Sheffield Health and Social Care

NHS Foundation Trust

Joint Learning Disabilities Service

Operational Guidance – An Appendix to the Joint Policy Framework on the Prevention and Management of the Use of Restraint

This guidance applies to the Joint Learning Disabilities Service in Sheffield and should be read in conjunction with other policies and procedures of Sheffield Health and Social Care NHS Foundation Trust and Sheffield Neighbourhoods and Community Care Services

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Contents

Section		Description	Page
1.	1.1 - 1.3	**Purpose of Document**	**3**
2.		**Background**	**4**
	2.1 - 2.8	General Principles	4 - 5
	2.9 - 2.18	Legal Framework	5 - 9
3.		**Procedures for Considering Restraint**	**9**
	3.1 - 3.7	Prevention	9 - 11
	3.8 - 3.12	Risk Assessment	11 - 13
	3.13 - 3.21	Documentation of Restraint	13 - 14
	3.22 - 3.23	Review	14 - 15
4.	4.1 - 4.2	**Unforeseen/Emergency Situations**	**15**
5.	5.1 - 5.3	**Training**	**15 - 16**
6.	6.1 - 6.2	**Complaints**	**16**
7.	7.1	**Support for the Implementation of the Policy**	**16**
8.	8.1 - 8.2	**Comments on/Review of this Guidance**	**16**
9.	9.1	**Accessible Guidance**	**16**
		References	**17 - 18**
Appendices			
Appendix 1		Restraint Support Structure	19
Appendix 2		Procedure for Considering Restraint	21
Appendix 3		Restraint Information Record	23 - 30
Appendix 3a		Straps and Harnesses	31 - 36
Appendix 3b		Bedrails and Cot Sides	37 - 42
Appendix 4		List of Useful Contacts	43
Appendix 5		Record of Incident leading to Restraint	45-46
Appendix 6		Groups Supporting Policy Implementation	47 - 48

1. Purpose

1.1 This guidance is based on the Joint Policy for the Prevention and Management of the Use of Restraint of Sheffield Health and Social Care NHS Foundation Trust (SHSC) and Sheffield Neighbourhoods and Community Care (NCC). It provides instruction about how the policy should be applied and must be adhered to by all staff of SHSC and NCC.

1.2 This guidance applies to all adults with learning disabilities receiving, or assessed as requiring, services that are provided, or commissioned, by SHSC or NCC. The guidance should be applied in all settings in which services are being delivered, for example, individuals' homes and day service settings.

1.3 Definition: What is Restraint?

The Oxford Dictionary defines "restrain" as "to check or hold in; to keep in check or under control; keep down".

Section 6(4) of the Mental Capacity Act 2005 defines restraint as follows:

- "Use force – or threaten to use force – to make someone do something that they are resisting, or
- Restrict a person's freedom of movement, whether they are resisting or not."

The guidance detailed in this document applies to many different types of restraint, including:-

- Physical restraint – such as, holding a person's hands to prevent them hitting someone or self injuring, "control and restraint" techniques, "passive holds", preventing someone from leaving an area against their will, removing someone to another area.

- Mechanical restraint (when items used to prevent/deter movement) – such as, use of lap straps, bed rails, helmets, splints, chair trays, vests, mitts.

- Chemical restraint – such as, medication, sedatives, tranquillisers.

- Restricting individuals' choices – such as, locking doors/cupboards, forcible seclusion, 1:1 supervision, pressure on individuals by more subtle means (for example, reminding the individual what relatives and friends would approve of).

- Withholding information – such as, not telling people about options or opportunities that may be available to them, not offering choices.

2. Background

General Principles

2.1 The main aim of the policy is to promote the prevention and minimise the use of restraint.

2.2 The policy is set within a context of service philosophy of non-invasive interventions, increasing peoples' skills and status, and helping individuals and teams make sound judgements by taking only those actions that are appropriate in an assessed situation. Appropriate actions are those which are legal and consistent with the aims and philosophies of the organisation and are in the best interests of the people we serve. They should take full account of the principles set out in the Mental Capacity Act (Department of Health, 2005a) and other relevant legislation (see paragraph 2.11).

2.3 As a general rule, any form of restraint is not acceptable unless it has been agreed as part of the individual's plan of care. Other options for managing the situation must have been considered first. All use of restraint must be agreed, risk assessed, recorded and reviewed by a multidisciplinary team. However there will be occasions when restraint results from an unforeseen/emergency situation (see paragraphs 4.1 and 4.2).

2.4 Restraint should always be the last resort, when all other less intrusive methods of management of the problem have failed to achieve desired outcomes. The least restrictive alternative for managing the situation should be used. The reasons for the restraint should be fully documented by a multidisciplinary team. The use of restraint should be honestly and openly acknowledged. It is the intention of the policy to encourage openness and ensure robust monitoring and review of procedures.

2.5 Restraint should not cause injury, pain, distress or psychological trauma. It should not undermine dignity, humiliate, or degrade the service user.

2.6 All use of restraint must be agreed, recorded and reviewed, and support should be identified for those operating a restraint, or seeking to remove a restraint. It is the responsibility of line managers to ensure that all staff has access to appropriate support, which is likely to vary in line with individual need. For example, opportunities to reflect about the incident individually or in a small group may be sufficient in some cases, whilst individuals experiencing longer term difficulties may wish to access Workplace Wellbeing, Personal Performance Consultant (PPC) or a similar organisation. Professional Social Work Organisations also offer a range of support networks. Opportunities for reflection should be provided within each unit.

2.7 It is intended that, through this guidance, the expertise and resources of SHSC and NCC be shared in pursuit of the highest standards of client and patient care attainable. It is recognised that this partnership needs to be extended to include service users and their carers in developing, implementing and reviewing practice. This will be the responsibility of the Joint Policy Steering Group on Restraint (see paragraph 7.1).

2.8 SHSC and NCC are committed to ensuring that support structures are in place to enable effective policy implementation and review. These structures are the Alternatives to Restraint Practice Development Group, the Learning Disability Implementation Group and the Joint Policy Steering Group on Restraint (see **Appendix 1**).

Legal Framework

2.9 It is essential that the use of any form of restraint must be considered in the context of the legal framework. SHSC and NCC are fully aware of the legal protection afforded to all citizens and laws which may be infringed by the use of restraint.

2.10 This guidance does not apply specifically to those who, due to mental health problems, are inpatients on hospital wards. Service provision in this setting is governed by Chapter 15 'Safe and therapeutic responses to disturbed behaviour' in 'Mental Health Act (MHA) 1983 Code of Practice' (Department of Health, 2008), and by 'Management of the Secluded Patient' (SHSC Risk Management Department, November 2006), Prevention and Management of Violent Behaviour Policy (SHSC Risk Management Department, February 2006) and the National Institute for Clinical Excellence (2005) Guidelines 'Violence : The short-term management of disturbed/violent behaviour in psychiatric in-patient settings and emergency departments'. These documents should be consulted together with this guidance for inpatient provision.

2.11 The policy framework has been informed by Section 7 of the Local Authority and Social Services Act (1970) and more recently by Valuing People (Department of Health, 2001), Human Rights Act (1998), MHA (1983), Mental Capacity Act (MCA, Department of Health, 2005a) and Care Standards Act (2000). It is also set in a context of the requirements of the Health and Safety Executive and the National Health Service Counter Fraud and Security Management Service. There is no legislation that specifically addresses the use of physical restraint with people with a learning disability.

2.12 The provisions in the MCA 2005 that limit liability do not extend to deprivation of liberty. This can only be done under the MHA 1983 or by order from the Court of Protection.

2.13 The policy will operate alongside parallel policies on Safeguarding Adults, Consent, Health and Safety, Mental Health, Sexual Health and the Prevention and Management of Violent Behaviour. Consideration must also be given to the issue of Advanced Statements/Directives (SHSC Advanced Statements/Advanced Directives Guidance to Staff).

