Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

STANDARD OPERATING PROCEDURE	**Safety Interventions and Clinical Holding for Adults SOP**
SOP ID NUMBER	**TW23-047 SOP 1**
VERSION NUMBER	**1.0**
APPROVING COMMITTEE	**Safeguarding Effectiveness Group (SEG)**
DATE THIS VERSION APPROVED	**July 2023**
RATIFYING COMMITTEE	**PARG (Policy Approval and Ratification Group)**
DATE THIS VERSION RATIFIED	**November 2023**
AUTHOR(S) (JOB TITLE)	**MCA/DoL's Lead**
DIVISION/DIRECTORATE	**Corporate**
WHICH POLICY ASSOCIATED TO?	Safety Intervention and Clinical Holding for Adults and Children Policy Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) TW13-039 Managing Violence and Aggression Policy TW10-028 Therapeutic Management of Vulnerable Adults with Challenging Behaviour.TW13-026 Restrictive Physical Intervention Therapeutic Holding and Restraint for Children and Young People TW13-026 SOP 2 Mental Capacity Amendment Act (2019). Mental Health Act (1983) Human Rights Act (1998) NICE guideline [NG11]Published: 29 May 2015 CQC briefing Guide on mechanical and Physical Restraint WWLNHS Safeguarding Adults Policy TW21-034 Appropriate Use of Enhanced Care TW16-027 Bed Rails Policy- TW16-027 Delirium: The Prevention, Recognition and Management of Delirium in Critical Care TW17-015 Nasal Bridle Policy TW10-007 Covert Medication SOP TW10-037 SOP 18 Use of Mittens SOP TW12-019 Dignity in Care Policy TW13-030
CONSULTED WITH?	Safeguarding Effectiveness Group Least Restrictive Core Group NMALT NMAHP

DATES PREVIOUS VERSION(S) RATIFIED	
DATE OF NEXT REVIEW	**November 2026**
MANAGER RESPONSIBLE FOR REVIEW (Job Title)	**Assistant Director of Safeguarding**

AT ALL TIMES, STAFF MUST TREAT EVERY INDIVIDUAL WITH RESPECT AND UPHOLD THEIR RIGHT TO PRIVACY AND DIGNITY

VERSION CONTROL

Version	Date	Amendment

1. INTRODUCTION

1.1 Restrictive Practice is defined as '*any practice or intervention that has the effect of restricting the rights or freedom of movement of a person with the primary purpose of protecting the person from harm or harming others*.'

1.2 Least restrictive practice means applying a model of care that enhances the person's autonomy, and respects their rights, individual worth, dignity and privacy.

1.3 Least restrictive practive promotes a strength based and person centred approach to delivering care and support whilst minimising the use of restraint. This approach can be used with individuals who may present with behaviour that challenges. Least restrictive practice involves person-centred planning, communication and effective recording and monitoring.

1.4 Staff must be aware of any restrictions that they may be placing the patient under when they are delivering care.These include the use of cotsides, covert medications, hand mittens etc. Staff should ask themselves whether these restrictions are necessary and have they explored all other methods of engaging the person and delivering the care needed.

1.5 Often the use of restrictive practice is when the person is displaying behaviour that challenges. This has been recognised as a means of communicating need in both the person with or lacking capacity. Behaving in a particular way may allow an individual to obtain something tangible or to avoid a situation they do not wish to participate in.

1.6 To enable an individual the most opportunity to communicate with those around them, staff must plan for and accommodate their communication needs; this could be through simply giving the person the time and opportunity to speak. It may also be, by facilitating communication through Makaton, visual aids or utilising other professionals or family and friends who know the person well to understand the best way to communicate. Whatever their requirements, effective communication is essential to delivering person-centred least restrictive care.

1.7 Trauma in childhood can have a significant negative impact on people throughout their lives due to their feelings of disempowerment, perception of reduced control or autonomy, lack of trust in others and feelings of unworthiness. This can manifest as presenting behaviours symptomatic of Trauma and which should be addressed sensitively and appropriately.

1.8 Trauma informed care and practice is a strengths-based framework that emphasises physical and psychological safety, creating opportunities for people with lived experience to rebuild a sense of control and empowerment. It supports services moving from a caretaker to a collaborator role, as well as providing a supportive environment for workers, reducing the risk of vicarious and secondary trauma.

1.9 Every patient and service user should have a Person-Centred Plan, which is created in collaboration with the person (and/or an advocate) and their network of support. Care Plans will be developed that reflect the outcome of Person-Centred Care, should reflect the individual's communications needs, and management of known behaviours that challenge. Plans will contain bespoke, and progressive goals.

2. DEFINITIONS

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

2.2 Chemical restraint: the use of medication which is prescribed and administered for the purpose of controlling behaviour, where it is not prescribed for the treatment of a formally identified physical or mental illness.

