CP21
Restrictive Practice Policy (Children and Adults)

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1.0 Introduction

The Royal Wolverhampton NHS Trust is committed to delivering the highest standards of health, safety and welfare to its patients, visitors, people who receive healthcare in the community and employees. Restrictive interventions can delay recovery and has been linked to causing serious physical and psychological trauma, and even death. Restrictive interventions **must** therefore only ever be used in extreme life-threatening situations or as part of an agreed care plan (DOH, 2014).

The Trust recognises that violence and aggressive behaviour can escalate to the point where restrictive interventions may be needed to protect the safety of a person(s) whether that be a patient, member of staff or general public, but strongly advocates that this is always used only as a last resort and when there is no other alternative action that can be taken to prevent serious harm. The general principles that guide the development and implementation of this policy have been adopted from those outlined in guidance on the use of restrictive practices (RCN, 2013) and these are:

- Human rights must be always protected
- Understanding people's behaviour allows their unique and individual needs to be identified and quality of life enhanced
- Involvement and participation of service users, their families and carers is essential
- People must be treated with compassion, dignity and kindness
- Health and adult social care services must keep people safe and free from harm
- Positive relationships between services and the people they support are key to recovery; they must be protected and preserved. If restrictive interventions are used it must only ever be as a last resort, and it is undertaken in a proportionate and least restrictive way The most common reasons for needing to use restrictive interventions
- Physical assault.
- Dangerous or threatening or destructive behaviour.
- Non-compliance with treatment; for people and patients who lack mental capacity.
- Self-harm or risk of physical injury either deliberately or by accident, to self or others; this could include risks associated with absconding or falls.
- Extreme and prolonged over-activity likely to lead to physical exhaustion.

In adhering to this document, all applicable aspects of the Conflicts of Interest Policy (GOP109) must be considered and addressed. In the case of any inconsistency, the

Conflict-of-Interest Policy is to be considered the primary and overriding Policy.

2.0 Scope The safe and ethical use of all forms of restrictive interventions

The legal and ethical basis for organisations to allow their staff to use restrictive interventions as a last resort is founded on eight overarching principles (DoH, 2014):

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

2.1 What is 'Reasonable' in Law

The management of difficult and challenging behaviour is an activity requiring compassion and respect for the rights of the individual, balanced against the risk of harm to themselves, staff and members of the public. Restraining any challenging or aggressive behaviour by physical or chemical means should only be used when it is reasonable to do so. Restraint must only be considered when all other practical means of managing the situation, such as de-escalation, distraction, verbal persuasion, adjustments to the environment, voluntary 'time out', or gaining consent to taking medication, have failed or are judged likely to fail in the circumstances. The self-respect, dignity, privacy, cultural values, race, and any special needs of the patient/person should be considered in so far as is reasonably practicable. For the purposes of considering what may be construed as reasonable in law***, the Criminal Law Act 1967, Section 3*** states: 'A person may use such force as is reasonable in the circumstances in the prevention of crime, or in effecting or assisting in the lawful arrest of offenders, suspected offenders, or persons unlawfully at large'. Using this

example, it is not possible to set out comprehensively when it is reasonable to use force; no two threatening situations are ever identical. However, what constitutes 'reasonable' will require staff in each situation to consider the following points carefully:

- Where a technique is applied, it must be done in a manner that attempts to reduce rather than provoke a further aggressive reaction.
- The numbers of staff involved should be the minimum necessary to restrain the violent individual, whilst minimising injury to all parties
- The force used must be proportionate to the risk and the minimum necessary to be able to contain the situation
- To take no action could be seen as negligent where the outcome results in self-inflicted injury to the individual or in injury to others
- To convict a person of using unreasonable force, a court must be satisfied that no reasonable person in a similar position would have considered the action of the use of such force justified

3.0 Statement of Intent

The purpose of this document is to provide guidance to managers and staff (including security officers) of our legal and professional responsibilities in relation to the nature, circumstances and use of approved restrictive interventions currently adopted by the Trust. Its aim is to help all involved act appropriately in a safe manner, thus ensuring effective responses in potential or actual difficult situations. This policy must be utilised for any neurodiverse patients (for example ADHD, or Autistic patients) who may at times have highly individualized responses to individual triggers – this can in response to stimuli such as sights, smells, sounds and tastes. Triggers can be individual triggers of patient's past experiences, resulting in either 'internal' (memory or emotion), or 'external' (environmental).

The policy will ensure that patient's rights to dignity, self-determination and safe treatment are not compromised and that actions to use physical intervention does not breach the law

- To ensure that patients, visitors and staff feel safe and secure.
- To ensure that individuals who have capacity give consent to any method of physical intervention techniques used and that where an individual lacks capacity to give consent, (a 2-stage capacity assessment must be undertaken) any physical intervention is agreed by the multi-disciplinary team with the patients advocate or representative. And that they are used in the least restrictive manner

- To ensure that de-escalation techniques have been exhausted and that physical intervention techniques are used as a last resort.
- To ensure that physical intervention techniques used are only facilitated by staff who have undergone training in the techniques.

Physical interventions should be viewed as a final option in a hierarchy of therapeutic interventions. When using reasonable force, it is important to note that what is reasonable in the short term might not be reasonable in the long term as other preventative and/or therapeutic strategies become effective. Prior to physical intervention techniques being prescribed by a registered healthcare professional the patient will be risk assessed and where physical intervention is used monitoring mechanisms will be put in place and followed.

4.0 Roles and responsibilities

4.1 Board of Directors

The Trust board is responsible for determining the governance arrangements of the Trust including effective risk management processes. It is responsible for ensuring that the necessary clinical policies, procedures and guidelines are in place to safeguard patients and reduce risk. In addition, they will require assurance that clinical policies, procedures and guidelines are being implemented and monitored for effectiveness and compliance.

4.2 The Chief Executive

The Chief Executive has overall responsibility for patient safety and ensuring that there are effective risk management processes within The Royal Wolverhampton NHS Trust which meet all statutory requirements and adhere to guidance issued by the Department of Health. They hold each line manager accountable for meeting objectives and to work together towards meeting the objectives approved by the Board.

4.3 Lead Director

The Director of nursing is responsible for:

- Presenting the policy to the ratification group
- Providing assurance to the group that the policy is compatible with Trust Objectives
- Ensuring that the policy complies with all relevant statutory requirement sand other standards
- Implementation, monitoring and compliance with policy, including reporting to Trust Executive groups or the Board as necessary

- Ensuring the policy is reviewed and revised as per timescales on the cover page

4.4 Medical Staff

Staff are responsible for patient assessment and the prescribing of medication where indicated as outlined within the Trust policies. Medical staffs are responsible for the monitoring of dosage and continuing need for the duration of the drug prescription. It is essential that the patient, nurses and carers be informed of the reason for prescription together with the intended outcomes.

4.5 Clinical Directors / Heads of Nursing / Matrons

Clinical Directors, Heads of Nursing and Matrons are required to ensure that

- All staff are aware of their role under the policy
- Staff have received sufficient training to implement the policy in operational practice
- Ensuring incidents / issues are reported as specified
- Monitoring / Audits and Evaluations are carried out as specified

4.6 Senior Sisters, **Department Managers or equivalent**

This group will be responsible for the day-to-day implementation of the policy by ensuring that:

- This document is made available to all staff within their department
- The staff, they are responsible for, implement and comply with this document
- Those staff who will undertake any procedural elements contained within this document have been trained and deemed competent to do so

4.7 Multi-disciplinary Members (Physiotherapists, Occupational Therapists)

Members of the MDT are responsible for participating within Team the risk assessment as required. MDT members are responsible for developing and following the restraint plan of care

4.8 Education and Development Leads

To ensure that when staffs are being trained in the use of restrictive physical intervention or restraint that reference is made to Mental Capacity Act and the Deprivation of Liberties Safeguards. Similarly, they made aware of the Trust values. The Trust provides internal 'IKON' de-escalation training via the Acute Mental Health Team, which teaches that restraint should be used as a last-resort option, (other least restrictive options must be attempted

first).

4.9 All Staff

All staff who encounter patients or people, who could demonstrate challenging behaviour and therefore may require restrictive interventions to keep them or others safe from harm, are responsible for complying with this policy. A management plan should be completed and put in place and shared with members of the team including security staff who may be called to support staff to enable them to support more effectively. For any incidences where restrictive intervention or manual restraint is used staff **must** ensure vital signs are reliably recorded and acted on during and after restraint and a (Datix) clinical incident report completed. This will be evidenced by the clinical incident reporting process, and reports provided by the Acute Mental Health Team.

4.10 Security Officers

All incidents relating to physical intervention will be managed by the clinician, however where security officers are available, they are responsible for:

- Being fully conversant with this policy and relevant associated policies
- Assisting with patients who may require physical intervention
- Being competent to carry out physical interventions of patients when required
- Completing physical intervention training successfully, this includes IKON (de-escalation) training provided by the Acute Mental Health Team.
- Ensuring when carrying out physical interventions, that they take their lead from the clinician in charge when available
- Documenting all episodes of physical intervention through the Trust's Incident Reporting Process

4.11 The Police

The Police will only attend the Trust when a crime has been committed. Security Officers should always be called for assistance in the first instance for incidences occurring within the hospital or hospital grounds. Police are unlikely to attend or affect an arrest where a patient lacks capacity unless life is threatened. When the police arrive at the scene all relevant information, including the mental capacity of the patient at the time of the incident, should be provided to them so that they can determine the appropriate course of action. In cases where a clinician determines that a patient requires urgent medical attention but is incapable of informed choice, the clinician may administer the appropriate treatment. Police

officers requested to restrain an individual for the purposes of such treatment to prevent death or serious injury, may lawfully apply proportionate and necessary force to assist. In such cases the Mental Capacity Act 2005 and the common law defence of necessity apply. Police will only restrain a patient when informed by a clinician that the individual needs urgent medical attention and is incapable of informed choice. Details of the attending police officers, i.e. their name, collar number, the police station at which they are based and the action that they have taken should be recorded and added to the Clinical Incident report.