2.14 There are a number of legal definitions that it is important to understand with regards to restraint (Harris, Allen, Cornick, Jefferson and Mills, 1996; Lyon, 2004):-

Protection of the individual – under law, every person is entitled to live without interference from others. Obvious types of interference which are recognised

within criminal law include imprisonment, assault or battery. Additional protection is provided under civil law within which the precise definition of what constitutes an illegal act is slightly broader. Examples of acts that might be considered unlawful (under criminal law) or torts ('wrongs' under civil law) are:-

- False imprisonment – this could include seclusion, confinement in a room, tying someone to a chair and preventing by any means a person leaving a room or building.
- Assault – this could include shaking a fist, throwing an object, drawing an injection and the threatened use of a restraining device.
- Battery – this could include touching, holding, pushing, stitching up clothing and putting in bed.

This is not a complete or exhaustive list and is likely to include other activities involved in restraint.

(Lyon, 1994).

2.15 However, in law, there are a number of recognised defences which may be used to justify or excuse an otherwise illegal act. For example, every person is entitled to protect him or herself from injury even if this involves holding/pushing (technically assaulting) another person. The law recognises that it is appropriate to take action to prevent other people being harmed or to prevent damage to property (Harris et al., 1996).

2.16 Duty of care – a duty of care exists where duties and responsibilities are imposed upon professionals or unpaid carers. This basically means taking reasonable care to avoid acts or omissions which are likely to cause harm to another person. Judgements about what is or is not a 'reasonable' course of action may be made with reference to the following:

- The conduct of other practitioners with similar skills and responsibilities.
- An appropriate body of expert opinion.
- What is reasonable in the circumstances.
- The foreseeable risks associated with a course of action

(Dimond, 1995).

Professional codes of conduct cover issues relevant to this topic and must be adhered to in relation to matters such as Duty of Care, safety of patients and others and risk assessment.

2.17 Capacity to make decisions – The imposition of a treatment against a person's wishes would constitute an illegal act. If a restraint is proposed as part of a treatment approach staff must determine whether or not a person is capable of giving consent, in line with the MCA (Department of Health, 2005a). If the person is deemed not to be able to give consent then there is no one else who can give consent on their behalf. The MCA sets out the principles about how decisions should be made where a person lacks capacity. It emphasises that this applies to making a 'particular decision at a particular time'. However, such people may be treated without consent provided the treatment is in their 'best interests' and is the least restrictive of their basic rights and freedoms. 'Best interests' go wider than best medical interests, to include factors such as the wishes and beliefs of the patient when competent, their current wishes, their general well being and their spiritual and religious welfare. People close to the individual may be able to give information on some of these factors. Where the individual has never been competent, relatives, carers and friends may be best placed to advise on the person's needs and preferences. If the person is deemed able to give consent and withholds that consent, this should be documented. The person should be referred to the Community Learning Disabilities Team, who may consult the Ethical Advisory Group. Staff members should also take account of guidance on unforeseen/emergency situations (points 4.1 and 4.2).

Issues related to restraint require two additional conditions that must be satisfied in order to protect staff from liability:

1. They must reasonably believe that it is necessary to restrain the person who lacks capacity in order to prevent them coming to harm.

2. Any restraint must be reasonable and in proportion to the potential harm.

Using excessive restraint could leave someone liable to a range of civil and criminal penalties. For instance it may be necessary to accompany someone when going out because they cannot cross roads safely, but it may be unreasonable to stop them from going outdoors altogether.

If a person has been assessed as lacking capacity then any action (including the use of restraint) must be made in their best interests. Staff must make reference to the MCA guidance for their own organisation (SHSC or NCC). Broadly speaking, the decision-maker must consider a number of factors when working out what is in the person's best interests. These will include:

- Not to make assumptions about their best interests merely on the basis of their age, appearance, condition etc.

- The decision-maker must consider all the relevant circumstances relating to the decision in question.

- The decision-maker must involve the person as fully as possible in the decision.

The decision-maker must consult other people where appropriate and take into account their views as to what would be in the person's best interests, especially:

- Anyone previously named by the person lacking capacity as someone to be consulted.
- Carers, close relatives or close friends or anyone else interested in the person's welfare.
- Any attorney appointed under a Lasting Power of Attorney.
- Any deputy appointed by the Court of Protection to make decisions for the person.

Staff, family and friends may not always agree about what is in the best interests of an individual. The decision-maker will need to clearly demonstrate in the records that any decision has been based on all available evidence and has taken account of all conflicting views. If there is a dispute the following should be considered:

- Involve an advocate who is independent of all parties involved.
- Obtain a second opinion.
- Hold a formal or informal case conference.
- Go to mediation.
- Make an application to the Court of Protection for a ruling.

Where the restraint involves limiting the person's freedom (for example, locking doors, not allowing the person to go out alone, moving the person into hospital or a different place of residence), the outcomes of the Bournewood ruling should be fully considered (see, for example, Department of Health, 2005b, Holland, 2005). The Deprivation of Liberty Safeguards will become a statutory obligation in April 2009 (see Ministry of Justice 2008). They will apply to people in hospitals and care homes that lack the capacity to make decisions about their care and are deprived of their liberty. Service guidance will be made available to staff to enable them to comply with this. The SHSCT Locked Door Policy (SHSC Risk Department, 2007) should also be consulted in settings where it applies and the need to involve an Independent Mental Capacity Advocate should be considered.

2.18 Overall, it is clear that most forms of restraint should be regarded as illegal unless there is a clear justification that can withstand examination in a court of law. There will be no protection from liability for using restraint unless :

- The person using it reasonably believes that it is necessary to prevent harm to the person who lacks capacity; and

- The amount of restraint used and the amount of time it lasts for must be a proportionate response to the likelihood and seriousness of harm.

Consequently the minimum amount of force necessary must be used for the shortest period of time possible

Use of restraint is likely to be defensible where it is used to prevent:

- Self harm
- Injury to others
- An offence being committed

Any intervention should avoid contact that might be misinterpreted as sexual. It must also be used in a way that is sensitive to, and respects, the cultural expectations of services users and their attitude towards physical contact.

3. Procedure for Considering Restraint

3.1 When a restraint is suggested or foreseen, the following steps should be undertaken - Risk assessment of the situation, Prevention, Documentation of Restraint, Risk Assessment of Restraint, Referral to the Community Learning Disabilities Team and Review. An overview is given in **Appendix 2**. This procedure should be followed for each different type of restraint. Examples of good practice and poor practice with regards to restraint can be found in Harris et al. (1996). The SHSC Prevention and Management of Violent Behaviour Policy should also be consulted, where appropriate.

<u>Prevention</u>

3.2 Prevention strategies concern attempts to understand behaviours/circumstances that have the potential to lead to restraint and ensuring that service users' assessed needs are met in ways that minimise the necessity for restraint. This should include exploration and discussion of why and for whom the behaviour/circumstance is a problem, as well as the function it may serve for the individual. Ideas about good practice can be found in the British Psychological Society Challenging Behaviours Clinical Practice Guidelines (Ball, Bush & Emerson, 2004). For staff within SHSC, the 'Prevention and Management of Violent Behaviour' policy (SHSC Trust Risk Management Department, February 2006) should be consulted. Staff in NCC can consult 'Violence at Work – A Policy Statement' (Sheffield City Council, June 2004).

3.3 The plan of care should be based on a functional analysis of why the behaviour or circumstance is occurring/what the person is trying to communicate and why there is a need for strategy and intervention. Functional analysis involves attempts to understand the reasons for a behaviour. This can be done by looking at the –

- Antecedents – what happens immediately before a behaviour occurs

- Behaviours – what the behaviours of concern are

- Consequences – what happens after the behaviour has occurred (and may therefore be reinforcing it)

For example, through such a process, it may be felt that a particular behaviour occurs as an individual's way of avoiding specific task demands. This would give rise to potential ways to reduce the behaviour. Further details on functional analysis can be found in the British Psychological Society Challenging Behaviour Guidelines (Ball, Bush & Emerson, 2004).

