



**Public – To be published on the Trust external website**

# Safe use of Tear Proof Clothing

Supporting Behaviours that Challenge (BtC)

**Ref: CLIN-0019-004-v1.1**

Status: Approved

Document type: Procedure

Overarching policy: [Supporting Behaviours That Challenge](#)

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# 1 Introduction

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Whilst staff will make every attempt to support an individual's behaviour using the principles of Positive Behaviour Support and least Restrictive Practice, it is acknowledged that occasions may occur where due to the level of distress or presentation of a patient's behaviour, staff will be required to restrict a patient's access to their typical day time clothing providing them with special tear-proof clothing (TPC) as an alternative.

Tear proof clothing are items of clothing, normally referred to as 'Anti-Ligature' or 'strong' clothing, that a patient may utilise when experience high levels of distress and the risk to life is imminent and replaces the patients 'everyday' clothing to act as deterrent for future behaviours. The instigation by staff of the removal of normal daytime clothing 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. This type of restriction has the potential to cause harm and distress to a patient, as such it must only be used when clinically indicated and no other alternative that maintains the safety of the patient is available. If implemented the outlined procedure must be followed at all times.

The procedure for the safe use of Tear Proof Clothing links with Our Journey to Change as it focuses on providing patients with both safe and person-centred support in the management of behaviours that challenge (BtC).

## To co-create a great experience for our patients, carers and families, so you will experience:

- **Outstanding** and compassionate care, all of the time.
- **Access** to the care that is right for you.
- **Support** to achieve your goals.
- **Choice** and control.

## To co-create a great experience for our colleagues, so you will be:

- **Proud**, because your work is meaningful.
- **Involved** in decisions that affect you.
- **Well led** and managed.
- That your workplace is **fit for purpose**.

## To be a great partner, so we will:

- Have a **shared understanding** of the needs and the strengths of our communities
- Be **working innovatively** across organisational boundaries to improve services.
- Be **widely recognised** for what we have achieved together.

## 2 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.
Tear Proof Clothing	A form of restrictive intervention that refers to the use of anti-ligature or strong clothing that prevents the risk or attempt of self-harm.
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.

## 3 Purpose

Following this procedure will help the Trust to:-

- Manage and reduce high levels of behaviour distress and risk behaviours to swallowing and ligature attempts
- How to effectively commence and demission the use of TPC within practice
- Use TPC safely
- Monitor and review the use of TPC
- Audit the use of TPC within inpatient services

## 4 Who this procedure applies to?

This procedure applies to all Trust staff involved with the authorisation or implementation of the use of Tear Proof Clothing. Following this procedure will ensure all patients' rights are respected and safety of patients is maintained at all times.



### Respect

- Listening
- Inclusive
- Working in partnership



### Compassion

- Kind
- Supportive
- Recognising and Celebrating



### Responsibility

- Honest
- Learning
- Ambitious

## 5 Related documents

This procedure refers to:-

- ✓ Harm Minimisation Policy: Ref CLIN-0017-v8.1  
<https://intranet.tewv.nhs.uk/download.cfm?doc=docm93jjm4n1265.pdf&ver=10297>
- ✓ Rapid Tranquillisation (RT) Policy CLIN-0014-v8.1  
<https://intranet.tewv.nhs.uk/download.cfm?doc=docm93jjm4n1300.pdf&ver=7234>
- ✓ Blanket restrictions: Policy on the use of Global Restrictive Practices (Blanket Restrictions) in InPatient Units Ref: CLIN-0089-v2  
<https://intranet.tewv.nhs.uk/download.cfm?doc=docm93jjm4n1304.pdf&ver=10345>
- ✓ Safe use of Physical Restraint Techniques Procedure, Ref CLIN-0019-002 v1  
<https://intranet.tewv.nhs.uk/download.cfm?doc=docm93jjm4n1303.pdf&ver=9778>
- ✓ Seclusion and segregation Procedure , Ref CLIN 0019 001 v2  
<https://intranet.tewv.nhs.uk/download.cfm?doc=docm93jjm4n1312.pdf&ver=3436> Ref: CLIN-0019-v7 Page 14 of 29 Ratified date: 10 March 2021
- ✓ Supporting Behaviours that Challenge Policy Last amended: 10 March 2021
- ✓ Procedure for addressing verbal aggression towards staff by patients, carers and relatives Ref CLIN-0019-003-v1  
<https://intranet.tewv.nhs.uk/download.cfm?doc=docm93jjm4n1334.pdf&ver=3449>
- ✓ Privacy and Dignity Policy Including Eliminating Mixed Sex Accommodation Requirements Ref: CLIN-0067-v4  
<https://intranet.tewv.nhs.uk/download.cfm?doc=docm93jjm4n1298.pdf&ver=8350>
- ✓ Human Rights, Equality and Diversity Policy, Ref: HR-0013-v8  
<https://intranet.tewv.nhs.uk/download.cfm?doc=docm93jjm4n1360.pdf&ver=7521>
- ✓ MHA 1983 Code of Practice (CoP)

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## 6 Principle of Use of Tear-proof Clothing (TPC)

### 6.1 Guidance of Use of Tear Proof Clothing

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The instigation by staff of the removal of normal daytime clothing 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.

