NHS
Humber Teaching
NHS Foundation Trust

Physical Restraint Policy
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1. INTRODUCTION

Some people who need the support of mental health and learning disabilities services require on occasions to be cared for under special conditions that are viewed as restrictive interventions. Even when restrictive interventions are used as an appropriate response to maintain safety, it is accepted that the potential negative outcomes, including physical and psychosocial trauma, can lead to fragmented therapeutic relationships and inequalities of care and support. When using restraint, staff need to be aware of the risks of re-traumatising those individuals who have a history of trauma, and need to ensure they are working in a trauma informed way.

Humber Teaching NHS Foundation Trust is committed to reducing the use of restrictive interventions. Where restrictive interventions are used to prevent harm to the patient or others, services will ensure that they are used:

- Safely and effectively
- As a last resort
- With the least possible force, and
- For the shortest possible duration.

These commitments are met by staff training, working collaboratively with patients and their families, ensuring good leadership of services, maintaining appropriate environments, availability of meaningful therapies and activities, individualised care (which includes crisis and risk management plans), support and engagement, and the involvement and empowerment of patients.

This policy outlines the statutory responsibilities of all staff in relation to the physical restraint of patients under our care. The associated procedures, review requirements and documentation for physical restraint of patients are addressed separately and described more fully within respective appendices to this Policy. Governance processes are detailed in section 9 - Monitoring and Audit.

The Mental Health Act – Code of Practice 2015 defines physical restraint as being "*direct physical contact where the intention is to prevent, restrict or subdue movement of the body (or part of the body) of another person*".

The Code of Practice (26.62) clearly stipulates that: "*Restrictive interventions should never be employed to deliberately punish or humiliate, and staff should not cause deliberate pain to a person in an attempt to force compliance with their instructions except in the most exceptional circumstances to mitigate an immediate risk to life".*

The policy should be read in conjunction with Chapter 26 of the MHA 1983 Code of Practice (2015) on safe and therapeutic responses to disturbed behaviour.

The guiding principles related to the Mental Health Act are:

Least restrictive option and maximising independence Where it is possible to treat a patient safely and lawfully without detaining them under the Act, the patient should not be detained. Wherever possible a patient's independence should be encouraged and supported with a focus on promoting recovery.

Empowerment and involvement Patients should be fully involved in decisions about care, support and treatment. The views of families, carers and others, if appropriate, should be fully considered when taking decisions. Where decisions are taken which are contradictory to views expressed, professionals should explain the reasons for this.

Respect and dignity Patients, their families and carers should be treated with respect and dignity and listened to by professionals.

Purpose and effectiveness Decisions about care and treatment should be appropriate to the patient, with clear therapeutic aims, promote recovery and should be performed to current national guidelines and/or current, available best practice guidelines.

Efficiency and equity Providers, commissioners and other relevant organisations should work together to ensure that the quality of commissioning and provision of mental healthcare services are of high quality and are given equal priority to physical health and social care services. All relevant services should work together to facilitate timely, safe and supportive discharge from detention.

There is an acknowledged implication that the use of physical restraint involves the use of force against resistance, and the Care Quality Commission requires that patients must not be subject to "unnecessary or disproportionate restraint" (CQC, Fundamental Standards).

Humber Teaching NHS Foundation Trust is committed to reducing the use of all restrictive interventions, and to ensuring that they are only used as a last resort, when all other options have been explored. The deliberate application of pain or of painful holds during restraint cannot be justified unless there is an immediate threat to life.

2. SCOPE

This policy is aimed at all staff who are concerned with the use of physical restraint in all Trust mental health and learning disability inpatient settings. This includes staff applying physical restraint and those responsible for the training, management, monitoring and evaluation of staff and their performance in this area of practice.

This policy will be used to guide practice in any service or incident where physical restraint is considered or used.

This policy does not concern itself with the application of disengagement techniques or the use of other restrictive interventions.

All instances of restraint on Trust premises must be reported onto Datix.

3. POLICY STATEMENT

All staff have a statutory obligation to follow the standards and processes set out within the Mental Health Act (1983) Code of Practice 2015 and the Mental Health Units (Use of Force) Act 2018. The procedures outlined in this Policy are in line with the requirements of the Code and the statutory guidance to the Mental Health Units (Use of Force) Act 2018. There must be no exceptions.

The policy aims to:

- ensure the physical and emotional safety and wellbeing of the patient.
- ensure that the patient receives the care and support rendered necessary by their restraint both during and after it has taken place.
- set out the roles and responsibilities of staff, and
- set requirements for recording, monitoring and reviewing the use of restraint and any follow-up action.

4. DUTIES AND RESPONSIBILITIES

Chief Executive
The chief executive has overall responsibility to ensure that policies and processes are in place for the treatment of the patients subject to restraint.

Chief Operating Officer
The chief operating officer as lead director has responsibility to ensure that this policy is understood and adhered to by all clinical staff and that all the processes are in place to ensure the policy is fully implemented.

Medical Director
The medical director is responsible for ensuring that this policy is understood and carried out by medical staff involved in the implementation of this intervention.

Divisional Clinical Leads
Have responsibility for ensuring that all clinical staff within the division are familiar with the requirements of the policy and are able to implement them.

Modern Matrons
The modern matrons have the responsibility to ensure that all nursing staff working within inpatient areas comply with the policy and ensure it is implemented effectively and safely.

Responsible Clinician
Has specific responsibilities for the review of restraint and has ultimate responsibility for the care and treatment of the patient.

Charge Nurses/Registered clinical staff/other clinical staff
Must be aware of and comply with their responsibilities to implement the policy.

Clinician involved in restraint
Will ensure that the requirements of the Restraint Policy are met during any episode of restraint, specifically including:

- An awareness and understanding of Chapter 26 of the MHA Code of Practice (the Code)
- Use of the Trust- approved training model of restraint (De-escalation management intervention (DMI))
- Following the patient's Positive Behaviour Support plan wherever possible
- Monitoring physical condition whilst the patient is in restraint
- Communicating with, and responding to requests from, the patient in line with the management plan
- Calling for assistance from colleagues as required
- Escalating concerns about the patient immediately if any concerns arise
- Completion of Lorenzo adverse incident form and Datix

5. PROCEDURES

5.1. Approved Model of Physical Restraint

The Trust has a single approved model of physical restraint for mental health and learning disability services De-escalation management intervention (DMI) https://dmi.mpft.nhs.uk.