5.0 Procedure(s)

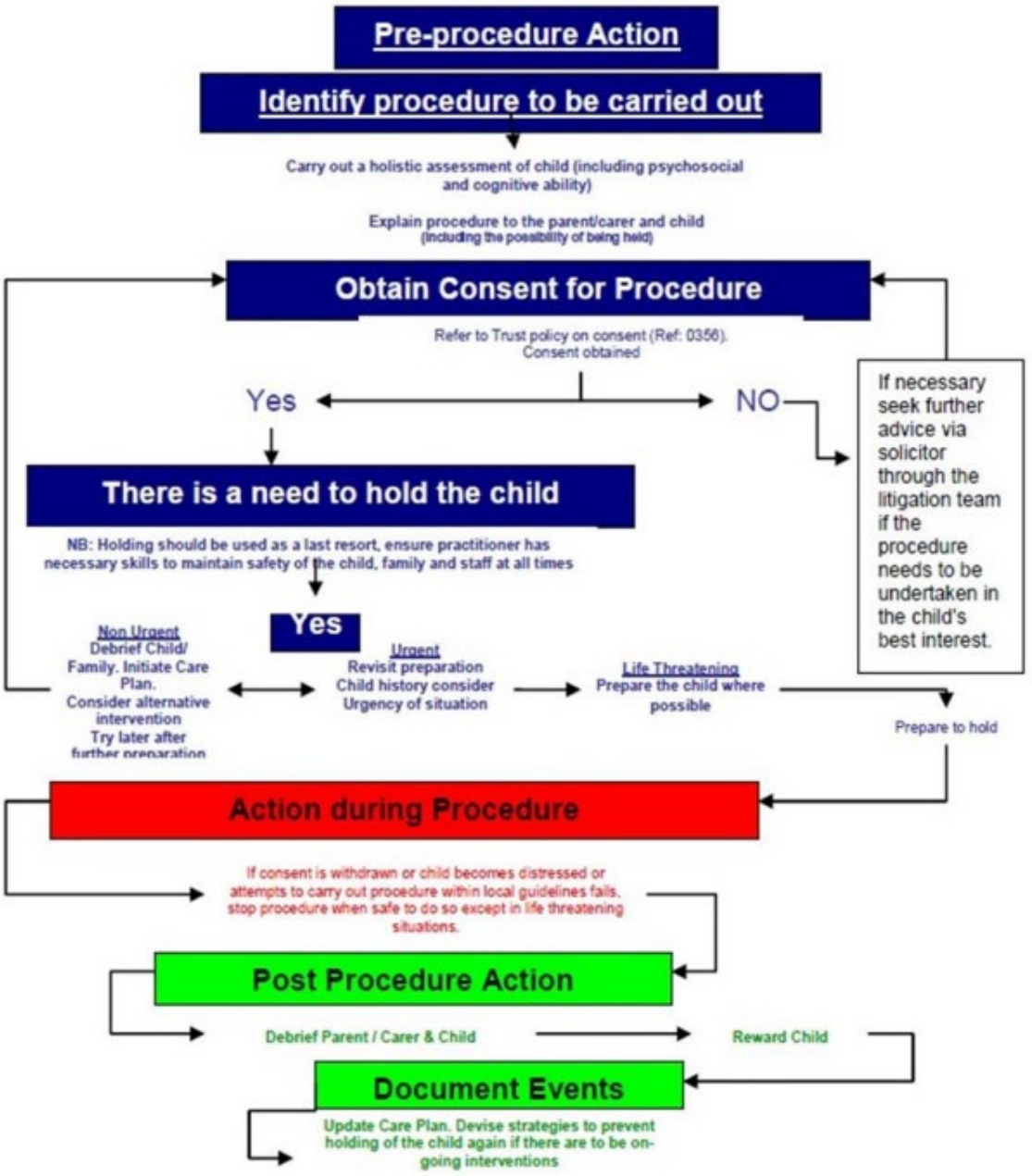
5.1 Purpose of restrictive physical intervention

The purpose of restrictive physical intervention is to reduce the risk of harm to the individual, other patients, staff and the wider public.

Restrictive practice in the care of Children and Young People
(including paediatric and non-paediatric areas)

This section of the policy is designed to define therapeutic holding and restrictive physical intervention and allow the practitioner to ensure the care or treatment that they are offering is lawful, legitimate, and the least restrictive reasonable option available. Where the use of restraint/ clinical holding and containing children and young people is concerned, practitioners must consider the rights of the child and the legal framework surrounding children's rights.

Child restrictive practices Algorithm



The purpose of this part of the policy is to guide practitioners and enable them to carry out Restrictive Physical Intervention or Therapeutic Holding in a safe manner, which ensures minimal trauma and distress for the child/ young person and their family.
To highlight the necessity for the appropriate use of de-escalation technique, distraction, play therapy and alternatives.

To highlight the need for good communication, consent, training and documentation.

5.2 When restrictive physical intervention may be used

Restrictive physical intervention might justifiably be used where:

- An adult is displaying behaviour that is putting themselves at risk of harm
- An adult is being physically assaulted
- An adult is displaying behaviour that is putting others at risk of harm
- Requires necessary urgent/ lifesaving treatment and therefore staff are acting in the persons best interests
- Staff need to administer necessary care that is in the patient's best interests.
- Non-compliance with treatment; for people and patients who lack mental capacity.
- Self-harm or risk of physical injury either deliberately or by accident, to self or others; this could include risks associated with absconding or falls
- Extreme and prolonged over-activity likely to lead to physical exhaustion.

When a patient has a behaviour or management plan in place. However, anybody considering using physical intervention techniques on a patient must have objective reasons to justify why that restrictive physical intervention is necessary. It must demonstrate that the person is likely to suffer harm unless a proportionate response is used. It is therefore imperative that a risk assessment is completed and documented (Appendix 4). (Unless it is an emergency).

5.3 When restrictive physical intervention should not be used

Physical restrictive intervention can also be unlawful, and inappropriate. Restraint may not be used for treatment, punishment, behaviour modification, staff convenience or on an "as needed" basis (PRN orders). Any physical intervention must be the most appropriate alternative available and only be used when other non-physical techniques have been determined to be ineffective.

5.4 Preventing the need for Restrictive Interventions

5.4.1 The Patient's Behaviour, Underlying Condition and Treatment

Understanding a patient's behaviour and responding to individual needs should be at the centre of (patient) all healthcare. All people/patients should be assessed comprehensively to establish what sort of therapeutic behaviour management might be of benefit.

This will involve identifying the underlying cause of the behaviour (agitation, aggression, absconding, developmental age/cognitive ability etc.) and deciding whether the behaviour

needs to be prevented.

People may demonstrate behaviours that are challenging and potentially harmful because:

- They have challenging or complex needs that are not being met. These could be associated with unusual needs and personal preferences, sensory impairments, or mental or physical health conditions.
- They are exposed to challenging environments, examples of which might include environments which are barren and lack stimulation, where there are high levels of noise or disturbance.
- There may be institutional blanket rules, restricted or unpredictable access to preferred activities (such as locked doors, lack of access to outdoor space or refreshments).
- There is insufficient availability of positive social interactions, or where personal choices are not offered and/or honoured resulting in a loss of control.

Assessment of Behaviour

The aim of behaviour assessment is to establish an objective baseline and to gain information about the circumstances of behaviour. ABC (Appendix 5) is a strategy that is both relatively easy to use and adaptable to most situations. Firstly, the target behaviour should be identified. ABC involves identifying what occurred prior to the behaviour (Antecedent), describing the Behaviour and then recording what happened after the behaviour (Consequence).

The antecedent identifies possible triggers for the behaviour and the consequence identifies what reinforces or maintains the behaviour.

Behaviour Management Strategies

- Consistency
- Structure
- Reward

Distraction Possible physical causes to consider are:

- Hypoxia
- Hypotension
- Pyrexia
- Need to empty bladder or bowel

- Pain or discomfort
- Electrolyte or metabolic imbalance
- Anxiety or distress
- Mental illness e.g. dementia
- Other form of memory impairment
- Drug dependency or withdrawal
- Brain insult / injury or cerebral irritation
- Reaction / side effect of medication
- Intoxication (due to alcohol, drug overdose or drugs of abuse).

Alternative Methods Prior to the decision to use physical intervention, alternative methods must be exhausted. The following table includes possible interventions dependent on patient behaviour.

Patient Behaviour	**Possible Interventions**
Inappropriate attempts to get out of bed / chair with a resultant high risk of falling and injury	• Lower the bed height • Falls Monitor • Ultra-Low-profile bed
Pulling at invasive devices	• Posey mitts (additional risk assessment required for this option). • Long sleeved clothes
Restless/wandering	• Medical & psychological assessment – use of the behavioural chart • Programme of activities • Purposeful wandering - Should not be viewed as problematic behaviour- allow patient to walk with supervision- discuss with family members • Baffle locks to main doors *Also refer to DOLs policy (CP02).
Inappropriate sexual behaviour	• Provide privacy, draw curtains around patient
Violent and/or aggressive behaviour	• Follow behaviour management plan • Consider one to one care

	• Involve carers to support care • Security presence • Contact police if severe aggression and violence- (this will be inappropriate if the person lacks capacity)

The use of medication can also be considered, and the following policies and guidelines should be referred to:

- Management of Behavioural and Psychological Symptoms of dementia policy
- Acute Confusional State (Delirium) in older people guidance

5.5 The Patient's Mental Capacity It is necessary to consider the patient's mental capacity. A mental capacity assessment relates to a single point in time and to a specific decision. Individual patients cannot simply be described as "lacking capacity". A patient's capacity may fluctuate from time to time.

The Mental Capacity Act presumes that all persons 16 and over have the ability to make their own decisions and protects their right to make and act on their own free and informed decisions.

The five principles of the Mental Capacity Act are shown below.

- A person must be assumed to have capacity unless it is proved otherwise
- A person must not be treated as unable to make a decision unless all practicable steps to help have been taken without success
- A person is not to be treated as unable to make a decision merely because an unwise decision is made
- An act done, or decision made under the Act for, or on behalf of a person who lacks capacity, must be done in their best interests
- Before an act is done, or a decision made, consideration must be given to whether the same outcome can be achieved in a less restrictive way

Staff must explain any proposed procedure in an easily understandable way to enable a patient or their representative to give consent to make their own decisions. They **must** support the patients or their representative to give consent to ask questions and to weigh up information relevant to the decision to be made.

Stage 1 – Does the person have an impairment of the mind or brain or is there some sort of temporary disturbance affecting the way their mind or brain works. If yes, proceed to stage

2 Stage 2 – If so, does that impairment or disturbance mean that the person is unable to make the decision in question at the time it needs to be made? – assess the following:

- Does the person have a general understanding of what decision they need to make and why they need to make it?
- Does the person have a general understanding of the likely consequences of making, or not making, this decision?
- Is the person able to understand, retain, use and weigh up the information relevant to this decision?
- Can the person communicate their decision (by talking, using sign language or any other means)? Would the services of a professional (such as a speech and language therapist) be helpful? Any 'no' response in stage 2 will mean that the patient lacks the capacity to make a particular decision at a particular time Patients who may require the use of physical intervention techniques must be assessed against this test in relation to his/her capacity to agree / understand the use of physical intervention and the process fully documented. Where the patient has capacity, verbal consent/refusal to the use of physical intervention must be recorded. Where the patient lacks the capacity to decide about the use of physical intervention, a best interest's assessment must also be completed and recorded. Forms for both capacity and best interests can be located on the Trust's intranet. The patient's relative or independent mental capacity advocate will need to be consulted

5.6 Level of Restrictive physical intervention

Restrictive physical intervention should always be by the least restrictive means possible, and where the individual has capacity, with his or her consent. Any Physical intervention used, must be a proportionate response to the likelihood and seriousness of harm and that this is an agreed method of managing challenging behaviour. Staff must only use physical intervention techniques that have been identified as part of formal training as identified in the Trust training needs analysis. Any action intended to restrain a patient who lacks capacity will not attract protection from liability unless the following conditions are met:

- Before doing the act, reasonable steps are taken to establish whether the individual lacks capacity in relation to the matter in question: and
- When doing the act, it is reasonably believed that the person being cared for or treated

lacks capacity in relation to the matter and it will be in the best interests of the person being cared for or treated for the act done

- The person intervening must reasonably believe that restraint is necessary to prevent harm to the person who lacks capacity, and
- The amount or type of restraint used and the amount of time it lasts, must be a proportionate response to the likelihood and seriousness of harm

5.7 Care Planning

Where there is a known likelihood that restrictive interventions might need to be used an appropriate care plan with a review date must be devised by the multidisciplinary team in advance and in discussion and agreement with the person, patient, their careers, relatives or advocates.

This must identify:

- The assessment of the triggers and causes of a person's challenging behaviour, whether these are environmental, physical or psychological.
- The treatment and management strategies to address the causes of the challenging behaviour.
- The prevention of the harmful behaviours by recognising the triggers to them and the behavioural modification strategies such as de-escalation, verbal persuasion, distraction, diversion.
- The management plan when or if the person's behaviour does escalate to a point where they place either themselves or others at significant risk of harm. This could include the use of restrictive interventions if deemed necessary. If restrictive interventions are deemed necessary, then the reasons for this and when and how it will be implemented must be clearly documented.
- Individual risk factors which suggest a person is at increased risk of physical and/ or emotional trauma must be taken into account when planning and applying restrictive interventions. For example, this would include recognising that for a person with a history of traumatic sexual/ physical abuse, any physical contact may carry an additional risk of Causing added emotional trauma or for a person known to have muscular-skeletal problems such as a curvature of the spine, some Positions may carry a risk of injury.
- Any obsessions or autistic tendencies

5.8 Preventative / Alternative Measures to Physical Restraint.

De-escalation techniques must always be considered in the first instance. De-escalation Techniques:

5.8.1 Diversion Therapy

Intervention and de-escalation must be instigated early, if it becomes clear that an aggressive episode of behaviour is likely to occur, and this must be individualised to the person concerned. These approaches will include and focus on negotiation, communication, use of staff body language, personal space etc. The overall aim will be to maintain safety at all times. It must be decided where is appropriate to deliver these distraction /diversion therapies as it may not be appropriate that the patient be taken out of the ward environment for safety reasons. If this is the case, then these therapies should be provided on the ward so that the patient can be observed at all times by staff.

