Inappropriate use of restraint may be considered a form of abuse.

To help protect the interests of people with whom restrictive interventions are used it is good practice to involve the person, and where possible, family /carers / advocates or other relevant representatives in planning, monitoring and review.

All restrictive interventions should be for the shortest time possible and use the least restrictive means to meet the immediate need based on the fundamental principles detailed within *Positive and Proactive Care (*DoH, 2014*)*.

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This policy provides information and guidance on the use of restrictive interventions for adult patients within Worcestershire Acute Hospitals NHS Trust. The key principles within this document are:

- Compliance with the relevant rights in the European Convention on Human Rights
- Involvement and participation of people with care and support needs and their representatives is essential, wherever practicable and subject to the person's wishes and confidentiality obligations
- People must be treated with dignity, compassion and kindness
- Staff must support people to balance safety from harm and freedom of choice
- Positive relationships between people who deliver services and the people they serve must be protected and preserved
- Understanding people's behaviour allows their unique needs, aspirations, experiences and strengths to be recognised and their quality of life to be enhanced

1.1 Relevant Best Practice and Legislation

All staff should act within the principles set out in Positive and Proactive Care, and any use of restrictive interventions should be in line with the MHA Code of Practice 2015, Mental Capacity Act 2005, Human Rights Act 1998 and common law principles.

1.2 Context

Guidance from the Department of Health (DoH), Positive and Proactive Care, places an increasing focus on the use of preventive approaches and de-escalation for managing behaviour that services may find challenging. Some groups are more at risk than others, for example those with a learning disability, autism, mental health condition, dementia, delirium etc.

2. Scope of this document

This policy applies to all staff working within Worcestershire Acute Hospitals NHS Trust who may be involved in the care of patients who may require some form of restrictive intervention in order to provide treatment or protect them or others from harm.

This Policy should be used in conjunction with the following Policies /procedures:

- Mental Capacity Act (2005)
- Deprivation of Liberty Safeguards (2009)
- Consent to Treatment
- Management of Violence & Aggression
- Application of Mittens as a Physical restraint for Patients requiring naso-gastric feeding
- Adult Rapid Tranquillisation in the Emergency Department (WAHT-A&E-033)
- Mental Health Act

Key information for staff

Trust Key Documents can be found here:
index

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2.1 Prisoners

The control and order of prisoners whilst they are undergoing medical treatment, is the responsibility of the Governor / Director or person in charge of the establishment (DOH, 2014).

2.2 Appropriate Training

Details of physical **restrictive intervention *techniques* are not included within this Policy as these techniques should only ever be used by staff whom have received the appropriate training**.

Details of personal safety / therapeutic holding training can be found on the Training & Development page of the Trust intranet.

Security staff will be trained to Security Industry Authority (SIA) and MAYBO training standards in accordance with their licence to practice.

All staff will receive mandatory medical emergency / resuscitation training in accordance with their job role.

All staff will receive Conflict Resolution training as part of their mandatory training.

2.3 Security Staff

Situations may arise where additional support is required. In these instances, security staff should be contacted via:
WRH – Exn 39903 or emergency bleep 899
ALEX – Exn 44843 or bleep 1123
KTC – Porters via bleep 3253

2.4 Police

There are occasions when the Police may be required to provide help and support:

- A violent situation where the safety of patients, staff or others is at risk
- If a patient has left the ward or hospital site, location unknown and they are assessed as being at serious risk of harm
- A crime has been committed e.g. assault

2.5 Restrictive Interventions in Pregnancy

In the event restrictive interventions are required in pregnancy then a multi – professional approach should be taken to minimise any risk to both mother and unborn.
Staff need to be alert to positioning of both mother and baby, use of medications and associated risks.

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3. Definitions

The Department of Health and Social Care (2015) defines restrictive interventions as: "Deliberate acts on the part of other person(s) that restrict an individual's movement, liberty and/or freedom to act independently in order to:

- Take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken; and
- End or reduce significantly the danger to the person or others."

The Mental Capacity Act (2005) states 'someone is using restraint if they: use force – or threaten to use force – to make someone do something they are resisting, or restrict a person's freedom of movement, whether they are resisting or not'.

Restraint does not necessarily require the use of force, but can also include acts of interference, such as moving someone's walking frame out of reach.