The MHA 1983 Code of Practice (CoP) provides guidance on the use of tear proof clothing (Section 26.161 – 26.167). Key points include:

- Tear proof clothing should never be a first line response or used as a 'blanket rule' within services
- The dignity of patients should be a primary consideration when using tear proof clothing
- The use of tear proof clothing should be proportionate to the risks faced and only used for as long as necessary
- Tear proof clothing should never be used as a substitute for enhanced levels of support and observation

The restriction of access to normal daytime clothing as an intervention is likely to be implemented by nursing teams under the supervision of the nurse in charge of the ward where the patient is detained. However, the authorisation for this intervention can only be provided by the patient's responsible clinician and this authorisation cannot be delegated.

### 6.2 Decision to Implement Tear Proof Clothing

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The MHA 1983 CoP is explicit that the use of tear proof clothing should be authorised by the patients Responsible Clinician and so the expectation is that it should always be authorised by the Responsible Clinician or Out of Hours, the On Call Consultant.

It is recognised that there may be extreme circumstances where a very urgent response to risk and severe behavioural disturbance is required and under these circumstances it may not always be practical to seek the authority of the Responsible Clinician in advance however attempts to do so should still be made and evidenced. If staff are unable to contact the Responsible Clinician, they should contact their Matron and / or Head of Service to notify them of the situation and agree ongoing arrangements for contacting the Responsible Clinician.

The authorisation should be provided at the earliest possible opportunity and the reason for the delay clearly documented in the Electronic Care record (ECR).

The restriction of access to normal daytime clothing as an intervention is likely to be implemented by nursing teams under the supervision of the nurse in charge of the ward where the patient is detained. However, the authorisation for this intervention can only be provided by the patient's responsible clinician and this authorisation cannot be delegated.

The decision to use tear proof clothing should only be taken if the service user demonstrates severe behavioural disturbance that places them at significant risk from displaying self-harm where clothing may be used. Examples include:

- Ligature tying
- Swallowing

### **6.3 Considerations for restricted access to normal daytime clothing**

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The restriction of access to normal daytime clothing can have a significant negative impact on a patient. Consideration of the patient's Human rights needs to be carefully considered. The removal of clothing can leave patients feeling degraded and potentially expose them 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 situation 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.

A patients expressed wishes where available (through Advance Decision making for example) should be considered before the use of tear proof clothing. Consideration should be made to the needs of the individual and highlight sensitive issues such as privacy & dignity / gender / previous trauma / culture.

If any aids usually held by the person are being removed e.g., spectacles / hearing aids, prosthetic limbs, denture. Identify what adjustments have been made to support the patient, minimising potential impact and meeting their needs i.e., written instruction.

A patient in tear proof clothing is able to keep personal items of religious or cultural significance (such as items of jewellery) as long as they do not compromise their safety or the safety of others.

If personal items or clothing with religious or cultural significance need to be restricted, due to safety, then staff must consider its impact and develop additional interventions which may help to minimise the potential harm that can result from the intervention i.e. specifying the gender of staff supporting the patient with use of TPC that supports the patient's religious beliefs.

Where clothing / jewellery needs to be restricted this is done so by staff members of the same sex as the patient where possible and in a manner which preserves dignity and maintains safety.

Staff 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. It is important to consider a 'graded' approach to the restriction of potentially harmful items of normal clothing

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## 7 Implementation of Tear Proof Clothing

### 7.1 Storage, Care and Condition of Tear Proof Clothing

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Services will closely monitor any stored tear proof clothing for signs of wear and tear. Making sure it is of good quality and available in sizing that reflects the needs of the service user group.

Where a patient has a preauthorised plan for the use of tear proof clothing then individual items should be identified and allocated to the individual in an appropriate size.

Tear proof clothing should not be shared between individuals except in cases of unplanned; emergency i.e., if correct sizing or preferred style is not available, TPC not in use may be utilised until patient specific clothing can be ordered and made available.