The continued suitability of this model of physical restraint, and of the quality of the training delivered to staff, will be the concern of Divisions in conjunction with the Training Department. This

will include staff and patient feedback and any additional intelligence/information through an appropriate feedback model.

5.2. Training

All staff undergoing DMI training will be required to complete BLS or ILS training and be refreshed annually in line with statutory/mandatory requirements. For those staff working in children's services they will need to be up to date with PILS (paed immediate life support) and have attended consent training which will cover the assessment of 'Gillick' competency, Mental Health Act and Mental Capacity Act (MCA) training.

Staff working in environments whereby physical restraint maybe required must be up to date with the mandatory training on Autism and Learning Disabilities i.e. Oliver McGowan.

Managers of staff entering a post where physical restraint may occur must prioritise this training on induction and ensure that refresher training takes place through the managerial supervisory process. An inability to complete the training will be addressed in conjunction with the Personnel/Human Resources Department with regards to the staff member's ability to fulfil the requirements of the post.

Where staff are not expected to participate in physical restraint but work in an environment where there are specific risks in relation to challenging behaviours, they must be made aware of what will be expected of them should an incident take place (which may range from taking no action, raising the alarm, or supporting others by sitting with the other patients for example).

Physical restraint refresher training will be undertaken annually a standard of DMI a requirement of CQC and new training standards. By exception in agreement with the Positive Engagement Team this can be extended, depending on individual circumstances.

DMI restraint training will include:

- Conflict resolution
- De-escalation
- Restraint techniques
- Disengagement techniques

Additional training, which includes use of safety pods, will be provided to staff working within the CAMHS inpatient service who may be involved in the restraint of young people in relation to nasogastric feeding.

Divisions will monitor compliance levels of staff training in the use of physical restraint through monthly performance reports.

5.3. Implementation of Physical Restraint

Pre-assessment: All patients undergo a physical health screen on admission to an inpatient unit; this screening will highlight any conditions that may increase the risk of harm or present as challenges in the event that restraint may be required.

With the exception of non-urgent cases (see 5.3.12 below), physical restraint will be considered as one of a range of restrictive interventions, including seclusion and rapid tranquillisation. Any combination of these should only be used as a last resort, when reasonable alternatives have been exhausted or are not available, including attempts at de-escalation. The intervention(s) applied must be the most proportionate response to the nature and degree of risk that is to be managed: protecting the patient from self-harm or harm to others. For some individuals, restraint may carry more risk compared to other approaches such as seclusion. Proportionate clinical rationale must be given whenever a restrictive intervention is utilised.

It is important that sufficient members of staff that are appropriately trained are used in the implementation of physical restraint. This may vary subject to the situation and planned intervention and will be described in DMI training. The Trust has a duty under the Health and Safety at Work Act to ensure that there is sufficient staff on duty, appropriately trained to manage incidents of violence and aggression. Should staff members not feel able to safely respond to the situation, for example an individual is using or threatening use of a weapon, the police must be called by dialing 999 (See Appendix 2).

It is expected that staff rostering will include ensuring that sufficient appropriately trained staff are on duty in order to effectively implement restraint when necessary. Where this is not the case, escalation processes must be used to highlight this to managers in order that the safer staffing requirements are met, in line with the division staffing escalation SOP.

Any use of physical restraint must be necessary, appropriate, reasonable, proportionate and justifiable to that individual. It must be for the minimum amount of time that is possible.

Any use of physical restraint will respect the dignity, human rights and (where possible) the preferences of the patient, as may have been agreed in an advance decision and this will include consideration of cultural, gender and any other pertinent issues. For example, in the case of an Autistic patient, the restraint may cause additional pain and further distress due to sensory issues. Staff will be aware of the requirement that article 8 of the European Convention on Human Rights prohibits inhuman or degrading treatment.

All restrictive interventions can pose risks (which can include positional asphyxia), and these risks can vary between interventions and between individuals. Staff will practice in such a way as to ensure that any such risks are eliminated or minimised.

The Code states:

"*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 monitor the individual's airway and physical condition to minimise the potential of harm or injury. 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;*
- *emergency resuscitation devices should be readily available in the area where restraint is taking place; and*
- *a member of staff should take the lead in caring for other patients and moving them away from the area of disturbance.*" (Chapter 26.71).

The Code requires that all patients who are assessed as liable to present with behavioural disturbance have a care or treatment plan focused on this. As well as describing preferred primary and secondary de-escalation techniques, the care or treatment plan should also describe tertiary strategies, which for some patients may include restraint. All such patients in Trust mental health and learning disability wards will have an individualised and wide ranging care or treatment plan which should, wherever possible, be devised in conjunction with the patient and their carers. The care or treatment plan will include the expressed preferences of the patient, known effective de-escalation techniques, any known physical risks attached to restraint. Patients who are well known with longer term contact with services may benefit from having a Positive Behaviour Support (PBS) plan.

In the event it is unavoidable to use floor-based restraint patients should be held in the supine (face up) position.

Preparing for, during and after an episode of physical restraint, a member of staff will lead the restraining team and be responsible for the patient's physical wellbeing, protecting and supporting the patient's neck and airway, communicating with the patient and monitoring the patient's vital signs.

Consideration must also be given to the likely psychological impact of physical restraint, and staff will be aware that the experience of being restrained may be traumatic for all patients and it risks re-traumatising people with a trauma history. In addition, those with sensory challenges will be unduly traumatised by any physical contact e.g. Autism. Patients' preferences in terms of the gender of staff carrying out such interventions should be sought and respected. Any expressed preferences will be described in a care or treatment Plan and followed. In the event of an emergency intervention where those preferences are not met, this must be clearly recorded in the patient record and appropriate support and explanation provided to the patient.

If there is any indication of deterioration in physical health and/or of physical distress, the restraint is to be discontinued immediately and medical assistance sought. This may be the medic on call or 999 dependent on clinical assessment by the lead clinician for the restraint.

Prolonged restraint (NICE NG10, 2015 suggests 10 minutes) should be avoided where possible. In the event of a prolonged restraint, consideration should be given to alternatives, such as the use of seclusion or of rapid tranquillisation.

The deliberate application of pain or of painful holds during restraint cannot be justified unless there is an immediate threat to life.