Any act of restraint has a potential to interfere with a person's human rights.

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

3.1 Meanings of terms associated with the use of Restrictive Interventions

Refer to Appendix 1.

4. Responsibility and Duties

All Employees

All Trust staff should be aware of, and comply with this guidance and are responsible for reporting any incidents or complaints related to the use of this policy via the DATIX incident reporting system.

Matrons / Ward / Department Managers

Are responsible for:

- Implementation of this policy within individual clinical areas
- Investigation of any incidents related to the use of this policy
- Ensuring an immediate post incident debrief is undertaken and recorded

Divisional Governance teams

Will monitor trends and disseminate any learning from incidents where restrictive interventions have been used. This will include post-incident debriefs /reviews where restrictive interventions have had to be used

Key information for staff
Post incident debrief guidance

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Post-Incident-Debrief
ing-Guidance-for-staf

Post incident support guidance for staff

Post-Incident-Suppor
t-Guidance-Poster-1.p

Chief Nursing Officer (CNO)

The Trusts CNO has overall Executive responsibility and accountability for the Trust in respect of safeguarding. The CNO ensures:

- Compliance with this Policy and corresponding legislation and guidance.
- The Trust has effective systems to review cases and identify changes which would improve procedures and practice.
- The Trust has effective reporting and recording arrangements

5. Policy Detail

5.1 Types of restrictive intervention

5.1.1 Physical Restraint

The MHA Code of Practice (2015, DH) definition of physical restraint is 'any direct physical contact where the intervener's intention is to prevent, restrict, or subdue movement of the body, or part of the body of another'.

The use of physical restraint can be hazardous for both the patient and staff and therefore must only be undertaken by staff who have been trained in therapeutic handling (or equivalent) techniques.

Staff should continue to communicate with the person throughout any period of restraint in order to continually de-escalate the situation. **People should NEVER be restrained in a way that adversely impacts on their airway, breathing or circulation,** and the mouth and nose must never be covered unless being directly attended by a medical professional who has assumed responsibility for ensuring adequate oxygen is being provided and the airway is patent. Pressure must not be incurred to the neck, rib cage or abdominal regions.

Physical restraint or breakaway techniques that involve the use of pain must never be used other than for the purpose of an immediate rescue in a life-threatening situation.

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5.1.2 Mechanical Restraint

Mechanical restraint refers to: 'the enforced use of mechanical aids such as belts, cuffs and restraints to forcibly control a patient's movement for the prime purpose of behavioural control.

Mechanical restraint should never be a first line means of managing disturbed behaviour and its use should be exceptional. Examples include use of handcuffs for security purposes, use of mittens to prevent pulling out of feeding tubes, cannulas etc.

Exceptional circumstances where mechanical restraint needs to be used may be when the restraint is used to limit self-injurious behaviour of extremely high frequency and intensity e.g. where devices such as arm splints or cushioned helmets may be required to safeguard a person from the hazardous consequences of their behaviour. In such cases this should form part of an agreed care plan in accordance with the Mental Capacity Act and where appropriate, best interest decision making principles.

5.1.3 Chemical Restraint

Chemical restraint refers to the use of medication which is prescribed, and administered for the purpose of controlling or subduing disturbed / violent behaviour, where it is not prescribed for the treatment of a formally identified physical or mental illness.

Chemical restraint should only be used for a person who is highly aroused, agitated, overactive, and aggressive, is making serious threats or gestures towards others, or is being destructive to their surroundings, when other therapeutic interventions have failed to contain the behaviour.

Chemical restraint should only ever be delivered in accordance with acknowledged, evidence-based best practice guidelines. Prescribers should provide information to staff regarding any ongoing physical monitoring that may be required if chemical restraint is administered.

The use of medication to manage acutely disturbed behaviour must be a very short term strategy designed solely to reduce the immediate risk. Oral medication should always be considered first. Where rapid tranquillisation in the form of intramuscular injection is required, the prescriber should indicate the preferred injection site having taken full account of the need to avoid face down (prone) restraint.

5.1.4 Seclusion

Seclusion refers to the supervised confinement and isolation of a person, away from other users of services, in an area from which the person is prevented from leaving. Its sole aim is the containment of severely disturbed behaviour which is likely to cause harm to others.