Each ward that may use a tear proof clothing, will assess the required amount of tear proof clothing required based on clinical risk assessment particularly in relation to self-harming behaviour (as a guide this would be 2 sets of clothing per individual required).

Used Tear proof clothing must be laundered locally.

The life of an item of tear proof clothing largely depends upon a numbers of factors:

- How long it has been in circulation
- How many times has it been laundered?
- What temperature it has been laundered at
- The likelihood of excessive temperatures in the drying process
- If it shows signs of wear, fraying, worn edges, broken stitches.
- If it has been washed with detergent containing bleaching agents.
- If the clothing appears to be faded.

### 7.2 Patient requesting the use of Tear Proof Clothing

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Whilst rare, staff must be aware that on occasions an individual patient may request to use tear proof clothing as part of their individually identified coping strategies and as an aid to support their recovery. In these instance patients will be given access to tear proof clothing, however access to their own personal clothing will not be limited or restricted in any way.

In these circumstances the choice to use tear proof clothing is made solely by the patient, capacity to make this decision is assumed to present, if it is not clear that capacity is present then assessment is required and should be clearly documented.

Patient requested use is not considered a restriction as the patient can return into their normal day time clothing at any point.

It is expected that their decision will be developed into a co-produced behaviour support plan recorded in line with Advanced decision processes. The individual will be offered the support of

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independent advocacy to develop this and ensure appropriate safeguards are in place. Guidance on areas for consideration in a plan are in Appendix 1

The co-produced plan will be implemented and reviewed in line with this clinical procedure (Appendix 2 and Appendix 4) and these reviews will identify ways to support the patient in reducing their reliance on this strategy and promoting increased opportunities to use alternative coping mechanisms.

Use of tear proof clothing will be recorded in a detailed case note / activity note and guidance on consideration of content is in Appendix 3

### **7.3 Planned use of Tear Proof Clothing**

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In situations where ongoing risk assessment has identified that the risk presentation may be high particularly where there is a concern of shredded clothing being used to self-harm or attempt suicide, the responsible clinician for the patient can authorise the potential need for typical day time clothing to be restricted and tear proof clothing to be offered in its place.

If authorisation is agreed via the responsible clinician and supported by the Multi-disciplinary team (MDT) it is expected that this agreement will be reviewed a minimum of monthly via ward round/MDT if the plan has not needed to be implemented. If it has been implemented, reviews will take be expected to take place in line with this procedure (Appendix 2 and Appendix 4).

The MDT Decision should then be subject to a complex case discussion (refer to appendix 5 : Complex Case Panel) and as a minimum the Positive and Safe lead for the Trust and a Trust safeguarding team representative should also be in attendance.

If a patient presents with behaviours of concern and an authorisation has been put into place, the nurse in charge, with the support of the clinical team, will consider if the risks present meet the agreed parameters (as identified in the individuals plan) and therefore restrict the patients access to normal daytime clothing. The patient will then be supported to change into tear proof clothing

Staff will be expected to utilise a graded response whilst offering support to patients when changing into tear proof clothing, focusing upon the use of verbal de-escalation and therapeutic engagement to support patients to wear tear proof clothing. Physical restraint techniques should only ever be used as when clinically indicated and there are no alternative available options for safely managing the risk and it is proportionate to the risks present at that time

Use of tear proof clothing will be recorded in a detailed case note / activity note and guidance on consideration of content is in Appendix 3

The plan (Appendix 1) will be authorised, implemented, and reviewed in line with this clinical procedure (Appendix 2 and Appendix 4) and these reviews will identify ways to support the patient in reducing their reliance on this strategy and promoting increased opportunities to use alternative coping mechanisms.

Relevant parties will be notified of use in line with this procedure (Appendix 2)

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## 7.4 Unplanned use of Tear Proof Clothing

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There may be exceptional circumstances when a patient presents with behaviours of significant and imminent concern that may require a restriction to be placed on their access to typical day time clothing and this possibility has not been foreseen. The use of tear proof clothing in these circumstances would be unexpected and not have been considered as necessary previously by the clinical team

The nurse in charge of the ward should seek urgent clinical advice and discuss the authorisation for the use of tear proof clothing with the Responsible Clinician or duty Consultant if out of Hours.

Implementation of the restriction of access to normal daytime clothing will be discussed and authorised in line with this clinical procedure (Appendix 2)

The recording of the decision to restrict access to normal daytime clothing will be completed in line with this clinical procedure (appendix 3).

Reviews of the restriction of access to normal daytime clothing will be completed in line with this clinical procedure (Appendix 2 and Appendix 4).