5.4. Prone Restraint

Face down restraint has been highlighted as a high risk restrictive intervention implicated in the deaths of individuals due to asphyxia. The Department of Health (2014) advocates for the significant reduction in the use of prone restraint If prone restraint is necessary, use it for as short a time as possible (NICE NG10, 2015).

In HTFT prone restraints are by exception and not used unless absolutely necessary. It should only ever be used to promote the safety of, and prevent injury to, the patient. All incidents of prone restraint are scrutinised in the Reducing Restrictive Intervention group (RRI) and in Clinical Risk Management Group.

Prone restraint is dictated by the patient either due to:

a. The motion they are going i.e. pushing forward on their knees going forward to the floor.

b. It may be the preferred way the patient has stated they would like to be supported in restraint and is included in the patient's care plan; this could be in an advance statement.

c. Trauma informed care - the patient has stated or shown signs of distress when in a supine restraint.

Prone restraint is taught in DMI to manage specific interventions and the Trust will support staff that utilise face down prone restraint, if necessary, in those situations only.

Seclusion - unless the patient willingly takes themselves into the seclusion suite (the preferred option), they are supported in a level 2 hold, and asked to walk forward into the suite and staff then walk away from the patient towards the door. If more restrictive intervention is required the person will be supported in a level 3 hold with a 3rd person in front and the patient is asked to go to their knees, 3rd person is then removed, then arms released leaving the patient sat on their knees.
If the patient dictates that they are going to prone i.e. they continue to push forward, staff are taught to safely manage the decent forward and either exit as soon as they can or turn the patient over depending on the dynamic risk assessment at the time. If a patient has any mobility issues they must not be left in a prone (face down) position.

Administration of Rapid Tranquilisation (RT) - there are circumstances where a patient is unwilling to accept medication and RT is the appropriate option to support the immediate management of violent and aggressive behaviour.

All other methods of delivery must be considered before the use of prone restraint for the administration of RT:

a. Patient preference, advance statement and trauma informed care
b. Patient is standing (all appropriate IM sites)
c. Supine with arm down by the side of the body (IM Deltoid)
d. Side loading - IM in the Deltoid (patient laying on their side - IM MUST be ready for Administration and in the room as the patient weight will be on the arm close to the ground).
e. Side Loading - IM in the Vastus Lateralis and rectus femoris (patient laying on their side - IM MUST be ready for Administration and in the room as the patient weight will be on the arm closed to the ground).

Another consideration to reduce the amount of time in side loading would be a safe delivery system that could be given through clothing (i.e. how an EpiPen can be given IM through clothing).

Whenever face down prone restraint is utilised, a medic must attend the ward and review the patient within one hour of application. Any patient who is administered RT or is secluded is also subject to a medical review within one hour, therefore the medical review should include a review of all restrictive practices and the psychological and physical wellbeing of the patient.

The nurse leading the restraint where face down prone restraint has been utilised must ensure the commencement of physical observation monitoring must commence physical observation monitoring every 15 minutes for the first hour until medical review is completed. If the patient refuses intervention this must be recorded in the notes and a general observation made of their presentation and behaviour. Any concerns must be reported to the medic on review or where serious concerns are observed call 999.

Following medical review, an agreed schedule of ongoing monitoring can be agreed as required for the patient.

A Datix **must** be completed for the application of face down prone restraint. Details must include the rationale (Seclusion exit/IM administration) utilising the restraint forms in order that accurate monitoring and reporting of the use of face down restraint can take place. This **must** be scanned into the Datix.

All prone restraints will be reviewed weekly at the Corporate Safety huddle and the Trust Clinical Risk Management Group.

Datix incidents will be reviewed within the operations directorate and the Charge Nurse and/or Matron will contact the DMI team as they deem appropriate, requesting a review on the restraint that took place being in line with the training, and whether additional training would be beneficial.

A quarterly report will go to RRI (generated by the Chief Operating Officer) detailing the incidents that have occurred, the investigation outcome and the recommendations. This report will enable the Trust to determine if more exploration work is needed on incidents relating to restraint. It will be fed into the MH legislation steering group and into committee in line with current governance arrangements.

The DMI team may be contacted by a charge nurse and/or matron if they require bespoke individualised training in relation to the care team's management of a patient.

5.5. Planned Restraint

In certain circumstances, it may be appropriate to use physical restraint as a planned intervention to carry out a clinical procedure, such as taking bloods, or assist patients with their personal care (see 5.9.2).

Where restraint is planned as a potential intervention to provide personal care, there must be documented evidence of a capacity assessment and best interest discussion, in line with the safeguards provided within the Mental Capacity Act. This must involve the carer and other professionals and provide clear rationale as to why a level of restraint may be required in order to meet personal care needs.

The decision should be recorded in the care plan and recorded in Lorenzo under the restrictive intervention tab. This will enable the Trust to have oversight of all planned restraints currently approved within the Trust.

The decision must be reviewed every four weeks by the MDT and two professionals independent to the MDT on the unit. Suggested appropriate professionals could include representative from the Trust Safeguarding team, senior nursing professional from Nursing and Quality Directorate, consultant psychiatrist or psychologist from another unit, divisional lead, matron from another Division.

In the event that restraint is utilised to support a patient who is not detained under the Mental Health Act and who does not have capacity to meet their personal care requirements or a physical intervention, this must be clearly documented as time and date specific within their notes as having been part of a MCA and Best Interest process.

Observation of the wrists and arms where holds have taken place should be undertaken after every restraint to ensure that any change to skin integrity is noted and a record made on a body map. Carers should be updated if any concerns arise about skin integrity. Physical observations and medical intervention should only be required if the patient escalates as per 5.5.7.

It is essential that consistent categorisation of incidents is followed, without which data to compare progress against our 'Reducing the Need for Restrictive Interventions' plan will be un-measurable. Following any occasion where an unplanned restraint intervention is used a full record should be made in the clinical notes and this should be formally reported through Datix. Planned restraint

needs to be an MDT decision, including Safeguarding, that is care planned for and each episode is recorded via an adverse incident on the right hand side of the screen in Lorenzo (if recorded in the adverse incident tab in clinical charts this does not report via the MHDS); a datix is not routinely required.