Only people detained under the Mental Health Act should be considered for seclusion. Where this is the case, the Mental Health Act Code of Practice lays down clear procedures for the use of seclusion, including its initiation, on-going implementation, review and termination. Mental Health Liaison Service can provide further support, advice.

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Key Information for staff

Mental Health Liaison Service

- Bleep 195 Worcestershire Royal Hospital
- Bleep 1234 Alexandra Hospital

Side room or single room facilities may be used for infection control purposes or to ensure the privacy and dignity of prisoners or those at the end of life. This does not necessarily constitute the use of seclusion as a form of restraint. This may be a complex issue which should be discussed on a case by case basis and the respective professionals involved e.g. infection control team.

5.2 Assessment prior to using a restrictive intervention

The choice of restrictive intervention must always represent the least restrictive option to address the immediate need /risk and include:

- **The environment** – the care environment can have either a positive or negative effect on patients. Every effort should be made to reduce the negative impact of the environment. Examples include – extreme staffing shortages impacting on the quality of care or levels of supervision, restricted observation in patient areas, high levels of noise or disruption, boredom, lack of stimulation, negative attitudes, poor communication skills of staff, multiple moves during admission

- **Behaviour and underlying condition** – understanding a patient's behaviour and responding to individual needs should be at the heart of patient care. All patients should receive a comprehensive assessment in order to establish what sort of therapeutic intervention may be of benefit. This should include where possible, identification of the underlying cause of the behaviour (agitation, wandering, absconding etc.) and deciding whether the behaviour poses a risk.

Possible causes to consider are:

- Hypoxia
- Hypotension
- Pyrexia
- Need to empty bladder or bowel
- Pain or discomfort
- Anxiety or distress
- Mental illness e.g. dementia
- Memory impairment
- Drug dependency or withdrawl
- Brain insult /injury or cerebral irritation
- Reaction /side effect of medication
- Intoxication (due to alcohol, drug overdose or drugs of abuse)
- Frustration

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- Feeling threatened –being in hospital can often impact upon a person's privacy and dignity resulting in feelings of loss of independence

Having identified triggers for the behaviour, staff should then decide on appropriate strategies for dealing with this in conjunction with the multidisciplinary team (this should include treatment of any underlying cause).

5.3 Duty of Care & De-escalation

Identifying de-escalation techniques that have worked in the past increases the likelihood that de-escalation will be effective and restraint won't be necessary. De-escalation should start when the first signs of agitation, irritation, anger or aggression are recognised. Should a situation escalate to a point at which restrictive intervention is needed, de-escalation should still continue to be attempted. (https://www.nice.org.uk/guidance/qs154/chapter/quality-statement-2-preventing-and-managing-violent-or-aggressive-behaviour).

In exercising our duty of care, staff must:

- Understand how the person is feeling, seeing all behaviour as a form of communication about feelings
- Reassure the person, acknowledge you can see they are upset
- Not use labels or negative words, use positive language
- Adopt a problem solving approach
- Look for triggers, and resolve or remove them
- Know the person, their history, people closest to them
- Talk to the person –how can you help?
- Concentrate on the persons feelings and needs
- Keep the person occupied – using activities that stimulates their interest
- Avoid confrontation and arguing – do not take it personally
- Be aware of warning signs – anxiety, agitation, restlessness
- If the person is physically violent give them space and avoid closing in and trying to restrain
- Be aware of your own body language, response, tone etc

5.4 Patients who lack Mental Capacity

Any decision to use restrictive interventions for a person, whom lacks mental capacity, must be made in the best interests of the person within the framework of the Mental Capacity Act. Where patients lack mental capacity to consent to their care or treatment then a formal Mental Capacity Assessment should be completed and Best Interest Decision recorded.

The person making the decision will need to:

- Consider all of the relevant circumstances
- Consider whether the decision can be delayed until the person regains capacity
- Involve the person as fully as possible in making the decision and any act done for them
- Consider the persons past and present wishes and feelings
- Consider any advance decisions to refuse treatment or statements made about how they should be cared for and supported (including whether the person has a Donee of Lasting Power of Attorney or a deputy with the legal authority to make decisions)

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- Consult the persons family & informal carers
- Consider the persons beliefs and values that would be likely to influence their decision if they had capacity
- Take account the views of an independent mental capacity advocate (IMCA) or other key people (such as family members and those who usually provide care and support)
- Consider whether it is the least restrictive option, in terms of the persons rights and freedoms, by which to meet the persons need

If the Mental Health Act and/or Mental Capacity Act do not apply, the use of force is only legally justified for the purposes of self- defence, defence of others, prevention of crime, lawful arrest or to protect property.