3.4 It is possible that through understanding the behaviour and adapting the environment or ways of working accordingly, the need for restraint can be greatly reduced or eliminated.

3.5 Service users' assessed needs should always be met in ways that minimise the necessity for restraint. NCC Assessment and Care Management will assess using The Single Assessment Process and Fair Access to Care. An appropriate care plan will be formulated to ensure risks will be minimised (see 3.13). When a person has mental health problems, the Care Programme Approach (CPA) will be used. Where there are recognised risks, an adequately funded package will ensure appropriate services are established and monitored. A record must be made of what solutions to behaviour have been proposed, their rationale and outcome. This should be part of a thorough documentation of the circumstances surrounding the proposed restraint (see **Appendix 3**).

3.6 Prevention strategies can be divided into two main types – primary prevention and secondary prevention (Harris et al., 1996).

Primary prevention strategies concern adaptations that can be made to an individual's immediate and wider environment, as well as to the care they receive, in order to minimise the number of situations in which restraint may need to be considered.

Primary prevention Adaptations in order to minimise the numbers of situations in which restraint may need to be considered.	▪ Promoting a culture that values service users ▪ Helping service users avoid situations that are known to provoke violent or aggressive behaviours (for example, congregate settings where there are few options for individualised activities) ▪ Establishing and monitoring care programmes that are responsive to individual needs ▪ Creating opportunities for service users to engage in meaningful activities that include opportunities for choice and a sense of achievement **Cont/..**

	▪ Developing staff expertise in working with service users who present challenges to services

Secondary prevention strategies (also known as reactive strategies) concern attempts to prevent developing situations escalating to a level at which restraint may need to be used. They should follow the principle of least restrictiveness and least intrusiveness. A plan including such strategies should offer advice on responding to lower levels of challenging behaviour in ways that help to diffuse further behavioural escalation. Some ideas for secondary prevention strategies that may be effective can be found in the table below. Different prevention strategies will be effective for different individuals. Appropriate strategies for each individual should be written into their plan of care.

Secondary prevention Recognising the early stages of a behavioural sequence that may lead to violence or aggression and attempting to 'diffuse' the situation to prevent it getting worse	▪ Not responding to challenging behaviours ▪ At the same time attempting to cue in or reinforce alternative more positive behaviours ▪ Removing demands ▪ Diversion to a reinforcing or compelling event or activity ▪ Strategic capitulation (giving the person the thing that they want) ▪ Low arousal approaches where others stay calm, quiet and non-threatening (e.g., by maintaining interpersonal space) and try to avoid escalating arousal and the risk of physical violence

(Bush, Ball & Emerson, 2004)

3.7 There are some situations in which prevention strategies may have adverse effects on the service user's welfare or quality of life (for example, being denied opportunities to attend certain activities because they take place in congregate settings). The effects of prevention strategies on service users' quality of life should always be considered. Thorough risk assessments should be carried out and the outcomes documented in care plans (see **Appendix 3**).

Risk Assessment

3.8 Whenever it is foreseen that a service user might require some form of restraint, a risk assessment must be carried out by a multidisciplinary team that identifies the benefits and risks associated with intervention strategies. This risk assessment must be carried out in line with the SHSC Prevention and Management of Violent Behaviour Policy and the NCC 'Violence at Work' (Sheffield City Council, June 2004) policy and must be recorded in detail in the care plan. The proforma in **Appendix 3** can be used to do this.

3.9 Although the focus must always be on the needs of the service user, agencies must not lose sight of other relevant issues such as duty of care, service user, public and staff safety. The decision to use a restraint may be made when the risks of not using such an intervention are outweighed by the need to intervene.

3.10 When a restraint is proposed it is important that appropriate steps are taken to minimise the risk to both service users and staff.

3.11 The following questions should be asked as part of a comprehensive risk assessment around a restraint –

Potential risks to service users	▪ Would methods other than restraint achieve the desired outcome? ▪ Is there a possibility of injury to the individual (including consideration of any medical conditions/contraindications to the restraint that the person may have)? ▪ Is there a possibility of pain, distress or psychological trauma to the individual? ▪ Is there a possibility of the individual's dignity being undermined or of them being subject to degradation or humiliation? ▪ Is there the possibility of distrust arising or personal relationships being undermined? ▪ Is there a possibility of restriction of freedom of expression? ▪ Does the seriousness of potential harm outweigh the harm to the service user or somebody else, or serious damage to property, if restraint is used?
Potential risks to staff and others	▪ Is there a possibility of injury to staff/others? ▪ Is there a possibility of distress or psychological trauma to staff/others? ▪ Could staff be challenged in court? ▪ Is there a possibility of disciplinary action being taken against staff?
Potential risks of not intervening	▪ Would staff be in breach of their duty of care? ▪ Would the service user or others be injured or abused? ▪ Would property be seriously damaged? ▪ Would there be a possibility of legal action around the above?

Adapted from Harris et al (1996)

3.12 In the rare situations in which it is deemed necessary for a physical intervention to be used, the technique employed must be consistent with the British Institute of Learning Disabilities Code of Practice for the Use of Physical Interventions, 2nd Edition (2006). Only staff trained in the appropriate methods should use physical interventions. Any physical intervention must only employ the minimum amount of force necessary, for the minimum period of time.

Documentation of Restraint

3.13 The care plan/person centred plan of the individual should contain all relevant information regarding the plan of care that has been drawn up by the multidisciplinary team for the individual.

3.14 Whenever a restraint is anticipated, this should be fully documented in the individual's plan of care/person centred plan. This process should be multi-disciplinary if possible. Proformas for doing this can be found in **Appendix 3**. For most restraints, **Appendix 3** should be used. **Appendix 3a** can be used for straps/harnesses to stop someone *falling* out of the chair (as opposed to stopping them *getting* out of the chair). **Appendix 3b** can be used for bed rails to stop someone *falling* out of bed (as opposed to stopping them *getting* out of bed). If straps/harnesses or bed rails are used for any other reason than to stop someone *falling,* then **Appendix 3** should be used.

3.15 Providing staff have complied with the Mental Capacity Act (Department of Health, 2005a) and the Deprivation of Liberty Safeguards (Ministry of Justice 2008) in assessing a person's capacity and have acted in the person's best interest, they will be able to carry out many aspects of a person's personal care without their consent. In these circumstances, they must demonstrate that they have assessed capacity, reasonably believe it to be lacking and then acted in what they reasonably believe to be in the person's best interests. Full records must be kept of what has happened, all the options considered and how decisions were made/whether the person's consent was obtained.

3.16 It must be specified in the care plan when a service user's activities put others at risk.

3.17 All meetings and agreements concerning the use of the restraint should be formally documented in the plan of care.

3.18 A record should be made each time the restraint is used (except where restraints are prescribed by an allied health professional for therapeutic use – for example, a harness for use when toileting). The record should include details of when the restraint was used and for how long. It should include names of staff and service users involved, the reason for using restraint in preference to another strategy, the type of restraint employed, the date and duration of the restraint and whether the service user or anyone else experienced injury or distress and, if they did, what action was taken. Further, if first aid or medical treatment is employed following the restraint, details of the procedures used should be recorded. A restraint/incident form for doing this for SHSC staff can be found in **Appendix 5**. This form should be

submitted to the SHSC risk department and a copy kept in the person's care plan. If the same restraint is used for the same reason multiple times within the same shift, then only one form needs to be completed (detailing the number of times the restraint was used). Relevant NCC reporting procedures should be used by staff of that organisation.

3.19 All restraints (or variations to restraints) should be referred to the Community Learning Disabilities Team (CLDT, see point 3.20). In the interim period (before a restraint has been considered by the CLDT), those involved in a person's care should act in the spirit of the policy, reviewing the current risk assessment. As many stakeholders or interested people as possible should be involved in discussions and decisions.