Clinical judgement is required as to when a planned restraint intervention may have to be escalated and becomes a clinical incident on Datix. Should a patient become distressed and resist the intervention beyond the known or anticipated need, which results in a higher level of hold or the intervention of other staff than is defined in the care plan, this should then be regarded as a restraint to manage aggressive behaviour and be recorded as clinical incident on Datix. In these cases staff should also follow the guidance for observations and review in line with unplanned restraint.

All episodes of planned restraint should be reviewed at least weekly with the MDT and evidence of this should be found in the MDT notes.

Any restraint that involves taking a person to the floor cannot be pre-planned and must be recorded as a clinical incident. All prone restraints are reviewed by the Corporate Safety Huddle and the CRMG.

5.6. Restraint: Children and Young People Under 18

Where the use of restrictive physical interventions is concerned, consideration must be given to the rights of the child and the legal framework surrounding children and young people. Physical restraint must be used with great caution in children and young people due to the increased risk of injury associated with immature musculoskeletal systems. Restraint has been identified as harmful to children and young people, particularly in secure services. Clinical holding has been distinguished from restrictive intervention by the degree of force used, the intention of the hold and the agreement of the young person, (Bray et al. 2014) but should still be considered a restrictive physical intervention and reported via Datix.

If restraint is the only option, nursing staff must ensure that physical observations are undertaken every 15 minutes post-restraint for a minimum of one hour. A member of staff must be assigned to observe the young person for the initial four-hour period following individual risk assessment. Refusal to allow physical observations to be taken must be recorded in the records and documented assessment of the young person's presentation must be made in place of these observations. The initial hour of observation and recording of PAWS (young people under 16)/NEWS 2 (over 16/adults) must be undertaken by a registered practitioner.

Whenever face down prone restraint is utilised, a medic must attend the ward and review the patient within one hour of application. For all other situations where a patient has been restrained consideration must be made as to whether or not a medical review is required. This should be based on the level of restraint used, the length of time a person was restrained, their individual history (for example physical health, mental health, trauma), physical exertion used during the restraint, any injuries observed or reported, and their presentation immediately following the restraint. Based upon this, it is then at the discretion of a registered nurse as to whether or not a patient requires a medical review face-to-face, a telephone consultation with a medic, or ongoing follow-up by a registered nurse/ongoing monitoring by the nursing team.

The admission/welcome documentation shared with families and or carers supporting a young person into the CAMHS inpatient services. Must include information that informs on the potential for restrictive practice including, restraint, seclusion or rapid tranquilisation. The wording needs to ensure understanding that this is not routine practice and will only be implemented should the young person become a serious risk to themselves or others as a result of deterioration in mental health and wellbeing.

5.7. Specific considerations for Physical Restraint of those people who are or who may be autistic or neurodivergent:

- Staff working in environments whereby physical restraint maybe required must be up to date with the mandatory training on Autism and Learning Disabilities i.e. Oliver McGowan.
- Any use of physical restraint will respect the dignity, human rights and (where possible) the preferences of the patient, for example in the case of an Autistic patient, it will be taken into consideration that the restraint may cause **additional pain** and further distress due to potential sensory issues.
- Consideration must also be given to the likely psychological impact of physical restraint, and staff will be aware that the experience of being restrained may be traumatic for all patients and it risks re-traumatising people with a trauma history. In addition, those with sensory challenges may be unduly traumatised by **any** physical contact.
- Staff should not assume understanding as in some cases a patient maybe struggling with their thought processes which will disable their ability to fully understand at different times e.g. Autistic patient, maybe struggling with overwhelm, sensory overload, delayed processing of information etc. Those who are autistic may agree without fully understanding the context of what is being said at the time i.e. people pleasers. Additional time may be necessary to consider questions being asked.
- To consider reasonable adjustments to be made when explaining and providing information, such as written information for those more visual in their processing.
- Move patient to a quiet area to enable them to "stabilise", as if sensory overwhelmed may find the environment challenging which could be contributory to any anger outbursts or sudden changes in behaviour i.e. they may need to feel safe versus the need for restraint. Ideally this quiet area would be identified in advance with any autistic patients, so they know where this area is and may indeed follow staff if prompted to the area.

5.8. The Police use of Restraint in Mental Health and Learning Disability Settings

A memorandum of understanding has been approved which outlines the circumstances in which police may be called to support providers of mental health and learning disability services.

The police have key commitments to providers, staff and patients which include (but is not limited to) for the purposes of this policy:

- Through effective response; the prevention of immediate risks to life and limb, immediate risk of serious harm to persons or serious damage to property

Should a situation that requires restraint and the potential for additional restrictive interventions be required, in order to manage a serious patient safety incident; it is the Provider duty to ensure that enough staff are on duty and are adequately trained to carry out these procedures. The police may be required if there are immediate concerns of risk with serious injury and existing mechanisms have been unsuccessful. Staff should ensure in these circumstances when calling the police for immediate response they outline the immediate risks and severity.

Staff should ensure they read the Memorandum and note example scenarios. Additional work to further develop the MoU between Humberside Police and Humber Teaching NHS Foundation Trust will take place through the Crisis Care Concordat:

5.9. Use of restraint in Acute Hospitals

Patient detained under the MHA to a ward in an acute hospital.
Under these circumstances the acute hospital is the detaining authority; the patient is **not** Humber's patient. Humber have a Service Level Agreement (SLA) with the acute Trust to provide a nominated Responsible Clinician, but the acute Trust are responsible for commissioning their own mental health nursing support where required.

Patient detained under the MHA to a Humber unit but subsequently admitted to a ward in an acute hospital (i.e., patient taken to HRI under S17 leave due to physical health condition)
Under these circumstances Humber remains the detaining authority, so the patient continues to be our patient. Humber staff can support the acute hospital in physical restraint if it is in relation to health problems relating to the patient's mental health condition. This would require pre planning with acute staff regarding the use of restraint in these incidences where possible.

Without written agreement from the acute Trust (i.e. in the form of an SLA) to carry out restraint on their behalf, Humber staff cannot support HRI in physical restraint if it is for physical health issues **unless** there are proper clinical grounds to believe that they are the symptoms or manifestations of a disability or disorder of the mind i.e. eating disorder or injuries caused by self-harm due to the mental health condition.

It is permissible for Humber staff to utilise physical restraint if the physical hold is to prevent the patient from harming themselves or others.