Deprivation of Liberty Safeguards (DoLS) should be implemented if the person is subject to continuous supervision and control and is not free to leave, and lacks the mental capacity to consent to these arrangements. If a Deprivation of Liberty is necessary, it can only be authorised by a procedure set out in law.

5.5 Care Planning

Individualised support plans, incorporating behaviour support plans, must be implemented for all people who use services who are known to be at risk of being exposed to restrictive interventions.

Any person who can reasonably be predicted to be at risk of being exposed to restrictive interventions must have an individualised behaviour support plan.

Skilled assessment is required in order to understand probable reasons why a person presents behaviours of concern; what predicts their occurrence and what factors maintain and sustain them. This requires consideration of a range of contextual factors including personal factors, mental and physical health, communication skills and the person's ability to influence the world around them. Patterns of behaviour provide important data, skilled analysis of which enables key areas of unmet need to be understood. Behaviour support plans which have been informed by an assessment of these factors ensure that aspects of the person's environment that they find challenging are identified and addressed, that quality of life is enhanced and that wherever possible people are supported to develop alternative strategies by which they can better meet their own needs.

The behaviour support plan must detail the responses such as de-escalation techniques, distraction, diversion and sometimes disengagement to be used by carers/staff when a person starts to become anxious, aroused or distressed.

Behaviour support plans include guidance as to how people should react when a person's agitation further escalates to a crisis where they place either themselves or others at significant risk of harm. This may include the use of restrictive interventions.

Key information for staff

Restraint Reduction Network: Example of a support plan which can be adapted for adults in your care:

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My-Support-Plan.pdf

Learning Disability Liaison Service:
Learning Disabilities (worcsacute.nhs.uk)

5.6 Reporting of injuries

Any injury to a patient, member of staff or visitor to the Trust premises involving the use of restraint should be reported in accordance with the Trust incident reporting procedure. Incidents involving the use of any form of restraint should be documented within the patient's medical record.

5.7 Communication and Documentation

Clear communication with patients and their families is essential in relation to the use of any form of restraint. Where possible, written information should be provided to support any verbal information given. When restraint is used, the reason for this should be explicit and clearly documented in the patient records. The care plan should include:

- The rationale for the use of restraint
- Is this the least restrictive option, what else has been considered?
- Risk assessment
- Frequency of re-assessment of the need for restraint
- All discussions that have taken place to allow the patient to give informed consent and to assess best interests
- Any de- escalation techniques considered

5.7.1 Learning Disability - Documented review of restrictive intervention

Use of a restrictive intervention should be accompanied by a documented review that includes the following:

- review of the delivery and outcome of the restrictive intervention, whether it was needed and how it could be avoided (and if so, what action will be taken)
- assessment of the safety, efficacy, frequency of use, duration and continued need for reactive strategies
- involvement of everyone who cares for the person with a learning disability, including their family members and carers, and the person themselves, if possible

(Learning Disability – behaviour that challenges. NICE Quality standard 10. Updated July 2019)

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6. Implementation

6.1 Plan for implementation

The latest version of this Policy can be found on the Trust intranet site key document and safeguarding pages.

6.2 Dissemination

Staff will be advised of the updated Policy via dissemination by attendees of the Trust Integrated Safeguarding Committee and associated governance committees.

6.3 Training and awareness

Where therapeutic handling is essential to role this will be recorded in ESR. Personal Safety training is available to all staff via ESR.
Security staff training will be provided by their employer in accordance with Security Industry Authority (SIA) and MAYBO training standards.
Conflict Resolution training is mandatory for all staff.