5.8.2 Involving relatives

Relatives and carers can provide a known and reassuring face to patients and their presence can assist greatly in reducing their anxieties that may cause distress, aggression & violence. Consider calling the relative or carer to sit with the patient if they are becoming distressed, agitated and becoming either verbally or physically aggressive.

5.8.3 Environment

The patient's environment can include both the physical environment and the level and qualification of staff. Considerations must include how to manage the patient's environment or care setting to limit the potential for violent and/or aggressive behaviour. A noisy environment can cause increased anxiety and agitation in some patients. Similarly frequent changes of ward or bed space can increase these levels

- Consider issues of comfort for catheterised patients such as securing the catheter, for example, the use of leg bags instead of long bags,
- Long sleeved clothes to cover an intra-venous line,
- Place the bed in its lowest position if appropriate
- Modify lighting
- Modify sound

5.8.4 Verbal/non-verbal communication

Your body language and tone of voice can often prevent an aggressive situation from

escalating. Talk in a firm but quiet, calm voice and do not hurry the person. Do not stand over the patient or keep your arms crossed as these actions imply threat or dominance.

- Use of an interpreter if there is a language barrier or a representative if the patient is vulnerable i.e. has dementia, learning disabilities.
- Use of sign language as appropriate
- Ensure hearing aids are working and insitu.
- Ensure patient has appropriate spectacles / visual aids.
- Ensure all staff is aware of any communication barriers.
- Use of easy read or symbols, hospital communication book and toolkit

5.8.5 Reduction in the use of interventions that may trigger challenging Behaviour (if not contra-indicated).

- Intravenous cannula,
- Naso-gastric tubes,
- Catheters
- Other patient attached equipment

5.8.6 Complementary and Alternative Therapy

- Massage – can be beneficial in promoting relaxation and reducing pain
- Music Therapy – Reduces agitation in confused patients and can reduce anxiety and pain.
- Therapeutic touch (e.g. holding a patient's hand) Staff are reminded (excerpt taken from Gov.uk) - … ('common law') has established that touching a patient without valid consent may constitute the civil or criminal offence of battery. Further, if healthcare professionals

(or other healthcare staff) fail to obtain proper consent and the patient subsequently suffers harm as a result of treatment, this may be a factor in a claim of negligence against the healthcare professional involved." The aim is for staff to provide support whilst continuously assessing the level of need and risk, and the patient's mental health and overall wellbeing.

5.9 Physical Restraint

5.9.1 Co-ordination of restrictive interventions

Consideration must be given to the cause of aggressive or violent behaviour which, if treated could reverse this behaviour e.g. oxygen when hypoxic, pain relief when in

pain. Consider the triggers for violent and aggressive behaviour. Such specific treatment should be implemented as a priority to prevent restrictive interventions being needed.

- In all wards / clinical departments where the use of restraint is foreseeable there must be a cardiac arrest trolley available (inpatient and hospital-based departments only) Allocate responsibility to an identified senior member of staff to co-ordinate the incident. Important qualities include familiarity with the person, ability to use clear, direct, uncomplicated communication throughout the procedure, and knowledge of any risks associated with physical restraint. Allocate responsibility to an appropriately qualified member of staff to support the restrained person during and after the restraint.

5.9.2 Implementation of Physical Interventions/Restraint

Any staff using physical restrictive interventions must have undergone training. Staff should:

- Wherever possible use de-escalation techniques irrespective of the stage of the restraint
- Never restrain a person in a prone/face down position on any surface, not just the floor
- Ensure that one member of staff leads the team and assumes control of the person being restrained throughout the process. He or she must ensure that the restrained person's head and neck is appropriately supported and protected, and the airway and breathing are not compromised
- Monitor the person's airway and physical condition throughout the physical restraint to minimise the potential of harm or injury.
- Communicate with the person throughout any period of physical restraint to continually attempt to reassure the person throughout procedure/ or to de-escalate the situation
- For safety reasons, only hold / apply pressure to the person's limbs. Under no circumstances must direct pressure be applied to the neck, thorax, abdomen, back or pelvic area
- Avoid prolonged physical intervention / immobilisation, consider rapid tranquillisation or seclusion (which may be safer where appropriate) as alternatives
- Use skills and techniques that do not use the application of pain

- Ensure that the level of force applied must be reasonable, necessary and proportionate to a specific situation, and must be applied for the minimum possible amount of time
- Post-restraint, ensure the person who has been restrained is appropriately observed for a period of up to 24 hours. During this time physical observations must be recorded by a member of the clinical team appropriately and the observing nurse be fully aware of the possibility of restraint/positional asphyxia.

5.9.3 Physical and Psychological Monitoring

Monitoring the person's physical and psychological monitoring is important during and after restraint. This must be documented as part of the risk assessment and also in the plan of care. Observations that include vital clinical indicators such as pulse, respiration, level of consciousness and complexion (with special attention to pallor or discolouration) must be carried out and recorded on an observation chart and staff should be trained so that they are competent to interpret these vital signs. Monitoring must be undertaken by the clinical team in attendance and the need for neurological observations including conscious levels must be assessed and documented on appropriate chart This is especially important:

- Following a prolonged or violent struggle
- If the person has been subject to enforced medication or rapid tranquilisation
- If the person is suspected to be under the influence of alcohol or illicit substances
- If the person has a known medical condition which may inhibit cardiopulmonary function e.g. obesity (when face down), asthma, heart disease etc. If the person's physical condition and/ or their expressions of distress give rise to concern, the restraint must stop immediately. monitoring of the individuals psychological and physical well-being for as long as clinically necessary after using physical restraint.

5.10 Arrangements for Rapid Tranquilisation / Chemical Restraint

- Chemical restraint must be used only for a person who is highly agitated, overactive or aggressive, is making serious threats or gestures towards others, is being destructive to their surroundings or when other therapeutic interventions have failed to contain the behaviour.
- Any decision to chemically restrain a person must be made by the multidisciplinary team. Any longer-term chemical restraint requirements should be risk assessed and

agreed and documented following MDT discussions.

- The use of medication to manage acutely disturbed behaviour must be a very short-term strategy designed solely to reduce immediate risk; this is distinct from treating any underlying mental illness.
- The associated term 'rapid tranquillisation' refers to intramuscular injections and oral medication. Oral medication should always be considered first. Please refer to the Rapid Tranquilisation algorithms (Appendix 2).
- Where rapid tranquillisation in the form of an intramuscular injection is required, the prescriber should indicate the preferred injection site having taken full account of the need to avoid face down restraint.
- Prescribers should also provide information to those who provide care regarding any physical monitoring that may be required as well as the medication to be used and the route of medication.
- In carrying out rapid tranquilisation, the patient must be able to respond to communication throughout the period of rapid tranquilisation. The aim of the rapid tranquilisation is to achieve a state of calm sufficient to minimise the risk posed to the patient or to others (NICE guidance 25). Medication for rapid tranquilisation, particularly in the context of physical intervention, should be used with caution owing to the following risks:

* Loss of consciousness instead of tranquilisation
* Sedation with loss of alertness
* Loss of airway
* Cardiovascular and respiratory arrest
* Interaction with medicines already prescribed or illicit substances taken
* Possible damage to patient-staff relationship
* Underlying physical disorders

- All staff involved in administering or prescribing rapid tranquillisation or monitoring patients to whom parenteral rapid tranquillisation has been administered, should receive ongoing competency training to a minimum of Immediate Life Support.
- Chemical restraint should be used only for a person who is highly agitated, overactive or aggressive, is making serious threats or gestures towards others, is being destructive to their surroundings or when other therapeutic interventions have failed to contain the behaviour.
- Any decision to chemically restrain a person should be made by the multidisciplinary

team. Any longer-term chemical restraint requirements should be risk assessed and agreed and documented following MDT discussions.

- The use of medication to manage acutely disturbed behaviour must be a very short-term strategy designed solely to reduce immediate risk; this is distinct from treating any underlying mental illness.
- The associated term 'rapid tranquillisation' refers to intramuscular injections and oral medication. Oral medication should always be considered first.
- Where rapid tranquillisation in the form of an intramuscular injection is required, the prescriber should indicate the preferred injection site having taken full account of the need to avoid face down restraint.
- Prescribers should also provide information to those who provide care regarding any physical monitoring that may be required as well as the medication to be used and the route of medication. Please refer to **Rapid Tranquilisation algorithms** at the back of this policy.

5.11 After care

After rapid tranquilisation is administered, staff must recognise the importance of nursing the patient in the recovery position (where safely possible). Staff must monitor and document vital signs on an observation chart. The need for neurological observations including level of consciousness must be assessed and documented on appropriate chart or Vital Pac. Patient hydration status must also be assessed staff should monitor and document vital signs namely***, Pulse, blood pressure, respiratory rate, temperature, level of hydration and level of consciousness at least every hour until there are no further concerns about their physical health status***. ***Vital signs must be monitored every 15 minutes if the maximum dose has been exceeded or the service user:***

- appears to be asleep or sedated
- has taken illicit drugs or alcohol
- has a pre-existing physical health problem
- has experienced any harm because of any restrictive intervention

5.12 Record Keeping

Any incident of challenging behaviour that has required restrictive interventions to be applied, must be documented in the patient's medical records and an incident

recorded as per the Trust Incident Management Policy. Documentation should include:

- Mental capacity assessment
- Best interests' assessment where required
- Type of behaviour displayed
- Reasons as to why the patient may be behaving in this way
- Restrictive physical intervention risk assessment
- Discussion with the patient, or patient's representative if the patient lacks capacity to understand the arrangements, regarding the use of restrictive physical intervention, in addition, where restrictive physical intervention is to be used the following must be documented:

* Type of restrictive physical intervention
* Rationale for the use of restrictive physical intervention
* Patient consent/non-consent for the use of restrictive physical intervention

- A plan of care must be completed with specified review times Restrictive Physical Interventions
- Must be a last resort
- Must aim to be in the best interest of the person – **but that can also be to stop them from hurting YOU!**
- Should risk assess for known concerns e.g. Poor balance, osteoporosis
- Should be part of the patient's care plan and clearly documented
- Staff will need to consider Deprivation of Liberty safeguards for those clients who lack capacity

5.13 Post incident reviews

Following an incident whereby restrictive interventions have been deployed it is best practice to undertake a post incident review. The aims of post-incident reviews are to:

- Evaluate the physical and emotional impact on all individuals involved (including any witnesses)
- Identify if there is a need for, and if so, provide counselling or support for any trauma that might have resulted
- Help people who use services and staff to identify what led to the incident and what could have been done differently
- Determine whether alternatives, including less restrictive interventions, were

considered

- Determine whether service barriers or constraints make it difficult to avoid the same course of actions in future
- Where appropriate, recommend changes to the service's philosophy, policies, care environment, treatment approaches, staff education and training
- Where appropriate avoid a similar incident happening on another occasion whenever a restrictive intervention has been used, staff and people should have separate opportunities to reflect on what happened. People with cognitive and/or communication impairments may need to be helped to engage in this process. People who use services should not be compelled to take part in post-incident reviews. They must be told of their right to talk about the incident with an independent advocate (which may include an independent mental health advocate or independent mental capacity advocate), family member or another representative. Immediate or post-incident reviews should:
- Acknowledge the emotional responses to the event
- Promote relaxation and feelings of safety
- Facilitate a return to normal patterns of activity
- Ensure that all appropriate parties have been informed of the event
- Ensure that necessary documentation has been completed
- Begin to consider whether there is a specific need for emotional support in response to any trauma that has been suffered. In more serious incidents a more in-depth review process, typically the next day, should be considered. Reviews should be in a blame free context. The aim being to understand from the person's point of view how the service failed to understand what they needed, what upset them and how things could be done better next time. The care team together with the person, their families and advocates should consider whether behaviour support plans or other aspects of individual care plans need to be revised /updated in response to the post-incident review. Any organisational factors such as the need for policy reviews, environmental modifications, staffing reviews or training needs must be formally recorded and reported.