3.20 Once a restraint has been considered following the procedure above, full documentation (using the proforma in **Appendix 3**) should be forwarded to the CLDT, along with the Single Assessment Process contact assessment. Members of the Community Learning Disabilities Teams can refer using an Internal Referral Form (along with the proforma in **Appendix 3**).

3.21 The CLDT will consider the proposed restraint and may either agree it is the least restrictive option or make suggestions for alternative ways of handling the situation. In particularly difficult or unusual situations, the CLDT may decide to discuss the situation with the Ethical Advisory Group/Safeguarding Adults Office. The person's GP will be informed of the outcome of the referral, unless the person requests otherwise.

Review

3.22 Each individual restraint must be reviewed no later than three months after it was agreed (in accordance with the British Institute of Learning Disabilities Code of Practice for the Use of Physical Interventions, 2nd Edition (2006)) and every three months thereafter. Once a restraint has been considered by the CLDT and the most satisfactory way of handling the situation agreed upon, responsibility for carrying out and recording three-monthly reviews rests with the service provider.

3.23 The following situations should prompt an emergency review of the restraint (adapted from Harris et al., 1996) –

- Restraints are used more frequently than had been recorded in the care plan.
- Restraints are used with increasing frequency over time.
- Staff report that the agreed procedures do not enable them to control the person's behaviour.
- Injuries to the person receiving the restraint.
- Injuries to staff involved in using restraint.

- Any indication that restraints are not being employed according to the agreed procedures.

- The development of new challenging behaviours (other than those initially identified) which may also require the use of restraints.

The review should be carried out by the care team. The review and new plan of action should be documented on a 'Restraint Information Record' (**Appendix 3**) and the person must be re-referred to the Community Learning Disabilities Team as soon as possible (as in 3.20).

4. Unforeseen/Emergency Situations

4.1 All staff affected by the policy has a duty of care to ensure the safety of all service users. There may be occasions upon which it unexpectedly becomes necessary to restrain an individual in a way that has not been discussed or documented in their care plan. This would occur when they or someone else is in immediate danger. For example, it may be necessary to take action to stop an individual running into a road when they are in danger of being hit by a car. Any restraint used in an emergency situation should be carried out according the principles of this policy (i.e., using the least amount of force necessary, for the shortest amount of time necessary) and within the guidance provided by the Mental Capacity Act (Department of Health, 2005a).

4.2 In these circumstances, it is important that the incident is documented (using the SHSC Joint restraint/incident form or the relevant NCC form). The incident should be discussed and the outcomes of this discussion documented in order that similar situations can be appropriately handled in the future. To this end, a care plan review should be carried out by the care team within 3 working days of the unforeseen restraint taking place. The person should be referred to the Community Learning Disabilities Team as soon as possible. The procedures in this document should be used at such a review to consider the future management of such situations.

5. Training

5.1 In addition to SHSC and NCC mandatory training requirements, training around this policy and the use of restraint in general will be provided to all staff as an integral part of their induction and other training initiatives. It should be part of a broader package of training around working with individuals who show challenging behaviours or who lack capacity. It will be the responsibility of individual line managers to ensure that their staff has the appropriate training and updates in line with a reviewed plan. No member of staff should use restraint unless he/she has been trained in the use of that particular restraint. The exception to this is emergency situations (see section 4 of this guidance).

5.2 SHSC and NCC are committed to developing a joint training strategy to ensure that staff gain:

- An understanding of the cultural and diverse needs of service users.

- An understanding of the Joint Policy framework on the Prevention and Management of the use of Restraint.

- An awareness of good working practices, including de-escalation and the prevention and reduction of risk.

- The knowledge and skills to assist in the implementation of this guidance in the workplace.

5.3 After training, staff should be competent in knowing about issues of restraint and their responsibilities with regard to this issue.

6. Complaints Procedure

6.1 Service users have the right to complain about the use of restraint. Individuals should be supported in accessing the usual complaints processes (SHSC and NCC).

6.2 If staff members have concerns about the way in which restraint is being used, they should report these via their governance reporting procedures, for example line management and team meetings. They may also make use of the relevant complaints procedures (see 6.1), grievance procedures and whistleblowing procedures, as appropriate.

7. Support for the Implementation of the Policy

7.1 The implementation of the policy will be supported by the Joint Policy Steering Group on Restraint, the Learning Disability Implementation Group and the Alternatives to Restraint Practice Development Group (see **Appendix 6**).

8. Comments on/Review of this guidance

8.1 The Learning Disabilities Implementation Group on Restraint will monitor and review this policy. Therefore, any comments about its content or application should be directed to this group via Anita.Winter@shsc.nhs.uk

8.2 These procedures will be reviewed after six months and then on an annual basis. Review will be more frequent if changes in the relevant legislation/codes of practice/structures/organisations necessitate this.

9. Accessible Guidance

9.1 An accessible booklet concerning issues about restraint in Sheffield is available from www.signpostsheffield.org.uk or by contacting the Learning Disability Implementation Group via Anita Winter@shsc.nhs.uk

References

Ball, T., Bush, A., & Emerson, E. (2004). Psychological interventions for severely challenging behaviours shown by people with learning disabilities. Leicester: British Psychological Society.

British Institute of Learning Disabilities (2006) Code of Practice for the Use of Physical Interventions: 2nd edition. Kidderminster: BILD

Care Standards Act (2000) London: The Stationery Office

Department for Constitutional Affairs (April 2007). Mental Capacity Act 2005 Code of Practice

Department of Health (2001) Valuing People: A New Strategy for Learning Disability for the 21st Century
Department of Health (2005a) Mental Capacity Act. London: HMSO

Department of Health (2005b) "Bournewood" Consultation: The approach to be taken in response to the judgement of the European Court of Human Rights in the "Bournewood" case. Available online: http://www.dh.gov.uk/Consultations/ClosedConsultations/ClosedConsultationsArticle/fs/en?CONTENT_ID=4113613&chk=oDJvUU

Department of Health and Department for Education and Skills (July 2002). Guidance for Restrictive Physical Interventions: How to provide safe services for people with Learning Disabilities and Autistic Spectrum Disorder

Department of Health (April 2007). Mental Health Policy Implementation Guide: A Learning and Development Toolkit for the whole of the mental health workforce across both health and social care

Department of Health (2008) Code of Practice: Mental Health Act 1983. Laid before parliament pursuant to Section 118 of the Act. London: The Stationary Office

Dimond, B. (1995) Legal aspects of nursing. London: Prentice Hall

Harris, J., Allen, D., Cornick, M., Jefferson, A. & Mills, R. (1996). Physical interventions: A policy framework. Kidderminster: BILD

Holland, A. (2005, June). The Royal College of Psychiatrists: Response to the Bournewood Consultation. Available online: http://www.rcpsych.ac.uk/press/parliament/bournewoodresponse.htm

Human Rights Act (1998) London: The Stationery Office

Local Authority and Social Services Act 1970

Lyon, C.M. (1994). Legal issues arising from the care, control and safety of children with learning disabilities who also present challenging behaviour. London: The Mental Health Foundation

Lyon C.M. (2004). Physical interventions and the law. Kidderminster: BILD

Management of the Secluded Patients, Sheffield Health and Social Care NHS Foundation trust Risk Management Department, November 2006.

Mental Health Act (1983) London: The Stationery Office

Ministry of Justice (2008) Mental Capacity Act 2005: Deprivation of Liberty Safeguards. Code of Practice to supplement the main Mental Capacity Act 2005 Code of Practice. Laid before Parliament in draft June 2008, pursuant to sections 42 and 43 of the Act.