7 Monitoring and compliance

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Page/ Section of Key Document	Key control:	Checks to be carried out to confirm compliance with the Policy:	How often the check will be carried out:	Responsible for carrying out the check:	Results of check reported to: *(Responsible for also ensuring actions are developed to address any areas of non-compliance)*	Frequency of reporting:
	WHAT?	**HOW?**	**WHEN?**	**WHO?**	**WHERE?**	**WHEN?**
NHSE – Learning Disability Improvement Standards	Trusts must demonstrate that they vigilantly monitor any restrictions or deprivations of liberty associated with the delivery of care and treatment to people with learning disabilities, autism or both	DoLS are monitored via Datix. Outcomes to be reviewed for patients with a LD, autism to ensure any restriction proposed or used meets the requirements of the legal frameworks – necessary, reasonable, proportionate based upon the risk of harm etc.	Dip sample of DoLS cases quarterly	Named Nurse Safeguarding Adults Lead Nurse Patient Experience	Via Trust reporting and governance structures onwards to Trust Board LD Improvement Standards via Healthcare Standards	Quarterly
NHSE – Learning Disability Improvement Standards	Trusts have governance processes for measuring the use of restraint and other restrictive practices, including detailed evidence-based recommendations to support the discontinuation of planned prone restraints and reduction in unwarranted variation in use of restrictive practices. They can demonstrate that alternative approaches are being deployed.	Datix incident reporting Post incident review Policy & Procedure Personal Safety training Conflict Resolution training LD Steering Group (relaunch Sept 2023).	Dip sample of cases where restraint has been used	Named Nurse Safeguarding Adults Lead Nurse Patient Experience	Via Trust reporting and governance structures onwards to Trust Board LD Improvement Standards via Healthcare Standards	Quarterly

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8 Policy Review

This Policy will be reviewed every 3 years in accordance with WAHT Key Document review process or in the event of any significant change to procedure.

9 References

	Code:
Mental Capacity Act Code of Practice (2005)	
Mental Health Act Code of Practice (1983) updated 2017	
Deprivation of Liberty Safeguards (2009)	
Human Rights Act (1998)	
Care Quality Commission - Brief guide: restraint (physical and mechanical) – 8 Principles 20180322_900803_briefguide-restraint_physical_mechanical_v1.pdf (cqc.org.uk)	
NHS England – Reducing long term segregation and restrictive practice NHS England » Reducing long term segregation and restrictive practice	
Restraint Reduction Network – My Support Plan My_Support_Plan_updated.indd (restraintreductionnetwork.org)	
HM Government –Positive & Proactive Care: reducing the need for restrictive interventions (2014)	
Learning Disability: behaviour that challenges. NICE Quality Standard 10 (Updated July 2019)	
Social Care Institute for Excellence (SCIE): At a glance 16: Managing risk, minimising restraint. Updated 2021	
Nursing Times https://www.nursingtimes.net/roles/learning-disability-nurses/reducing-restrictive-interventions-in-people-with-challenging-behaviours-11-11-2019/	
Health & Safety Policy	WAHT-CG-125
Adult Rapid Tranquillisation in the Emergency Department	WAHT-A&E-033
Policy for Consent to Examination or Treatment	WAHT – CG-075
Violence Prevention Reduction and Management of Violence and Aggression Policy	WAHT-CG-006
Application of Mittens as a Form of Physical Restraint for Patients requiring Naso-gastric Feeding	WAHT-MED-014

10 Background

10.1 Equality requirements

Refer to Supporting Document 1.

10.2 Financial risk assessment

Refer to Supporting Document 2.

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10.3 Consultation

Review and update to existing Policy

Contribution List

This key document has been circulated to the following individuals for consultation;

Designation
Anna Sterckx – Head of Patient , Carer & Public Engagement
Joanna Hendy – Clinical Lead, Acute Mental Health Liaison
Julie Noble – Health & Safety Manager
Emma Mackey – LD Liaison Service
Sam Jauncey – LD Liaison Service
Stuart Close - ISS Security
Patient Safety Team
BAME Network
Chris Doughty – Resuscitation Officer
Laura Veal – Consultant Obsteatrician
Healthcare Standards

This key document has been circulated to the chair(s) of the following committee's / groups for comments;

Committee
Integrated Safeguarding Committee
Clinical Governance Group
Patient Safety

10.4 Approval Process

This Policy will be approved via the Integrated Safeguarding Committee, Policy Working Group, and onward progression to CGG and Trust Governance Committees.

10.5 Version Control

This section should contain a list of key amendments made to this document each time it is reviewed.