5.14 When and how to call Security Officers/The Police

The Trust has a duty under the Health and Safety at Work Act 1974 to provide a safe and secure environment for its staff, patients and visitors. Staff are encouraged to call

security (or the police where security officers are not available i.e. community services), to inform them of any potential threats to staff or patient safety or if staff are being threatened or attacked. If security officers are available, they will call the police to assist if deemed necessary. Security staff (and police where appropriate) will remain until the patient has calmed down to a state where staff are no longer deemed at risk. Contact details for **Security Services can be contacted via switchboard on 01902 307999.** All incidents relating to physical intervention will be managed by the clinician, however where security officers are available, they are responsible for:

- Being fully conversant with this policy and relevant associated policies
- Assisting with patients who may require physical intervention
- Being competent to carry out physical interventions of patients when required
- Completing physical intervention training successfully
- Ensuring when carrying out physical interventions, that they take their lead from the clinician in charge
- Documenting all episodes of physical intervention through the Trust's / Contractors Incident Reporting Process. Careful consideration should be given to the degree of involvement by a security officer and/or the police. Some patients' behaviour deteriorates in the presence of a uniformed officer therefore it is appropriate in some circumstances that they maintain as low a profile as possible. The degree of intervention or interaction with the patient must be determined by the healthcare clinician and the security officers (or police) given instructions from them. Following the initial incident, security officers (or the police) must not be detained in the ward or clinical area for observation/deterrent purposes.

6.0 Audit / monitoring arrangements

Monitoring Process	**Requirements**
Who	ward/ department staff
Standards Monitored	types of 'restraint' used
When	quarterly monitoring
How	Incident Reporting via Datix
Presented to	Safeguarding Operational Group Mental Health Steering Group
Monitored by	Safeguarding Operational Group
Completion/Exception	**Safeguarding Committee**

reported to	

7.0 Training:

Training will be provided as identified in the Trust Training Needs Analysis. Security staff employed directly by the trust will be eligible for training specific to their role. Agencies who provide Security staff to work within The Royal Wolverhampton Trust are required to give assurance that their staff are appropriately trained. IKON management of challenging behaviour training will be provided by RWT, with in-house trainers responsible to deliver appropriate training to all front facing clinical staff

8.0 Definitions: Description of prevalent terms used in the document

Restraint The Royal College of Nursing (2008) defines restraint as 'stopping a person doing something they appear to want to do'. Under section 6(4) of the Mental Capacity Act 2005, someone is using restraint if they: Use force – or threaten to use force – to make someone do something they are resisting, or restrict a person's freedom of movement, whether they are resisting or not. Methods of restraint can be physical or chemical. For this policy, physical interventions can be skilled hands-on method of physical restraint involving trained designated healthcare professionals to prevent individuals from harming themselves, endangering others or seriously compromising the therapeutic environment. Its purpose is to safely immobilise the individual concerned.

Physical restraint or restrictive intervention

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

Mechanical restraint or restrictive intervention

Mechanical restraint refers to: 'the use of a device to prevent, restrict or subdue movement of a person's body, or part of the body, for the primary purpose of behavioural control'.

Chemical restraint or restrictive intervention

Chemical restraint refers to: 'The use of medication which is prescribed and administered for the purpose of controlling or subduing disturbed/violent behaviour,

where it is not prescribed for the treatment of a formally identified physical or mental illness'.

Bed Rails A device attached to either side of the bed. Bed rails may also be known as cot sides, side rails, bed guards, safety sides and split rails. They should not be used for restraining patients

Deprivation of Liberty:

The Human Rights Act 1998, Article 5 Right to Liberty and Security, means that no-one should be deprived of their liberty save in exceptional circumstances to do with lawful arrest and detention, for the prevention of spread of infectious diseases, for the safe detention of those of unsound mind and circumstances requiring deportation. In April 2009, the Deprivation of Liberty Safeguards assumes legal force and provides standards of care required to ensure that persons are not deprived of their liberty unlawfully. On the 19th March 2014 the Supreme Court ruled that 'All people who lack the capacity to make decisions about their care and residence and under the responsibility of the state, are subject to continuous supervision and control and lack the option to leave their care settings, **ARE** deprived of their liberty'. Harm To injure, hurt or abuse (Department of Health 2003).

Mental Capacity

Mental capacity is the ability to make an informed decision. This includes the ability to make a decision that affects daily life, such as when to get up, what to wear or whether to go to the doctor when feeling ill, as well as more serious or Significant decisions. It also refers to a person's ability to make a decision that may have legal consequences, for them or others. Examples include agreeing to have medical treatment, buying goods or making a will. A person must be assumed to have capacity unless it is established that they lack capacity. Capacity must be assessed using the two-stage test provided for in the **Mental Capacity Act 2005** and associated Code of Practice. (See RWT Integrated Mental Capacity Act Policy).

Posey Mitts

Mittens that can be worn by patients to prevent them from picking, scratching or interfering with invasive devices. Posey Mitts are designed for purpose and reduce the risk of contractures.

Proportionate Response:

Using the least intrusive type and minimum amount of restraint to achieve Specific outcome

Relational Security

Clients' needs are met through the development of trusting and genuinely Therapeutic relationships with the client by members of the care team within Safe and fully explained boundaries (Department of Health 2003).

Safe

Freedom from physical, mental, verbal abuse and/or injury to self and others (Department of Health 2003).

9.0 Legal and professional Issues

- Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenge. NICE guideline. May 2015
- Department of Health (2014) Positive and Proactive Care: reducing the need for restrictive interventions
- Nursing and Midwifery Council-(2015)-Code of Conduct
- Royal College of Nursing (2008) let's talk about restraint, rights, risks and responsibilities
- Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenge. NICE guideline. May 2015
- Violence and aggression: short term management in mental health, health and community settings NICE guideline May 2015
- Restraint Reduction Network standards. - 2025

10.0 References

National Institute of Health and Care Excellence (NICE)

https://stpsupport.nice.org.uk/cypmentalhealth/index.html

Mental Health Act (MHA)

https://www.legislation.gove.uk[ga/1983/20/contents

Royal College of Paediatrics and Child Health

https://www.rcph.ac.uk/key-topics/child-mental-health

Royal College of Emergency Medicine

https://rcem.ac.uk/wp-content/uploads/2022/09/RCEM-Acute-Insight-Series-Mental-Health-Emergency-Care.pdf

Department of Health (2014) Positive and Proactive Care: reducing the need for restrictive interventions

11.0 Related Polices:

Deprivation of liberties safeguards policy v2.1 01/2025

Health and Safety Policy v7.0 11/2024

Risk Management and Patient Safety Reporting Policy v17.9

Safeguarding adults' policy v2.0 09/2024

Safeguarding children's policy v6.2 02/2025

Conflict of Interest Policy

Mental Health Act Policy v1.5 03/2025

Enhanced Supervision policy

Right Care Right Person SOP (supersedes absconding, and Missing Person policies for Mental Health patients)

12.0 Appendices

Providing further information on any related documents, including step by step procedures forms, or guidance which are deemed relevant within document

Part A - Document Control

Policy Number & Version number: **CP21** V1.0	**Document Title** Restrictive Practice Policy (Children and Adults)	**Status:** Final		**Author:** L Evans, Matron – Mental Health **Chief Officer Sponsor:** Chief Nursing Officer
Version / Amendment History	Version	Date	Author	Reason
	1.0	Jan. 2026	Matron – Mental Health	New policy (supersedes CP59, Restraint Policy)
Intended Recipients: This policy is applicable to all staff who come into contact with CYP / Adults who present to the Trust in mental health crisis.				
Consultation Group / Role Titles and Date: Paediatric Governance Group Mental Health Steering Group Trust-wide policy group				
Name and date of group where reviewed	Mental Health Steering Group – March 2025 Trust Policy Group – January 2026			
Name and date of final approval committee	Trust Policy Group – January 2026			
Date of Procedure/Guidelines issue	January 2026			
Review Date and Frequency (standard review frequency is 4 yearly unless otherwise indicated – see section 3.8.1 of Attachment 1)	January 2030			

Training and Dissemination: Targeted emails, access to policies via the staff intranet.	
Publishing Requirements: Can this document be published on the Trust's public page: **Yes** If yes you must ensure that you have read and have fully considered it meets the requirements outlined in sections 1.9, 3.7 and 3.9 of OP01, Governance of Trust-wide Strategy/Policy/Procedure/Guidelines and Local Procedure and Guidelines, as well as considering any redactions that will be required prior to publication.	
To be read in conjunction with:	
Initial Equality Impact Assessment: Completed Yes **Full Equality Impact assessment (as required): Completed Yes** If you require this document in an alternative format e.g., larger print please contact Policy Management Officer for Trust- wide documents or your line manager or Divisional Management Office for Local documents.	
Contact for Review	Lee Evans, Mental Health Matron RWT.
Monitoring arrangements	Exceptions escalated via Patient Safety Group /Safeguarding Committee.
Document summary/key issues covered. This is a policy to guide staff members on when and how it may be appropriate to instigate 'restrictive practice' with our patients.	
Key words for intranet searching purposes	Crisis Mental Health CYP Self-harm Suicide / suicidal ideation

[Appendix 1] CYP pathway

Surname	Unit No
Forename	NHS No
Address	DOB
Postcode	(or affix patient label)

INITIAL ASSESSEMENT (Part A) TO COMMENCE IN ED AND Continuation of care if requiring treatment to be completed by PAU (Part B)

Patients Preferred Name: .....

Patients Preferred Pronoun: .....

Child and Young Person Crisis pathway

Service contact details	
CAMHS	*Eating Disorder Teams*
01922 607000 *01902 444144*	
CAMHS single point of access **01922 607 000** **01902 444144**	*Out of hours Black Country Mental Health Trust* **01922 607 000** **01902 444144**
	Dorothy Pattinson Hospital **01922 607000** **Penn Hospital** **01902 444144**

Important Contacts for the CYP		
Name	Relationship to CYP	Contact number

(Examples: parent, social worker, support worker etc…)

Document Guide:

Assessment Instructions for use.

This pathway should be used for all Children/Young People years who present to hospital with a mental health concern or appear to be in crisis.

.

All Trust healthcare professionals caring for Child/Young Person with a mental health or crisis concern must use this document to evidence the care given.

- Throughout admission the care plan should be readily accessible to all members of the multi-disciplinary team.
- On discharge the care plan must be filed in the Child/Young Person's medical records.

The pathway must be used in conjunction with

- Mental Health Act Policy
- Rapid Tranquilisation algorithms (adopted from Black Country Heath cares' MHLS guidance).

Advice and guidance must be sought from the CAMHS Crisis team. Tel: **01922 607 000 and out of hours 0800 008 6516**

The pathway is a legal record of care and documentation must conform to the standard required for any other part of the record i.e., dated, signed, timed and legible.

Completion of the signature sheet.

This ensures that those using the care plan can be identified. You can then use your initials in the care plan instead of your full signature and full name.