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## 7.5 Restricting Access to underwear

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In line with least restrictive expectations, the removal or restriction of underwear can only be considered when patients are placed in seclusion and their risks are unable to be managed through enhanced observation and engagement.

Staff must be aware that removal or restriction of typical daytime clothing does not automatically include the patient's underwear. Specific consideration needs to be given to the removal of underwear especially garments below the waist. Staff must be aware of increased risk of trauma/re-traumatisation in these circumstances.

The restriction of access to underwear requires authorisation from the Responsible Clinician and cannot be pre-authorized and must be considered and authorised on each occasion in line with unplanned use in appendix 2. The possibility of restricting access to normal underwear, wherever possible should be discussed in advance with the patient. This must be supported by their advocate and their views obtained.

The restriction of access to underwear requires clear and explicit justification and should be in addition to the considerations given to any restriction of access to normal daytime clothing. The following should be included in the recording of the decision:

- The patient's views and wishes including their understanding of what other options may be available to manage the current risks
- Why increased enhanced supportive engagement and observation cannot address the safety concerns.
- Consideration of underwear made from alternative materials e.g., paper underwear.
- Whether there are issues relating to menstruation, access to necessary products and how the patient will be supported to manage this need, including staff support to minimise

the potential significant impact on the patients Human Rights and the protection of their privacy and dignity.

- Whether there are continence issues, access to necessary products, support mechanisms in place to keep the immediate environment clean and how these will be addressed.
- Whether there are variations in restriction / access based on the time of day (e.g. night or day) or the location of the service user such as isolated areas like seclusion / bedroom?
- Additional privacy and dignity issues and the type of tear proof clothing being used e.g. shorts or dress?
- Levels of observation to be provided including specific consideration of the gender of staff.

Reviews of the restriction of access to underwear should be undertaken by the MDT a minimum of 24 hourly and must include the Responsible Clinician. Out of hours the on-call Consultant and First on call Manager must be included in the review discussion. An urgent review should be arranged to review the plan and should include the Trust Positive and Safe Lead Nurse, Unit social worker, Trust Safeguarding representative and the Head of Service and / or Head of Nursing. Reviews should be recorded in line with guidance in this procedure (Appendix 4)

## 8 Monitoring and Review

Reviews should include how the patient is involved in the decisions and a discussion with the patient of the processes and what is expected so that they can wear their usual and preferred clothing. At these times staff should support patients to consider the use of Advocacy services.

The reviews should be carried out and documented on Paris in line with appendix 2 and appendix 4 of this clinical procedure

Matrons for each clinical area that has tear proof clothing 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 Audit of the use of Tear Proof Clothing

Adherence to the procedure will be regularly reviewed by ward/unit managers. Use of Tear proof Clothing will be audited annually via the TEWV central audit programme as part of the Positive & Safe Audit.

All uses of Tear proof clothing will be reported review via locality Management governance boards (LMGB). Use of Tear proof clothing is reported as a restrictive intervention in TEWV and will be monitored via Positive and Safe Dashboard, and included in the annual Trust wide Positive and Safe Report

## 10 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.
- Managers at all levels are responsible for ensuring that staff are aware of the location of this procedure and any associated equipment. This information is given to all new staff on induction. They are also responsible for assisting staff to keep up to date with any changes to this procedure, although individuals have ultimate responsibility for their own practice.

### 10.1 Training needs analysis

Staff/Professional Group	Type of Training	Duration	Frequency of Training
Clinical Inpatient Staff	Positive Approaches Training	4 days initial training/2 day refreshers	Bi Annually

## 11 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 Positive and Safe Audit	Annual Audit led by Lead Nurse: Positive and Safe Care	Reported to Trust Wide Quality Assurance Committee via Annual Positive and Safe Plan

## 12 Document control (external)

To be recorded on the policy register by Policy Coordinator

Date of approval:	03 February 2022	
Next review date:	30 June 2025	
This document replaces:	Tear Proof Clothing Use Procedure Ref: CLIN-0019-004-v1	
This document was approved by:	Name of committee/group	Date
	Positive and Safe Advisory Group	03 February 2022
This document was ratified by:	Name of committee/group	Date
	n/a	
An equality analysis was completed on this document on:	07 January 2022	
Document type	Public	

### Change record

Version	Date	Amendment details	Status
1	16 Mar 2020	New document	Withdrawn
1	Sept 2020	Review date extended	Withdrawn
1	March 2020	Review date extended to 16 June 2021	Withdrawn
1	15 June 2021	Review date extended to 30 Sept 2021	Withdrawn
1.1	03 Feb 2022	<ul style="list-style-type: none"> <li>• Full review with minor changes</li> <li>• Procedure updated to provide additional clarity to Appendices 3 and 4</li> <li>• Procedure formatted to new procedure template</li> <li>• Quality Impact Assessment Reviewed and updated</li> </ul>	Published
1.1	Feb 2025	Review date extended to 30 June 2025	Published