Date	Amendment	By:
July 2023	Full Policy review and rewrite	Head of Safeguarding

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Supporting Document 1 - Equality Impact Assessment Tool
To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

NHS
Worcestershire
Acute Hospitals
NHS Trust

Herefordshire & Worcestershire STP - Equality Impact Assessment (EIA) Form
Please read EIA guidelines when completing this form

Section 1 - Name of Organisation (please tick)

Herefordshire & Worcestershire STP		Herefordshire Council		Herefordshire CCG	
Worcestershire Acute Hospitals NHS Trust	x	Worcestershire County Council		Worcestershire CCGs	
Worcestershire Health and Care NHS Trust		Wye Valley NHS Trust		Other (please state)	

Name of Lead for Activity	**Deborah Narburgh**

Details of individuals completing this assessment	**Name**	**Job title**	**e-mail contact**
	D Narburgh	**Head of Safeguarding**	**deborah.narburgh@nhs.net**
Date assessment completed	**05.07.2023**		

Section 2

Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.)	**Title:** Restrictive Interventions - Adults
What is the aim, purpose and/or intended outcomes of this Activity?	This Policy provides information and guidance on the use of restrictive interventions for adult patients within Worcestershire Acute Hospitals NHS Trust. The key principles within this document are: • Compliance with the Human Rights Act 1998 • Compliance with the Mental Capacity Act (2005) • Compliance with the Mental Health Act Code of Practice (2015) • Compliance with Department of Health best practice guidance – Positive & Proactive Care (2014)

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	• Compliance with Common Law principles • Any restrictive intervention must be necessary, reasonable, proportionate to the risk of harm, the least restrictive intervention and used for the least time possible • Involvement and participation of people with care and support needs and their representatives is essential, wherever practicable and subject to the person's wishes and confidentiality obligations • People must be treated with dignity, compassion and kindness • Staff must support people to balance safety from harm and freedom of choice • Positive relationships between people who deliver services and the people they serve must be protected and preserved • Understanding people's behaviour allows their unique needs, aspirations, experiences and strengths to be recognised and their quality of life to be enhanced
Who will be affected by the development & implementation of this activity?	x❑ Service User x❑ Patient x❑ Carers x❑ Visitors x❑ Staff ❑ Communities ❑ Other _____ ❑
Is this:	x❑ Review of an existing activity ❑ New activity ❑ Planning to withdraw or reduce a service, activity or presence?
What information and evidence have you reviewed to help inform this assessment? (Please name sources, eg demographic information for patients / services / staff groups affected, complaints etc.	Relevant Law and best practice guidance
Summary of engagement or consultation undertaken (e.g. who and how have you engaged with, or why do you believe this is not required)	Existing Policy /procedure
Summary of relevant findings	Rewrite to reflect current legislation and best practice principles. Strengthened document in accordance with at risk groups e.g. Learning disability, autism

Section 3

Please consider the potential impact of this activity (during development & implementation) on each of the equality groups outlined below. **Please tick one or more impact box below for each Equality Group and explain your rationale**. Please note it is possible for the potential impact to be both positive and negative within the same equality group and this should be recorded. Remember to consider the impact on e.g. staff, public, patients, carers etc. in these equality groups.

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Age		x		

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Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Disability		x		Best practice NICE guidance has been incorporated into Policy revision.
Gender Reassignment		x		Policy applicable to all adults
Marriage & Civil Partnerships		x		Policy applicable to all adults
Pregnancy & Maternity		x		Policy applicable to all adults
Race including Traveling Communities		x		Policy applicable to all adults
Religion & Belief		x		Policy applicable to all adults
Sex		x		Policy applicable to all adults
Sexual Orientation		x		Policy applicable to all adults
Other Vulnerable and Disadvantaged Groups (e.g. carers; care leavers; homeless; Social/Economic deprivation, travelling communities etc.)		x		Policy applicable to all adults
Health Inequalities (any preventable, unfair & unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental & economic conditions within societies)		x		Policy applicable to all adults

Section 4

What actions will you take to mitigate any potential negative impacts?	Risk identified	Actions required to reduce / eliminate negative impact	Who will lead on the action?	Timeframe