National Institute for Clinical Excellence (2005). Violence: The short-term management of disturbed/violent behaviour in psychiatric in-patient and emergency department guideline

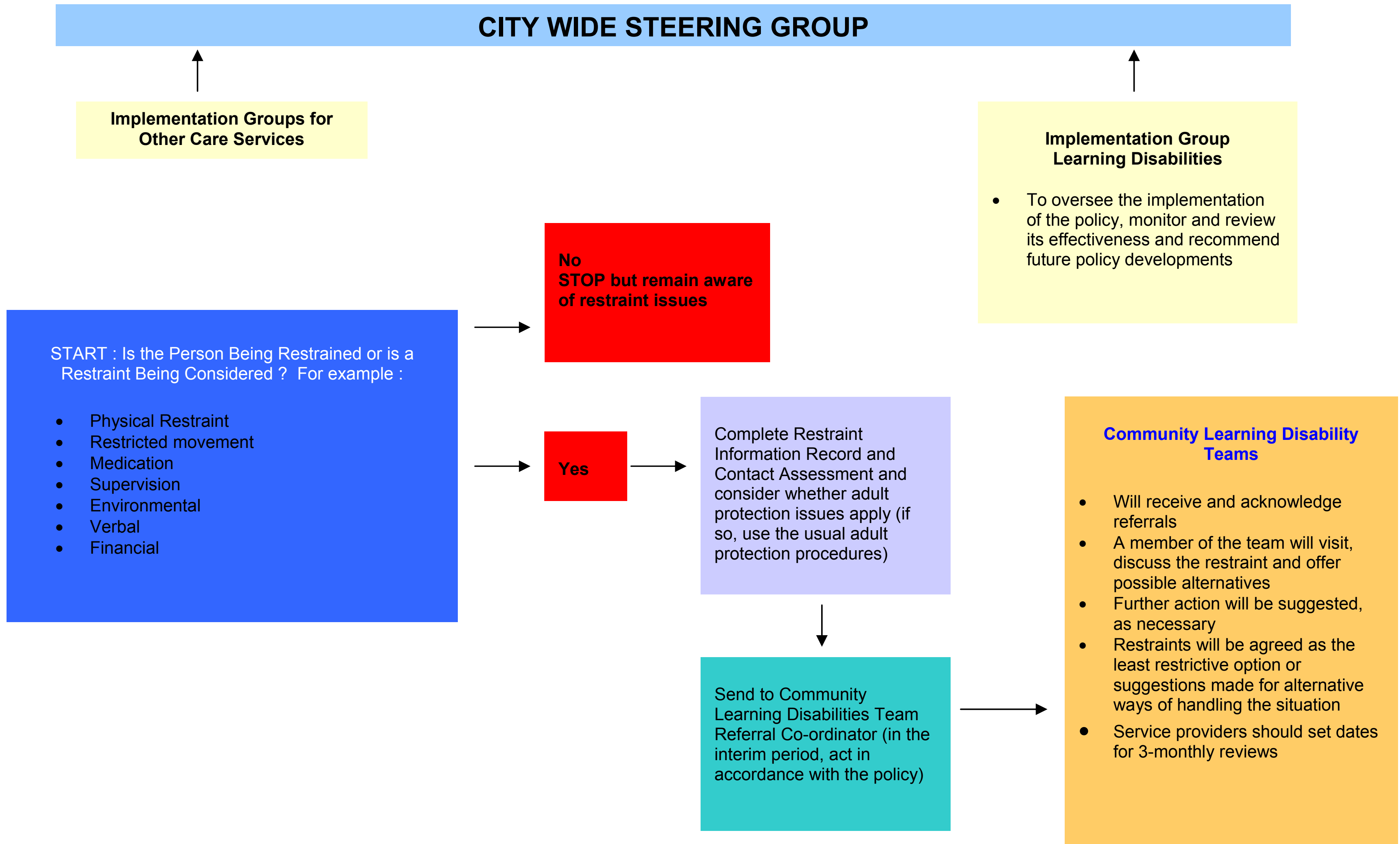
Sheffield City Council (June 2004) Violence at Work – A Policy Statement

Sheffield Health and Social Care NHS Foundation Trust (2003) Grievance Procedure

Sheffield Health and Social Care NHS Foundation Trust (2006) Prevention and Management of Violent Behaviour Policy

Sheffield Health and Social Care NHS Foundation Trust (2003) Whistleblowing Policy and Procedure

APPENDIX 1 – PREVENTION AND MANAGEMENT OF THE USE OF RESTRAINT



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APPENDIX 2

Procedure for Considering Restraint

STEP 1

Complete the Restraint Information Record to form part of the person's care plan carefully considering risk assessments and prevention strategies.

STEP 2

Send the competed Restraint Information Record, along with a Single Assessment Process Contact Assessment to the Community Learning Disabilities Team Referral Co-ordinator at:

North Sheffield	South Sheffield
Ivy Lodge Clinic	Lightwood House
254 Rutland Road	Lightwood Lane
Sheffield	Sheffield
S3 9PR	S8 8BG
Fax Number: (0114) 271 6973	Fax Number: (0114) 271 6550

STEP 3

Whilst awaiting input, act in the spirit of the Policy.

STEP 4

The Community Learning Disabilities Team will agree the restraint as the least restrictive option or make suggestions for alternative ways of handling the situation.

STEP 5

Review the restraint not less than once every three months or sooner if the situation changes.

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Sheffield Health and Social Care

NHS Foundation Trust

APPENDIX 3

Restraint Information Record

Name of Individual: ……………………………………………………………………….…

Date of Birth: ……………………………………………………………………….…

Address: ……………………………………………………………………….…

……………………………………………………………………….…

Telephone Number: ……………………………………………………………………….…

Please Specify the Type of Restraint This Form is About (Please complete a separate form for every restraint being used)

……………………………………………………………………………………………………

Does the person have the capacity to consent to the plan detailed in this document?

……………………………………………………………………………………………………

If yes, do they give their consent to the plan and are they aware that they can withdraw that consent? (see SHSC/NCC guidance about Advanced Directives)

……………………………………………………………………………………………………

If no, is there a chance that they may have the capacity to consent at the time that the restraint is being used and how will this be handled?

……………………………………………………………………………………………………

If no, how have you ensured that the plan is in the person's interests, as described by the Mental Capacity Act (for example, has a Best Interests meeting been held?)

……………………………………………………………………………………………………

STEP 1 - Why is restraint being considered? (State the behaviour/situation of concern)

……………………………………………………………………………………………………

STEP 2 (a) - Who might be at risk from the behaviour/situation and how?

……………………………………………………………………………………………………

Who?	Is there any Risk?	How Might They Be At Risk?
The person themselves	Yes/No	
Others who use the same service	Yes/No	
Staff/other non-family carers	Yes/No	
Family	Yes/No	
Anyone else (including members of the public)	Yes/No	

2 (b) - Consider Article 2 of the Human Rights Act 1998 – Is there a risk that someone's life may be endangered by the behaviour/situation?

……………………………………………………………………………………………………

……………………………………………………………………………………………………

2 (c) - Is there a risk of serious damage to property? (If so, please specify)

……………………………………………………………………………………………………

STEP 3 - What makes the behaviour/situation more likely to arise?
3 (a) - General setting conditions (such as noise and transition points between activities)

……………………………………………………………………………………………………

3 (b) - More immediate triggers (such as being asked a question and being ignored)

……………………………………………………………………………………………………

STEP 4 - What primary prevention strategies can be used in relation to this situation?

4 (a) - List primary prevention strategies that can be used. Please specify any risks associated with these strategies, including risks to the person's quality of life (please include strategies that have been discounted and the reasons why they have been discounted)

Primary Prevention Strategy	Risks Associated with this Strategy	Has this Strategy been discounted? If so, why?

4 (b) - Could any of these strategies infringe upon the person's rights under the Human Rights Act (1998)?

…………………………………………………………………………………………………

Article 2 – Right to Life (i.e., could the person's life be put in danger by the strategy?)

…………………………………………………………………………………………………

Article 3 – Freedom from torture and inhuman or degrading treatment (i.e., could the prevention strategy be considered as torture/inhuman/degrading?)