At the top of every page include Child/Young Person's name, unit number, and date of birth

Date and time all entries. Write in black ink.

Risk Assessment.

The risk assessment contained in this document describes the **minimum level of assessment** that should be completed for **all** Children/Young People who present with a mental health or crisis concern.

Section A: to be completed by the Emergency department.

- Complete document part A
- Offer patient We Can Talk Care Plan
- Complete CAMHS referral (Via ask EARL)
- Complete MARF if identified
- Complete RCEM risk assessment
- Complete RCEM care plan based on risk outcome.

Section B: is to be completed by PAU/ Ward.

- Transfer of care
- Review risk assessment (renew or update if risk behaviours have changed)
- Accept handover.
- Complete care plan
- Complete discharge planning

Section A:

Reason for admission:	

Item	Yes	No	Signature/ name stamp
Is the patient accompanied by an appropriate adult?			
Have you completed the room risk assessment tool? (as per ligature policy)			
Does the patient require a cubicle close to the nursing station?			
Other comments:			

Patient details	
Patient description	
Height, weight, Build	
Hair colour	
Eye colour	
Clothing	

Absconding patients (If required)				
	Yes	No	Time	Signature
Security contacted				
Parent/ guardian contacted				
Police contacted				
Police Log Number : (***insert here***)				
Social worker (if required)				
Incident report submitted				

My Care Plan

My name is..... My pronouns are.....

Date of attendance..... Hospital no.....

How do you feel?

Or choose from the below:

What can make me worse when I am struggling?

What is the best way to communicate with me when I am struggling?

What things can keep me safe?

How can you support me?

What's brought you here today?

Is the way you feel worse than normal?

Are there important people in my life?

Who could be here to support me?

General Likes

General Dislikes

RCEM CYP Risk Assessment Tool

To help determine the level of risk, **this tool is not to be used to make a decision for discharge.*

Assessment Categories		
1. Background history and general observations	**Yes**	**No**
• Immediate risk to self, you or others?		
• Does the young person have any **immediate** (i.e. within the next few minutes or hours) plans to harm self or others?		
• Is the young person aggressive and/or threatening?		
• Is there any suggestion, or does it appear likely that the young person may try and abscond?		
• Does he/she have a history of violence?		
• Has the young person got a history of self-harm?		
• Has the young person a history of mental health problems or known to CAMHS ?		
If yes to any of the above, record details below: If previous self-harm: How long ago was the last attempt? ……		
2. Appearance and behaviour	**Yes**	**No**
• Is the young person obviously distressed, markedly anxious or highly aroused?		
• Is the young person behaving inappropriately to the situation?		
• Is there a difference in the young person's baseline presentation?		
• Any safeguarding issues?		
If yes to any of the above, record details below:		

3. Issues to be explored through brief questioning		
Why is the young person presenting now? What recent event(s) precipitated or triggered this Presentation? Give Details below:		
• What is the young person's level of social support (i.e. family members, friends)? Give details below:		
	Yes	**No**
• Does the young person appear to be experiencing delusions or hallucinations?		
• Does the young person feel controlled or influenced by external forces?		
• Are there major housing or accommodation problems? i.e. homeless / serious safeguarding concerns		

If yes to any of the above, record details below:

4. Suicide risk screen – greater number of positive responses suggests greater level of risk

	yes	no	d/k		yes	no	d/k
Previous self-harm	☐	☐	☐	High lethality of previous attempt	☐	☐	☐
Bullying	☐	☐	☐	i.e. hanging/gassing/ jumping/drowning	☐	☐	☐
Suicide plan/expressed intent	☐	☐	☐	Sexuality Issues	☐	☐	☐
Current suicidal thoughts/ideation	☐	☐	☐	Family history of suicide	☐	☐	☐
Hopelessness/helplessness	☐	☐	☐	Lack of social support	☐	☐	☐
Depression	☐	☐	☐	Family concerned about risk	☐	☐	☐
Evidence of psychosis	☐	☐	☐	Disengaged from services	☐	☐	☐
Alcohol and/or drug misuse	☐	☐	☐	Poor compliance with treatment	☐	☐	☐
Chronic physical illness/pain	☐	☐	☐	Poor school performance	☐	☐	☐

Alcohol Consumption/ Illicit Drug Consumption

Was alcohol/ illicit drugs consumed as part of the act or within 6 hours of the act? (*Please circle*) Yes/No/Don't Know
If yes, what and how much ……

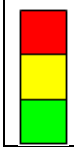
Current Contact with Services

At the time of attendance Is the patient receiving a service from CAMHS / social worker / Looked after child/ other (*Please circle*) Yes/No/Don't Know
If yes, please √ box and name service (e.g., CAMHS, Social services)

Service .....❑ CAMHS team.....❑
(i.e., has been seen by a member of the CAMHS team and has further appointments)

Diagnosis: (*Please circle*) Yes/No/Don't Know If yes, diagnosis: ……

What category of overall risk have you identified?
Give reasons and rationale for your decision



Signed: …… Designation: ……

Print Name: …… Date: ……

Formulation of assessment (prompts)
Refer to the risk assessment matrix below and summarize:

- What is the key problem?
- What is the level of risk – e.g. low, medium, high? Refer to Matrix below
- What is the level of supervision needed for the young person

Actions required before care planning completed:

Action required	Yes	No	Time	Staff Name	Comments
Check Fusion/Careflow for any known alerts (including CPIS)					
MARF Completion and Submission					
CAMHS / MHLS referral					

Circle the level of Risk identified and complete/ consider recommendations:

MENTAL HEALTH RISK ASSESSMENT MATRIX		
Level of risk	**Key assessment information**	**Nursing actions**
LOW RISK	• Mental health problem may be present, but person has no immediate thoughts of plans regarding harm to self or others. • May have already engaged in impulsive self-harming behaviour but now regrets actions and **has no a plan or thoughts relating to further self-harming behaviour**. • Young person and parent/guardian is confident about maintaining his/her own safety and will provide support on discharge.	• Referral to CAMHS managed by ED team • Can sit in waiting room, general Observations, reassess if young person becomes increasingly agitated • Provide relevant patient and carers leaflets/information. • Call CAMHS between the hours of 08:00- 18:00 for face-to-face assessment – time confirmation required. • Incident and escalate any delays in access to appropriate assessment (>4 hours).

MENTAL HEALTH RISK ASSESSMENT MATRIX		
Level of risk	**Key assessment information**	**Nursing actions**
MEDIUM RISK	• Mental health problem(s) present and/or has non-specific thoughts or ideas regarding harm to self or others – e.g. regrets that self-harm failed to lead to death, but no intention to undertake further self-harm. • There is no plan to act on self-harming or suicidal thoughts. • However, the young person's mental state is at risk of deterioration, and they may be physically vulnerable in certain circumstances.	• Referral to CAMHS managed by ED team • Place in ED cubicle near to nursing station • Place on Crisis observation chart for 30-minute check. (see crisis observation chart below). • Provide relevant patient and carer information. Incident and escalate any delays in access to appropriate assessment (>4 hours). Restraint / restrictive practice • At every opportunity de-escalation techniques are to be utilised, to support the patient to engage in care required. • Follow LEAST RESTRICTIVE practice to support patient care needs.

MENTAL HEALTH RISK ASSESSMENT MATRIX		
Level of risk	**Key assessment information**	**Nursing Actions**
•HIGH RISK	• Serious mental health problem(s) present, including possible features and symptoms of psychosis. • May well have definite plans to engage in further self-harming behaviour, or to harm others. • Has clearly identifiable risk characteristics, such as imminent thoughts or plans relating to self-harm (or harm to others) or suicide. • May have already engaged in self-injurious or self-harming behaviour, and *on-going suicidal intent remains.* • May lack capacity and competence to consent to or refuse on-going care and treatment. • Young person likely to act upon thoughts of self-harm or injury at the earliest opportunity. • Mental state will certainly deteriorate without intervention and will almost certainly be physically vulnerable. • Young person has made attempts to leave the department/ward or you have reason to believe they intend to do so.	• Refer to CAMHS for mental health assessment and a risk plan developed to address immediate or short-term risk indicators. • The young person's mental state may deteriorate and increase level of risk. • Place in cubicle close to Nursing station, with room risk assessment tool completed. • Identify level of observation required. - If deemed locally that a 1:1 is required, NIC to escalate as per local Enhanced supervision policy) (including security provision) - Observations can be continual or identified as 15 minute or 30-minute observations following the crisis observation chart. • If person is non-compliant, Common-Law powers should be used to temporarily detain the person pending a full mental health assessment. • Consider having security present if identified as a required need due to increasing levels of violence and aggression. • CAMHS/ MHLS face to face assessment to take place at the earliest opportunity, if there are delays in accessing support required, incident and escalate through appropriate channels. • Urgent response from CAMHS service should be offered within 1 hour or referral. Staff to complete incident forms if delays occur. • All reasonable attempts should be made to stop the person leaving the department before a mental health assessment. The presence of hospital security staff may be required. Observations if required for very high risk 1:1 observations to be discussed and agreed, i.e. – if 2:1 observations is required.

RWT Rapid Tranquilisation guidance – see Appendix 2.

Rapid Tranquilisation

1- Adhere to the guidance of the rapid tranquilisation policy.
2- Rapid Tranquilisation is to only be considered when least restrictive options have been evidenced and failed
3- The use of Rapid tranquilisation must be agreed by a CAMHS consultant, a lead medic in ED, a Paediatric medic and NIC. (Out-Of- Hours CAMHS Consultant to be contacted on 01902 414444 Penn Hospital Switchboard).
4- Administration of rapid tranquilisation to follow best practice as per guidelines.
5- If Lorazepam is used – equal volume of compatible solution. (1:1 water for injection)
6- Post administration observations to be completed as per policy.

Post rapid tranquilisation:

- *Observations every 15 minutes for the first hour*
- *Then hourly until no concerns (minimum of four hours)*

The Royal Wolverhampton
NHS Trust

Crisis Observation chart :

Date / Time	Mental State				
Signature	Calm	Distressed	Agitated	Aggressive	Absconded
Comments / Actions					
Date / Time	Mental State				
Signature	Calm	Distressed	Agitated	Aggressive	Absconded
Comments / Actions					
Date / Time	Mental State				
Signature	Calm	Distressed	Agitated	Aggressive	Absconded
Comments / Actions					
Date / Time	Mental State				
Signature	Calm	Distressed	Agitated	Aggressive	Absconded
Comments / Actions					
Date / Time	Mental State				
Signature	Calm	Distressed	Agitated	Aggressive	Absconded
Comments / Actions					
Date / Time	Mental State				
Signature	Calm	Distressed	Agitated	Aggressive	Absconded

Transfer of care

Transfer to PAU or Ward:

Action	Yes	No	N/A	Signed
Verbal Handover completed, including risk assessment and required observation levels.				
Adequate staff identified to complete transfer				
CAMHS referral complete				
MARF referral complete (if required)				
PEWS score:				
Crisis Risk identified (Low, medium, High)				
Completion of paediatric transfer risk assessment. (Physical Health)				
Wrist Band				

Discharged:

Action	Yes	No	N/A	Signed
Returned all belongings				
Mental Health Discharge pack provided.				
Discharge summary sent to GP				
Informed social worker or any relevant team.				
Wrist Band removed/ Any Cannulas removed				

Action checklist	Yes	No	N/A	Signed
Ensure transfer of care to/from (PAU/ Ward) is complete				
Discharge planning – CAMHS / Home etc				
Care Plan				
Risk assessment reviewed				
Risk assessment updated (if risk has changed)				

Section B

Escalation of concerns
Are there any barriers to discharge planning? Are there any delays in access to appropriate teams, i.e., CAMHS/ social care? Other:
What escalations have already taken place

Care plan

MY CARE PLAN	Patient Name: NHS No: Date of Care Plan: Review date: Mental Health Team Contact details:	Care Co-ordinator/core worker: Contact number: Appt frequency: Capacity/ Competence: MHA: Section 117 aftercare:

My goals:	To meet my goals we have agreed on the following plan:
To: - - - -	- - - -

To meet my goals we have agreed on the following plan:

How will I achieve this?	How will I know when I have got to where

My 'Wellness' Plan

What are my early warning signs?	What can I do to help myself?
- -	- -
How can others tell when I am not feeling my best?	What can others do to help me?