2.3 Environmental restraint: the use of obstacles, barriers or locks to prevent a person from moving around freely. Additionally, the use of enhanced observation to supervise a person and not allow them to freely leave.

2.4 Mechanical restraint: the use of a device (eg mitts) to prevent, restrict or subdue the movement of a person's body.

2.5 Proportionate response: using the least intrusive and minimum amount of restraint to achieve a specific outcome.

3. PROCEDURE

3.1 Identification of the early signs that the person is becoming distressed should be addressed to prevent an escalation of the behaviour. If the person has a previous history of certain behaviours, then recognition of these signs should be documented and the staff caring for the person should be made aware.

3.2 The Procedure must:

- Comply with national policy
- Ensure standards in quality of practice
- Reduce risk to the individual and others
- Encourage staff to consider their practice
- Be able to justify the need for any restrictions implemented
- Reduce the risk of low level restrictions developing into more severe restrictions
- Be regularly reviewed
- Establish restriction reduction plans

3.3 Please follow flow chart for de-escalation guidance (appendix 2).

3.4 If physical restraint is required for de-escalation or clinical holding for medical intervention, please follow flow chart (appendix 3).

4. HUMAN RIGHTS ACT

Implications of the Human Rights Act have been taken into account in the formulation of this document and they have, where appropriate, been fully reflected in its wording.

5. ACCESSIBILITY STATEMENT

This document can be made available in a range of alternative formats e.g. large print, Braille and audio cd.

For more details, please contact the HR Department on 01942 77 3766 or email equalityanddiversity@wwl.nhs.uk

APPENDICES

APPENDIX 1

DEFINITIONS OF RESTRICTIVE INTERVENTIONS		EXAMPLES
Physical Restraint	Any direct physical contact where the intervener's intention is to prevent, restrict, or subdue movement of the body or part of the body of another person	Physically holding Level 4 enhanced care
Chemical Restraint	The use of medication which is prescribed and administered for the purpose of controlling or subduing behaviour.	Use of oral/SC/Im sedations e.g. haloperidol, lorazepam Oral sedations given covertly
Environment Restraint	The use of obstacles, barriers or locks to prevent a person from moving around freely	Door lock
Seclusion	The supervised confinement and isolation of a person away form others, in a n area from which the person is prevented from leaving	Use of 1:1 in side room
Psychological Restraint	Depriving a person of choices, controlling them through not permitting them to do something, making them do something of setting limits on what they can do, without physically intervening. The includes the use of threats of coercion	Using threatening language
Mechanical Restraint	The use of a device to prevent, restrict or subdue the movement of a person's body or part of the body, for the purpose of behavioural control	Use of bed rails, mittens, Naso Gastric Tube bridles

APPENDIX 2

If the patient displaying behaviours that are a risk to themselves or others:

Approach the person from the side
Remain calm and ask the person if there is something you can do to help
COMMENCE DE-ESCALATION TECHNIQUES

Consider Environmental factors which may be causing or contributing to this behaviour. Adapt or modify the environment where possible to reduce stress triggers or stimuli. Consider the following:-

- Noise
- Lighting
- Temperature

ENCOURAGE PATIENT TO MOVE TO A QUIETER AREA ON THE WARD/DEPARTMENT TO MAINTAIN THEIR PRIVACY AND DIGNITY

COMMUNICATION IS ESSENTIAL IN DE-ESCALATION

Give the person your full attention
Actively listen, be non judgemental, be empathetic, paraphrase what they are telling you to let them know you have heard them
Ensure correct method of communication including verbal and non verbal methods, pictures, MAKATRON, hearing amplifiers, liaising with family or other professionals including the Learning Disabilities Team, Interpreter services (BSL, Language)
Identify any unmet needs
Consider Trauma Informed Care:-
the person may be reliving a traumatic experience and may not respond to verbal directives
- **keep them safe and wait for the experience to finish**

Address Underlying Causes/Unmet Needs
Physiological , psychological and pharmacological, pathological reasons for behaviour eg, pain and discomfort, thirst, hunger, constipation, fear, withdrawal from drugs and or alcohol, acute delirium.
Person revisiting previous trauma
Review and update persons care plan

Does the person have capacity to consent to the restrictions?

If patient has capacity and **does not consent** restrictions cannnot be put in place
Contact security/police
submit Datix report

YES NO

If the person is lacking in capacity
Complete the Mental Capacity Assessment on HIS and submit a Derpivation of Liberty (Dols) Form 1
Inform Next of Kin

When restrictions are deemed necessary ensure least restrictive and proportionate option is identified and implemented.
If restrictions are required to undertake clinical interventions, please follow relevant policy and SOP (i.e., use of covert medications, use of mittens, use of NG bridle)

Once restrictions have been implemented staff must ensure that the patient's care plan is updated with relevant information including:

- Reason for restriction
- Duration of restriction with times for review
- De-escalation plan
- Document Nok informed

COMPLETE DATIX AND POST INCIDENT DEBRIEF

Appendix 3

Crisis Development Model Aide Memoir

The purpose of the Crisis Development Model a four stage model to guide staff to use the right approaches for the person and minimise the likelihood of risk behaviour escalating and restrictive practices being used.
In the event that a restriction is required to maintain safety of either staff, the patients or visitors to the trust then the lowest level of restraint should be used for the minimal mount of time to re-establish a safe environment.