…………………………………………………………………………………………………

Article 5 – Deprivation of Liberty (i.e., is the person being deprived of their liberty?)

…………………………………………………………………………………………………

Article 8 - Right to respect for private and family life

…………………………………………………………………………………………………

Article 10 - Freedom of expression

…………………………………………………………………………………………………

STEP 5 - What are the signs that the situation is starting to escalate?

(Consider use of traffic light system Green = behaviour at baseline level, Amber = problems are about to occur, Red = challenging behaviour)

GREEN:

…………………………………………………………………………………………………

AMBER:

…………………………………………………………………………………………………

RED:

…………………………………………………………………………………………………

STEP 6 - What secondary prevention strategies can be used in relation to this situation (interventions to de-escalate an escalating situation without the use of restraint)? Please include any strategies that have been considered and discounted and the reasons why .

Secondary Prevention Strategy	Risks Associated with this Strategy	Has this Strategy been Discounted? If so, why?

6 (a) - Could any of these strategies infringe upon the person's rights under the Human Rights Act (1998)?

Article 2 – Right to Life (i.e., could the person's life be put in danger by the strategy?)

……………………………………………………………………………………………

Article 3 – Freedom from torture and inhuman or degrading treatment (i.e., could the prevention strategy be considered as torture/inhuman/degrading?)

……………………………………………………………………………………………

Article 5 – Deprivation of liberty (i.e., is the person being deprived of their liberty?)

……………………………………………………………………………………………

Article 8 - Right to respect for private and family life (i.e., could it be seen that this is being infringed?)

……………………………………………………………………………………………

Article 10 - Freedom of expression

……………………………………………………………………………………………

STEP 7 - Please detail the restraint being used/proposed to be used, including time limits.

7 (a) - What is the restraint being used/proposed to be used?

……………………………………………………………………………………………

7 (b) Please detail any risks associated with the restraint (see over)

Risk	Please Specify Nature of Risk	What Actions will be Taken to Minimise the Risks?
Risks to the person		
Risk of injury to the person (include consideration of any specific medical conditions or contraindications to the restraint)		
Pain to the person (include consideration of any specific medical conditions or contraindications to the restraint)		
Distress to the person		
Psychological trauma to the person		
Risk of the person's dignity being undermined or of them being subject to degradation or humiliation		
Risk of distrust arising or personal relationships being undermined		
Any other risks to the person		
Risks to staff		
Risk of injury to staff		
Risk of distress/psychological trauma to staff		
Risk of distress/psychological trauma to staff		
Risk of disciplinary action against staff/challenge in court		
Any other risks to staff (please specify)		
Risks to others		
Any risks to anyone else (please specify)		

Please detail when it is inappropriate to use the restraint:-

…………………………………………………………………………………………………

Could the restraint infringe upon the person's rights under the Human Rights Act (1998)?

Article 3 of the Human Rights Act 1998 – freedom from torture or inhuman or degrading treatment.

…………………………………………………………………………………………………

Article 5 – deprivation of liberty.

…………………………………………………………………………………………………

Article 8 – right to respect for private and family life.

…………………………………………………………………………………………………

Article 10 – freedom of expression

…………………………………………………………………………………………………

STEP 8 - Specify any risks that remain unmanaged

…………………………………………………………………………………………………

STEP 9 - What procedures will be followed after a restraint incident?

…………………………………………………………………………………………………

STEP 10 - How does this plan support the person's access to community living?

…………………………………………………………………………………………………

STEP 11 - What recording needs to be completed after a restraint is used?

…………………………………………………………………………………………………

STEP 12 - Who has been involved in this discussion? Has the client/carer agreed to the plan?

…………………………………………………………………………………………………

STEP 13 - Specify the last review date for this plan and the next date it will be reviewed -

Last review date:

…………………………………………………………………………………………………

Next review date:

…………………………………………………………………………………………………

Consider Article 14 of the Human Rights Act (1998) –

Could it be argued that the person is being discriminated against on grounds such as disability, race or gender in the suggestion of these prevention strategies and restraint?

…………………………………………………………………………………………………

Does the person want to receive copies of letters relating to this referral?

…………………………………………………………………………………………………

Name and Address of Individual's GP:

…………………………………………………………………………………………………

…………………………………………………………………………………………………

Name and Address of Service Manager:

…………………………………………………………………………………………………

…………………………………………………………………………………………………

Name, Address and Contact Number for Day Services (if applicable):

…………………………………………………………………………………………………

…………………………………………………………………………………………………

Date Completed:

…………………………………………………………………………………………………

Name:

…………………………………………………………………………………………………

Address:

……………………………………………………………………………………………

……………………………………………………………………………………………

Please Return this Form with a Single Assessment Process Contact Assessment to:

North Sheffield
Community Learning Disabilities Team Referral Co-ordinator
Ivy Lodge Clinic
254 Rutland Road
Sheffield
S3 9PR
Telephone Number (0114) 271 6982
Fax Number (0114) 271 6973

South Sheffield
Community Learning Disabilities Team Referral Co-ordinator
Lightwood House
Lightwood Lane
Sheffield
S8 8BG
Telephone Number (0114) 271 6551
Fax Number (0114) 271 6550

Sheffield Health and Social Care

NHS Foundation Trust

APPENDIX 3a

Restraint Information Record
Straps and Harnesses

Name of Individual: ………………………………………………………………………….…

Date of Birth: ………………………………………………………………………….…

Address: ………………………………………………………………………….…

………………………………………………………………………….…

Telephone Number: ………………………………………………………………………….…

Please Specify the Type of Restraint This Form is About (Please complete a separate form for every restraint being used)

………………………………………………………………………………………………

Does the person have the capacity to consent to the plan detailed in this document?

………………………………………………………………………………………………

If yes, do they give their consent to the plan and are they aware that they can withdraw that consent? (see SHSC/NCC guidance about Advanced Directives)

………………………………………………………………………………………………

If no, is there a chance that they may have the capacity to consent at the time that the restraint is being used and how will this be handled?

………………………………………………………………………………………………

If no, how have you ensured that the plan is in the person's interests, as described by the Mental Capacity Act (for example, has a Best Interests meeting been held?)

………………………………………………………………………………………………

STEP 1 - Why is restraint being considered (state the behaviour/situation of concern)?

………………………………………………………………………………………………

If this is to stop the person falling out of the chair? – go to step 2 and continue this form

If this is to stop the person getting out of the chair? - discontinue use of this form and use general Restraint Information Record (Appendix 3).

If this is for any other reason, go to Step 2 and continue this form.

STEP 2 (a) - Without the strap(s)/harness who might be at risk and how?

Who?	Is there any Risk?	How Might They Be At Risk?
The person themselves	Yes/No	
Others who use the same service	Yes/No	
Staff/other non-family carers	Yes/No	
Family	Yes/No	
Anyone else (including members of the public)	Yes/No	

2 (b) - Consider Article 2 of the Human Rights Act 1998 – Is there a risk that someone's life may be endangered without the straps(s)/harness?

…………………………………………………………………………………………………

…………………………………………………………………………………………………

STEP 3 - Is there anything that makes it more likely that the person will fall out of the chair (for example, epilepsy, distractions, sensory impairment)?

…………………………………………………………………………………………………

…………………………………………………………………………………………………

STEP 4 - Which alternatives have been considered and what are the risks associated with them (including "is this also a restraint")?

Alternative	Risks	Is this appropriate to use? If not, why not?	Is this also a restraint?
Tilting facility on chair			
Use of tray			
Having the person sitting at a table			
Increased staffing			
Medication review			
Other (please specify) - use more paper if needed			

STEP 5 - Please give details about the use of the strap(s)/harness
How long does the person spend in the chair?

……………………………………………………………………………………………

……………………………………………………………………………………………

Are there times when the person is in the chair that the strap(s)/harness are not to be used?

……………………………………………………………………………………………

……………………………………………………………………………………………

Does the person have time out of the chair (for example, on beanbags)?