What I plan to do when in a crisis?	What I would like people to avoid doing? - -

My Current Medication
Who prescribes this for me:

Useful Contacts:

www.youngminds.org.uk **Text YM to 85258 24/7 text service** **www.mind.org.uk – 0300 123 3393** **www.childline.org.uk** **CALM helpline for men; calmzone.net** **0800 58 58 58** **PAPYRUS – 0800 068 4141** **Please insert names of care team familiar to you and their contact details**…… ……... ……	**The Samaritans: 116 123 (24 hour phone line)** **-Sane line (Mental Health Helpline): 0300 304 7000 (6pm-11pm daily)**	**CAMHS Team** (including the crisis team) Tel No:01922 607 000 My contact number……..
Who can have a copy of this care plan?	**Anything else that is important to my care?**	My care coordinator / core worker has produced this care plan with me and has also provided me with a copy of this. **Young Person's signature:** **Date:** **Patient or patients nominated representative:** **Signature:** **Date:**

Algorithm 1: Rapid Tranquillisation - Working Age Adult (18-65 years)

Aims:

- To reduce suffering for the patient: psychological or physical (through self-harm or accidents).
- To reduce risk of harm to others by maintaining a safe environment.
- To do no harm (by prescribing safe regimes and monitoring physical health).

De-Escalation & Non-Drug Approaches	
Use non-threatening, non-verbal communication	Maintain adequate distance
Ensure environment is conductive to calmness	Converse and try to develop a therapeutic relationship with patient throughout
Move to a safe place or seclude	

Administration of Rapid Tranquillisation

Before administering drugs for rapid tranquillisation:

Consult any advance decisions / statements. **Always offer oral medication first. If the total dose is above BNF limits you must contact the consultant psychiatrist.**	
Agree suitable therapeutic goal (e.g. level of sedation or control	Consider individual risk factors (e.g. physically ill patients may require lower doses than healthy adults).
Note previous medicines/response and total medicines in the last 24 hours (including regular).	Consider physical health, drug use & presentation

Unknown or Neuroleptic Naïve Patient Oral Medications: Lorazepam or risperidone	**Known & Confirmed History of Antipsychotic use:**
	Oral Medication: Lorazepam OR risperidone OR haloperidol AND promethazine
Allow at least 1 hour for response to oral. Continue non-drug approaches.	*Allow at least 1 hour for response to oral. Continue non-drug*

	If unsuccessful	
IM Medication: **Lorazepam** *Wait 30 minutes for response.* *Repeat if partial response.* *If no response:* **Haloperidol** *(Only after >1 hour post lorazepam IM).* **OR haloperidol** *with either* **promethazine** OR lorazepam *(only in patient with no cardiac disease*	**IM Medication:** **No cardiac disease** (confirmed by ECG) **Haloperidol** *with either* **promethazine** OR **lorazepam** *Wait 30 minutes for response.* *Repeat if partial response* *If no response* **lorazepam** OR *haloperidol*	**Unknown or confirmed cardiac disease** *Lorazepam or haloperidol* *Wait 30 minutes for response* *Repeat if partial or no response*

Oral Medication Dosing:	**IM Medication Dosing:**
Lorazepam 1-2mg (Max 4mg/24 hours)	**Lorazepam** 1-2mg (Max 4mg/24 hours)
Haloperidol 5-10mg (Max 20mg /24 hours)	**Haloperidol** 2.5-5mg (Max 12mg/24 hours)*
Promethazine 25-50mg (Max 100mg/24 hrs)	**Promethazine** 25-50mg (Max 100mg/24 hrs)
Risperidone 1-2mg (Max 6mg/24 hours)	

Ensure baseline & ongoing monitoring is recorded appropriately (where possible) on relevant monitoring form:

Oral PRN monitor hourly for minimum one hour on MEWS form. Further monitoring as clinically appropriate.

Algorithm 1: Rapid Tranquillisation - Working Age Adult (18-65 years)

a. Evidence
   i. The best evidence for benefit over risk of harm is for IM lorazepam used alone and the combination of IM haloperidol plus an IM promethazine.
   ii. When IM haloperidol is combined with IM promethazine there is some suggestion that risk of movement-related side effects may be reduced.
   Iii In contrast, the combination of an IM benzodiazepine plus IM haloperidol does not appear to be more effective than an IM benzodiazepine used alone.
   iv. While IM haloperidol used alone is more effective than placebo, it clearly carries greater risk of extrapyramidal and other side effects when compared with placebo or an IM benzodiazepine.

Choice depends on current treatment.
   i. If patient is established on antipsychotics, lorazepam may be used alone.
   ii. If the patient uses 'street drugs' or already receives regular benzodiazepines, an antipsychotic may be used alone.

Ensure procyclidine injection is available. Antipsychotics may cause acute dystonic reaction.

Ensure flumazenil injection is available to reverse effects of lorazepam injection.

The maximum dose of haloperidol is 20mg/24 hours by any (combined) route(s) – this should not be exceeded without obtaining specialist advice – and not more than 3 I/M doses may be given in any 24-hour period. **Wait 2 hours between doses.**

Intramuscular haloperidol, intramuscular lorazepam or intramuscular haloperido +promethazine must not be administered within 1 hour of each other.

Haloperidol IM is already diluted before administration.

Lorazepam should be mixed 1:1 with water for injection before injecting. The following table provides injection volumes for delivering various doses of lorazepam once diluted.

Dose of lorazepam Required	Volume of undiluted lorazepam (4mg/mL)	Volume diluted
0.5 mg (500mcg)	0.125mL	0.25mL
1.0mg	0.25mL	0.5mL

The maximum daily dose of haloperidol is either 20mg orally or 12mg by intramuscular injection. Maximum doses will need to be adjusted if a combination of both routes is used. The bioavailable equivalence of haloperidol being approximately 10mg oral: 6mg intramuscular.

The recommended dose of promethazine is 25mg to 50mg (including adolescents aged 16 years and over). The lower dose should normally be used initially and titrated upwards according to response if necessary. Repeat doses should not be considered within an hour of a previous dose and a maximum dose of 100mg in 24 hours should not be exceeded. Doses of up to 150mg have been used but this would be unlicensed use.

Algorithm 2: Rapid Tranquillisation – Older Persons (>65 years) excluding dementia

Aims:

- To reduce suffering for the patient: psychological or physical (through self-harm or accidents).
- To reduce risk of harm to others by maintaining a safe environment. · To do no harm (by prescribing safe regimes and monitoring physical health).

De-Escalation & Non-Drug Approaches:

Maintain adequate distance.	Use non-threatening, non-verbal communication
Ensure environment is conductive to calmness.	Converse and try to develop a therapeutic relationship with patient throughout
Move to a safe place or seclude	

Administration of Rapid Tranquillisation

Before administering drugs for rapid tranquillisation:

Consult any advance decisions / statements.	**Contact the consultant psychiatrist. If the total dose is above BNF limits you must consult**
Agree suitable therapeutic goal (e.g. level of sedation or control)	Consider individual risk factors (e.g. physically ill patients may require lower doses than healthy adults).
Note previous medicines/response and total medicines in the last 24 hours (including regular).	**Always offer oral medication first**

Unknown or Neuroleptic Naïve Patient:	**Known and Confirmed History of Antipsychotic use:**
Consider physical health, drug use & presentation **Oral Medication:** **Lorazepam** OR *Risperidone* OR **haloperidol AND lorazepam** *Allow at least 1 hour for response to oral approaches. If unsuccessful or patient refuses:* **IM Medication:** **Lorazepam** Unknown or confirmed cardiac disease *Wait 30 minutes for response.* *Repeat if partial response.* *If no response:* **Haloperidol** with either **promethazine** OR **lorazepam** *Wait 30 mins for response.* *Repeat if partial response.*	**Oral Medication:** **Promethazine** *If unsuccessful or patient refuses:* **IM Medication:** Lorazepam OR haloperidol No cardiac disease (confirmed by ECG) *Wait 30 mins* *Repeat if partial response. (Only after >1 hour post lorazepam IM).*

Oral Medication Dosing:	**IM Medication Dosing:**
Lorazepam 0.5-1mg (Max 2mg/24 hours)	**Lorazepam** 0.5-1mg (Max 2mg/24 hours)
Haloperidol 0.5-1mg (Max 3mg /24 hours)	**Haloperidol** 0.5mg (Max 3mg/24 hours)
Promethazine 10-25mg (Max 50mg/24 hrs)	**Promethazine** 12.5-25mg (Max 50mg/24 hrs)

Algorithm 2: Rapid Tranquillisation – Older Persons (>65 years) excluding dementia

a. Evidence
   i. The best evidence for benefit over risk of harm is for IM lorazepam used alone and the combination of IM haloperidol plus an IM promethazine
   ii. When IM haloperidol is combined with IM promethazine there is some suggestion that risk of movement-related side effects may be reduced.
   iii. In contrast, the combination of an IM benzodiazepine plus IM haloperidol does not appear to be more effective than an IM benzodiazepine used alone.
   iv. While IM haloperidol used alone is more effective than placebo, it clearly carries greater risk of extrapyramidal and other side effects when compared with placebo or an IM benzodiazepine.

b. Choice depends on current treatment.
   i. If patient is established on antipsychotics, lorazepam may be used alone.
   ii. If the patient uses 'street drugs' or already receives regular benzodiazepines, an antipsychotic may be used alone.

c. Ensure procyclidine injection is available. Antipsychotics may cause acute dystonic reaction.

d. Ensure flumazenil injection is available to reverse effects of lorazepam injection.

e. The maximum dose of olanzapine is 20mg/24 hours by any (combined) route(s) – this should not be exceeded without obtaining specialist advice – and not more than 3 I/M doses may be given in any 24-hour period. Wait 2 hours between doses.

f. Intramuscular haloperidol and intramuscular lorazepam must not be administered within 1 hour of each other.

g. Lorazepam should be mixed 1:1 with water for injection before injecting. The following table provides injection volumes for delivering various doses of lorazepam once diluted.

Dose of lorazepam Required	Volume of undiluted lorazepam (4mg/mL)	Vol after dilution
0.5 mg (500mcg)	0.125mL	0.25mL
1.0 mg	0.25mL	0.5mL

h. The maximum daily dose of haloperidol is either 5mg orally or 5mg by intramuscular injection. Maximum doses will need to be adjusted if a combination of both routes is used. The bioavailable equivalence of haloperidol being approximately 10mg oral: 6mg intramuscular.

i For promethazine, in the elderly, (and in physically debilitated patients and those with impaired renal, hepatic, cardiac or respiratory function), there are no specific dose recommendations but lower doses should be considered and particular caution should be exercised in patients with a diagnosis of dementia.

Algorithm 3: Rapid Tranquillisation – Dementia Services

Aims:

- To reduce suffering for the patient: psychological or physical (through self-harm or accidents).
- To reduce risk of harm to others by maintaining a safe environment.
- To do no harm (by prescribing safe regimes and monitoring physical health).

De-Escalation & Non-Drug Approaches	
Maintain adequate distance.	Use non-threating, non-verbal communication
Ensure environment is conductive to calmness. Move to a safe place or seclude	Converse and try to develop a therapeutic relationship with patient throughout

Before administering drugs for rapid tranquillisation:

Consult any advance decisions / statements.	If the total dose is above BNF limits you must contact the consultant psychiatrist.
Agree suitable therapeutic goal (e.g. level of sedation or control)	Consider individual risk factors (e.g. physically ill patients may require lower doses than healthy adults).
Note previous medicines/response and total medicines in the last 24 hours (including regular medications).	Always offer oral medication first

Consider physical health & presentation

Unknown or Neuroleptic Naïve Patient:

Oral Medication:
Lorazepam OR **Promethazine**
Allow at least 1 hour for response to oral. Continue non-drug approaches.