Mental Health Act Code of Practice

13.37 "The Act regulates medical treatment of mental disorder for individuals who are liable to be detained under the Act. This may include treatment of physical conditions that is intended to alleviate or prevent a worsening of symptoms or a manifestation of the mental disorder (e.g. a clozapine blood test) or where the treatment is otherwise part of, or ancillary to, treatment for mental disorder.

13.38 Where individuals liable to be detained under the Act have a physical condition unrelated to their mental disorder, consent to treat this physical condition must be sought from the individual. If the individual does not have the capacity to consent, treatment can be provided under the MCA as long as it is in their best interests". **Please note the use of the MCA in this situation is a decision for the acute Trust and would still not give Humber staff authority to support in the use of physical restraint without written agreement in the form of a SLA.**

Informal patient in an acute hospital, or patient admitted as an informal patient to a Humber unit but subsequently admitted to an acute hospital, due to physical health condition.
Under these circumstances Humber staff have no jurisdiction to offer any support without the patient's consent. If there were concerns about the patient's own safety or the protection of others and they were wishing to leave the ward, it would be up to the acute hospital doctor to consider whether the use of Section 5(2) Mental Health Act 1983 would be appropriate pending an assessment under the Act.

If the patient was presenting as a risk to themselves and a doctor was not available at this point to consider the use of S5(2) then the acute Trust staff could legally use the Mental Capacity Act to stop them from leaving if the patient lacked capacity to consent to remain as an informal patient. In respect of Humber staff, if the patient were admitted as an informal patient to a Humber unit, then it would be appropriate under 'duty of care' or 'common law' to prevent the patient from leaving if staff believed them to be a significant risk to themselves or others. The acute Trust staff or their security staff would take over at the earliest opportunity.

It is important that any action taken should be clearly documented using the appropriate format making it clear what legal framework was used.

Staff are requested to complete a datix for all incidents where restraint has been used in an acute setting so that the occurrences can be monitored to ensure staff are provided with the correct guidance for all situations.

CAMHS patients in acute hospital
HUTH staff are encouraged to request consultation or advice from CAMHS Inreach Service in matters of restraint of young people who are detained /requiring interventions at a HUTH hospital.

5.10. Post Incident: Monitoring, Debriefing and Review

Staff will be very aware of the physical strain on respiratory and cardiac systems whilst being restrained and of the potential for psychological trauma after being restrained.

Patient's vital signs (pulse, respiration, complexion (pallor and/or discolouration)) will be monitored and recorded every 15 minutes for a minimum of one hour after restraint. Where the patient refuses to engage with staff, staff will observe and document respirations, complexion (pallor and/or discolouration) and activity for the following hour.

Any observed deterioration in physical health will indicate urgent medical review and/or 999 responses.

Whenever face down prone restraint is utilised, a medic must attend the ward and review the patient within one hour of application. For all other situations where a patient has been restrained consideration must be made as to whether or not a medical review is required. This should be based on the level of restraint used, the length of time a person was restrained, their individual history (for example physical health, mental health, trauma), physical exertion used during the restraint, any injuries observed or reported, and their presentation immediately following the restraint. Based upon this, it is then at the discretion of a registered nurse as to whether or not a patient requires a medical review face-to-face, a telephone consultation with a medic, or ongoing follow-up by a registered nurse/ongoing monitoring by the nursing team.

In the event of a medic not being available to undertake the post restraint medical review of a patient the procedure for escalation detailed in Appendix 2 must be followed.

The ward manager of any service area will ensure that all episodes of physical restraint are followed (at the appropriate time) by a post incident review and/or debrief for staff, patients and any witnesses. Patient post incident review should be undertaken separately and when the patient feels able to contribute.

Any such post incident review/debrief will be undertaken by a clinician of suitable seniority, with the requisite training and experience, and who was not directly involved in the incident wherever possible. Debriefs will only be carried out by trained Clinicians.

The aims of post incident review/debrief is to:

- evaluate the physical and emotional impact on all individuals involved (including any witnesses).
- identify if there is a need, and if so, provide counselling or support for any trauma that might have resulted.
- Conversations/counselling with children or individuals with a learning disability will need to be adapted to ensure there is full understanding.
- help people who use services and staff to identify what led to the incident and what could have been done differently.
- determine whether alternatives, including less restrictive interventions, were considered.
- determine whether service barriers or constraints make it difficult to avoid the same course of actions in future.
- where appropriate recommend changes to the service's philosophy, policies, care environment, treatment approaches, staff education and training.
- where appropriate, avoid a similar incident happening on another occasion. (DoH, 2014)

Patient post incident review / debrief must include the above factors and if the patient wishes offer an opportunity to develop a plan to manage any future incidents. If the patient declines post incident review / debrief, this must be recorded in their notes and an opportunity to review / debrief be left open for them to follow up when they feel able.

5.11. Recording/Monitoring/Investigation

Physical restraint will, at times, be applied in urgent and emergency situations, when there is not time for wider consultation with other clinicians. Furthermore, the use of physical restraint will, at times, lead to complaints. It is a requirement that all staff involved in the use of physical restraint will be able to account for their practice, and that they will be supported by the Trust when their use of physical restraint has been deemed measured and reasonable at the time of the incident. Part of this process is that all uses of physical restraint will be comprehensively documented and investigated.

All incidents of physical restraint will be documented on Datix and discussed in the daily safety huddle by senior clinicians. This is now a reporting requirement.

A Physical Restraint Record will be completed on Lorenzo in the adverse incident tab on the right hand side of the screen in Lorenzo (if recorded in the adverse incident tab in clinical charts this does not report via the MHDS) . This record should be fully completed and will provide the factual evidence base for investigation and audit of clinical care provision.

All episodes of physical restraint will be subject to review by the full clinical team at the next available opportunity. Where planned restraint for personal care is used, medical staff are to review the patient following each instance of holding techniques being used.

5.12. Managing Violence and Aggression: Deviation from Trust Policy

There are very rare occasions where the use of DMI has been ineffective in an emergency situation, in this event the team must ensure a Datix is completed.

In the event staff find themselves in such a situation, the following guidance is provided from the Positive Engagement team which outlines “reasonable force”.

- The force used must be proportionate to the risk and the minimum necessary to be able to contain the situation. In a self-defence situation the aim of using force should be to create a window of opportunity for escape for ourselves and/or our colleagues/other patients/visitors.
- *Where a technique is applied, it must be done in a manner that attempts to reduce rather than provoke a further aggressive reaction.*
- *The numbers of staff involved should be the minimum necessary to restrain the violent individual, whilst minimising injury to all parties.*

Staff are reminded of Policy point 5.3.11 “The deliberate application of pain or of painful holds during restraint cannot be justified unless there is an immediate threat to life.” Any application of pain, including flexion to induce compliance must be reported through Datix.

5.13. Restraint and the Removal of Ligatures

Please refer to the Removal of Ligatures and Safe Use of Ligature Cutters Proc447

5.14. Equipment

- Safety Pods – Safety Pods (as designed and supplied by UK Pods Ltd) have been approved for use by services / divisions subject to approval by divisional Clinical Networks and ratification by the Reducing Restrictive Interventions group. All staff using Safety Pods must have been trained in their use by or through the Training Team.

- Services will not improvise or use any other equipment for this purpose, other than the Safety Pod.

6. EQUALITY AND DIVERSITY

An Equality and Diversity Impact Assessment has been carried out on this document using the Trust-approved EIA.

This policy aims to ensure that people are in receipt of services that are safe, effective and led by the needs of the person. The standards within the policy will be applied equally to all patients irrespective of the protected characteristics of the Equality Act 2010. Where individuals are being detained or receiving treatment under the terms of the Mental Health Act, no group will be treated less favourably.

The impact assessment has identified that the trends in the use of the Mental Health Act will be monitored by the Mental Health Act Legislation Committee against National Equality and Diversity data to identify any impacts on the target groups.

Where patients' legal status is affected, we have a clear duty to inform them of their rights regardless of their main language or communication difficulties. DVDs are available in 28 languages (other than English) with the rights of detained patients.

When patients are detained with any impairment to understanding, clinical staff must identify this need as soon as possible and access appropriate interpreter support (e.g. Language specialist, BSL interpreter, Independent Mental Health Advocate). All staff will ensure that patients are repeatedly advised of their rights using these methods of interpretation.

Staff should not assume understanding as in some cases a patient maybe struggling with their thought processes which will disable their ability to fully understand at different times. For example an Autistic Patient, maybe struggling with feeling overwhelmed, sensory overload, delayed processing of information etc. They may also agree without fully understanding the context of what is being said at the time i.e. people pleasers.

Religious beliefs will be respected and the Trust Chaplain will support access to relevant faith leaders and information. All clinical settings (wherever possible) should accommodate individual prayer/meditation space with appropriate access facilities.

7. MENTAL CAPACITY

The Trust supports the following principles, as set out in the Mental Capacity Act and has applied them in the development of this policy:

1. A person must be assumed to have capacity unless it is established that they lack capacity.
2. A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
3. A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
4. An act completed, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
5. Before the act is completed, or the decision made, regard must be had as to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

8. IMPLEMENTATION

This policy will be disseminated by the method described in the Policy and Procedural Documents Development and Management Policy.

All staff must receive appropriate and relevant induction and knowledge of restraint policy in areas where restraint is used.

The Restraint Policy will be used by the PET trainers as a resource in delivering DMI training.

9. MONITORING AND AUDIT

Compliance against the requirements of this policy will be monitored by individual Divisions via their clinical governance arrangements. All restrictive interventions are monitored on a monthly basis via the Reducing Restrictive Interventions Group to consider the use of all forms of restrictive interventions in order to identify prevalence, trends, lessons to be learned and good practice. Data will be supplied by the Trust performance department to monitor use in all inpatient mental health and learning disabilities wards. This group will identify hotspots, changes in prevalence, etc., and will monitor the use of prone restraint. A quarterly report will then feed into the Mental Health Legislation Committee.

All reported instances of restraint involving Trust patients are reviewed by the corporate safety huddle on a daily basis by a multi-disciplinary team including senior nurse representation and clinical staff from each of the Trust's divisions. The incidents are considered by the group to confirm that all required information regarding the means of restraint used, length of restraint and appropriate monitoring / review of the patient following the restraint has been appropriately recorded on the Trust DATIX system.

Any instances of prone restraint will also be considered by the huddle, and the nature and length of these restraints will also be confirmed with the reporting team. In addition, where an incident of prone restraint is confirmed, a briefing report will be commissioned by the daily huddle to explore the incident in further detail. Completed prone restraint briefing reports are considered by the Trust's Clinical Risk Management to ensure that appropriate actions have been taken and that there is sufficient assurance in place around the maintenance of patient safety during and following the instance of restraint.

This information is reported to the Mental Health Legislation Committee within its quarterly reporting cycle (RRI report), and where required associated actions should be agreed as part of the quarterly committee meeting. Any identified actions will be used to inform the development and review of this policy.

Compliance with DMI training monitored via ESR and presented at monthly RRI Group.
RRI training facilitated by Matrons is also monitored via ESR.

10. REFERENCES / DEFINITIONS

- Positive and Proactive Care: reducing the need for restrictive interventions (DoH, 2014)
- NG10. Violence and aggression: short-term management mental health, health and community settings (NICE, 2015)
- Mental Capacity Act (MCA) (DCA, 2005)
- Mental Health Act Code of Practice (DoH, 2015)
- Human Rights Act 1998

- Mental Health Units (Use of Force) Act 2018 available online at https://www.legislation.gov.uk/ukpga/2018/27/enacted
- Patient Safety Alert ref NHS/PSA/W/2015/011 – The importance of vital signs during and after restrictive interventions/manual restraint (NHS England, 3rd December 2015) available online at www.england.nhs.uk/wp-content/uploads/2015/12/psa-vital-signs-restrictive-interventions-031115.pdf
- Care Quality Commission Brief Guide to Inspectors – Restraint (physical & mechanical) (CQC, 2016) available online at 20180322_900803_briefguide-restraint_physical_mechanical_v1.pdf (cqc.org.uk)
- Fundamental Standards of Care (CQC, 2016) available online at www.cqc.org.uk/content/fundamental-standards
- Memorandum of Understanding – The Police Use of Restraint in Mental Health & Learning Disability Settings- College of Policing Protocol for Police and Mental Health staff in (rcem.ac.uk)

  CQC Brief: restraint (physical and mechanical) available online at Brief guide: restraint (physical and mechanical)
- Bray L, Snodin J & Carter B (2014) Holding and restraining children for clinical procedures within an acute care setting: an ethical consideration of the evidence. Nursing Inquiry, 22 (2), PP 157-67. In: RCN (2019) Restrictive physical interventions and the clinical holding of Children and young people. Guidance for nursing staff
- Restraint Reduction Network (RRN) Training Standards available online at https://restraintreductionnetwork.org/know-the-standard/

Appendix 1: Escalation Procedure for Medical Examination

Out of Hours

- Ward/unit staff will contact the duty doctor to undertake post restraint medical examination as stipulated in policy.
- If the duty doctor is not able to undertake the medical examination within the stipulated timescale, then the duty doctor is required to contact the on-call consultant. The on-call consultant should support and advise the duty doctor to facilitate a timely medical examination and if necessary to attend the ward/unit to undertake the medical examination if the delay in the duty doctor attending is unacceptable.
- The duty doctor is required to inform the ward if the medical examination cannot be undertaken in the stipulated timescale.
- Any failure to meet the requirements of medical examination must be recorded by the ward on the Datix system as a moderate harm. The delay in medical examination should be escalated to the on-call manager.

In Hours

- Ward staff will contact the duty doctor to undertake medical examination as stipulated in policy.
- If the duty doctor is not able to undertake the medical examination within the stipulated timescale, then the duty doctor is required to contact the Responsible Clinician or the Responsible Clinician cover. The Responsible Clinician is required to support and advise the duty doctor to facilitate a timely medical examination, and if the delay in the duty doctor attending to undertake the medical examination is unacceptable, the Responsible Clinician should attend to undertake the medical examination.
- The duty doctor is required to inform the ward if the medical examination cannot be undertaken in the stipulated timescale.
- Any failure to meet the requirements of post restraint medical examination must be recorded by the ward on the Datix system as a moderate harm.

Appendix 2: Guidance for Staff: The Role of Police in Responding to Incidents in Mental Health Settings

This guidance is written in accordance with Memorandum of Understanding: The police use of restraint in mental health and learning disability settings, College of Policing 2017.

Each situation will be judged on its individual merits.

Examples that may require a police response:

- Immediate risk to life and limb
- Serious damage to property (that will endanger safety of others)
- Offensive weapons
- Hostages

When contacting the police for immediate assistance staff need to provide the operator with as much information about the situation as possible, ensure you describe the serious level of risk that is presented by the patient(s).

Information about the patient (current/background, the patient's legal status) needs to be provided to the police operator and any potential known risks. Explain what has already been attempted and that the situation is beyond the scope of health care interventions.

You need to be explicit that the police are not being called because there are not enough staff, or not enough staff to restrain. The police must only be called because the serious risk is not manageable by health care staff. See examples above.

If possible the incident needs to be taking place near the staff member who is reporting the incident, so the operator can hear the noise/event in the background.

Agree with the police where you will meet them on site, particularly if the situation involves hostages or dangers to the public. Agree with the police that a registered clinician will be responsible for oversight of the patient's physical health whilst the police intervene.

If the police use a restrictive intervention with the patient, health care staff are **RESPONSIBLE for monitoring the PHYSICAL HEALTH of the patient during and post intervention**, just as they would if health care staff had restrained the patient. Any injuries that occur to the patient during police intervention must be recorded in the patient notes and on Datix. The police will make their own records but health care staff are responsible for the patients' wellbeing whilst they remain on Trust premises. Follow this policy should concerns arise about physical wellbeing.

All positive and negative responses staff receive from the police they need to inform the Safety Advisor & Accredited Local Security Management Specialist as soon as possible and they will contact the Trust's liaison directly for them to investigate and support staff's requests for police attendance (during working hours).

All incidents where Police have been required to support us on Trust premises should be reviewed in line with the Memorandum of Understanding and actioned by the corporate Safety Huddle.

Full copy of the memorandum of understanding can be found here:
http://www.college.police.uk/News/College-news/Pages/Mental_health_restraint_MoU.aspx.

Appendix 3: Document Control Sheet

This document control sheet, when presented to an approving committee must be completed in full to provide assurance to the approving committee.

Document Type and Title:	Policy – Physical Restraint		
Document Purpose:	This policy provides the framework and guidance to support staff in the situations when use of restraint is appropriate. Physical skills training must be completed prior to the use of physical restraint, which supports the policy requirements. This policy is in line with the MHA Code of Practice.		
Consultation/ Peer Review	Date	Group / Individual	
list in right hand columns consultation groups and dates	21.06.23	Mental Health Legislation Steering Group	
	13.06.23	Reducing Restrictive Interventions Group	
	15.06.23	QPAS	
	June / July 2024	Adult Mental Health Co-production Group mailing list	
	17.07.23	QPaS	
	09.07.24	Reducing Restrictive Interventions Group	
	17.07.24	Mental Health Legislation Steering Group	
	08.08.24	QPAS	
Approving Body:	QPAS	Date of Approval:	8 August 2024
NB All new policies and policies subject to significant amendments require approval at EMT and Board ratification.		*(see document change history below for minor amendments and dates)*	
Ratified at:	Trust Board	Date of Ratification:	N/a
Training Needs Analysis: *(please indicate training required and the timescale for providing assurance to EMT as the approving body that this has been delivered)*		Financial Resource Impact:	
Equality Impact Assessment undertaken?	Yes [√]	No [ ]	N/A [ ]
	If N/A, state rationale:		
Publication and Dissemination	Intranet [√]	Internet [ ]	Staff Email [√]
Master version held by:	Policy Management Team [√]	Author to send final document to HNF-TR.PolicyManagement@nhs.net	
Implementation:	*Describe implementation plans below - to be delivered by the author:* Implementation will consist of: • Dissemination to staff via Global email • Teams responsible for ensuring policy read and understood		
Monitoring and Compliance:	Monitored via the Positive Engagement Team and LSMS for reports to police.		

Document Change History:			
Version Number / Name of procedural document this supersedes	*Type of Change i.e. Review / Legislation*	*Date*	*Details of Change and approving group or Executive Lead (if done outside of the formal revision process)*
1.0	*New policy*	*1.3.2017*	*New policy*
1.01	*Review*	*April 2017*	*Amendments from older people's services*
2.0	*Review*	*December 2017*	*Updated to reference Lorenzo reporting system and forms* *Reviewed training compliance refreshers* *Reviewed process for staff requesting police support* *Additional guidance on how to manage aggression when techniques are insufficient.*
2.01	*Review*	*October 2019*	*Minor changes re. DMI training and to take account of CAMHs inpatient service*
2.02	*Interim Review*	*June 2020*	*Minor change re 5.12 Equipment – Safety Pods*

3.0	*Full Review*	*August 2020*	*Full Review*
4.0	*Full Review*	*June 2023*	*Review – Manor amendments include* *-section added on the use of restraint in Acute Hospitals (5.8)*
	Update from QPaS	*June 2023*	*Section added on the use of restraint in Acute Hospitals (5.8)* *Approved through QPaS 27-July-23 but requires EMT approval as major changes due to adding section 5.8* *Section 5.4 strengthened to emphasise that prone restraint is by exception and that incidents of prone restraint are scrutinised.* *Approved EMT 29-Aug-23 with Board ratification on 27-Sept-23*
4.1	*Reviewed*	*August 2024*	*Reviewed. Rewording of prone restraint narrative on pages 8 and 9. Additions of more detailed consideration for autistic people at 5.7. Approved at QPaS (8 August 2024).*

Appendix 4: Equality Impact Assessment (EIA)

For strategies, policies, procedures, processes, guidelines, protocols, tenders, services

1. Document or Process or Service Name: ***Physical Restraint Policy (M-012)***
2. EIA Reviewer (name, job title, base and contact details): ***Michelle Nolan, Mental Health Act Clinical Manager***
3. Is it a Policy, Strategy, Procedure, Process, Tender, Service or Other? ***Policy***

Main Aims of the Document, Process or Service

This policy outlines the statutory responsibilities of all staff in relation to the physical restraint of patients under our care. This policy is aimed at all staff who are concerned with the use of physical restraint in all Trust mental health and learning disability inpatient settings. This includes staff applying physical restraint and those responsible for the training, management, monitoring and evaluation of staff and their performance in this area of practice.

Please indicate in the table that follows whether the document or process has the potential to impact adversely, intentionally or unwittingly on the equality target groups contained in the pro forma

Equality Target Group	Is the document or process likely to have a potential or actual differential impact with regards to the equality target groups listed?	How have you arrived at the equality impact score?
1. Age 2. Disability 3. Sex 4. Marriage/Civil Partnership 5. Pregnancy/Maternity 6. Race 7. Religion/Belief 8. Sexual Orientation 9. Gender Reassignment	Equality Impact Score Low = Little or No evidence or concern (Green) Medium = some evidence or concern(Amber) High = significant evidence or concern (Red)	a) who have you consulted with b) what have they said c) what information or data have you used d) where are the gaps in your analysis e) how will your document/process or service promote equality and diversity good practice

Equality Target Group	Definitions	Equality Impact Score	Evidence to support Equality Impact Score
Age	Including specific ages and age groups: Older people, Young people, Children, Early years	Low	Staff should always ensure that any use of physical restraint is used only after having due regard to the individual's age and having taken full account of their physical, emotional and psychological maturity.
Disability	Where the impairment has a substantial and long term adverse effect on the ability of the person to carry out their day to day activities: Sensory, Physical, Learning, Mental Health (and including cancer, HIV, multiple sclerosis)	Low	The Trust is committed to protect human rights and freedoms, and to reduce the disproportionate use of physical restraint and discrimination against people sharing particular protected characteristics under the Equality Act 2010, including disabled people. For patients who have a communication need or have English as their second language consideration must be given to providing information in an accessible format.
Sex	Men/Male, Women/Female	Low	The Trust is committed to protect human rights and freedoms, and to reduce the disproportionate use of force and discrimination against people sharing particular protected characteristics under the Equality Act 2010, including women and girls.
Married/Civil Partnership		Low	
Pregnancy/ Maternity		Low	Staff should always ensure that any use of physical restraint is used only after having due regard to the individual's maternity status and having taken full account of their physical, emotional and psychological wellbeing.

Race	Colour, Nationality, Ethnic/national origins	Low	The Trust is committed to protect human rights and freedoms, and to reduce the disproportionate use of physical restraint and discrimination against people sharing particular protected characteristics under the Equality Act 2010, including people from black and minority ethnic backgrounds. It is acknowledged that for any patient whose first language is not English, as information needs to be provided and understood, staff will follow the Trust interpretation procedure.
Religion or Belief	All Religions Including lack of religion or belief and where belief includes any religious or philosophical belief	Low	The MHA Code of Practice details the need for non-discriminatory practice and application of the MHA as well as highlighting the requirement for awareness of, sensitivity to and appropriate accommodation of any preferences, needs or requirements related to religious or other belief systems.
Sexual Orientation	Lesbian, Gay Men, Bisexual	Low	The MHA Code of Practice details the need for non-discriminatory practice and application of the MHA as well as highlighting the requirement for awareness of, sensitivity to and appropriate accommodation of any preferences, needs or requirements related to sexual orientation.
Gender Re-assignment	Where people are proposing to undergo, or have undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attribute of sex	Low	The MHA Code of Practice details the need for non-discriminatory practice and application of the MHA as well as highlighting the requirement for awareness of, sensitivity to and appropriate accommodation of any gender identity related preferences, needs or requirements. We recognise the gender that people choose to live in hence why the terms gender identity and gender expression ensure we are covering the full spectrum of LGBT+ and not excluding trans, gender fluid or asexual people.

Summary

The standards and principles described within the policy prompt the clinician to have regard to individual holistic needs of the patient in relation to use of physical restraint.

It is felt that this policy and any associated documentation would seek to uphold principles of individualised planning and arrangements for ongoing care needs.

The policy takes significant consideration of the protection of all service users and their carers under the Equalities Act 2010 and the Human Rights Act. Significant attention has been paid to ensure that no groups are discriminated against either directly or indirectly.

Healthcare staff, managers and independent advocates have a professional responsibility to be alert to the disproportionate use of force, to know what they must do if they witness or suspect the abusive use of force, and to take action. Staff must ensure they understand their safeguarding responsibilities and are familiar with the trust's safeguarding policies and procedures. If staff witness or suspect the inappropriate or disproportionate use of force, they should immediately raise their concerns with the staff involved in the first instance and then escalate if necessary.

EIA Reviewer: ***Michelle Nolan***

Date completed: ***July 2024***	Signature: ***M Nolan***