journey to change

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

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Safe Use of Mechanical Restraints Equipment

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Overarching policy: Supporting Behaviours that Challenge

Contents

1 Introduction

This procedure outlines the rationale and guidance underpinning the use of Mechanical Restraint Equipment within TEWV.

Any use of restrictive interventions within TEWV should always be considered as a last resort , clearly identified as the least restrictive option and should be for the shortest amount of time possible.

Any use of mechanical restraint should always be considered in conjunction with Chapter 26 of the Mental Health Act Code of Practice (2015).

Our Journey To Change sets out why we do what we do, the kind of organisation we want to become and the way we will get there by living our values, all of the time. To achieve this, the Trust has committed to three goals.

This procedure supports all three goals of Our Journey To Change.

1.1 Strategic goal 1: To co-create a great experience for patients, carers and families

Implementing this procedure provides assurance to patients, carers and families that any use of mechanical restraint is clearly defined, and the appropriate levels of care are offered to patients in what is often a very difficult and challenging time

Due to the seriousness of the use of this type of approach the procedure articulates the monitoring, reporting and oversight required when this approach is used

Importantly, patients, carers and families can be assured that patients' dignity and physical wellbeing will be supported at all time

1.2 Strategic goal 2: To co-create a great experience for our colleagues

The procedure will ensure that colleagues understand their roles and responsibilities, including for the approval, recording, monitoring and review of use of mechanical restraints equipment and any follow up actions. When staff understand their roles and their duties, they can be confident that the actions that they take are appropriate and consistent with best practice.

1.3 Strategic goal 3: To be a great partner

Procedures that ensure the safety and wellbeing of patients, including from ongoing monitoring and oversight assists the Trust when working with key partners either to improve services or to jointly care for patients.

1.4 Trust values and behaviours

Having clear definitions for mechanical restraints equipment and related care and support will help to ensure we live our values of respect, compassion, and responsibility.

2 Purpose

Following this procedure will help the Trust to: -

- Ensure the physical safety and mental wellbeing of the patient.
- Ensure the use of mechanical restraints are considered in accordance with the organisation's commitment to the reduction of restrictive interventions.
- To practice in accordance with the relevant legal frameworks, protecting the human rights of patient.
- Ensure the patient receives trauma informed care rendered necessary when utilising mechanical restraints.
- Distinguish between the different levels of mechanical restraint in relation to tiered behavioural support i.e., movement to seclusion/segregation
- Ensure all staff are aware of their roles and responsibilities regarding the use of Mechanical Restraints.
- Set requirements for recording, monitoring, and reviewing the use of mechanical restraint and any follow up actions from usage.

3 Who this procedure applies to

- Those patients identified as receiving support using mechanical restraint equipment
- Staff involved in the implementations, monitoring or governance of the use of mechanical restraint

4 Related documents

The Person Centred Behaviour Support Policy https://intranet.tewv.nhs.uk/download.cfm?doc=docm93jijm4n1278.pdf&ver=9772 defines the standards for care and treatment in support those with behaviours challenge which you must read, understand and be trained in before carrying out the procedures described in this document.

This procedure also refers to:-

- Harm Minimisation Policy: Ref CLIN-0017 https://intranet.tewv.nhs.uk/download.cfm?doc=docm93jijm4n1265.pdf&ver=10297
- Safe use of Physical Restraint Techniques Procedure, Ref CLIN-0019-002 https://intranet.tewv.nhs.uk/download.cfm?doc=docm93jijm4n1303.pdf&ver=9778

- Seclusion and segregation Procedure , Ref CLIN 0019 001 https://intranet.tewv.nhs.uk/download.cfm?doc=docm93jijm4n1312.pdf&ver=3436
- Procedure for addressing verbal aggression towards staff by patients, carers and relatives Ref CLIN-0019-003 https://intranet.tewv.nhs.uk/download.cfm?doc=docm93jijm4n1334.pdf&ver=3449
- Human Rights, Equality and Diversity Policy, Ref: HR-0013 https://intranet.tewv.nhs.uk/download.cfm?doc=docm93jijm4n1360.pdf&ver=7521