If unsuccessful or patient refuses:

IM Medication:
Lorazepam

Wait 30 minutes for response.

Repeat if partial or no response.

Known and Confirmed History of Antipsychotic use:

Lorazepam
OR **Haloperidol** AND **Promethazine**
Extreme caution in use haloperidol in Lewy Body dementia or Parkinson's disease dementia

Allow at least 1 hour for response to oral. Continue non-drug approaches. If unsuccessful or patient refuses:

IM Medication:

No cardiac disease (confirmed by ECG)	**Unknown or confirmed cardiac disease**
Haloperidol AND **Promethazine** Wait 30 minutes for response. Repeat if partial or no response.	**Lorazepam** Wait 30 minutes for response. Repeat if partial response. If no response: Lorazepam

Oral Medication Dosing:	**IM Medication Dosing:**
Lorazepam 0.5mg – 1mg (Max 2mg/24 hours)	**Lorazepam** 0.5-1mg (Max 2mg/24 hours)
Haloperidol 0.5 -2.5mg (Max 5mg/24 hours)	**Haloperidol** 1.0-2.5mg (Max 5mg/24 hours)
Promethazine 10mg -25mg (Max 50mg/24 hours)	**Promethazine** 25-50mg (Max 100mg/24 hrs)

Algorithm 3: Rapid Tranquillisation – Dementia Services

a. Evidence
   i. The best evidence for benefit over risk of harm is for IM lorazepam used alone and the combination of IM haloperidol plus an IM promethazine.
   ii. When IM haloperidol is combined with IM promethazine there is some suggestion that risk of movement-related side effects may be reduced.
   iii. In contrast, the combination of an IM benzodiazepine plus IM haloperidol does not appear to be more effective than an IM benzodiazepine used alone.
   iv. While IM haloperidol used alone is more effective than placebo, it clearly carries greater risk of extrapyramidal and other side effects when compared with placebo or an IM benzodiazepine.

b. Choice depends on current treatment.

c. Ensure procyclidine injection is available. Antipsychotics may cause acute dystonic reaction.

d. Avoid antipsychotics in patients with Lewy Body Dementia

e. Ensure flumazenil injection is available to reverse effects of lorazepam injection.

f. Lorazepam should be mixed 1:1 with water for injection before injecting. The following table provides injection volumes for delivering various doses of lorazepam once diluted.

Dose of lorazepam Required	Volume of undiluted lorazepam (4mg/mL)	Vol after dilution
0.5	0.125mL	0.25mL
1.0	0.25mL	0.5mL

g. The maximum daily dose of haloperidol is either 5mg orally or 5mg by intramuscular injection. Maximum doses will need to be adjusted if a combination of both routes is used. The bioavailable equivalence of haloperidol being approximately 10mg oral: 6mg intramuscular.

h. For promethazine, in the elderly, (and in physically debilitated patients and those with impaired renal, hepatic, cardiac or respiratory function), there are no specific dose recommendations but lower doses should be considered and particular caution should be exercised in patients with a diagnosis of dementia.

Algorithm 4 Rapid Tranquillisation – Learning Disabilities

De-Escalation & Non-Drug Approaches	
Maintain adequate distance.	Use non-threating, non-verbal communication
Ensure environment is conductive to calmness. Move to a safe place or seclude	Converse and try to develop a therapeutic relationship with patient throughout

Before administering drugs for rapid tranquillisation:

Consult any advance decisions / statements.	If the total dose is above BNF limits you must contact the consultant psychiatrist.
Agree suitable therapeutic goal (e.g. level of sedation or control)	Consider individual risk factors (e.g. physically ill patients may require lower doses than healthy adults).
Note previous medicines/response and total medicines in the last 24 hours (including regular medications).	Always offer oral medication first

Consider physical health & presentation

Unknown or Neuroleptic Naïve Patient:

Oral Medication:
Lorazepam OR **Promethazine**
Allow at least 1 hour for response to oral. Continue non-drug approaches.

If unsuccessful or patient refuses:

IM Medication:

Lorazepam

Wait 30 minutes for response.

Repeat if partial response

If no response:
Haloperidol (only after >1 hour post lorazepam IM) OR **haloperidol** AND **Promethazine** *(in patient with no cardiac disease – confirm by ECG)*

Known and Confirmed History of Antipsychotic use:

Oral Medication:
Lorazepam OR **Haloperidol** AND **Promethazine**
Allow at least 1 hour for response to oral. Continue non-drug approaches.

If unsuccessful or patient refuses:

IM Medication:

No cardiac disease (confirmed by ECG)	Unknown or confirmed cardiac disease
Haloperidol AND **Promethazine** Wait 30 minutes for response. Repeat if partial or no response.	**Lorazepam** Wait 30 minutes for response. Repeat if partial response. If no response: Lorazepam OR haloperidol

Oral Medication Dosing:	IM Medication Dosing:
Lorazepam 0.5mg – 1mg (Max 2mg/24 hours)	**Lorazepam** 0.5-1mg (Max 2mg/24 hours)
Haloperidol 0.5 -2.5mg (Max 5mg/24 hours)	**Haloperidol** 1.0-2.5mg (Max 5mg/24 hours)
	Promethazine 12.5mg – 25mg (Max 50mg/24 hours

Algorithm 4: Rapid Tranquillisation – Learning Disability

a. Evidence
   i. The evidence for use in patients with learning disability is limited and extrapolated from adult
   ii. The best evidence for benefit over risk of harm for general adult population is for IM lorazepam used alone and the combination of IM haloperidol plus an IM promethazine.
   iii. When IM haloperidol is combined with IM promethazine there is some suggestion that risk of movement-related side effects may be reduced.
   iv. In contrast, the combination of an IM benzodiazepine plus IM haloperidol does not appear to be more effective than an IM benzodiazepine used alone.
   v. While IM haloperidol used alone is more effective than placebo, it clearly carries greater risk of extrapyramidal and other side effects when compared with placebo or an IM benzodiazepine.

b. Choice depends on current treatment.
   i. Particular consideration needs to be given to the higher susceptibility of patients with learning disability to side effect and the potential for paradoxical reactions to benzodiazepines.
   ii. If patient is established on antipsychotics, lorazepam may be used alone.
   Iii. If the patient uses 'street drugs' or already receives regular benzodiazepines, an antipsychotic may be used alone.

c. Ensure procyclidine injection is available. Antipsychotics may cause acute dystonic reaction.

d. Ensure flumazenil injection is available to reverse effects of lorazepam injection.

e. The maximum dose of olanzapine is 20mg/24 hours by any (combined) route(s) – this should not be exceeded without obtaining specialist advice – and not more than 3 I/M doses may be given in any 24-hour period. Wait 2 hours between doses.

f. Intramuscular Haloperidol, intramuscular lorazepam or intramuscular promethazine must not be administered within 1 hour of each other.

g. Lorazepam should be mixed 1:1 with water for injection before injecting.
The following table provides injection volumes for delivering various doses of lorazepam once diluted.

Dose of lorazepam required	Volume of undiluted lorazepam (4mg/mL)	Vol after dilution
0.5	0.125mL	0.25mL
1.0	0.25mL	0.5mL

h. The maximum daily dose of haloperidol is either 20mg orally or 12mg by intramuscular injection. Maximum doses will need to be adjusted if a combination of both routes is used. The bioavailable equivalence of haloperidol being approximately 10mg oral: 6mg intramuscular.

i. For promethazine, in LDS, (and in physically debilitated patients and those with impaired renal, hepatic, cardiac or respiratory function), there are no specific dose recommendations but lower doses should be considered

Specialist advice for working outside the appropriate algorithm

(NB. Recommended adult doses are quoted. Doses will usually be lower in the elderly, those with a learning disability and in children and young people).

10.1 Advice must be sought from the consultant or appropriate specialist, at any stage of RT, if any doubt exists regarding how best to proceed or if the treatment algorithms have been followed and there is no improvement.

10.2 Physical illness should be re-investigated.

10.3 **They may only be prescribed by a consultant psychiatrist or appropriate specialist who has previous experience of their use.** Any decision to use these treatments must only be taken when more conventional treatments have failed and the reason for use must be fully documented in the patient's notes. The advice below relates to use in adults.

10.4 Levomepromazine 12.5-50mg IM is highly sedative. Avoid in adults over 50 years due to significant hypotensive effects. Avoid in children and adolescents. This is not recommended as an RT treatment (NICE and BAP)

10.5 Aripiprazole 9.75mg IM can be considered however NICE did not recommend its use due to lack of evidence of efficacy in rapid tranquillisation compared to the recommended agents. BAP 2018 stated that aripiprazole IM is effective.

Aripiprazole is less hypotensive and sedative than olanzapine, and may be considered on these grounds.

10.6 IM Midazolam **can no longer be considered (outside ITU)** due to the relatively a relatively high risk of respiratory depression. It is on the Department of Health's Never Events List 2012/2013. The NPSA continues to advice restricted use outside theatres and ITU, except in Palliative, End-Of-Life care

Appendix 3 – Observation Record Sheet

Affix Patient Label

Name……..

Reg No……..

Date of Birth…….

Date		Hospital site and ward	
Time	**Name of observing member of staff**	**Job title/Grade** Please include if employed by RWT or via Nursing Agency – and which	**Note of engagement undertaken during time and observations made** (to include times and whereabouts of patient when intermittent checks were made if patient on Level 1 or 2 observations, please also include the patient's perspective)
00:00 – 01:00			
01:00 – 02:00			
02:00 – 03:00			
03:00 – 04:00			
04:00 – 05:00			
05:00 – 06:00			
06:00 – 07:00			
07:00 – 08:00			
08:00 – 09:00			
09:00 – 10:00			
10:00 – 11:00			
11:00 – 12:00			
12:00 – 13:00			
13:00 – 14:00			
14:00 – 15:00			
15:00 – 16:00			
16:00 – 17:00			
17:00 – 18:00			
18:00 – 19:00			
19:00 – 20:00			
20:00 – 21:00			
21:00 – 22:00			
22:00 – 23:00			
23:00 – 00:00			

Notes to assist handover

Appendix 4 – Risk Assessment Template

(Insert own details and location)

Location		Lead Assessor		Assessment Number	NHS:
Department				Assessment Date	

Activity

Description of task / process / environment being assessed	.							
Activities Involved								
Who can be harmed	Staff	Patient	Visitors / Public	Contractors	Acceptable level	Risk managed by Ward/dept/ service manager	Reviewed by Directors to confirm it is non corporate	Reviewed by Directors to confirm it is non corporate

Likelihood	1	2	3	4	5
1	1	2	3	4	5
2	2	4	6	8	10
3	3	6	9	12	15
4	4	8	12	16	20
5	5	10	15	20	25
	Consequences				

Likelihood X **Consequences**

Rating 1 = Rare
Rating 2 = Unlikely
Rating 3 = Possible
Rating 4 = Likely
Rating 5 = Almost certain

Rating 1 = Insignificant
Rating 2 = Minor
Rating 3 = Moderate
Rating 4 = Major
Rating 5 = Catastrophic

No	Tell us what the hazards are	Tell us how can people be harmed	Likelihood	Consequences	Risk (LXC)	Tell us what your current control measures are to prevent people from being harmed	Risk Evaluation			Additional control needed? Action No
							Likelihood	Consequences	Risk (LXC)	
1										
2										
3										
4										
5										
6										
7										

Control Improvements

Action No	Recommended additional control measures	Responsibility	Target Date	Date completed
1		Nurse in charge		

Additional Notes

	 ☐	 ☐	 ☐	 ☐	 ☐	 ☐	 ☐	 ☐	☐
Specification									

PPE Required

Declaration

If the above control measures are implemented as the risks posed by task / process / environment assessed will be controlled to as low as is reasonably practicable.