……………………………………………………………………………………………

……………………………………………………………………………………………

Please list any contra-indications to the person being out of their chair/any reasons why it might be important to limit their time out of the chair (for example, postural management)

……………………………………………………………………………………………

……………………………………………………………………………………………

STEP 6 - Please detail any risks associated with the strap(s)/harness

Risk	Please Specify Nature of Risk (please state if it is not applicable)	What Actions will be Taken to Minimise the Risks?
Risks to the person		
Risk of injury to the person from the strap(s)/harness (include consideration of any specific medical conditions or contra-indications to the strap(s)/harness)		
Risk of pain to the person from strap(s)/harness (include consideration of any specific medical conditions or contra-indications to the strap(s)/harness)		
Distress to the person		
Psychological trauma to the person		

Risk	Please Specify Nature of Risk (please state if it is not applicable)	What Actions will be Taken to Minimise the Risks?
Cont/ … Risks to the person		
Risk of the person's dignity being undermined or of them being subject to degradation or humiliation		
Risk of distrust arising or personal relationships being undermined		
Any other risks to the person		
Risks to staff/family/carers		
Risk of injury to staff/family/carers		
Risk of disciplinary action against staff/challenge in court		
Any other risks to staff (please specify)		
Risks to others		
Any risks to anyone else (please specify)		

STEP 7 - Please detail when it is inappropriate to use the strap(s)/harness?

……………………………………………………………………………………………

……………………………………………………………………………………………

STEP 8 - Could the strap(s)/harness infringe upon the person's rights under the Human Rights Act (1998)? Consider in particular:-

Article 3 - freedom from torture or inhuman or degrading treatment.

……………………………………………………………………………………………

Article 5 – deprivation of liberty.

……………………………………………………………………………………………

STEP 9 - Specify any risks that remain unmanaged

……………………………………………………………………………………………

……………………………………………………………………………………………

STEP 10 - Who has been involved in this discussion? Has the client/carer agreed to the plan?

……………………………………………………………………………………………

……………………………………………………………………………………………

STEP 11 - Specify the last review date for this plan and the next date it will be reviewed:

Last Review Date:

……………………………………………………………………………………………

Next Review Date:

……………………………………………………………………………………………

Consider Article 14 of the Human Rights Act (1998) –

Could it be argued that the person is being discriminated against on grounds such as disability, race or gender in the suggestion of these prevention strategies and restraint?

……………………………………………………………………………………………

Does the person want to receive copies of letters relating to this referral?

……………………………………………………………………………………………

Name and Address of Individual's GP:

……………………………………………………………………………………………

……………………………………………………………………………………………

Name and Address of Service Manager:

……………………………………………………………………………………………

……………………………………………………………………………………………

Name, Address and Contact Number for Day Services (if applicable):

……………………………………………………………………………………………

……………………………………………………………………………………………

Date Completed:

……………………………………………………………………………………………

Name:

……………………………………………………………………………………………

Address:

……………………………………………………………………………………………

……………………………………………………………………………………………

Please Return this Form with a Single Assessment Process Contact Assessment to:

North Sheffield
Community Learning Disabilities Team Referral Co-ordinator
Ivy Lodge Clinic
254 Rutland Road
Sheffield
S3 9PR
Telephone Number (0114) 271 6982
Fax Number (0114) 271 6973

South Sheffield
Community Learning Disabilities Team Referral Co-ordinator
Lightwood House
Lightwood Lane
Sheffield
S8 8BG
Telephone Number (0114) 271 6551
Fax Number (0114) 271 6550

Sheffield Health and Social Care

NHS Foundation Trust

APPENDIX 3b

Restraint Information Record
Bed Rails/"Cot Sides"

Name of Individual: …………………………………………………………………………….

Date of Birth: …………………………………………………………………………….

Address: …………………………………………………………………………….

…………………………………………………………………………….

Telephone Number: …………………………………………………………………………….

Please Specify the Type of Restraint This Form is About (Please complete a separate form for every restraint being used)

…………………………………………………………………………………………………

Does the person have the capacity to consent to the plan detailed in this document?

…………………………………………………………………………………………………

If yes, do they give their consent to the plan and are they aware that they can withdraw that consent? (see SHSC/NCC guidance about Advanced Directives)

…………………………………………………………………………………………………

If no, is there a chance that they may have the capacity to consent at the time that the restraint is being used and how will this be handled?

……………………………………………………………………

If no, how have you ensured that the plan is in the person's interests, as described by the Mental Capacity Act (for example, has a Best Interests meeting been held?)

…………………………………………………………………………………………………

STEP 1 - Why is restraint being considered? (State the behaviour/situation of concern)

…………………………………………………………………………………………………

If this is to stop the person <u>falling</u> out of bed? - go the STEP 2 and continue with this form.

If this is to stop the person <u>getting</u> out of bed? - discontinue use of this form and use general Restraint Information Record (Appendix 3).

If this is for any other reason, go to STEP 2 and continue with this form.

STEP 2 (a) - Without the bed rails/"cot sides" who might be at risk and how?

Who?	Is there any Risk?	How Might They Be At Risk?
The person themselves	Yes/No	
Others who use the same service	Yes/No	
Staff/other non-family carers	Yes/No	
Family	Yes/No	
Anyone else (including members of the public)	Yes/No	

2 (b) - Consider Article 2 of the Human Rights Act 1998 – Is there a risk that someone's life may be endangered without the bed rails/"cot sides"?

……………………………………………………………………………………………………

STEP 3 - Is there anything that makes it more likely that the person will fall out of the bed (for example, epilepsy, distractions, sensory impairment)?

……………………………………………………………………………………………………

STEP 4 - Which alternatives have been considered and what are the risks associated with them (including "is this also a restraint")?

Alternative	Risks	Is this appropriate to use? If not, why not?	Is this also a restraint?
Bed being placed up against a wall			
Mattress being placed on the floor			
Crash mat on the floor next to bed			
Alternative bed - for example, double bed, specialist bed, futon			

Alternative	Risks	Is this appropriate to use? If not, why not?	Is this also a restraint?
	Cont … from previous page		
Sleep system			
Tucked in blankets/sheets			
Increased staffing levels			
Other			

STEP 5 - Please detail any risks associated with the bed rails/"cot sides"

Risk	Please Specify Nature of Risk (please state if it is not applicable)	What Actions will be Taken to Minimise the Risks?
	Risks to the person	
Risk of injury to the person from the bed rails/"cot sides" (include consideration of any specific medical conditions or contra-indications to the bed rails/"cot sides")		
Risk of entrapment in bed rails/"cot sides"		
Risk of the person falling over the top of the bed rails/"cot sides"		
Distress to the person		
Psychological trauma to the person		
Risk of person's dignity being undermined or of them being subject to degradation or humiliation		
Risk of distrust arising or personal relationships being undermined		
Any other risks to the person (please specify)		
	Risks to staff/family/carers	
Risk of injury to staff/family/carers		
Risk of disciplinary action against staff/challenge in court		
Any other risks to staff (please specify)		

Risk	Please Specify Nature of Risk (please state if it is not applicable)	What Actions will be Taken to Minimise the Risks?
Cont … Risks to others		
Any risks to anyone else (please specify)		

STEP 6 - Please detail when it is inappropriate to use the bed rails/"cot sides"?

……………………………………………………………………………………………

……………………………………………………………………………………………

STEP 7 - Could the bed rails/"cot sides" infringe upon the person's rights under the Human Rights Act (1998)? Consider in particular:-

Article 3 - freedom from torture or inhuman or degrading treatment.

……………………………………………………………………………………………

Article 5 – deprivation of liberty.

……………………………………………………………………………………………

STEP 8 - Specify any risks that remain unmanaged

……………………………………………………………………………………………

STEP 9 - Who has been involved in this discussion? Has the client/carer agreed to the plan?