5 Definitions

Term	Definition
Restrictive Interventions	An intervention that prevents a person from behaving in ways that threatens to cause harm to themselves, to others, or to Trust property and/or equipment.
Mechanical Restraint	A form of restrictive intervention that 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.
Risk Assessment	A systematic process of evaluating the potential risks that may be involved in a patients care plans and Behaviour Support Plan.
Behaviour that Challenges	Behaviour that is in response to and communicates unmet needs when an individual struggles to communicate their needs in other ways often due to factors such as anxiety, neglect, abuse, learning disabilities and conditions like dementia.
Behaviour Support Plan	A plan that assists a member in building positive behaviours to replace or reduce a challenging/dangerous behaviour. This plan may include teaching, improved communication, increasing relationships, and using clinical interventions.
Ministry of Justice Order Patients	The assessment, admission, treatment (and rehabilitation) of psychiatric patients with forensic/criminalised behaviour that poses significant risk or harm to self and others.

6 Use of Mechanical Restraints

6.1 Introduction

Patients experiencing behavioural distress must always be supported using the guiding principles set out with the Trust Policy for Supporting Behaviours that challenge.

TEWV acknowledge that situations may occur when a patient's behavioural distress can lead to an imminent and significant risk to life and Mechanical restraint may need to be considered as a clinical intervention to mitigate the immediate risks.

The instigation by staff of mechanical restraint is a highly restrictive intervention. This restriction should only be used when all other interventions have been attempted to support the patient in reducing behavioural disturbance and attempts of self- harm. The application of the least restrictive option should always be considered.

6.2 What are Mechanical Restraints (MR)?

The Restraint Reduction Network Standards (2019) define a Mechanical Restraint as *"the enforced use of a device that forcibly controls and subdues movement of a person's body with the aim of controlling their behaviour, involving the use of a mechanical aid to prevent, restrict or manage extreme aggressive behaviour directed towards others or to limit self-injurious behaviour of extremely high frequency and intensity".*

The Mental Health Act (MHA; 1983): Code of Practice is explicit that the use of mechanical restraint : for use of a mechanical restraint:

- Should only be used exceptionally, where other forms of restriction cannot be safely employed, used in line with the principle of "least restrictive option
- should not be an unplanned response to an emergency
- never be used as an alternative to inadequate staffing.

Mechanical restraints have the potential to cause physical and iatrogenic harm and distress and harm to patients. Consideration must always be given to the potential of iatrogenic harm that can result from this type of restraint and the impact this can have upon patient's behaviour.

The use of mechanical restraints can have a significant negative impact on a patient. Consideration of the patient's Human rights needs to be carefully considered. The use of mechanical restraints can potentially patients to significant psychological risk; however, this needs to be balanced with that ability to protect a patient's right to life. The reality in an emergency is that staff managing risk may have limited time to consider all factors. However, the impact on patients must be a high priority in decision making

6.3 Types of Mechanical Restraint

the Trust recognises that there are various forms of mechanical restraint equipment that will be used in different circumstances to meet a patient's needs. In order to support and safeguard patient effectively Mechanical Restraint Devices are classified into 2 specific thresholds; Tier 1 and Tier 2, depending on the level of restriction they place upon the patient and considered in relation to;

- Patient specific needs
- Type, Frequency and Severity of Behaviour that challenges (BTC)
- Patient and Service specific assessments of risk
- Legal Constraints ie Ministry of Justice Orders (MoJ)

Tier 1

Tier 1 Mechanical Devices may be utilised when:

- A patient is not displaying Behaviours that challenge
- Designed to reduce potential physical risks to patients ie falls,
- Implemented to provide improvements in quality-of-life ie wheelchairs.

Tier 1 Mechanical Restraint Devices identified within TEWV:

- Lap straps/belts
- Helmets for head banging
- Car Transportation Harness

Tier 2

Tier 2 Mechanical Devices are devices that are used in response to:

- high levels of BTC and distressing behaviour that cannot be safely managed through the use of other restrictive interventions
- presentation of significant behavioural distress that poses a significant risk to the patient, staff and others that cannot be mitigated using other interventions.
- For patients subject to MoJ Orders who require emergency medical treatment

Tier 2 Mechanical Restraint Devices identified within TEWV:

- Emergency Restraint Cuffs (ERCs)
- Emergency Restraint Belts (ERBs)
- Trans E Slide

Tier 2 Mechanical Devices are identified as a significant form of restrictive intervention as such will only be utilised within specialist care services i.e., Secure Inpatient Services (SIS). Any use outside of these areas will require the director of Nursing & Governance or nominated deputy to be involved within the authorisation process.

7 Implementing Mechanical Restraints

7.1 Potential Impact of the use of Mechanical Restraint Devices

Use of mechanical restraints may have a psychological impact on service patients and this must be considered whenever they are used. Often, they can activate historical trauma events and leave service users feeling without control and powerless which can be very triggering for those who have suffered from abuse of trauma.

Safety plans should include a conversation about how that person may want you to engage if and when mechanical restraints are needed, and what factors need to be considered to ease the psychological impact.

It is essential that staff are aware of this and ensure that they meaningfully explore this with the person who is wearing/potentially requiring mechanical restraints. Observations need to consider signs of re activation of trauma along which can and does present as threat responses fight/flight/freeze. Reassuring and validating acknowledgement of the distress wearing these restraints should be part of any conversations with those affected with exploration of how this may be mitigated in any way we can.

7.2 Authorisation of the use of Mechanical Devices

The use of any mechanical restraint devices should only be approved following a Multi-Disciplinary Team (MDT) consultation, that should include the following:

- Patients Responsible Clinician (RC) or nominated deputy,
- Representatives from nursing staff or AHPs providing care or treatment,
- Where appropriate, family or carers,
- Patients responsible Commissioning Authority,
- Patients Independent Mental Health Advocate (IMHA), where available,
- Patients views of the intervention.

The use of Tier 1 Mechanical Restraint Devices can be agreed at MDT level, it should be clearly recorded within the patients PARIS record, the patient's safety plan and a specific intervention plan for use of the intervention.

Interventions plans for the use of tier 1 mechanical restraint devices must be approved via Associate Clinical and Nursing directors for your service.

Following approval at MDT, the use of Tier 2 devices must be supported via senior leaders/managers within the organisation. See appendices 1 - Tier 2 device Authorisation form. Written approval from three staff Band 8 and above, one must be the patients RC or nominated deputy.

Following completion of the authorisation form to utilise a Tier 2 Mechanical Restraint Devices, the following people must be notified of the decision:

- Responsible clinician or duty doctor if not present for the MDT decision making
- Clinical Director for the Speciality
- General Manager
- Associate Director of Nursing for the Care Group to inform the Director for Nursing and Governance
- TEWV Safeguarding team and Lead Nurse for Positive & Safe Care
- Mental Health Legislation Team
- Patient Independent Mental Health Advocate

In individualised cases, patients may require the use of a mechanical device as an emergency to help move or transfer a patient whilst in behavioural distress to prevent harm to self and others.

A mechanical device may be used for a longer period if required for the patient to attend assessment of medical needs or transfer to appropriate services.

The details of the use of a mechanical restraint must be included in the management plan and are to include how long the restraint were used for, when they were checked and if they were removed and the period they were removed.

7.3 Patients Subject to Ministry of Justice (MoJ) Orders

- There may be occasions Mechanical Restraints ie belts and/or cuffs is required for transportation when moving prisoners into health care settings. In these instances, staff should follow process outlined in section 5.2 Authorisation of Mechanical Restraints.
- The use of mechanical devices in these circumstances should be informed by an assessment of the risk posed by the patient.
- If seeking medical treatment, escort staff should make medical staff aware of any risks.
- If requested by medical staff, restraint devices can be removed for the purposes of treatment.
- Consideration must be given to the patients privacy and dignity and previous trauma at all times.

7.4 Tier 2 Approval Outside of Normal Working Hours

Prior and pre-empted discussions of Tier 2 Mechanical Restraint Devices approval with the MDT should take place to identify and devise a plan for the patient and utilisation of a mechanical devise out of hours, where applicable:

- Appendix 1 form may be completed in certain situations where the MDT has taken place with all disciplines involved and agreed. This is to be used as a **once only form and requires a new form to be signed each occurrence.** (Form to have 2 signatures completed in case of an emergency, from Band 8A or above)
- In the event of out of hours, the same procedure should apply to utilise a mechanical restraint
- The Nurse in Charge (NIC) will contact the wards On-call Manager discussing to what has been agreed in previous MDT meetings, highlight the agreed plan and signed authorisation form.
- The use of mechanical devices will not be used unless final authorisation is granted from the on-call manager. (On-call manager will give authorisation for third signature).
- Following the use, an MDT will reconvene to revisit pre-discussed risks, discuss any new issues ad review patients Interventions plan. **A new Appendix 1 form must also be completed.**

7.5 Use of Mechanical Restraint Devices outside of Inpatient Services

If TEWV community staff are working with a service-user in a community setting and the use of a mechanical restraint device by an external agency is identified, the rationale for its use must be examined. Staff must also ensure that a legal and good practice framework is in place to justify its use in practice and that a patient's human rights are respected at all times

When working with a service-user, living in the community, TEWV community staff should expect to be involved in the decision-making process regarding the use of mechanical restraint devices. This includes the ongoing monitoring of their use whilst that person has an open referral with the community team.

If the use of mechanical restraint has been identified TEWV community staff must also ensure that:

- Its use is detailed in a behaviour support plan.
- There is a system for monitoring for its use.
- There is a plan detailing how to try and reduce use of the device over time.
- The organisation has a policy for the use of mechanical restraint.

If mechanical restraint is being used, TEWV community staff will check that an assessment of the person's physical health has occurred. The purpose of this assessment is to identify if there are any contra-indications to the use of the device. Identified health factors must be considered in the process of risk assessment, when deciding if it is appropriate to use mechanical restraint. Similar consideration must also be applied to the possible impact of recent and historical trauma.

If mechanical restraint is being used, TEWV staff must ensure that there is a process for routinely monitoring the physical and emotional impact of the intervention in the short, medium, and longer term.

8 Developing Intervention Plans for the Use of Mechanical Restraint Devices

8.1 Intervention Plans for Mechanical Restraint Devices Usage

Following the approval of any Mechanical Restraint Device, a intervention plan should be developed and agreed within the Multi-Disciplinary team, including the patient, family and/or carers if appropriate, including:

- Clear rationale for why a mechanical device is being utilised, including evidence of consideration given to alternative options of treatment, that the device is the "least restrictive" option and considers the human rights of patient.
- Patient views on the restriction, including how they will be given information on the intervention and offered the opportunity to contribute and give feedback.
- Evidence that, where appropriate, carers or family have been consulted before authorising use of a mechanical device.

- A care plan that focuses on what needs to be achieved for the mechanical device to be removed
    - The care plan should focus on dynamically understanding the conditions of least restrictive practice and should provide specific reference to how it links to patients Behaviour Support plan
- Identify space in the ward/service where the mechanical device is to be implemented, including specific consideration that has been given to support patients' needs.
- privacy and dignity are respected andStaff must be aware of the negative impact on the protected characteristics: Race, Religion and Belief, Disability, Sex, Age and Gender Reassignment that this clinical intervention can create. Whilst all steps to mitigate its impact must be taken, it may not be removed; as a result such significant impact should only ever be considered in the context of both imminent and significant risk to the patient's health
- Consideration of how wider treatment will continue to be delivered including access to both psychological and pharmacological treatments where appropriate.
- Evidence that the TEWV Safeguarding Team and Positive and Safe lead has been notified regarding the implementation of a mechanical device

8.2 Reporting the use of Mechanical Restraint Devices

When a mechanical device has been utilised:

- A notification should be made to relevant professionals involved including those identified in 5.2,
- Documented on the patients PARIS records,
- Datix form will be completed,
- Matrons for each clinical area will be expected to provide a report of its use (including if it has not been used) into the local Quality Assurance Governance Group (QuAG) and the service will include this in its report to LMGB so any use can be reported into the Trust wide Quality Assurance Committee (QuAC).

9 Monitoring and Reviews of Mechanical Restraint Devices

9.1 Monitoring and Review during usage of Tier 1 Mechanical Restraint Devices

- Tier 1 Mechanical Restraint Devices will likely be used on a continuous basis and therefore does not need to be reported within DATIX system.
- There is an expectation in intervention plans for the use of Tier 1 devices that they will be reviewed at least monthly through collaborative reviews with consideration given to whether the plan needs to remain in place.

9.2 Monitoring and Review during usage of Tier 2 Mechanical Restraint Devices

- An individual who is mechanically restrained should be under continuous observation throughout.

- The individual should be reviewed by a nurse every 15 minutes throughout the use of a Mechanical Restraint Device.
- The individual should have a medical review at least 1 hour after commencement of the device by a medical practitioner, subsequently there should be medical reviews completed 4 hours thereafter.
- Staff should constantly monitor for signs of discomfort or physical distress.
- Verbal de-escalation and reassurance should be offered throughout the intervention
- Staff should closely monitor equipment with potential impact for failure of equipment.
- All monitoring will be recorded in patients PARIS records

10 Post-incident review of the use of Mechanical Restraint Devices

Any use of Tier 2 Mechanical Restraint Devices will require the completion of a Post-Incident Review for both the patient and staff involved.

11 How this procedure will be implemented

• This procedure will be published on the Trust's intranet and external website.
• Line managers will disseminate this procedure to all Trust employees through a line management briefing.
• Staff made aware of Trust wide guidance within mandatory and statutory Positive Approaches Training

11.1 Training needs analysis

Staff/Professional Group	Type of Training	Duration	Frequency of Training
Staff agreed via local TNA	Face to Face	1 day	Annually

12 How the implementation of this procedure will be monitored

Auditable Standard/Key Performance Indicators	Frequency/Method/Person Responsible	Where results and any Associate Action Plan will be reported to, implemented and monitored; (this will usually

			be via the relevant Governance Group).
1	Restrictive intervention usage monitored via the Positive & Safe Dashboard	Board: every 6 months Operational Directors to report any usage monthly Care Group Directors of Nursing to review monthly	QuAC Care Group Boards Care Groups, Positive & Safe Groups
2	Positive & Safe Audit Framework	Spotlight Audit to be completed every 2 years	Care Groups, Positive & Safe Groups

13 References

- Care Quality Commission (2020) Out of Sight – Who Cares?
- College of Policing , (2017), Memorandum of Understanding – The Police Use of Restraint in Mental Health & Learning Disability Settingshttp://www.college.police.uk/News/College news/Pages/Mental_health_restraint_MoU.aspx
- Department of Health, 2014. Positive and Proactive Care: reducing the need for restrictive interventions, London: DH.
- Mental Health Act Code of practice 1983 (2015), Department of Health, The Stationary Office, London
- Mental Health Units Use of Forces Act (2019)
- MIND, 2013. Mental health crisis care: physical restraint in crisis, London: MIND.
- NICE (2015) NG10: Violence and aggression: short-term management in mental health, health and community settings
- NICE (2015): NG11 Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges
- NICE (2018) NG93: Learning disabilities and behaviour that challenges: service design and delivery
- NICE(2018) NG97: Dementia: assessment, management and support for people living with dementia and their carers.
- Positive Behaviour Support Academy (2015) Positive Behavioural Support Competence Framework [online] http://pbsacademy.org.uk/pbs-competence-framework/
- Restraint Reduction Network Standards (2019)
- Royal College of Psychiatrists, British Psychological Society, Royal College of Speech and Language Therapists (2016) Challenging Behaviour: A Unified Approach – Update Royal College of Psychiatrists

14 Document control (external)

To be recorded on the policy register by Policy Coordinator

Date of approval	05 May 2023
Next review date	05 May 2026
This document replaces	n/a - new document
This document was approved by	Trust wide Positive & Safe Group
This document was approved	07 July 2022
This document was ratified by	Director of Nursing and Governance
This document was ratified	05 May 2023
An equality analysis was completed on this policy on	10 January 2023
Document type	Public
FOI Clause (Private documents only)	n/a

Change record

Version	Date	Amendment details	Status
1	07 July 2022	New document	Approved
1	05 May 2023	Clarified monitoring section to make S.M.A.R.T.	Approved

Appendix 1 – Tier 2 Mechanical Restraint Devices Authorisation and Review Form

APPENDIX 1

To be completed BEFORE use of Tier 2 equipment

USE OF SOFT RESTRAINT DEVICES RECORD					
Patient's Name:				**Date:** (this is date devices are to be used on)	
Hospital No:			**MHA Status:**		
Name of Unit/Ward:					
Destination of Escort: (This is to include escort numbers ie: 4 x staff, 1 x driver, 1 x handcuff coordinator)					
SRB - Belts	**Yes**	**No**	**SRC – Cuffs**	**Yes**	**No**
Metal Cuffs	**Yes**	**No**	**Safe Holding Belt**	**Yes Use** Appendix 2	**No**

Checks to completed prior to use:				
Initial MDT Completed				
Medical Risk Assessment	Yes	No	Print:	Sign:
Risk Assessment	Yes	No	Print:	Sign:
Intervention Plan	Yes	No	Print:	Sign:
Evidence of patient been consulted prior to use (dependant on individual risk assessment)	Yes	No	Print:	Sign:
All other options attempted (Court Video Conferencing, Can general medical staff attend this unit)	Yes	No	Print:	Sign:
Consideration has taken place as to if the cuffs can be taken off, if requested or if in secure area such as court cell	Yes	No	Print:	Sign:
Advice for removal if required or asked whilst out				

Rationale for the use of Soft Restrain Devices: (eg. High absconsion, risk to public, MOJ etc)

Authorised by: (eg, General Manager, Responsible Clinician (RC), Security Manager, Modern Matrons, Service Managers, 1st On Call)	**Print:**
	Sign:
	Print:
	Sign:
	Print:
	Sign:
Soft Restraint Devices Coordinator : (Person applying SRC's or co-ordinating use of SRB's)	
Communication: (What did Co-Ordinator or Escort Lead explain to the patient regarding the procedure before the equipment was applied)	

Prior use: (What position was the patient in, was there any marks prior to use, did the patient consent, identify what checks were carried out, was RT used, what primary and secondary were used etc)

During use: (Identify what checks were carried out during use, was the equipment adjusted or removed for any reason, was transport used and what position was the patient placed in etc)

Post use: (identify what checks were carried out, were there any marks observed etc)

In the event of SRB's used, list the trained staff below: (eg: what was their role, upper belt, leg belt, mid section belt, left / right side, head person)

Any Marks or Injuries evident on the patient and any action taken after the removal of SRB and SRC's: (eg, redness, chaffing etc)

Debrief (Rapid Reflection) took place:

Staff	Patient
Date: (this is date debrief took place)	**Date:** (this is date debrief took place)

Explanation as to why this has not been facilitated: (ie: patient transferred to Prison, another service, if not clinically appropriate please identify a date when this is going to be addressed etc)

Staff present at Debrief (Rapid Reflection) : (Names and Job Titles)

Debrief / Rapid Reflection for Staff to include following:

- Are we all ok and safe? Yes/No
  If NO, what can we do to help feel safe?
- Is there anything we would do differently next time?
- What went well?

Debrief / Rapid Reflection for Patient to include the following:

- Are you feeling ok and safe?
- What can we do to help you feel safe?

Within 24hours or when appropriate

- Do you understand why staff needed to use restrictive interventions / Mechanical restraint?
- Did staff support you to feel comfortable and dignified?
- What could staff have done to support you better?
- If the situation arose again would you have preferred staff to use the equipment or using physical restraint?
- Is there anything you would do differently next time that staff can place in your Intervention Plan?

Staff conducting this conversation : **Date:**

Actions Following Rapid reflection:

- Has the patient and any patients witnessing the incident been debriefed YES/NO
- Would a facilitated debrief be helpful to the team
  YES/NO

(If YES notify the Ward Manager and Psychologist)

Datix completed and number:	

Following use of ERB's (belts) has the Patient had a medical review in the first 24hrs	**Yes**	**Date:**
Following use of SRD's has the Patient had a debrief in the 72hrs	**Yes**	**Date:**
In the event of transferring patient into care of another organisation (hospital / prison) staff have handed over that patient requires medical attention following use of devices	**Yes**	**Date:**

Safe Holding Belt (use new form when fully completed) (send original to Security Manager)

Patients Name……..NHS Num……Ward……

Date the Belt was used:		
Rationale Belt was used:		
Persons that applied the Belt and PAT (eg: what was their role, arm person, leg person, head person, who applied the SHB etc)		
Additional Comments/Post use de brief: (eg: was there any marks prior to use, did patient consent, checks carried out, how the situation went, any feedback from patient etc)	**Prior use:**	
	During use	
	Post Use	
Patient Debriefed	**Yes**	**Date:**
How long Belt was used for		

Any Marks or Injuries evident on the patient	

and any action taken after the removal of SHB: (eg, redness, chaffing etc)			
Datix completed and number:			
Following use of SRB's has the Patient had a medical review in the first 24hrs			

Risk Assessment Record Sheet for Safe Holding Belt

Safe Holding Belt **(use new form when fully completed)**

Patients Name……..NHS Num……..Ward……

Date Risk Assessment Completed	**Who completed this**	**Is the Safe Holding Belt to be continued to be used ?**		**Comments**
		Yes	**No**	
Next review date				
		Yes	No	
Next review date				
		Yes	No	
Next review date				
		Yes	No	
Next review date				
		Yes	No	
Next review date				
		Yes	No	
Next review date				
		Yes	No	
Next review date				

		Yes	No	

Appendix 2 - Equality Analysis Screening Form

Please note: The Equality Analysis Policy and Equality Analysis Guidance can be found on the policy pages of the intranet

Section 1	Scope
Name of service area/directorate/department	Positive & Safe Care
Title	Safe Use of Mechanical Restraints Equipment procedure
Type	Procedure
Geographical area covered	Trust wide
Aims and objectives	This procedure outlines the rationale and guidance underpinning the use of Safe Use of Mechanical restraint Equipment and should be read in conjunction with Chapter 26 of the Mental Health Act Code of Practice (2015) and aims to: • Ensure the safety and wellbeing of the patient • Ensure that use of mechanical restraint is considered in accordance with the organisations commitment to the reductions of all forms of restrictive intervention • Ensure the patient receives the care and support rendered necessary when utilising mechanical restraints. • Distinguish between mechanical restraint types in relation to tiered behavioural support i.e., movement to seclusion/segregation • Specify a suitable restraint that takes account of the patient's dignity and physical wellbeing. • Ensure all staff are aware of their roles and responsibilities. • • Set requirements for recording, monitoring, and reviewing the use of mechanical restraint and any follow up action.
Start date of Equality Analysis Screening	15th December 2022

End date of Equality Analysis Screening	10th January 2023

Section 2	Impacts
Who does the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan benefit?	All Patients admitted to TEWV inpatients
Will the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan impact negatively on any of the protected characteristic groups?	• **Race** (including Gypsy and Traveller) **NO** • **Disability** (includes physical, learning, mental health, sensory and medical disabilities) **NO** • **Sex** (Men, women and gender neutral etc.) **NO** • **Gender reassignment** (Transgender and gender identity) **NO** • **Sexual Orientation** (Lesbian, Gay, Bisexual, Heterosexual, Pansexual and Asexual etc.) **NO** • **Age** (includes, young people, older people – people of all ages) **NO** • **Religion or Belief** (includes faith groups, atheism and philosophical beliefs) **NO** • **Pregnancy and Maternity** (includes pregnancy, women who are breastfeeding and women on maternity leave) **NO** • **Marriage and Civil Partnership** (includes opposite and same sex couples who are married or civil partners) **NO** • **Armed Forces** (includes serving armed forces personnel, reservists, veterans and their families) **No**
Describe any negative impacts	Use of Mechanical restraint equipment is a high-risk intervention that can cause both physical and psychological harm to patients
Describe any positive impacts	The procedures defines the exceptional circumstances where mechanical restraint equipment may be required and outlines the expectations of staff in order for any deployment of equipment to be carried out safely.

Section 3	Research and involvement
What sources of information have you considered? (e.g. legislation, codes of practice, best practice, nice guidelines, CQC reports or feedback etc.)	Yes – see references section
Have you engaged or consulted with service users, carers, staff and other stakeholders including people from the protected groups?	Service users engaged as part of procedure development, unclear if those services included people form protected groups.
If you answered Yes above, describe the engagement and involvement that has taken place	Service users identified to contribute as part of task and finish group
If you answered No above, describe future plans that you may have to engage and involve people from different groups	

Section 4	Training needs
As part of this equality analysis have any training needs/service needs been identified?	No – note awareness training to be available for all inpatient staff
Describe any training needs for Trust staff	Agreed via local TNA, 1 day training required annually
Describe any training needs for patients	No
Describe any training needs for contractors or other outside agencies	No

Check the information you have provided and ensure additional evidence can be provided if asked

Appendix 3 – Approval checklist

To be completed by lead and attached to any document which guides practice when submitted to the appropriate committee/group for consideration and approval.

	Title of document being reviewed:	Yes / No / Not applicable	Comments
1.	**Title**		
	Is the title clear and unambiguous?	Y	
	Is it clear whether the document is a guideline, policy, protocol or standard?	Y	
2.	**Rationale**		
	Are reasons for development of the document stated?	Y	
3.	**Development Process**		
	Are people involved in the development identified?	Y	
	Has relevant expertise has been sought/used?	Y	
	Is there evidence of consultation with stakeholders and users?	Y	
	Have any related documents or documents that are impacted by this change been identified and updated?	N/A	
4.	**Content**		
	Is the objective of the document clear?	Y	
	Is the target population clear and unambiguous?	Y	
	Are the intended outcomes described?	Y	
	Are the statements clear and unambiguous?	Y	
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	Y	
	Are key references cited?	Y	
	Are supporting documents referenced?	Y	
6.	**Training**		
	Have training needs been considered?	Y	
	Are training needs included in the document?	Y	

	Title of document being reviewed:	Yes / No / Not applicable	Comments
7.	**Implementation and monitoring**		
	Does the document identify how it will be implemented and monitored?	Y	
8.	**Equality analysis**		
	Has an equality analysis been completed for the document?	Y	
	Have Equality and Diversity reviewed and approved the equality analysis?	Y	
9.	**Approval**		
	Does the document identify which committee/group will approve it?	Y	
10.	**Publication**		
	Has the policy been reviewed for harm?	Y	
	Does the document identify whether it is private or public?	Y	
	If private, does the document identify which clause of the Freedom of Information Act 2000 applies?	N/A	