Persons involved in assessment	
Signature of Lead Assessor	Date

Reviews – this assessment should be reviewed at intervals no greater than 12 months or when there are changes in operational procedure, personnel or the work environment.

Review date	Comments	Reviewed by	Signature

Review date	Comments	Reviewed by	Signature

Notes:
1. A copy of this document must be kept within the working areas accessible to all staff.
2. An electronic copy of this document must be forwarded to Hayley Harvey Health and Safety Admin Coordinator by the specified date

Appendix 5 – A.B.C. Chart

A.B.C Chart

Patient name:

DATE	ANTECEDENT	BEHAVIOUR	CONSEQUENCE	
	Reason for behaviour What happened/Who did what immediately?	What occurred? What did the patient do? What did the patient say?	Staff's reaction to the patient, how the situation was dealt with.	Did the tactic have the desired effect? How did the patient react? How long until they calmed down?

Mental Capacity Assessment for adults and young people

NHS Trust

The first principle of the Mental Capacity Act 2005 is that a person must be assumed to have capacity to make a decision or act for themselves unless it is established that they lack capacity for the specific decision. Before deciding that someone lacks capacity to make a particular decision it is important to take all practical and appropriate steps to enable them to take that decision themselves.

Surname	Unit No
Forename	NHS No
Address	DOB
Postcode	(or affix patient label)

Please tick if this assessment applies to: ☐ A young person (16-17 years) ☐ An adult (18 years or over)

What is the specific decision that needs to be made?

.....

.....

Two stage test of mental capacity: Diagnostic element

As part of the decision-making process can the person:

Understand the evidence relevant to the specific decision?

What evidence indicates that the person can or cannot understand the information? .....

.....

.....

Retain information?

What evidence indicates that the person can or cannot retain information?.....

.....

.....

Weigh up information?

What evidence indicates that the person can or cannot weigh up information?.....

.....

.....

Can the person communicate their decision verbally or non-verbally?

What evidence indicates that the person can or cannot communicate their decision?.....

.....

.....

Patient Name: .....NHS No:..... Unit Number:.....

Functional element

Does the person have an impairment of the mind or brain, or is there some sort of disturbance affecting the way their mind or brain works? This may be permanent or temporary, ☐ Yes ☐ No

If Yes, provide detail.....

.....

.....

.....

.....

If no. No further action required.

Does that impairment or disturbance mean that the person is unable to make the decision in question at the time it needs to be made? ☐ Yes ☐ No

Outcome of Mental Capacity Assessment:

On the balance of probabilities, there is reasonable belief that:

☐ The person has capacity to make this decision at this time

Or

☐ The person does not have capacity to make this particular decision at this time

If the person is assessed as lacking capacity then a best interest meeting must be considered and documented in the notes.

Detail of Assessor:

Name:.....
Signature:.....Designation:.....

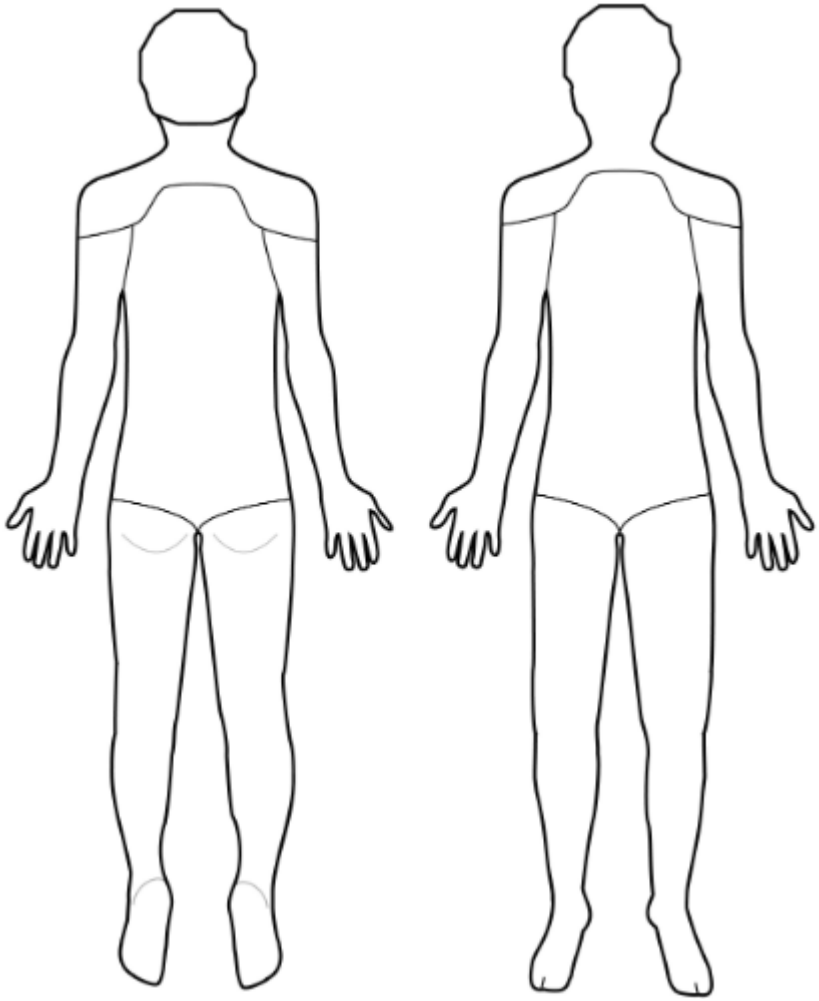
Date:.....Time:..... Stamp

The Royal Wolverhampton NHS Trust

Appendix 7 – Body Map for post-restraint

Patient's NHS number:_____

Print, use and attach these front and back body-map diagrams to detail any marks/injuries sustained by the patient as part of any restraint process. Ensure these are saved within the patient notes.



Appendix 8 - Therapeutic Observation & Engagement – Risk Assessment & Care Plan

Mental Health Act Status (please indicate if the person is detained under the Mental Health Act, and if so, which section?						
Is the patient under a DOLS?				**Yes**	**No**	**N/A**
Does the patient have capacity?	**Yes**	**No**	**Capacity assessment completed/documented?**	**Yes**	**No**	**N/A**
Has a safeguarding referral been completed? (if deemed necessary)				**Yes**	**No**	**N/A**
Risk Assessment Questions			**Risk**	**Additional information**		
Suicide						
Is there a current risk?			**10**	Patient verbalising intent – refer to PLT and inform medical team.		
Is there an historical risk?			**4**	Only include last 12 months		
No known risk			**0**			
Self-harm						
Is there a current risk?			**8**	Patient verbalising intent – refer to PLT and inform medical team.		
Is there an historical risk?			**4**	Only include past 12 months.		
No known risk			**0**			
Harm / Violence to others						
Is there a current risk?			**10**	Patient verbalising intent / refer to restraint procedure / inform patient of actions required / contact security team.		
Is there an historical risk?			**4**			
No known risk			**0**			
Self-Neglect						
Is there a current risk?			**4**			
Is there an historical risk?			**2**			
No known risk			**0**			

Harm from others		
Is there a current risk?	**4**	Ensure Security are aware / complete safeguarding referral
Is there an historical risk?	**2**	
No known risk	**0**	
Risk to Children		
Is there a current risk?	**8**	Inform Safeguarding team / complete safeguarding referral if required.
Is there an historical risk?	**4**	
No known risk	**0**	
Disengagement from Services / Absconding		
Is there a current risk?	**8**	
Is there an historical risk?	**4**	
No known risk	**0**	
Involvement with forensic / criminal justice services		
Is there a current risk?	**3**	
Is there an historical risk?	**2**	
No known risk	**0**	
Substance misuse		
Is there a current risk?	**3**	
Is there an historical risk?	**2**	
No known risk	**0**	
Accidents / Falls		Complete falls risk assessment
Is there a current risk?	**5**	
Is there an historical risk?	**2**	
No known risk	**0**	
Associated Physical / Medical Condition		
Is there a current risk?	**3**	
Is there an historical risk?	**2**	
No known risk	**0**	
Total		

Any other risks identified?	
Date / time	**Detail other risks identified:**

Level of agreed observation	
0 – 3 Level 1	**4 – 7 Level 2**
General observations, patient's location, safety must be visibly checked every hour. Patient can be cohorted. If situation / behaviour or condition changes, then consider increasing the level of supervision or escalate.	**Intermittent observations – the patient's location and safety must be visibly checked at specified intervals, please state the frequency of observations, i.e. every 5, 15, 30 minutes. Patient can be cohorted.**
8 - 9 Level 3	**10 + Level 4**
Continuous observation with the patient remaining in the full and interrupted eyesight of at lease one staff member at all times.	**Continuous observation with the patient remaining within arms length of at least one member of staff at all times. If level 3 or 4 please indicate how many people are required to provide observation, i.e. 1:1, 2:1 or other – please specify.**

Who is to provide this level of support				
CSW	Nursing Associate	Registered Nurse / Midwife	Registered Nurse – Mental Health	Specialist support required (Y / N) e.g. mental health nurse with CAMHS or eating disorder experience.

Date / time observation commenced	**Date / time review due (1st review must be no more than 24 hours after observation implemented)**

Full name and designation of person completing form

Who has been involved in the discussion and decision-making process to complete the risk assessment (please list all staff including job role)

Care plan
Risk Management plan – how are the risks identified above mitigated? (e.g. removal of ligature equipment to minimise potential ligature risk/patient to be nursed in side room/ engagement with 1:1 staff/access to telephones/internet/visitors/access to personal items including razors, bathroom privacy or supervision etc)
Action to take if patient tries to abscond/leave ward (Consider what action should take place if patient is under a DOLs or if the patient is detained under the Mental Health Act and can't legally leave, or if the patient has capacity to make the decision to leave against medical advice etc / document any discussions with patient about proposed actions).
Medication information (are there any medications that must be given/can't be omitted including medication that can be given against the patients will – covered under Section 3 of the Mental Health Act. Advice can be sought from Pharmacy including availability of specific mental health medication).
Escort level off the ward (please detail whether the patient is able to leave the ward area (for example to go to the shop or smoking arrangements) and if so, what necessary arrangements are in place for this i.e. security required, increase of staff levels, if family or visitors are able to be part of the escort. This includes if the patient needs to leave the ward area of medical reasons. This must include what contingency plans are in place for example if the patient's presentation does not appear to be settled to allow time off ward and what action must take place if the patient fails to return to the ward area).
Does the patient have any complex needs or specialist requirements? (please indicate what these are, who will provide theses and how these will be mitigated if not available, for instance patient requires a specialist eating disorders or CAMHS Nurse, this can also include if the patient has a learning disability, or autism, or if there is a DOLS inn place)

Therapeutic engagement and interventions – what is expected of the staff member providing supportive and therapeutic observations? (e.g. provision of activities, things to talk about, observations of presentation, mood, mental state, thoughts, behaviours, supporting or prompting for activities of daily living such as mealtimes, personal care, physical health care needs).
What action needs to occur in order for the level of observation to be decreased (in line with least restrictive practices) (e.g. concordance with physical health treatments/investigations required, engaging with staff, reduction of incidents, such as self-harm attempts).
Patient's views and wishes
Who has been involved in the discussions and decision-making process to complete the care plan above (please list all staff involved including job role)
Daily reviews and Reassessment of Risk Observation level must be reviewed on a daily basis, any changes made must be outlined below and reflected in the care plan and risk assessment document being updated.

Date/Time	Level of observation changed (Y/N)	Details of changes made	Print name, job title and sign