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How will you monitor these actions?				
When will you review this EIA? (e.g in a service redesign, this EIA should be revisited regularly throughout the design & implementation)				

Section 5 - Please read and agree to the following Equality Statement

1. Equality Statement

1.1. All public bodies have a statutory duty under the Equality Act 2010 to set out arrangements to assess and consult on how their policies and functions impact on the 9 protected characteristics: Age; Disability; Gender Reassignment; Marriage & Civil Partnership; Pregnancy & Maternity; Race; Religion & Belief; Sex; Sexual Orientation

1.2. Our Organisations will challenge discrimination, promote equality, respect human rights, and aims to design and implement services, policies and measures that meet the diverse needs of our service, and population, ensuring that none are placed at a disadvantage over others.

1.3. All staff are expected to deliver services and provide services and care in a manner which respects the individuality of service users, patients, carer's etc, and as such treat them and members of the workforce respectfully, paying due regard to the 9 protected characteristics.

Signature of person completing EIA	D Narburgh
Date signed	05.07.2023
Comments:	Policy applicable to all adults who may access services from the Trust.
Signature of person the Leader Person for this activity	
Date signed	
Comments:	

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Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document:	Yes/No
1.	Does the implementation of this document require any additional Capital resources	No
2.	Does the implementation of this document require additional revenue	No
3.	Does the implementation of this document require additional manpower	No
4.	Does the implementation of this document release any manpower costs through a change in practice	No
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	No
	Other comments:	Training for staff groups available via ESR.

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval

Appendix 1

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Table 1. Meanings of terms associated with use of restrictive interventions

Term	Meaning/notes
Restrictive intervention	Umbrella term for a whole range of acts that may infringe a person's human rights and freedom of movement, some of which are listed below. May also be called restraints
Chemical restraint	Use of medication – by intramuscular injection or given orally – to manage an individual's behaviour. Includes medication routinely prescribed or used "as required"
Physical restraint	Use of direct physical force to restrict freedom of movement
Clinical holding	Use of physical restraint to allow essential clinical assessment and treatment. Involves "immobilisation, which may be by splinting, or by using limited force". It can be a way to help children and adults, with their permission, to manage a painful procedure quickly or effectively (Royal College of Nursing, 2010). Should be recorded as a restraint
Prone restraint	A face-down, floor-based physical restraint, which is restrictive and risky for the person being restrained. Associated with high rates of injury and, in certain circumstances, death due to positional asphyxia
Seclusion	A particular type of environmental restriction whereby a person's freedom is restricted by confining them to a specific space (for example, a bedroom) or specially designated seclusion room. Does not necessitate locking of doors, as it could involve a worker holding the door from outside. Not to be confused with "time out", which is a punishment-based behavioural technique, or diversion to a low-stimulus environment (such as a quiet room) if an individual is over-stimulated or distressed – provided people are not confined there against their will and are free to leave at any point
Environmental restraint	Use of physical barriers to restrict freedom of movement, such as locked doors to restrict someone to an area (for example, a bedroom) or prevent them from accessing an area (for example, a kitchen)
Long-term segregation	The outcome when a multidisciplinary review and a representative from the responsible commissioning authority determine that a person should not be allowed to mix freely with other patients on the ward/unit on a long-term basis to reduce sustained risk of harm posed by the person to others (a constant feature of their presentation)
Mechanical restraint	Use of equipment that restricts freedom of movement – for example, handcuffs, belts, arm splints, some types of harness and restraint chairs
Restriction by default	Restricting someone in a more subtle way – for example, removing someone's walking aid so they cannot mobilise independently or placing furniture so that someone is unable to leave a room
Observations	Staff observations of an individual that may be required to maintain safety, depending on an individual's history and particular behaviours of concern. As this may be an invasion of the individual's dignity and privacy, it is regarded as a restriction
Technological surveillance	Use of technology (such as electronic systems, tracking devices or CCTV) to monitor a person's movements – although they may not, in themselves, restrict a person
Coercive practices	Use of threats, implied threats or other social pressures, such as taunting, mocking or humiliating, by people in positions of power (such as staff) to force supported individuals to do something against their will or stop them from doing something they would like to do

https://www.nursingtimes.net/roles/learning-disability-nurses/reducing-restrictive-interventions-in-people-with-challenging-behaviours-11-11-2019/

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