Disengagement Techniques

Principles of Disengagements	
Hold and Stablise (limit the range of motion)	When someone is holding you, they may simply need your attention, reassurance or stability. Hold and stabilise allows you to limit the persons movement to prevent harm.
Pull/Push (move in opposide directions)	Pulling and pushing at the same time in opposite directions weakens the persons grip whilse minimising any pain or injury.
Lever	Combinging momentum with movement around a single point creates linear and angular motion which can be more effective than pull/push

Key areas for consideration

- Duty of care with the best interest of the person in distress
- Any actions must be reasonable and proportionate to the behaviour
- Safety interventions must be the last resort and least restrictive
- The risks of doing something vs the risk of doing nothing
- You must uphold the persons human rights

Risk Assessment

Developing critical decision making skills enables you to remain in control of your own emotions and behaviours so staff can makde appropriate judgements about next steps.
In some situations, for example where clinical holding may be necessary, a risk assessment should be used to determine the threshold of reasonable, proportionate to the risk and least restrictive.

Holding Skills

At times, a physical response may be necessary to risk behaviours as a last resort.

Principles of Holding	
Outside/Inside Principle	Placing something on the outside and something on the inside of the limb and or body.
Limit the range of motion	Limiting or restricting the persons movement in order to manager the persons dynamic movement and prevailing risk.

Levels of Hold	
Low Level Hold	Minimum of 2 persons
Medium Level Hold	2-3 persons
High Level Hold	2-3 persons
Team Intervention	Minimum of 3 persons

Key areas for consideration

Physical restraint can have an adverse impact if performed incorrectly.

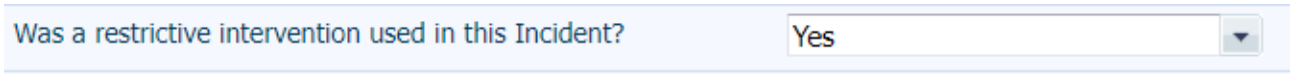
Psychosocial Injury	Including post traumatic stress disorder and damage to therapeutic relationships.
Soft Tissue Injury	Including injury to skin, muscles, ligaments and tendons.
Bone Injury	Including injury to joints and bones.
Respiratory Reduction	Including compromise to airway and gaseous exchange, which may result in respiratory failure.
Cardiovascular Compromise	Including compromise to the heart and the peripheral vascular system

At any time if a staff member is concerned about the individuals welfare and safety, they should clearly state 'medical emergency'. The term 'medical emergency' is an instruction for everyone involved in the restraint to immediately let go of the individual and begin necessary emergency aid.

Appendix 4

Reporting a restrictive intervention – Datix

Where a restrictive intervention is part of an incident response, this should be documented on the DIF2/DIF3 Datix Incident Form by selecting 'Yes' in the mandatory information section as shown below:-

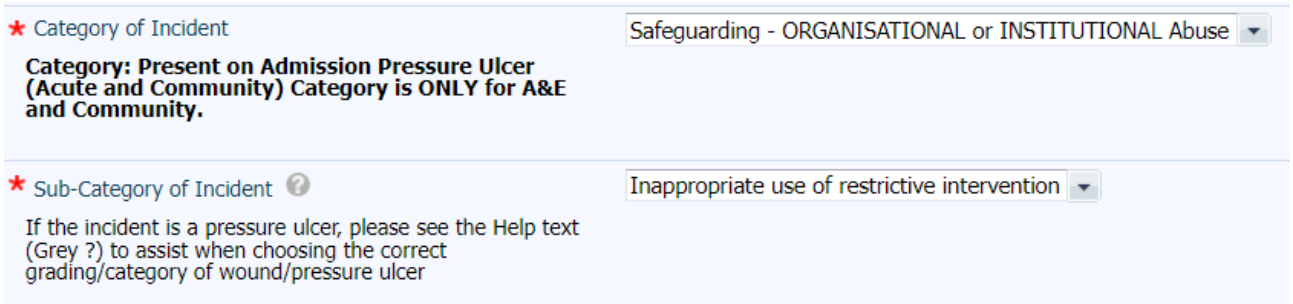


Select 'restrictive intervention' from the left hand menu and complete the restrictive intervention assessment form.

Where the inappropriate use of a restrictive intervention is the main focus of the incident, a separate incident DIF1 Form should be submitted using the most relevant category of incident from the following list:-

Safeguarding – Physical Abuse Incident:

Safeguarding – Organisational or Institutional Abuse Incident:



Security Incident: