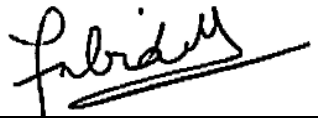
Birmingham and Solihull Mental Health NHS Foundation Trust

Mechanical Restraint Policy (including Soft Restraint System SRS)

Policy number and category	**RS 33**	**Risk & Safety**
Version number and date	**4**	**January 2023**
Ratifying committee or executive director	**Clinical Governance Committee**	
Date ratified	**June 2023**	
Next anticipated review	**June 2026**	
Executive director	**Medical Director**	
Policy lead	**Deputy Director of Nursing**	
Policy author *(if different from above)*	**Advanced Nurse Practitioner (AVERTS)**	
Exec Sign off Signature (electronic)		
Disclosable under Freedom of Information Act 2000	**Yes**	

Policy context

- This policy provides guidance around the overarching ethical principles that must be considered as part of the decision-making process for the application of mechanical restraints.
- Mechanical restraint may be used in the context of managing high-risk escorts outside of BSMHFT's perimeter.
- Mechanical restraint may be considered as a last resort for individuals who are exhibiting significant and life-threatening incidents of self-harm.
- Mechanical restraint devices may also be considered when service users who are already in manual physical restraint require re-location to a seclusion facility with a view to prevent prolonged physical restraint and termination of holds.

Policy requirement (see Section 2)

- As driven by the Mental Health Act Code of Practice (DH, 2015) this policy promotes and supports the implementation of the tertiary preventative strategy-based approach to violence reduction Trust wide. Mechanical restraint is also defined, and oversight maintained, under the guidance of the Mental Health Units (Use of Force) Act 2018.

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1. Introduction

1.1. Rationale

1.1.1 The use of Mechanical Restraint (MR) within Mental Health in-patient settings is highly contentious, sensitive and can be an emotive topic, its use should be exceptional.

1.1.2 The Mental Health Units Use of Force Act (2018) places statute obligations upon Trusts to identify what method of restrictive intervention is permitted within its services and what is permissible within specific service user populations. This will include the use of mechanical restraints.

1.1.3 Mechanical restraint should only be used exceptionally, where other forms of restriction cannot be safely employed. It should be used in line with the principle of least restrictive option and should not be an unplanned response in an emergency situation. Mechanical restraint should never be used instead of adequate staffing.

The Mental Health Units Use of Force Act (2018) defines mechanical restraint as '*the use of a device which is intended to prevent, restrict or subdue movement of any part of the patient's body, and is for the primary purpose of behavioural control;'* This is the definition that will be used for the purpose of this policy.

1.1.4 The use of MR is the most restrictive response for the management of acute levels of violence and aggression towards self or others. Its use should always be a last resort within clinical settings and must never be considered as usual practice. Consideration should always be given to less restrictive measures to manage service users based upon the presenting levels of risk and individual care needs.

1.1.5 Positive and Proactive Care: Reducing the need for Restrictive Interventions (2014) states; Violence to others "*The use of mechanical restraint to manage extreme violence directed towards others should be exceptional, and seldom used in this or other contexts outside of high secure settings"* (P.79).

1.1.6 Violence to self "*It is recognised that following rigorous assessment there may be exceptional circumstances where mechanical restraints need to be used to limit self-injurious behaviour of extremely high frequency and intensity"* (p.80).

1.1.7 BSMHFT acknowledges that in some exceptional circumstances, the use of MR may be the safest and least restrictive option to manage severely challenging behaviour that is likely to cause significant harm to self or others.

1.1.8 Any use of MR must be supported by an approved management plan and PBS/ care plan with the intention of minimising the risk during high-risk escorts; serious, life-limiting self-harm and the prevention of prolonged physical restraint within in-patient settings. There may be occasions where the request for MR may feature as part of an individual's advanced statement.

1.2. Scope (when, where and who):

1.2.1 This policy applies **only** within the context of Secure & Complex Care (SCC), FCAMHS and Low Secure Services, and acute Psychiatric Intensive Care Units (PICU), where staff have received appropriate training in the use of mechanical restraint, including handcuffs. Staff within these identified inpatient areas may consider the use of mechanical restraint (MR) in strict accordance with these policy guidelines, in order to reduce the risk of serious harm to a service user's health and possible violence against others whilst they are detained under the Mental Health Act 1983.

1.2.2 The application of any form of mechanical restraint in healthcare settings should be viewed as a contentious aspect of clinical care. Its use may be deemed necessary for those individuals who present a significant risk of absconding, risk of violence whilst being escorted outside secure environments (for essential purposes only), individuals subject to Home Office restrictions, or individuals who exhibit increased levels of harm to self or others who's increased levels of risk cannot be managed by less restrictive means.

1.2.3 Nice Clinical Guideline 10 stipulates in section 1.7.18 "Do not use mechanical restraint in children" it goes on to state in section 1.7.19 Healthcare provider organisations should ensure that, except when transferring young people between medium- and high-secure settings (as in recommendation 1.7.20), mechanical restraint in young people is used only in high-secure settings (on those occasions when young people are being treated in adult high-secure settings), in accordance with the Mental Health Act 1983 and with support and agreement from a multidisciplinary team that includes a consultant psychiatrist in CAMHS.

1.2.4 MR use should not be viewed in isolation, it use should be viewed as a tertiary restrictive intervention within the overall context of the Trusts reducing restrictive

practice workstream which aims to reduce the use of restrictive practices within the organisation commensurate with national guidance and statute legislation.

1.2.5 As part of the role of FCAMHS is to prevent transfer to HSS there may be consideration for the application of this policy. Any application of MR on a young person should immediately trigger a safeguarding referral. The safeguarding policy can be found here.

1.2.6 Only staff who have received appropriate instruction and training are permitted to apply MR. Please see section 3.26 for details.

1.2.7 Trust board ***must*** be consulted and sanction the service areas where Mechanical restraints can be considered and used, this should be escalated through established Trust governance processes. Should the need to extend the policy into other clinical areas of the Trust, the policy would need to undergo an immediate review.

1.2.8 **Any form of MR should not be used on a pregnant woman, or a woman suspected of being pregnant under any circumstances.** Wherever possible, the application of any MR device on a woman who is less than 6 months post-partum should be avoided.

1.2.9 All MR needs to go through a comprehensive governance process. Local programme governance committees will need to formally request use of the proposed MR device. This request should be escalated through governance channels including the Reducing Restrictive Practice Steering Group and Trust Clinical Governance committee. The use of any mechanical restraint device needs the explicit sanction of the Director of Nursing and Medical Director before it can be used within the clinical area.

1.2.10 Once sanctioned, a Standard Operating Procedure (SOP) should be developed for the use of the MR device within the respective service and should undergo a regular review process to ensure that the MR device is fit for the intended use and meets PUWER (1998) regulations.

1.2.11 Each individual application of existing MR should be escalated to and authorised by a senior clinical leader including Deputy Director of Nursing, Clinical Director, and Associate Director for the division. Should any of the authorising individuals not be available, their nominated deputies can be involved in the decision-making process.

1.2.12 In an emergency, MR may be considered as the only response to unexpected episodes of extreme violence. In these situations, MR could be justified to maintain the safety of the service user, other service users or staff. The use of MR should still be planned, and relevant sanction authorised and must be used within the legal framework of Proportionate, Legal, Acceptable, and absolutely necessary under the context of reasonable force. (Section 3 Criminal Law Act 1967).

1.2.13 Any use of MR should be reported to the Director of Nursing, Director of Operations and Medical Director as the earliest opportunity (out of hours this should happen at 09:00 the next working day).

1.2.14 Any use of MR must meet the statutory requirements set out in the Mental Health Units (Use of Force) Act 2018 and subsequent Trust policy **Safe Use of Force**

1.2.15 The Mental Health Act (1983) makes no reference to the use of MR on children or young people. BSMHFT advocates a thorough assessment for the need for MR considering a person's size, strength, emotional and physical maturity when planning interventions including the use of MR as per Nice Clinical Guideline 10.

1.2.16 The distribution of MR equipment will be done in strict accordance with governance arrangements of the suppling manufacturer. The decision-making process will consider the number of staff within the clinical area who have successfully completed and remain in date with the mandatory MR training.

1.2.17 This policy does not apply to Prison Health Care where separate policies for the use of Restrictive Physical Intervention and MR apply.

1.3. Principles

1.3.1. The Trust positively supports individuals with learning disabilities and ensures that no-one is prevented from accessing the full range of mental health services available. Staff will work collaboratively with colleagues from learning disabilities

services and other organisations, to ensure that service users and carers have a positive episode of care whilst in our services. Information is shared appropriately in order to support this.

1.3.2. The Trust acknowledges that there is no such thing as a 'safe restraint position' and there are no safe time parameters for the use of restraint.

1.3.3. De-escalation is an integral secondary preventative strategy in the prevention and management of violence that should permeate any restrictive intervention and be supported by solid clinical leadership at all levels. This is reinforced in the Trusts AVERTS training and the work undertaken to develop a suite of reducing restrictive practice training overseen by the Trusts Reducing Restrictive Practice Steering group. This work is supported through local clinical governance structures to ensure that physical intervention is not considered as a primary intervention in the prevention and management of violence and remains an option to be utilised as a last resort.

1.3.4. The Mental Health Units (Use of Force) Act 2018 defines mechanical restraint as: "*the use of a device which: is intended to prevent, restrict, or subdue movement of any part of the patient's body, and is for the primary purpose of behavioural control."* (TSO, 2018, p.2).

1.3.5. The Mental Health Act Code of Practice (1983) (updated 2015) states: "*Restraint which involves tying (whether by means of tape or by using a part of a client's garments) to some part of the building or to its fixtures or fittings must never be used".*

1.3.6. The management of violence is based on prediction, prevention, de-escalation and finally intervention. Individual elements of this process include environmental design, staffing and equipment of facilities, risk assessment, searching, de-escalation techniques, observation and other staff interventions. Interventions for continuing management of violence include rapid tranquilisation, seclusion and physical interventions. These are considered only once de-escalation and other strategies have failed to calm a service user. Active physical restraint of a service user would signify a failure of all other techniques and interventions and would only be a last resort as illustrated in the current trust Prevention and Management of Violence Policy. The use of mechanical restraints should only be considered when all options outlined have been exhausted.

1.3.7. This policy is structured to cover:

- **Overarching Principles** for using mechanical restraint to manage serious self-harm and ending prone restraint,
- The aspects of using MR to facilitate **high-risk escorts** outside of the hospital perimeter
- The aspects of using the MR to **manage self-harm**
- The aspects of using the MR to **manage prolonged restraint**
- The option to use MR in other **clinically challenging** scenarios based upon individual assessment of risk and the flexibility of the SRS.

2: The policy

2.1. The following principles should be applied when using MR to manage high-risk escorts outside of the hospital perimeter, incidence of serious and sustained self-harm, or for the purpose of conveyance or to end prolonged prone restraint.

2.2. The Mental Health Act Code of Practice 2015 requires that:
"The use of mechanical restraint should be approved following multi-disciplinary consultation (which should include an IMHA where the patient has one – see chapter 6). The nature of the multi-disciplinary team should be defined in a provider's policies. Provision for the use of mechanical restraint should be recorded as a tertiary strategy in the positive behaviour support plan (or equivalent). This plan should detail the circumstances which might warrant mechanical restraint, the type of device to be applied, how continued attempts should be made to de-escalate the situation and any special measures that are required to reduce the likelihood of physical or emotional trauma resulting." (DH, 2015, p. 296).

2.3. The Use of Force Act (2018), stipulates that service users should be given information about the use of MR. This should be provided in a variety of formats according to the individual needs of the service user and staff should make themselves available to ensure that there is clear understanding of the information that has been provided.

2.4. BSMHFT currently authorises the use of the Soft Restraint System (SRS), Soft Cuffs and metal chain linked handcuffs as authorised forms of MR. Any additional MR device needs to go through a stringent governance process and should be presented to the Reducing Restrictive Practice Steering group and local clinical governance committees with an accompanying SOP for agreement prior to being presented to the Physical health Committee, Health and Safety committee and Trust CGC for authorisation and sign-off for use within the Trust. MR must be sanctioned by the Medical Director and Director of Nursing prior to its intended use.

2.5. The use of handcuffs will always be considered as part of an individualised risk assessment and in accordance with any MOJ directives and in accordance with the provisions set out in The Mental Health Act Code of Practice Chapter 26. The frequency of their use for high-risk situations should not diminish the need for them to represent the least restrictive option available to the MDT. They will only be used in situations where they represent the most appropriate and pragmatic method of managing a patient's risk during an unavoidable escorted journey. In such situations, it is essential that the patient is formally assessed by their Clinical Team (or agreed out of hour's on-call service) and considered to present a significant level of risk of violence and/or absconding while on escort outside of the secure environment and that this is not reasonably manageable by other less restrictive means.

2.6. The SRS has current sanction for use if individuals require relocation into a purpose- built seclusion facility to prevent prolonged prone restraint or to prevent serious self-injurious activity. There may be additional applications of the SRS to manage a variety of situations where physical interventions are not appropriate due to the levels of risk posed by the service user. Sanction for the use of the SRS for alternative scenarios would need sign off at director level and an accompanying SOP for its intended use.

2.7. Any individual placed in MR ***must never*** be left alone. The application of MR should never be used in the absence of sufficient staffing levels or due to the absence of seclusion facilities.

2.8. The use of Mechanical restraint will trigger level 4 therapeutic observations.

2.9. Mechanical restraint should never be used as a threat or as a form of punishment.

2.10. On admission, as part of the initial admission process, consideration should be given to the appropriate management of the service user in cases of serious life-limiting self-harm and prolonged restraint. As a part of the admission process, all service users will receive a health and social care assessment. This will be a full assessment of need including risk, undertaken by a registered professional using the minimum standard of the L1 risk screening tool.

2.11. A full physical health assessment needs to be undertaken and documented in the physical health screening tool located on RiO where any contra indications for the use of MR must be recorded.

2.12. A Positive Behavioural Support (PBS) plan/care plan should be drawn up by the multi-disciplinary clinical team. This process should include as a minimum, the

Responsible Clinician and Unit Manager/senior practitioner working on the ward but would also generally include the team psychologist, occupational therapist, matron and social worker. Clinicians should use the PBS form contained within the MDT section on RiO.

2.13. Contemporaneous documentation of the decision-making process must be maintained within the service users RiO record, which highlights the risks versus the benefits of using the mechanical restraint equipment.

2.14. Documentation should include, why the MR is considered appropriate, what alternatives were considered and discounted and why, the individual wishes of the service user and family/ carers where appropriate.

2.15. Provision for the use of MR should be recorded as a tertiary restrictive strategy in the PBS plan, detailing which MR device may be used and under which type of clinical situation.

2.16. Authorisation for the use of MR equipment must be recorded in the RiO record with the names, dates and times that authorisation was given.

2.17. The planned use of mechanical restraint equipment will be to assist in the safer escort of individuals outside of the hospital perimeter, to relocate a service user to a purpose-built seclusion facility or to safely manage serious life-limiting self-injurious behaviour. Its use will be to safely manage behaviour that presents a significant risk to self or others.

2.18. The PBS plan /care plan should clearly document at what point MR would be used and give clear instructions as to the specific conditions of its use including maximum time, to what part of the body it may be applied along with the required physical observations and frequency of observations. The care plan should give specific rationale and targeted reasons for the use of the specified MR device.

2.19. If the service user has an IMHA, the IMHA should be involved in drawing up this part of the PBS plan/care plan. The service user should be involved in the decision-making process and the drawing up of the PBS plan/care plan if at all possible. The service user advocate and/or his legal advisor should be provided with a copy of the PBS plan/care plan at the request of the service user. Physical health risk factors, such as any external injuries, cardiac and respiratory risk factors should be considered and assessed as part of the care plan.

2.20. Should there be any exceptional circumstances or disagreement within the clinical team a second opinion on the PBS plan/care plan may be sought, from another responsible clinician and senior nurse.

2.21. An advanced directive from the service user with specific regard to the use MR needs to be considered, especially in cases where such interventions are being assessed by the clinical team. Any advanced directive made by the service user needs to be considered when drafting PBS plans/care plans.

2.22. The need to ensure the safety of the person to which to MR are applied remains paramount. Staff should ensure that the care and treatment and monitoring of the service user is established in accordance with the guidance contained in **appendix**15 & 16 for managing prolonged prone restraint and in the RiO in patient management section for managing serious life-limiting self-harm.

2.23. The Trust does not permit staff to use any other form of MR not contained within this policy, any time. MR devices will be stored in a designated area that is secure but is easy to access should MR be required; this area will be communicated to staff. Storage areas will remain at the discretion of local services.

3: The procedure:

On admission, a thorough risk assessment and management plan should be developed in direct consultation with the service user (wherever possible). This should include any documented risks, physical health concerns and identify if MR should be considered as an option for the individual. The decision should be clearly documented in the individuals care plan and reviewed on a regular basis. The information gathered as part of the admission process should form the basis of a PBS plan for the individual identifying primary and secondary preventative strategies and tertiary interventions where appropriate.

The MR options currently available to BSMHFT staff are included in the appendices of this policy. If the decision is made to consider the use of MR one of the options listed in appendices 2,6,9-11 should be considered. The AVERTS team should be consulted to assist with the decision-making process.

Once the clinical team have decided the MR should be considered for a service user, the decision-making model (DMM) should be applied to assist with decision making. Once complete the DMM can be forwarded on to the Medical Director and Director of Nursing to assist in the decision to authorise the use of MR.

3.1. <u>The Decision-Making Model (DMM)</u>

3.1.1. The Decision-Making Model (DMM) is a values-based tool that provides users with a simple, logical process to making evidence-based decisions.

3.1.2. The DMM allows organisations to ensure that decisions made for the use of MR have been taken whilst ensuring the least amount of restriction was used for the least amount of time and that the decisions made were appropriate and reasonable in the circumstances at the time the decision was made.

3.1.3. Decision makers can apply the model to structure the rationale of decisions made during an incident and can also be used to inform the decision-making process as to the suitability of MR for individuals.

3.1.4. The Decision-Making Model and supporting information can be found in appendix 8.

3.1.5. The medical director and director of nursing should be consulted and authorise the use of any MR device that is contained within a service users PBS plan. Ordinarily these decisions will be made during normal working hours following a meeting to discuss the overarching decision-making process and why the use of MR may be a necessity.

3.1.6. If a decision is required out of hours, the director on call and most senior nurse on call should be alerted and temporary authorisation gained. At the next available opportunity, a discussion should occur as per 3.1

3.1.7. When MR is required on an emergency basis staff should inform the medical director and director of nursing but the decision to use MR to minimise risk to the service user in terms of prolonged prone restraint remains with the clinical team in situ and should not delay implementation of the device.

3.1.8. All staff responsible for the application of the MR device must have received appropriate information and instruction for the device and its intended use and be confident and competent in its application. The staff member must be up to date with the required training.

3.1.9. Ordinarily, training in the use of MR will be facilitated through the Trust's AVERTS department. Where there is a new piece of equipment or where there is an immediate need that cannot be facilitated by the AVERTS training team, the company responsible for the Train the Trainer programme and provision of MR equipment should be contacted for the delivery of training.

3.1.10. Any member of staff who has lapsed for their AVERTS fundamental training will automatically lapse for any subsequent MR training that they have received. Only staff who are in date and 'live' on the training database will be permitted to undertake MR training.

3.1.11. Unit managers have a responsibility to monitor the training status and training requirements of their team. If the quota of trained staff falls below 75% no further MR equipment will be supplied until the 75% threshold has been reached.

3.1.12. All MR equipment will be sent to the AVERTS team who will distribute devices once the training threshold has been reached.

3.1.13. It is clinical areas responsibility to fund all MR devices for use in their respective clinical areas.

3.1.14. Unit managers are responsible to ensure that the authorised MR for their clinical areas is always available and ready to be deployed in an emergency. The equipment should be checked against the Equipment Care and Maintenance Guidance in appendix 9 and the Equipment Monitoring Sheet (appendix 10). This process should form part of the weekly unit checks and audited monthly by matrons for assurance.

3.1.15. The use of any form of MR should trigger a post-incident debrief and post-incident review to learn lessons and look to prevent the need for further use of MR. It is important that these discussions are documented clearly within RiO.

3.1.16. As part of the post-incident debrief, it is important to ensure that service user views and those of staff are captured. The discussions should be extended to any witnesses where possible. The RRP Steering group will invite the views of all stakeholders on a quarterly basis and incorporate into reports to Trust CGC.

3.1.17. All paperwork including service user‘s PBS plan, the recording of the incident and any other documentation that led to the incident must be available for analysis. Substantially incomplete recording and reporting should trigger a Safeguard incident report.

3.1.18. Every application of MR will need to be reviewed by local clinical governance committees and the RRP steering group. A quarterly report in the use of MR should be presented to Trust CGC and QPESc for quality, audit, and assurance purposes.

3.1.19. Any use of MR will need to feature as part of the monthly QPESc report. This report will be generated by the governance intelligence team and reviewed in the RRP steering group monthly.

3.1.20. When MR is applied, all staff members must observe for potential signs of positional asphyxia, these include;

- Exceptional or unexpected strength
- Unusual rises in body temperature
- Exceptional violence

- Abnormally high tolerance to pain
- Bizarre behaviour
- Sudden, abnormal passivity
- Noisy or laboured breathing
- Cyanosis

3.1.21. If any of the above are witnessed, the event should be treated as a medical emergency.

3.1.22. As per Mental Health Units (Use of Force) Act 2018 requirements, family members and/or carers must be alerted to any application of MR as soon a reasonable practical. Evidence that this has occurred must be documented in the service users RiO record.

3.2. Training in the application and use of MR

3.2.1. The AVERTS training team are accredited in the delivery of Mechanical restraint devices that have been authorised by Trust Board. All Mechanical restraint courses require staff to have completed a minimum of an annual (12 monthly) refresher in the specific form of MR for staff to remain compliant.

3.2.2. All MR training courses will have a traffic light attached as agreed by the Learning and Development oversight group. Chain-linked handcuff training is provided to all staff as determined by the TNA during their annual AVERTS training.

3.2.3. All nominated staff must have attended the original five day AVERTS training (or equivalent as detailed in the **Prevention and Management of Violence Policy**) and be up to date with their refresher requirements prior to attending MR training to becoming an approved user. Additionally, all staff applying MR must maintain their Update refresher training for AVERTS, ILS, ELS, Manual Handling and MR training (specific to their clinical areas identified needs) to remain compliant.

3.3. Responsibilities of third-party Transport providers

3.3.1 Third party transport providers are bound by the same provisions as Mental Health Units regarding reporting obligations set out in the Mental Health Units (Use of Force) Act 2018.

3.3.2 Any use of MR must be reported to the host unit and an Eclipse form completed detailing the type of MR used in transit, its purpose, duration of application and alternative strategies that were considered but discounted prior to the application of MR. It is the Nurse in Charge's responsibility to ask the transport providers if any form of MR was utilised during the escort and document all responses accordingly as per UoF statutory reporting procedures.

3.3.3 MR use by third part transport providers should be bought to the attention of the RRP steering group for review.

4: Responsibilities

Post(s)	Responsibilities	Ref
All Staff	Staff in areas that are authorised to use MR will be aware of this policy, the process for escalation and authorisation and, the requirements for safe application, monitoring, storage, maintenance, documentation, and training requirements for any member of staff who may be required for its application.	
Service, Clinical and Corporate Directors	Be aware of the policy contents and be able to assist in the informed decision-making process between clinical services and Directors. Awareness of the escalation process and the out-of-hours requirements should authorisation or application be required. Ensure that regular monitoring is held through local CGC's. RRP and Trust CGC	
Policy Lead	Through the Reducing Restrictive Practice Steering Group/ Trust CGC have oversight of the application of this policy in clinical services, including the findings of audit reports provided to the Reducing Restrictive Practice Steering Group from matrons and CNMs.	
Executive Director	To have an awareness of the policy and its contents and advise on escalation processes. The Medical and Nursing directors can authorise the use of MR and respond accordingly to potential issues regarding escalation. The Directors can authorise additional MR for specific services and should be aware of their duties under this policy. The executive directors can commission the RRP steering group for a deeper dive into incidents where required.	
Matrons/ Lead Nurses	Monitor the use of MR within their service Audit the use of all MR and the accurate physical health monitoring forms in areas that have been sanctioned for its use monthly and provide feedback on a minimum quarterly basis to the Reducing Restrictive Practice Steering Group. Ensure that all documentation for the use of MR is completed as per Use of Force statute requirements.	
Reducing Restrictive Practice Steering Group	A quarterly review of the use of MR and adherence to the policy would be conducted and presented to the divisional clinical governance committees and QPES. The results will be disseminated via the Trust Clinical Governance structures. These elements will be overseen by the Reducing Restrictive Practices Steering Group.	

5: Development and Consultation process

Consultation summary		
Date policy issued for consultation	21/11/2022	
Number of versions produced for consultation	1	
Committees / meetings where policy formally discussed	**Date(s)**	
Where received	**Summary of feedback**	**Actions / Response**
PICU forum	Amend terminology in section 2.5	Paragraph reviewed and shared with Dr Keneddy. Agreed appropriate language now utilised.

6: Reference documents

- Department of Health (2015) **Mental Health Act (1983) Code of Practice (Revised) London: TSO.**
- Department of Health (2015) **NG10: Violence and Aggression in Mental Health, Health and Community Settings. London: NICE.**
- Department of Health (2005) **Mental Capacity Act London: TSO.**
- Department of Health (2014) **Positive and Proactive Care: Reducing the need for Restrictive Interventions. London: TSO.**
- Department of Health (2018) **Mental Health Units (Use of Force) Act 2018 London: TSO.**
- TSO (1967) Criminal Law Act 1967 (legislation.gov.uk) Accessed 12th July 2022.
- Melia D., Williams M. (2022) *Safer Handling Soft Restraint Kit: Training Manual.* Preston: Defend Solutions Limited.

7: Bibliography:

None

8: Glossary

- **Advance Directive**: a statement explaining what medical treatment the individual would want or not want in the future, should that individual 'lack capacity' as defined by the Mental Capacity Act 2005.
- **Decision-Making Model (DMM):** is a values-based tool that provides users with a simple, logical process to making evidence-based decisions.
- **Mechanical Restraint (MR):** The use of a device which is intended to prevent, restrict, or subdue movement of any part of the patient's body and is for the primary purpose of behavioural control.
- **Positive Behavioural Support (PBS)**: A plan of care developed with the service user that documents how they deal with their frustrations, what strategies are effective at managing it and how staff should support them at points of crisis.
- **Positional Asphyxia**: Asphyxia caused due to the unusual position of the body, leading to the inability to expand the chest wall, which interferes with pulmonary ventilation, hence leading to respiratory failure. (Yadav *et al* (2011))
- **Prolonged restraint**: A restraint that lasts longer than 10 mins as per NICE clinical guideline 10.
- **Prone restraint:** Holding a person face down/on their front on any surface including the floor.
- **Restrictive Practice:** Any practice that limits or inhibits a person's freedom of movement or will for the sole purpose of minimising risk to self or others. This includes Physical and mechanical restraint, seclusion and observation.
- **Safer Holding System (SHS):** Is a soft restraint belt with soft restraint cuffs fixed in place and is an alternative to the SRS for self-harm. The retention strap sits around the persons abdomen and is not to be used as a compression strap.
- **SEELS (Safer Emergency Enveloping Lifting Sling):** Specialist equipment to lift and transport/carry a person between locations to reduce the risk of prolonged restraint.
- **Soft cuffs**: a soft material or fabric that is padded and designed to safely fit around wrists as an alternative to metal and plastic cuffs.
- **Soft Restraint System (SRS)**: a soft material or fabric that is padded and designed to safely fit around the limbs of an individual to limit mobility to prevent self-harm or harm to others.

9: Audit and assurance

Element to be monitored	Lead	Tool	Frequency	Reporting Committee
All use of mechanical restraint (MR) to be monitored and reviewed.	Chair and co-chair of RRP	GI generated report	Monthly	Reducing restrictive Practice steering group.
All use of MR should have the appropriate levels of physical health checks conducted.	Deputy Director of Nursing and Quality	Audit of RiO records, paper based records and in-patient portal dependent upon type of MR used.	Quarterly	Matrons to local CGC and RRP, Escalation to Trust CGC
Accurate reporting and recording of all use of MR as per Use of Force legislation	Deputy Director of Nursing and Quality	GI generated reports, monitoring of Eclipse entries.	Quarterly	Local CGC, RRP Steering group escalating to Trust CGC.
Service user/ staff/ witness views regarding the use of MR	Matrons linking in with P&E workers and reporting onto Deputy Director of Nursing and Quality	On-going work of Participation and experience engagement workers and the Trusts Experts by Experience	Annual report	Local CGC/ RRP steering group escalating to Trust CGC.
All use of MR should have a PBS/ Care plan detaining its use and a post-use evaluation.	Matrons/ ANP's to CNM's/ CD's on to Deputy Director of Nursing and Quality	Audit of RiO records	Monthly audit and quarterly report	Local CGC/ RRP steering group escalating to Trust CGC.
Completion of maintenance checks on all MR as per relevant appendices.	Matrons/ ANP's to CNM's/ CD's on to Deputy Director of Nursing and Quality	Audit of maintenance & usage logs	Monthly Audit and quarterly report	Local CGC/ RRP steering group escalating to Trust CGC

10. Appendices

Appendix 1- Equality Analysis
Appendix 2- The Use of Handcuffs for high-risk escorts
Appendix 3- Risk Assessment Considerations for Planning Escort using Handcuffs
Appendix 4- Handcuff Flowchart to assist with clinical decision making
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Appendix 6- The Soft Restraint System (SRS) formerly ERB
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Appendix 11- Utilising SEELS to assist with the relocation into a purpose-built seclusion facility.
Appendix 12- The Decision-Making Model (DMM)
Appendix 13- Mechanical restraint equipment monitoring standards
Appendix 14- Mechanical Restraint Equipment Monitoring Sheet.
Appendix 15- SRS to manage prolonged prone restraint, Safety Monitoring Sheet
Appendix 16- SRS (&SEELS) to manage prolonged prone restraint: Physical Observation Sheet
Appendix 17- Escalation and review table

Appendix 1: Equality assessment

Equality Analysis Screening Form

A word version of this document can be found on the HR support pages on Connect
http://connect/corporate/humanresources/managementsupport/Pages/default.aspx

Title of Proposal	Mechanical Restraint Policy		
Person Completing this proposal	Sam Howes	**Role or title**	ANP AVERTS
Division	People, Partnerships & Organisational Development	**Service Area**	Learning and Development
Date Started	18th July 2022	**Date completed**	18th July 2022
Main purpose and aims of the proposal and how it fits in with the wider strategic aims and objectives of the organisation.			
To ensure that if the Trust makes the decision to authorise mechanical restraint, this is done in line with statute, the Use of Force Bill, moral and ethical considerations, and that the least restrictive option is utilised to ensure patient safety and Staff and service user experience is not unduly compromised. There is a need to monitor Equality, Diversity, and inclusion to ensure that no person is unfairly discriminated as part of this policy.			
Who will benefit from the proposal?			
Staff and service users by ensuring patient safety is at the forefront of any decisions taken.			
Do the proposals affect service users, employees or the wider community? ***Add any data you have on the groups affected split by Protected characteristic in the boxes below. Highlight how you have used the data to reduce any noted inequalities going forward***			
The policy is a revision of the Emergency Response Belt policy and has been developed following consultation with clinical services and the changing needs of the organisation. There have been exceptional circumstances where the decision has been made to employ mechanical restraint when patient and staff safety have been at increased risk. The policy will affect service users and staff by maintaining safety in high risk challenging clinical situations. The decision to employ mechanical restraint within the organisation has			

been based upon data and the constant review of Eclipse forms. Monitoring and audit of the use of MR will be intrinsic to the policy and its use will be overseen by all levels of the organisation.
Do the proposals significantly affect service delivery, business processes or policy? ***How will these reduce inequality?***
The use of MR can have a benefit for keeping staff and service users safe and for preventing the need for prolonged physical restraint that can affect quality and experience for all parties involved.
Does it involve a significant commitment of resources? ***How will these reduce inequality?***
There is a significant commitment around training resource and provision. In areas where MR is sanctioned for use, a minimum of 75% staff must be trained in the device sanctioned and this training must be refreshed on an annual basis. The MR training will be a traffic light on specific staffs traffic light as already agreed by LD oversight group in April 2021. The use of MR will be under review including protected characteristics to ensure that the use of MR is equitable and that no particular group is disadvantaged by its use. There is already an organisational awareness that black men are 4 times more likely to be subject to higher levels of restriction and the incidents of restrictive practice and restraint are monitored through the Reducing Restrictive Practice steering group.
Do the proposals relate to an area where there are known inequalities? (e.g. seclusion, accessibility, recruitment & progression)
The proposals may allow for prevention of prolonged restraint to access purpose-built seclusion facilities or reduce the need for seclusion in some situations. It also reduces the need for prolonged physical holding which could have a positive impact upon service user and staff experience.
Impacts on different Personal Protected Characteristics – *Helpful Questions:*

Does this proposal promote equality of opportunity? *Eliminate discrimination?* *Eliminate harassment?* *Eliminate victimisation?*	*Promote good community relations?* *Promote positive attitudes towards disabled people?* *Consider more favourable treatment of disabled people?* *Promote involvement and consultation?* *Protect and promote human rights?*

Please click in the relevant impact box and include relevant data

Personal Protected Characteristic	No/Minimum Impact	Negative Impact	Positive Impact	Please list details or evidence of why there might be a positive, negative or no impact on protected characteristics.

Age	X			If MR is authorised for use on children and young people the clinical area needs to ensure that the authorisation and application is in keeping with the Children's Act (2004) and relevant Mental Health Legislation. In all but exceptional circumstances, MR should not be applied to children and young people. For all use in CAMHS/ FCAMHS a SoP should be written and signed off to include the necessary legislation that permits the use of MR.
Including children and people over 65 Is it easy for someone of any age to find out about your service or access your proposal? Are you able to justify the legal or lawful reasons when your service excludes certain age groups				
Disability	X			A full physical health assessment should be undertaken prior to the application of any form of MR. Where risks are identified MR should not be considered without a full case review and RC sign off.
Including those with physical or sensory impairments, those with learning disabilities and those with mental health issues Do you currently monitor who has a disability so that you know how well your service is being used by people with a disability? Are you making reasonable adjustment to meet the needs of the staff, service users, carers and families?				
Gender	X			On-going monitoring and review of MR and its application should identify if there is any gender bias in the application of MR which can be addressed through the RRP steering group and local governance committees.
This can include male and female or someone who has completed the gender reassignment process from one sex to another Do you have flexible working arrangements for either sex? Is it easier for either men or women to access your proposal?				
Marriage or Civil Partnerships	X			It is anticipated that Marriage or Civil Partnership will not have a negative impact in terms of discrimination as this policy ensures that all employees and service users should be treated in a fair, reasonable and consistent manner irrespective of this.
People who are in a Civil Partnerships must be treated equally to married couples on a wide range of legal matters Are the documents and information provided for your service reflecting the appropriate terminology for marriage and civil partnerships?				

Pregnancy or Maternity	X			Mechanical restraint should not be applied on any pregnant person or anybody 6 months post-partum. The application of MR is not permitted to this service user population.
This includes women having a baby and women just after they have had a baby Does your service accommodate the needs of expectant and post natal mothers both as staff and service users? Can your service treat staff and patients with dignity and respect relation in to pregnancy and maternity?				
Race or Ethnicity		X		As part of the ongoing monitoring of restrictive practices, the Trust has an obligation to monitor its use of MR to ensure that no race or ethnic group are adversely affected by its application.
Including Gypsy or Roma people, Irish people, those of mixed heritage, asylum seekers and refugees What training does staff have to respond to the cultural needs of different ethnic groups? What arrangements are in place to communicate with people who do not have English as a first language?				
Religion or Belief	X			It is anticipated that Religion or Belief will not have a negative impact in terms of discrimination as this policy ensures that all employees and service users should be treated in a fair, reasonable and consistent manner irrespective of this.
Including humanists and non-believers Is there easy access to a prayer or quiet room to your service delivery area? When organising events – Do you take necessary steps to make sure that spiritual requirements are met?				
Sexual Orientation	X			It is anticipated that Sexual Orientation will not have a negative impact in terms of discrimination as this policy ensures that all employees and service users should be treated in a fair, reasonable and consistent manner irrespective of this.
Including gay men, lesbians and bisexual people Does your service use visual images that could be people from any background or are the images mainly heterosexual couples? Does staff in your workplace feel comfortable about being 'out' or would office culture make them feel this might not be a good idea?				
Transgender or Gender Reassignment	X			It is anticipated that Transgender or Gender Reassignment will not have a negative impact in terms of discrimination as this policy

				ensures that all employees and service users should be treated in a fair, reasonable and consistent manner irrespective of this
This will include people who are in the process of or in a care pathway changing from one gender to another Have you considered the possible needs of transgender staff and service users in the development of your proposal or service?				
Human Rights		X		There is a possibility that a Service users Human Rights could be violated if MR is applied without statute authority or appropriate authorisation. The application of MR could be viewed as degrading or humiliating however to not apply it when there are no further options available could endanger a person's health and well-being.
Affecting someone's right to Life, Dignity and Respect? Caring for other people or protecting them from danger? The detention of an individual inadvertently or placing someone in a humiliating situation or position?				
If a negative or disproportionate impact has been identified in any of the key areas would this difference be illegal / unlawful? I.e. Would it be discriminatory under anti-discrimination legislation. (The Equality Act 2010, Human Rights Act 1998)				
	Yes X	**No**		
What do you consider the level of negative impact to be?	**High Impact**	**Medium Impact**	**Low Impact**	**No Impact**
			X	
If the impact could be discriminatory in law, please contact the **Equality and Diversity Lead** immediately to determine the next course of action. If the negative impact is high a Full Equality Analysis will be required. If you are unsure how to answer the above questions, or if you have assessed the impact as medium, please seek further guidance from the **Equality and Diversity Lead** before proceeding. If the proposal does not have a negative impact or the impact is considered low, reasonable or justifiable, then please complete the rest of the form below with any required redial actions, and forward to the **Equality and Diversity Lead.**				
Action Planning:				

How could you minimise or remove any negative impact identified even if this is of low significance?
By ensuring that legat processes are applied during every application of MR and that this is monitored and reviewed for every application of MR. What lessons can be learned and is there a less restrictive alternative that should be considered?
How will any impact or planned actions be monitored and reviewed?
As per audit and assurance framework embedded into the policy.
How will you promote equal opportunity and advance equality by sharing good practice to have a positive impact other people as a result of their personal protected characteristic.
By ensuring that protected characteristics are monitored as part of the overall review process for the authorisation and application of MR.
Please save and keep one copy and then send a copy with a copy of the proposal to the Senior Equality and Diversity Lead at bsmhft.edi.queries@nhs.net. The results will then be published on the Trust's website. Please ensure that any resulting actions are incorporated into Divisional or Service planning and monitored on a regular basis

Appendix 2

The Use of Handcuffs for high-risk escorts

1. The use of handcuffs should only ever be considered as an appropriate option when based on the outcome of a thorough, MDT assessment of an individual's risk, and then only when that outcome indicates that the individual is of a high risk of either absconding or violence and there is no other viable and safe alternative means of management. Risk assessment and process should take into account the formal risk assessment guidance contained in **appendix 4** and escort status flowchart in **appendix 5** .
2. If a journey outside the secure environment is unavoidable, it is essential that a full discussion take place to establish detailed plans to account for the specific risk management and security needs of the escorted journey. The patient's Responsible Clinician [RC] (or the on-call consultant if they are unavailable) should facilitate this discussion and include all relevant staff.
3. Handcuffs should only be applied to an individual for the purpose of conveyance outside of a secure environment where the journey is unavoidable.
4. Authorisation of the use of handcuffs will be documented in the Section 17 Leave Prescription on RiO.
5. Any risk assessment being carried out for the potential classification of a high-risk status should amongst other things include consideration of the following points:
    a. Previous/recent history of violence
    b. Previous/recent history of absconding
    c. Current leave status
    d. Current legal status
    e. Current mental state
    f. Potential risk to others e.g. previous victims or other identified individuals
6. Any individual who is designated a 'high risk' status should have their status re-assessed regularly as to whether it remains at an appropriate level, this should be evidenced in the minutes of the clinical team meeting and entered on to the individuals care records.
7. Permission to issue handcuffs for use with a patient will be recorded on the record form and stored in the patient's clinical records by the RC (or designated deputy) and Senior Nurse. In circumstances where permission from the RC or on-call consultant and Senior Nurse must be given by telephone (e.g. in out-of-hours emergency situations) the most senior nurse/manager (and doctor, if available) in the unit will make an entry in the patient's clinical notes, stating that the above persons have given their permission by telephone. The out of hours escalation process can be found in **appendix 5**.
8. A Registered Nurse will be nominated as in-charge of the escort and will be responsible for ensuring the appropriate and authorised use of handcuffs. Additionally, a Registered Nurse who is an 'approved handcuff user' would ideally be present with the patient at all times when handcuffs are used. For prolonged periods of the use of handcuffs (i.e. over more than one shift

period) adequate arrangements should be made for the correct number of approved users to assume responsibility for such periods.

9. The nurse in charge of the escort must submit an Eclipse incident report for every occasion where handcuffs are issued and/or used. This will include information as to the clinical and practical justifications for their issue and/or use throughout the escorted journey so that a full evaluation can be undertaken. This should also be recorded as a mechanical restraint incident and family members/ carers must be informed as per UoF requirements.

Planning for Court Appearances

1. A Registered Nurse will be nominated as in-charge of the escort and will be responsible for ensuring the appropriate and authorised use of handcuffs. Additionally, a Registered Nurse who is an 'approved handcuff user' must be present with the patient at all times when handcuffs are used. The 'approved user' who takes receipt of the equipment from the Duty Senior Nurse is responsible for ensuring the safe and secure storage of the handcuffs and keys throughout their use, and their return. For prolonged periods of the use of handcuffs (i.e. over more than one shift period) adequate arrangements should be made for the correct number of approved users to assume responsibility for such periods.

2. There should always be a clear plan in place for service users who have to present at court if alternative methods of giving evidence (ie video streaming) are not considered appropriate. Given the timescale involved in court appearances it is therefore appropriate that a plan is developed.

    - When the court date and venue is established the MDT should discuss the need for handcuffs using the risk assessment process established earlier in this policy.

    - The relevant court should be contacted by the most suitable mental healthcare professional and the following information relayed:

        1. That the person attending court will be in handcuffs
        2. State the risk factors involved if the handcuffs are removed
        3. Establish and document the court's position on handcuffs based on the information given
        4. Plan the escort and required resources based on this information
        5. Communicate the plan to the MDT and those who will be involved in the escort

Planning for Emergency Treatment

1. There should be a clear plan in place for service users who have previously required emergency admission to hospital for treatment.

2. The relevant treatment service (ie, A&E) should be contacted ahead of the escort and the following information relayed:

    - That the person attending for treatment will be in handcuffs
    - State the risk factors involved if the handcuffs are removed and ask they be communicated to medical staff
    - Establish and document the treatment area's position on handcuffs based on the information given
    - Plan the escort and required resources based on this information
    - Communicate the plan to the MDT and those who will be involved in the escort
3. If the service user has incurred an injury where it is likely the handcuffs will impede treatment and will have to be removed, appropriate staffing will be required to manage potential high-risk behaviour. Escorting staff should be clear what to do in such a situation prior to commencing the escort and will be informed by the individual's agreed risk management plan.
4. The agreed plan should be recorded in the patient's clinical records and specify:

    - The escorting staff requirements and their individual specific roles and responsibilities, including any strategic staff positioning at various points of the journey, e.g. when boarding or alighting the vehicle.
    - Communication arrangement between the base, the vehicle and the destination.
    - Consideration should also be given to the transport arrangements for outward and return journeys, including the type of vehicle (this should represent a level of security that is in keeping with the high-risk status of the individual), loading arrangements, seating arrangements, and unloading arrangements.
    - The route to the destination, the arrival point (this may include parking and/or drop off arrangements) and any arrangements to be received by other establishment/agency.
    - If external secure transport providers are used, then Trust staff will have an advocacy role to maintain the safety and wellbeing of the service user. These incidents need to be recorded on Eclipse as MR and Families/ carers informed as per UoF reporting requirements.

5. If a patient is assessed and considered to present a High-Risk Escort, the Clinical Team should consider whether or not the use of handcuffs represents an appropriate method of managing the identified risks. In emergency or unforeseen situations however, the RC or on-call consultant, Duty Senior Nurse and ward staff should make this assessment jointly.
6. The availability and use of handcuffs within SCOH/FCAMHS and AUCS PICUs will not normally be discussed in the presence of service users or visitors. However, a Clinical Team should always discuss the use of handcuffs with an individual service user for an escorted journey to or from the secure environment prior to the event to inform them of the decision to use handcuffs on the journey, the procedure, and to obtain their views, but does not include the patient's consent. The timing of the discussion with the service user is important, specifically where there is believed to be a risk of absconding, to

mitigate against the patient communicating details of the journey to anyone minded to assist the patient's abscond. In emergency situations, the on-call doctor and Duty Senior Nurse/manager will discuss this issue with the patient following discussion with the service user`s RC or on-call consultant. In the extreme circumstance in AUCS that the duty manager is a non-clinician, the nurse in charge will liaise with the manager using the MDT pre-agreed individual care plan that should have already been to support the decision-making on the use of handcuffs.

7. The handcuffs will be applied at the point of departure of the patient, and they must be removed immediately upon return. All journeys where service users are handcuffed should depart and arrive via the secure vehicle airlock (or PICU equivalent), which offers a discrete route and suitable location for handcuffs to be applied and removed prior to leaving and on re-entering the building via the same route.
8. Where the patient refuses to have handcuffs applied, an immediate risk assessment of the situation should be undertaken, and consideration given to the following options:
    - Termination of escort
    - Request police assistance
9. The application of handcuffs is a proactive way to manage prospective high-risk behaviours that have been established through robust risk assessment on an individual basis. It is therefore not considered appropriate for staff to carry handcuffs as a contingency plan, applying them if required and outside of a secure environment.
10. Where an escort is required due to an emergency outside of normal office hours (09:00- 17:00hrs), then the on-call manager should be immediately informed, this will enable them to respond in an advisory capacity to the staff facilitating the escort. If the on-call manager is a non-clinician the decision-making process will be informed by the existing MDT care plan for use of handcuffs with an individual patient, and the current risk assessments established by the nurse in charge at the time of escalation.
11. Where the escorting staff are faced with potentially making decisions relating to deviating from the agreed escort plan/procedure, or they feel they require an increased level of support they should consult with the on-call senior nurse before making said decisions. Contingency for removing the handcuffs while on escort should be included in the risk management plan.
12. Before the respective member of staff applies the handcuffs s/he must inform the patient clearly of what s/he intends to do. S/he must also inform the patient of his rights under these circumstances, including the right to complain and in particular provide an explanation about the complaints process.

EQUIPMENT SPECIFICATION, STORAGE & ISSUE

1. The type of handcuffs approved and provided for use within the Secure Care, FCAMHS services and AUCS is the 'curb-chain' type.
2. The handcuffs will be securely stored in an agreed designated locked cupboard at each of the secure environments the keys for which will be held in each sites' respective reception control room. Only an authorised Duty Senior Nurse may access the keys from the reception control room. Approved users will constitute any Registered Nurse that is up to date with their AVERTS training and deemed competent and confident through handcuff training and High-Risk Escort

training (where applicable). Any equipment removed from the cupboard (handcuffs and keys) must be signed out when they are issued recording the handcuff specific serial number.

3. In secure care services the Duty Senior Nurse will issue 1 pair of handcuffs and 2 keys to an 'approved user' for situations where a risk assessment and detailed care plan indicate the authorised and appropriate use of handcuffs on a patient during an escorted journey away from the secure environment. The Duty Senior Nurse and 'approved user' will both sign the appropriate record of issue and receipt. One key should be held by the "approved handcuff user" while the other is discreetly held by a colleague. Both keys should not be maintained on the same ring.
4. Upon return, the 'approved user' will return the handcuffs and 2 keys to the Duty Senior Nurse and they will both sign the appropriate record of return and receipt.
5. The ANP Risk and Security (ward manager or designated deputy in AUCS) will check the contents of the secure storage cupboard on monthly basis and make a record of their check in the appropriate record contained within the cupboard. The ANP for Risk and Security (ward manager or designated deputy in AUCS) will also be responsible for maintaining the handcuffs (e.g. lubrication at least every 6 months, with WD 40 or similar product), and report immediately if there are any items missing/damaged to the CNM or their designated deputy. Use of WD40 or similar product should be entered on the mechanical restraint equipment monitoring sheet. **Appendix 14**
6. In AUCS PICUs, the above procedures for allocating and returning and monitoring the use of handcuffs will be conducted by the nurse in charge, supported by the MDT agreed care plan for using handcuffs on an individual service user.
7. In AUCS PICUs handcuffs will be stored in a secure place on the unit accessible only to authorised staff and the location communicated clearly to staff, including TSS staff.
8. Handcuffs will only be applied and removed by identified health care professionals who have attended their AVERTS update which can be verified through their Fundamental Training status as evidenced by their individual training statement.
9. If the service user is on prolonged escort, registered staff should check the physical well-being of the service user every four hours in relation to the application of the handcuffs in line with the Mental Health Act Code of Practice. Checks should focus on:
    - Making sure there is no evidence of swelling on the wrists
    - Making sure there is capillary flow in fingertips.
    - Making sure that the service user is not in any form of discomfort due to handcuffs being in situ

REMOVAL OF HANDCUFFS WHILE ON ESCORT

1. As a general philosophy, once the handcuffs are applied, they should remain on for the duration of the escort, until returning to a secure setting, this may even include the individual accessing toilet facilities. Should the handcuffed individual require the toilet there should be a minimum of two gender specific staff available to accompany them. Staff will be expected to carry out a brief risk assessment of

the toilet area prior to use, assessing for any issues in regard to routes of escape, potential self-harm, access to weapons or risk to members of the public.

2. If treatment for any other reason may indicate the removal of handcuffs, then a pre-agreed plan of holding using AVERTS techniques should be implemented to minimise any identified risks due to the removal of the handcuffs. Post treatment handcuffs should be re-applied before holding is released (this should first be risk assessed in relation to the treatment received). If the individual refuses to have the handcuffs re-applied, staff should consolidate their current situation and contact their base for advice. In extreme circumstances it may be advisable to consider whether police attendance would be appropriate.
3. It may be deemed appropriate for handcuffs to be removed while using the toilet. This should be considered only if this is a strategy agreed by the clinical team and clearly documented in the service user's management plan prior to leaving for the escort. Two gender-specific staff members should be present throughout the time the individual is in the toilet area. Handcuffs should be reapplied afterwards and any issues with compliance should inform risk assessments for future escorts.
4. If the decision is made to remove the handcuffs to facilitate treatment, then handcuffs should be completely removed to avoid the risk of the equipment being used as a potential weapon against staff and members of the public.
5. Where admission to hospital is longer than one shift the use of handcuffs should be reviewed on a shift-by-shift basis by the Nurse in Charge of the ward and the escort lead and documented in the WHAT handover and progress notes.

Appendix 3

Risk Assessment Considerations for Planning Escort using Handcuffs

All patients have an assessment of their risk which is then documented in the clinical record to establish whether they are a high-risk escort. This guidance is to be used in conjunction with the Section 3 PROCEDURES and appendix 4 of the Handcuff Policy.

The decision to implement this procedure will be discussed and agreed at the Patient Clinical Team Meeting. This discussion must involve the multi-disciplinary team including the patient's Responsible clinician (RC) or nominated deputy. A formal risk assessment (again documented in the leave legal status of the clinical record) and a detailed care plan must be completed, which considers the following points:

- Nature of escort – planned/emergency
- Need for escort – can the procedure/event take place on the unit
- Duration of escort
- Patient's current physical state, particularly conditions or circumstances which could be relevant to use of handcuffs, e.g. muscular-skeletal injuries, cuts
- Current mental state of the patient
- Risk to public, staff or patient. To include risk of violence and aggression for the duration of the escort. Is the patient assessed to be compliant or non-compliant? What would be the indicators of non-compliance?
- Legal status
- Leave status
- Past/recent history of absconding
- Use of secure vehicle with trust driver
- Use of ambulance. An emergency transfer requiring the use of a Paramedic ambulance may still require the use of handcuffs. However, it is accepted that the risk of escape is overshadowed by the risk of a life-threatening condition. Handcuffs will not be used if this hinders any procedures to be undertaken by the paramedic staff. (Ref: Mental Health Act Conveyance Procedure. BSMHFT Policy MHA04)
- Destination – environment, exits, availability of waiting room, ability to accommodate patient and escorts. Familiarisation with the destination by staff will increase confidence and should be undertaken where practicable by at least one member of staff prior to undertaking a High-Risk Escort.
- Any circumstances in which a patient's handcuffs may potentially be removed and re-applied whilst outside of Secure Services e.g. certain treatments/therapies would need to be considered prior to the commencement of the escort. Any potential treatment options would need to be clearly discussed and planned for and based on clinical needs, this should be made clear at point of contact with destination prior to escort, as laid out in section 3.4 of this policy. For Treatments such as ECT or MRI where handcuffs would need to be removed this should occur after sedation and be

re-applied prior to full consciousness. A member of the medical team administering treatment has the potential to ask for staff to remove handcuffs to administer treatment and contingency for this built into any plan prior to the escort and communicated to all members of the team.

- If treatment for any other reason may indicate the removal of handcuffs, then a pre-agreed plan of holding using AVERTS techniques should be implemented to minimise any identified risks due to the removal of the handcuffs. Post treatment handcuffs should be re-applied before holding is released (this should first be risk assessed in relation to the treatment received). If the individual refuses to have the handcuffs re-applied, staff should consolidate their current situation and contact their base for advice. In extreme circumstances it may be advisable to consider whether police attendance would be appropriate. The AVERTS department can be contacted for further advice and support where required.
- Impact factors such as the numbers of escorting staff, their skills, ethnicity and gender mix along with physical comparison to the patient.
- A risk assessment of the area to which the patient is to be escorted and any action needed to reduce the risk of absconding. (This may need to take place immediately on arrival in some cases.)
- Risk of accomplice assisting the patient to abscond may be reduced by limiting knowledge of the escort date/time route etc., but staff will require clear guidelines on the procedure should this occur, and this should be discussed and formulated as part of the overall risk management plan previous recommendations and implications for future escorting events, made in the post-escort analysis.

Appendix 4

Handcuff Flowchart to assist with clinical decision making

This tool is intended to assist with structured clinical judgement when assessing and reviewing escorted leave. There may be other factors not indicated here which increase/decrease level of risk

FLOW CHART TO ESTABLISH ESCORT STATUS
Or All Escorted Community Leave

STRUCTURED CLINICAL JUDGEMENT
Is Nurse in Charge aware of any information that would increase risk status they must refer to Duty Manager/Senior Nurse/RC Consultant on call?

FACTORS THAT MAY INDICATE PATIENT LOW RISK

- MDT Assess low risk of absconding (No recent history or threat to abscond/escape)
- *No immediate danger to self or others if abscond/escape*
- *Current mental state stable*
- *Currently have community leave*
- *Compliant with treatment*

LOW

- Escort according to current leave entitlement
- Transportation negotiable with what is available
- Routine observation and report as per procedure

FACTORS THAT MAY INDICATE PATIENT MEDIUM RISK

- MDT assess medium risk of absconding (some historical facts or threat to abscond/escape)
- Some impulsivity of behaviour that may pose a risk to self or others if abscond/escape
- Current mental state can fluctuate
- Currently have escorted leave only outside secure perimeter

MANAGEMENT INTERVENTIONS

MEDIUM

- Number of escorts to be agreed by MDT,Duty senior nurse for unplanned escorts and clinical team
- Care plan to be formulated and agreed
- Transportation in Secure van/hospital transport
- Briefing Session to take place prior and post escort

FACTORS THAT MAY INDICATE PATIENT HIGH RISK

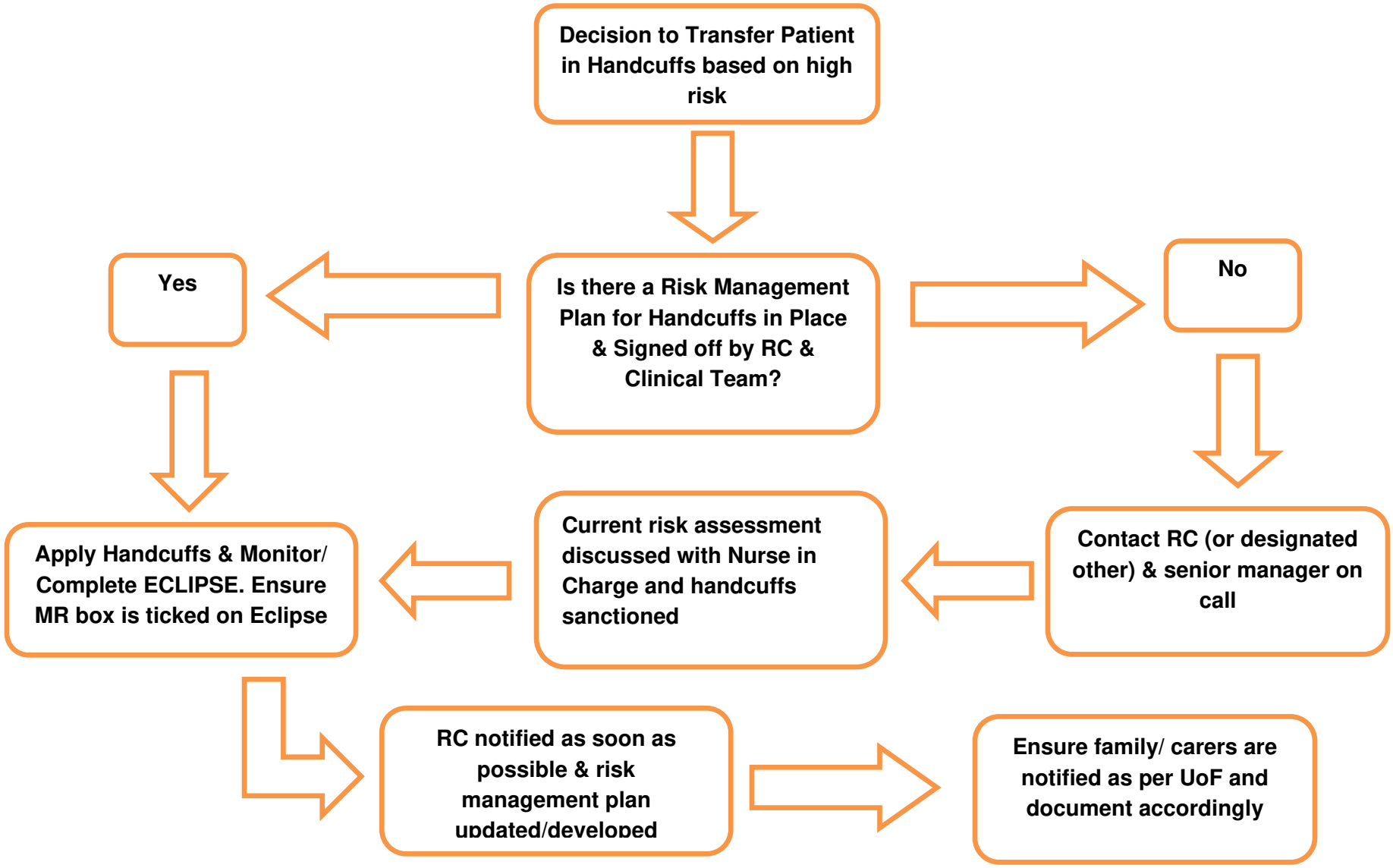
1. MDT assess high risk of absconding (historical and recent history or threat to abscond/escape)
2. Pose an immediate risk to self or others if abscond/escape
3. Exhibiting acute symptoms of mental illness and/or challenging behaviour
4. Have no leave outside secure perimeter
5. Patients detained under legal status 35, 36, 38, 47, 48, and 49

HIGH

- Is trip necessary? Can procedure/event take place on the unit?
- Minimum three escorts required (one registered nurse)
- Secure Transport, with additional driver that remains at escort venue (in house)
- Care plan formulated with Duty senior nurse outside office hours

Appendix 5

Handcuff Escalation Process Flowchart for Out of Hours (17:00 – 09:00)



Appendix 6

The Soft Restraint System (SRS) (Formerly ERB)

- The SRS is a set of (up to) three belts made of durable, strong material with strong Velcro fastenings. Its purpose is to provide a protective restraining device that offers staff the ability to safely de-escalate, manage or relocate a person who will be exhibiting a high level of risk to either themselves or others.

- The SRS reduces the need for prolonged physical intervention and enables staff to quickly move an individual out of the prone (face down) position.

- The SRS cannot be applied unless the individual's limbs are under control (either verbally or through physical intervention).

- The SRS should not be applied over injured limbs or over areas where there are issues with skin integrity or tissue viability.

- One belt may be used with two sets of soft cuffs to form a protection against serious self-harm. Up to three belts may be used with 2 pairs of soft cuffs in the relocation of a person into a seclusion facility.

- Soft-Cuffs are made of strong durable cloth with Velcro fastening. They can be used singularly as an alternative to metal, chain linked handcuffs by creating 2 loops to put the hands through, or 2 pairs of Soft-Cuffs in conjunction with the SRS.

- The SRS has authorisation in the Trust to be used for the management of serious life-limiting self- harm and to relocate an individual into a purpose-built seclusion room for the prevention of prolonged prone restraint.

- The use of the SRS will only be considered in situations where prolonged restraint can be prevented by its use and its use represents the most appropriate, last resort and pragmatic method of managing a service users' risk to self and others.

- The SRS utilized by the organization has been risk assessed to be used in conjunction with soft cuffs. Their use with the SRS is for the sole purpose of minimizing risk of the service users' arms struggling free during transit and compromising the safety of self and those members of staff carrying them.

- The SRS has multiple application options, the alternative uses may be considered by clinical services as part of a holistic assessment and management plan based upon individual presentation and assessment of need. Alternative applications of

the SRS would need to follow a stringent governance process as outlined in section 1.12 with clinical services developing a SoP to cover the intended additional use.

- Advice, guidance and discussions surrounding the additional use of the SRS should be done in full consultation with the AVERTS consultants and AVERTS training team.

- Only the SRS approved for use within BSMHFT is to be applied. Application should follow the process as taught in the AVERTS MR training.

Appendix 7

Using the SRS to manage serious life-limiting self-harm

- The escalation process flowchart for using the SRS for managing serious self-harm can be found below.
- **Escalation process Flowchart**

- Application of the SRS for self-harm will require a prescribed set of physical health observations to be conducted via the in-patient portal. The relevant documentation in the in-patient management section of RiO must be completed.

- Staff should make sure that the service user's fingers and hands are regularly checked for discolouration that may indicate the soft cuffs are applied too tightly.

- If the SRS is to be used for a prolonged period, then medical reviews may be adjusted after consultation and agreement with the RC & clinical team and clearly documented as part of the service users care record, and on the in-patient portal. There should be clear instructions on what elements may trigger a change in the frequency of reviews.

- The process outlined in 3.34 should also occur if the service user falls asleep with the SRS for self-harm in situ.

Appendix 8

Using the SRS to aid relocation into a seclusion facility and prevent prolonged prone restraint

- When a restraint becomes prolonged, and the service user continues to be un-cooperative the SRS may be used as a last resort to facilitate the relocation of the service user to a purpose-built seclusion facility.

- The number of belts to be applied to assist with the relocation of a service user into a seclusion room should follow the least restrictive option. If a service user is willing to walk to a seclusion facility with one belt and a set of soft cuffs, then this should be facilitated and where the application of further belts end.

- If a service user remains un-cooperative, then all 3 belts may be a necessity. Following application of the 3 belts, if a service user is willing to walk to the seclusion room, this should be facilitated.

- Only if a service user remains uncooperative should staff consider a full body lift to enable staff to move the service user into the seclusion room to terminate prolonged restraint.

- Once an SRS has been applied to the service user it may be possible to encourage a service user to walk to seclusion or if they remain uncooperative a full body lift may be possible more safely, enabling staff to move the service user to a seclusion room to terminate prolonged restraint.

- It is important that staff are clear about the safeguards in limitations provided by the Manual Handling Operations Regulations (MHOR 1992), Trust Manual Handling Policy and the current training in the prevention and management of violence. The MHOR do not permit full weight lifts of people unless the situation is exceptional or life threatening. Consequently, staff are not ordinarily expected to pick up or carry service users from one area to the seclusion room. Staff should encourage the service user to cooperate with them and walk to seclusion. Detailed guidance on risk assessing a situation can be found in the Trust Manual Handing Policy. (Link needed here).

- When a service user is being carried there must always be someone in situ to protect, monitor and support the person's head.

- Under ordinary circumstances the service user should not be in the SRS for longer than 30 minutes. This should be enough time to relocate the person to seclusion and for the SRS to be removed.

- In exceptional circumstances, for example where there is a delay in accessing a seclusion facility, the SRS may be in situ for longer than 30 minutes but must be supported by on-going risk assessment and continuing physical health monitoring. The decision to use the SRS in this context must be made by the clinical team in situ and involve a member of medical staff. 'Exceptional circumstance' does not extend to issues with inadequate staffing.

- The physical health observation forms should be completed for all instances where the SRS has been applied for the purpose of re-location. The required documentation can be found in appendix 11.

- The Trust is moving through a process where paper-based documentation is being replaced with electronic record keeping. The process described in section 3.46 may be superseded by the process described in section 3.31.

- The escalation process flowchart for using the SRS to relocate a person into a purpose-built seclusion facility to prevent prolonged prone restraint can be found below.

- **Escalation process Flowchart**

Appendix 9

Soft Restraint Cuff

- The Soft Restraint Cuff (SRC) provides a soft alternative to metal handcuffs and should be considered as a less restrictive option when the use of handcuffs is being considered.

- Any application of the SRC outside of its use with the SRS should be done in direct consultation with the provisions set out in sections 1.2.9-1.2.13 of this policy.

- The SRC is constructed from Velcro bands that are approximately 2 inches in width and utilises plastic buckles to allow for a firm fastening to be achieved and simple adjustment to be made if required.

- If the SRC are applied in any circumstances, the service user must be on level 4 therapeutic observations at all times.

- Observing staff need to be vigilant that the individual to whom the SRC's have been applied is not attempting to tamper with the cuffs or remove them.

- Observing staff should be aware that this could happen over a prolonged period of time.

- Staff need to maintain regular checks regarding the application of the cuffs and undertake regular physical checks as detailed in **appendix 16.**

- The SRC can be applied in the same position that conventional metal hand cuffs are applied. They can be applied palm to palm, stacked or used in conjunction with the SRS to secure arms to the rear or to the sides when attached to a waist belt for the management of serious self-harm.

- The SRC allows for wrists that do not fit into regular handcuffs to be managed.

Appendix 10

Utilising the Safe Holding System (SHS) as an alternative to the Soft Restraint System and Soft Cuffs to manage Serious, life limiting self-harm

- The Safe Holding System (SHS) is one soft restraint belt with a soft restraint cuff fixed in place and is a viable alternative to the equipment and process described in appendix 3.

- The SHS can be used in situations where the SRS for self-harm is considered and approved and the flow chart outlined in appendix 3 should be followed for authorisation for its use.

- There may be occasions when the SHS is not appropriate, for example when the individual has a larger girth meaning the SHS is too small.

- The SHS should be applied loosely (but not too loose as to fall off) over the lower abdomen, all physical health checks for the application of the SRS for self-harm will need to be followed as per RiO documentation.

Appendix 11

Utilising SEELS (Safer Emergency Enveloping Lifting Sling) to assist with the relocation into a purpose built seclusion facility.

- The SEELS is a piece of specialist lifting equipment used to relocate a person from one area to another.

- The SEELS should be used in conjunction with the SRS (see appendix 2.) therefore, its use should follow the process outlined in the SRS flowchart. Its use must be sanctioned by a Director of the Board and should form part of the persons PBS plan.

- The use of the SEELS will require staff to lift and carry the person to whom it has been applied.

- As BSMHFT is a no lifting Trust the SEELS use should be exceptional in serious life-threatening situations.

- There must be a full risk assessment for the application of the SEELS which gives a clear rationale as to why this person needs to be lifted and carried.

- The use of SEELS should always be planned with the most appropriate staff assigned to the task. The physical capabilities of the staff member must be taken into consideration.

- All discussions and decision making must be captured on RiO.

- Any use of SEELS must generate an Eclipse form.

- The use of SEELS should generate a clinical review that should be tabled for discussion in local governance committees.

- All staff applying the SEELS must have received the relevant training provided by the Trusts AVERTS team, all staff must be up to date with their AVERTS and MR training and must have completed the SEELS component of the training.

- All staff involved in the lifting and carrying of the person to who the SEELS has been applied must be up to date with their Manual Handing training.

- It will be the responsibility of the unit manager to keep a list of all staff who are up to date with AVERTS, AVERTS MR and Manual Handling training.

- A sufficient number of trained staff must be present for the application of the SEELS and for the lifting of the service user to be undertaken safely. The maximum carriage weight will be determined by the number of staff in attendance.

- Service users with a larger BMI will require more staff to be in attendance to support with the lift and relocation.

- The design of the SEELS allows for up to 8 members of staff to assist with the lifting process. An additional staff member must be present to manage the person's head. and monitor the physical health and well-being of the person in the SEELS.

- There should be one member of staff assigned to the co-ordination of the event, this person will be responsible for communicating with the person who is subject to the SEELS and for co-ordinating and communicating with the team of staff involved in the process.

- The SEELS has a colour coded system to assist with application; Red- Amber- Green. Green as the final Velcro Seals indicates that the device has been correctly applied.

- The clinical team should look to liaise with the Trusts manual Handling advisors for additional advice and guidance prior to using the SEELS.

- The SEELS has 4 different level handles to ensure that the carrying team position the service user in a horizontal position. The lifting team should use the specific handle for them, that prevents awkward postures and stooping to prevent the risk of injury.

- Sound manual handling principles and terminology as taught on Manual Handling Fundamental Training must be adopted when using the SEELS.

- If any member of the team experiences any difficulties, they should alert the co-ordinator at once and the manoeuvre should be stopped at once. The SEELS should be lowered to the floor and a different team member should take over from the person in difficulty.

- Subjects with an extreme BMI may be at risk during carriage in a SEELS. Individuals less than 5 feet tall should never be carried in a SEELS.

- Regular physical health monitoring of the person should be maintained whilst the person is in SEELS. This will include AcVPU, respiration rate, pulse, pulse oximetry (where appropriate) and capillary nail refill test.

- Any signs of respiratory distress, cyanosis or the service user saying they cannot breathe must be taken seriously and the planned intervention must cease with a full physical health check of the person.

- An Emergency response bag should accompany the escorting team at all times.

- The SEELS user manual will be issued to clinical areas once they have a minimum of 75% staff trained and equipment has been issued. The manual does not replace the need for staff to attend fundamental training and is purely intended as an aide memoir.

- **Escalation process flowchart**

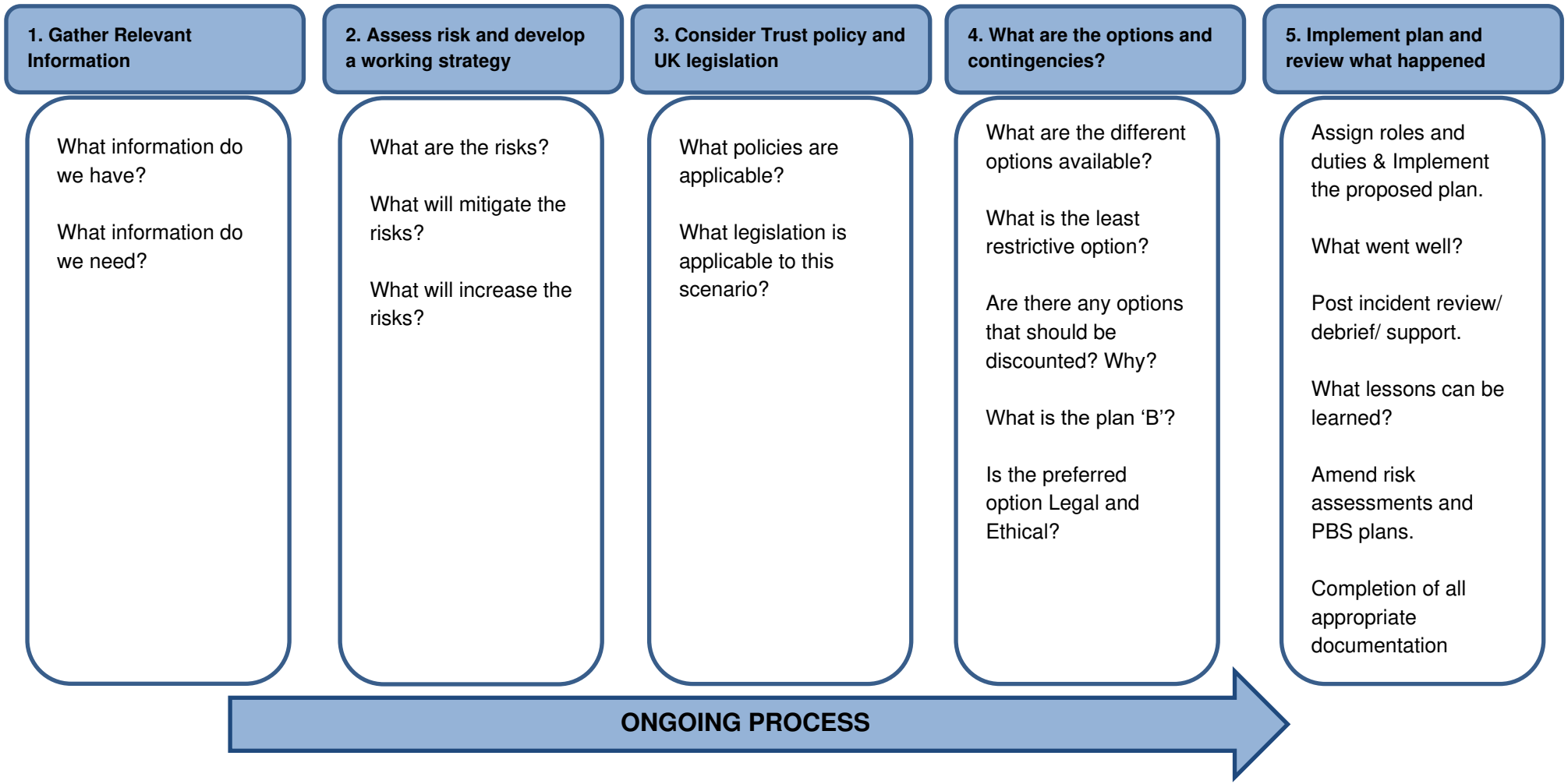
Appendix 12

The Decision Making Model (DMM)

Each domain of the model should assist staff in gathering the evidence to inform decision making. It encompasses the necessity to protect an individual's human rights and follows a sequential path to making informed decisions.

Below is an example of some of the considerations/ discussions that staff may have whilst deciding on whether to request authorisation for the use of MR.

National Decision-Making Model



Appendix 13

Mechanical restraint equipment monitoring standards

SRS Equipment Care and Maintenance Guidance

1. If the SRS is soiled following use, it should be washed in a washing machine at 30 degrees using mild detergent or anti-bacterial soap. Extensive soiling will warrant a replacement belt. The SRS can be placed in a pillowcase for washing to prevent the bits getting stuck in the Velcro.

2. The SRS should not be put in a tumble dryer as this degrades the Velcro material which fastens the belt. Once washed the belts should be placed in a secure place where they can dry naturally.

3. After the SRS's have dried, they should be re-checked and appropriately packed away in their case and stored in the dedicated location as agreed locally.

4. It is the responsibility of the ward manager to ensure that the SRS in their area is appropriately managed and maintained.

5. Nursing staff members should maintain a record of every wash by documenting this on the SRS Equipment Monitoring Sheet (appendix 10).

6. Weekly checks must be made of the belts with regards to the condition of the body construction, stitching and Velcro fastening and if found any faults must be documented on the SRS Equipment Monitoring Sheet and reported immediately to the ward manager. This will be audited by the matron monthly.

Secure & Complex Care Programme/ AUCS Handcuff Maintenance Record Log

1. Handcuffs should be kept in the agreed designated locations in SCOH, FCAMHS and AUCS and should be subject to a weekly review.
2. The handcuffs will need to be maintained on a regular basis to ensure the mechanisms are in working order. This requires manipulating the mechanism and applying lubricant (WD40) if required to ensure the mechanism does not seize. Lubricant should be used regardless at least every two months. Staff should use the maintenance log sheet (**appendix 14**) to record this check.
3.

Appendix 14

Mechanical Restraint Equipment Monitoring Sheet

Name of Device:

DATE	TIME	COMMENTS	PRINT NAME AND SIGNATURE

Appendix 15

SRS to Manage Prolonged Prone Restraint: Safety Monitoring Sheet

1. An SRS with Soft cuffs will only be applied by trained members of staff in accordance with the training provided. These members of staff will be current in ILS, ELS, AVERTS Manual Handling and SRS MR training.

2. After applying the belt initial checks for tightness and security will be completed, it should be possible to place at least two fingers underneath the belt and that securing straps are fastened down to the Velcro properly.

3. There will be a registered mental health nurse not involved in the physical intervention process who is responsible for carrying out observations on the service user 's physical health during this period. The member of staff (RMN) would carry out physical health observations immediately prior to the application of the SRS with soft cuffs. As far as practicable this would include blood pressure but would certainly require pulse rate and respiratory rate. Further observations would be carried out immediately after application of the SRS with soft cuffs. The member of staff would also speak to the service user to confirm that the service user is comfortable and not in severe pain or duress.

4. Physical Observation sheet should be used to document vital signs.

5. In line with the training package once the SRS has been applied **nursing staff must not leave the service user alone under any circumstances**. Level 4 observations should be maintained at all times.

6. Nursing staff are to familiarise themselves with the SRS Physical Observation recording notes.

7. The member of Nursing staff would check that the service user in restraint is able to continue normal respiration after application of the SRS by carrying out assessments of breathing. This will involve the designated nursing staff member observing and monitoring the client for signs of positional asphyxia. The nursing staff member will also be expected to carry out respiratory count for sixty seconds every five minutes and document the findings accordingly.

8. Regarding positional asphyxia, the named nursing staff member is to observe the service user for signs of difficulty, struggle or complaints of breathing. This would include:
    - Pain and its location
    - Signs of movement and symmetry around the chest wall and the observation of accessory muscles being used.
    - Signs of expansion and contraction around the abdomen area. Signs or record of the service user feeling sick or vomiting.

- Marked expansion of the veins around the neck region and swelling, redness or blood spots to the face or neck.

9. The designated nursing staff members who are carrying out respiratory counts on the service user are also expected to observe and monitor the rhythm, depth and noise (such as a wheeze or stridor) of the respirations. Where the breathing is very shallow and difficult to observe then the nursing staff member is to lightly rest their hands on the service user ‘s chest or abdomen to feel for movement. This must be clearly documented in all relevant documents. If the service user is observed to be not breathing normally then the SRS needs to be removed immediately and the emergency procedure to seek medical assistance needs to be implemented.

10. All staff involved in any restraint should also maintain a high level of awareness for signs of cyanosis, confusion, loss or reduced level of consciousness and signs of the service user becoming limp or unresponsive. Staff will need to adjust, loosen, or remove the SRS if the service user shows any signs of medical distress as outlined above.

11. All staff involved in any restraint are to observe the service user for any changes in behaviour, either escalating or de-escalating. These include observing the service user for signs such as sweating, hyperactivity, extreme paranoia, incoherent shouting, aggression, and bizarre and violent behaviour. If staff observe signs of severe sweating with incoherent speech or difficulty breathing, then the SRS should be removed immediately.

12. In accordance with the training once the SRS has been applied the service user must be moved from prone (face down) position as soon as their behaviour allows and when practical. The SRS would need to be removed as soon as possible or within 30 minutes of application.

13. In exceptional circumstances the SRS may be used beyond 30 minutes in keeping with appendix 4 of the Mechanical Restraint Policy and supported by ongoing clinical risk assessment and physical health checks.

14. Nursing staff trained in the use of the SRS and soft cuff application are to check the equipment prior to it being used and immediately after it is used and document accordingly on the SRS/ SEELS physical health monitoring sheet (appendix 12). It should always be possible to insert at least two fingers between the body and the SRS.

15. Consequent to the SRS being removed nursing staff are to check that the service user has not lost sensation in their limbs due to the SRS.

Appendix 16

SRS (& SEELS) to Manage Prolonged Prone Restraint: Physical Observation Sheet

Service user Name; ***Time of application;*** ***Date of application;***

Emergency Response Belt On							**Emergency Response Belt on**		**Emergency Response Belt Off**	
	Observations every 5 minutes						**RECORDING OF FINDINGS IMMEDIATELY AFTER APPLICATION**		**RECORDING OF FINDINGS IMMEDIATELY AFTER REMOVAL OF BELT**	
	5	10	15	20	25	30				
Signs of Positional Asphyxia							**AcVPU**		**AcVPU**	
Signs of swelling or bloodspots on neck or face							**Respiratory Rate**		**Respiratory Rate**	
Signs of Central or Peripheral Cyanosis							**Pulse Rate**		**Pulse Rate**	
Signs of Excited Delirium							**Temperature**		**Temperature**	
Signs of Air Hunger							**Pulse Oximetry**		**Pulse Oximetry**	
Signs of Confusion or Unconsciousness							**Capillary Refill**		**Capillary Refill**	
Signs of Loss of Sensation in Limbs									**Blood Pressure**	
SRS Check										
RESPIRATORY RATE										

Mark with a cross if no signs noted, mark with a tick if done or signs note. If abnormalities are detected during observations then the time of detection, the action taken and the outcome of the investigation should be recorded and clearly documented on the SRS Recording Sheet.

Service user Name; **Time of application;** **Date of application;**

Review Time (mins)	Comments	Signature and designation
5 mins		
10 Mins		
15 Mins		
20 Mins		
25 Mins		
30 Mins		
Post application Review Time (mins)		
5 mins		
10 Mins		
15 Mins		
20 Mins		
25 Mins		
30 Mins		

Appendix 17

Escalation and Review table.

Escalation	Reasons Why	People Involved	Outcome
1. Clinical team decide that the SRS may be appropriate for use. Escalate for review for **Serious self-harm.**	Through on-going risk and physical health assessment. Presentation of risk behaviour identified in PBS/advance directives.	Clinical Team. Executive Medical Director. Director of Nursing are contacted for authorization. *Out of hours* director on call. Most senior Medic and Most senior nurse make the decision.	Application should be recorded as MR and family/ carers informed. All documentation completed and Medical director and Director of nursing will be informed of decision to use/refuse the use of SRS. If OOH this should happen the next working day.
2. MDT decide following risk assessment that the SRS may be suitable to relocate to a seclusion facility and to **end prolonged restraint.**	Through on-going risk and physical health assessments. Risk behaviours identified in PBS plan/advance directives.	Clinical Team. Executive Medical Director. Director of Nursing are contacted for authorization. *Out of hours* director on call. Most senior Medic and Most senior nurse make the decision.	Potential for use of SRS to be incorporated to patients PBS plan for prevention of prolonged restraint (over 10 mins) if authorised. Its application should be recorded as MR and family/ carers informed.
3. MDT decide following risk assessment that the SRS and SEELS may be necessary to relocate a service user to a seclusion facility and to **end prolonged restraint.**	Through on-going risk and physical health assessments. Risk behaviours identified in PBS plan/advance directives. Identify and document why the SEELS is needed in addition to the SRS.	Clinical Team. Executive Medical Director. Director of Nursing are contacted for authorization. *Out of hours* director on call. Most senior Medic and Most senior nurse make the decision	Potential for use of SRS & SEELS to be incorporated to patients PBS plan for prevention of prolonged restraint (over 10 mins) if authorised. Its application should be recorded as MR and family/ carers informed.

4. MDT or Home Office decide that Handcuffs are necessary for a high-risk escort outside of the hospital perimeter.	Thorough documented assessment of risk or Home Office directive	Clinical Team. RC to approve application (on call consultant OOH)	Potential use of Handcuffs should be discussed as part of the MDT discussions and a care plan and assessment of risk should be formulated. This should be re-evaluated on a regular basis. All use should be reported and recorded as MR and all appropriate documentation completed.
Reviews	**Observations**	**Who's Involved**	**Outcome**
1. Ongoing throughout the process for **Serious self-harm.**	Level 4 observations. 3 staff – 1 patient.	2 people to apply the belt, either through restraint or standing with compliance from the patient. Up to 4 persons for the restraint.	Preventing the risk of Serious self-harm.
2. Ongoing throughout the process for **ending prolonged restraint.**	Level 4 continuous observations for the duration of the incident whilst MR is applied.	2 people to apply the belts. Up to 4 to restrain, 6 people to transport the person using the belts with an additional member of staff assessing physical and psychological wellbeing of the patient.	Preventing the prolonged use of prone restraint and transfer to a purpose-built seclusion facility.
3. Ongoing throughout the process for **ending prolonged restraint.**	Level 4 continuous observations for the duration of the incident whilst MR is applied.	2 people to apply the belts. Up to 4 to restrain, 8-12 people to transport the person using the SEELS (depending on size of person being lifted and physicality of staff involved) with an additional member of staff assessing physical and psychological wellbeing of the patient.	Preventing the prolonged use of prone restraint and transfer to a purpose-built seclusion facility.

4. On-going throughout the high-risk escort.	Level 4 continuous observations for the duration of the incident whilst MR is applied.	2 persons who are handcuff trained (minimum 1 RMN), minimum of 4 for the escort and the number of people identified as required for the escort. Any driver should not be included within the escorting numbers.	Safely manage high risk escorts outside of the hospital perimeter.