……………………………………………………………………………………………

……………………………………………………………………………………………

STEP 10 - Specify the last review date for this plan and the next date it will be reviewed:

Last Review Date:

……………………………………………………………………………………………

Next Review Date:

……………………………………………………………………………………………

Consider Article 14 of the Human Rights Act (1998) –

Could it be argued that the person is being discriminated against on grounds such as disability, race or gender in the suggestion of these prevention strategies and restraint?

………………………………………………………………………………………………

Does the person want to receive copies of letters relating to this referral?

………………………………………………………………………………………………

Name and Address of Individual's GP:

………………………………………………………………………………………………

………………………………………………………………………………………………

Name and Address of Service Manager:

………………………………………………………………………………………………

………………………………………………………………………………………………

Name, Address and Contact Number for Day Services (if applicable):

………………………………………………………………………………………………

………………………………………………………………………………………………

Date Completed:

………………………………………………………………………………………………

Name:

………………………………………………………………………………………………

Address:

………………………………………………………………………………………………

………………………………………………………………………………………………

See over

Please return this Form with a Single Assessment Process Contact Assessment to (see over):

North Sheffield
Community Learning Disabilities Team Referral Co-ordinator
Ivy Lodge Clinic
254 Rutland Road
Sheffield
S3 9PR
Telephone Number (0114) 271 6982
Fax Number (0114) 271 6973

South Sheffield
Community Learning Disabilities Team Referral Co-ordinator
Lightwood House
Lightwood Lane
Sheffield
S8 8BG
Telephone Number (0114) 271 6551
Fax Number (0114) 271 6550

Appendix 4

List of Useful Contacts

Adult Protection Contact - Neighbourhoods & Community Care Access Team Council First Stop Reception Howden House Union St Sheffield S1 2SH Telephone Number (Office Hours) - (0114) 273 4908 Telephone Number (Out of Hours) - (0114) 273 4446
Commission for Social Care Inspection - London 33 Greycoat Street London SW1P 2QF Telephone Number - 020 7979 2000 Fax Number - 020 7979 2111
Commission for Social Care Inspection - Sheffield Ground Floor - Floor 3 Waterside Court Bold Street Sheffield S9 2LR Telephone Number - (0114) 256 4530 Fax Number - (0114) 256 4556
Ethical Advisory Group c/o John Tomlinson Joint Learning Disabilities Service Fulwood House Old Fulwood Road Sheffield S10 3TH Telephone Number - (0114) 271 8807 Fax Number - (0114) 271 8829
Sheffield Citizen Advocacy Unit 9 Edmund Road Business Centre 135 Edmund Road Sheffield S2 4ED Telephone Number - (0114) 276 3110 Fax Number - (0114) 270 6577
Speaking Up for Action (SUFA) Unit 9 Edmund Road Business Centre 135 Edmund Road Sheffield S2 4ED Telephone Number - (0114) 282 3140 Fax Number - (0114) 270 6577

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Sheffield Health and Social Care NHS Foundation Trust

Record of Incident leading to Restraint **APPENDIX 5**

Date: …………………………………………… Ward/Department:……………………………………………….

Name of Service User: ………………………… Insight No: …………… MHA Section (if applicable): …..…

Sex: Male / Female Date of Birth: ……………………………………………………

Ethnic Origin: (please circle)

0 - White	*3 - Black other*	*6 - Bangladeshi*
1 - Black Caribbean	*4 - Indian*	*7 - Chinese*
2 - Black African	*5 - Pakistani*	*8 -Other/Not Known* …………………….........

Description of Incident/reason for restraint: (e.g. location, seclusion, de-escalation utilised) ***including injuries***.

……

……

……

Cause Group:………………………………………. Cause 1 ……………………………………..….

Cause 2 ……………………………………………

If Staff Injured during restraint

Name:…………………………………… Job Title:………………… Injury:………………………………………

Name of person in charge of restraint: …………………….….… Job Title:……………………….……………..

Type of intervention: Passive holding/Low level holding/Full limb management/Lapstraps/Bedrails/

chemical/mechanical/Other …………………....…………

Position of service user: Seated / Prone (face down) / Supine (face up) / Standing - Walking

If physical intervention used:

Type of hold: Active / Passive / Mechanical

Name of Staff	Limb	Trained? Y/N
1)		
2)		
3)		
4)		

If more people involved give names and explanation. Also record changes in limb management.

Time Restraint: (24 hour clock)

Start	Finish	Duration
:	:	:
:	:	:
:	:	:

Cumulative Total ………………………….

G. PERSON REPORTING THE INCIDENT.

Name: ……………………………………………………….………….. Designation: ………………………………………
(Please Print)
Signature : ………………………….…………. Tel No. ……..………………..……………… Date: ……/……/……

H. MANAGEMENT REPORT: *This section is to be completed by the person in charge using the Risk Assessment/Grading Matrix.*

What was the impact on the individual/service? INITIAL GRADE [ ]

If graded as moderate, major or catastrophic discuss with a more Senior Manager immediately.

CONTRIBUTORY FACTORS

ACTION TAKEN AND OUTCOMES

RECOMMENDATIONS

LESSONS LEARNED

Who Was Informed ?
Patient
Relative
Senior Manager
Pharmacist
Police (Incident Number)

I. RISK ANALYSIS - Could it happen again?

Severity [ ] **x Likelihood** [ ] **= Risk Rating** [ ]

If graded as moderate or high discuss with Senior Manager immediately, and fax to Risk Department within one working day on 0114 271 6392

J RIDDOR: Staff Incident - In order for the Trust to comply with RIDDOR the following section must be completed: Is the staff's injury, absence from work, or inability to perform normal duties likely to last for more than 3 days Yes No
Was this an act of violence or dangerous occurrence? Yes No
Is hospitalisation for more than 24 hours likely? Yes No

Name of Staff sustaining injury (PRINT) ………………………..… Date of Birth …../…../…..

Home Address ……………………………………………………………………………..

NH: Staff home address is required for completion of RIDDOR

Name of Person in Charge (printed) …………………………… Signature ……………………………..
Designation …………………………………………………….. Date ………………………………….

Copy to: Risk Management Department, Patients Notes, Senior Manager

Sheffield Health and Social Care NHS
NHS Foundation Trust

APPENDIX 6

Groups Supporting Policy Implementation

1. Joint Policy Steering Group on Restraint

The Joint Policy Steering Group on Restraint will:

- Oversee the implementation of the policy.
- Monitor and review the effectiveness of the policy.
- Make recommendations to Sheffield Health and Social Care NHS Foundation trust and Neighbourhoods and Community Care for future policy developments.
- Liaise with service users and carers to ensure that their views are considered in further developments and review of the policy.

2. The Learning Disability Implementation Group

The Learning Disability Implementation Group will:

- Develop and implement the operational guidance for learning disability services.
- Monitor and review the effectiveness of the guidance.
- Look at the statistics around the use of restraint in Sheffield
- Identify and make recommendations on structural or resource issues to the Joint Policy Steering Group on Restraint.
- Develop a Workforce Development plan to support the continued application of the Joint Policy Steering Group on Restraint and the Operational Guidance for the Joint Policy Framework on the Prevention and Management of the Use of Restraint

3. The Alternatives to Restraint Practice Development Group

The Alternatives to Restraint Practice Development Group will be involved in the following areas of work:

- Development of evidence based **care pathways** that identify good practice within Community Learning Disability Teams and link with other mainstream and specialist health services.
- Identifying appropriate **outcome measures**

- Maintaining **up-to-date knowledge** on innovations and practice.
- Collating and developing **resources** for use by service users, carers, services and agencies.
- **Identifying areas of unmet need** and inputting into service planning.
- **Identifying training and development needs**.
- Developing **links/networks** with other agencies/services.
- Developing systems which enable **good practice to be shared** across services/agencies.
- Identifying/undertaking/participating in **research** priorities.
- **Involving service users and carers** in the development and evaluation of learning disability practice.