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## Appendix 1 – Guidance on considerations for inclusions in the Behavioural Support plan (Intervention Plan)

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- The date of the Responsible Clinician decision to authorise tear proof clothing and the name of the authorising RC
- Which other members of the clinical team were involved in the decision
- Risks identified by the clinical team
- What is the behaviour that we are hoping to manage the risk of?
- What is the risk history in relation to this behaviour?
- Clinical rationale for the use of tear proof clothing
- Has the patient experienced trauma, what impact do we believe the use of tear proof clothing may have on that trauma i.e. behavioural escalation or re traumatisation
- What are we restricting or planning on restricting? (specific i.e. clothing/ jewellery)
- What alternative lesser restrictive interventions has been considered / attempted i.e. enhanced observation? (where is this documented)
- If used how will the restriction be implemented in practical terms including if this will include physical interventions
- If required what type of tear proof clothing will be used (have we considered patient preference in this?)
- What observational support will be offered in conjunction with the use of tear proof clothing?
- The engagement and observation level the service user is being supported with
- If any items of personal items of religious or cultural significance are being removed
- If any aids usually held by the person are being removed e.g. spectacles / hearing aids, what adjustments have been made to support the patient, minimising potential impact and meeting their needs i.e. written instruction
- How the patients privacy and dignity will be maintained
- What is or will be your process for reviewing the restriction (is the patient aware of the process?)
- What needs to be in place / is the patient aware of what is required to remove the restriction?
- What is the plan short and medium term / how do you know if the risk has reduced?
- How will this intervention be reviewed to reduce the likelihood of use over time?
- Does an advocacy referral need to be made?
- How has the patient been involved in the plan?
- How will the patient be involved in reviewing the plan?
- Has the carer been involved where appropriate

Restriction of access to normal underwear cannot be authorised in advance however if this may need to be considered as part of the clinical intervention then this should be included within the plan

It should be noted this list is not exhaustive.

## Appendix 2 – Tear Proof Clothing - Authorisation, Notification and Review Guidance

Authorisation:	PATIENT REQUEST	PLANNED	UNPLANNED		
<b>Professionals involved in planning of use</b>	Patient (with capacity) Advocate Responsible Clinician Social Worker Multi Disciplinary Team	Patient (with capacity) Advocate Responsible Clinician Multi Disciplinary Team Positive & Safe Lead	Modern Matron Responsible Clinician/ Duty Consultant <u>Out of Hours</u> On Call Consultant Senior Nurse on Duty / Night Coordinator		
<b>Authorisation</b>	Not Applicable	Responsible Clinician	Responsible Clinician / Duty Consultant		
<b>Where this is recorded.</b>	Activity recording (MDT) Intervention plan MCA1/2	VIA COMPLEX CASE PROCESS Activity recording (MDT) Intervention plan	Activity Recording		
<b>Who needs to be notified of immediate use</b>	Ward Manager Responsible Clinician Modern Matron	Responsible Clinician Head of Service Head of Nursing Trust Safeguarding – (automatic from patient safety via Datix notification)	Modern Matron Head of Service Head of Nursing Trust Safeguarding – Automatic from patient safety via Datix notification <u>Out of Hours</u> Duty Senior Nurse / Night Coordinator - 1st on call manager - Director On Call		
<b>Where this is recorded.</b>	Activity recording (MDT) Intervention plan Safety Summary	Activity note Datix	Activity recording (MDT) Safety Summary Datix		
Reviews of access to normal daytime clothing *see guidance for reviews related to restricted access to underwear.					
<b>When this needs to be monitored /reviewed</b>	Each change of shift	Every 24 hours	Over 48 hours	7 days or more, or 3 separate uses within a 7 day period	Pre authorised - Monthly via ward round/MDT complex case discussion.
<b>Who needs to be part of the review process.</b>	Handover of NIC	Patient Ward Manager Modern Matron Responsible Clinician	Responsible Clinician Head of Service Head of Nursing Social Worker Positive & Safe Lead Notify - Deputy Medical Director	Independent Responsible Clinician  Notify Positive & Safe Lead	Responsible Clinician MDT
<b>Where this is recorded.</b>	Activity Note Safety Summary		Activity Note Intervention plan Safety Summary		
<b>Who needs to be notified when its ended.</b>	Patient (with capacity) Social Worker Advocate Responsible Clinician Multi Disciplinary Team				
<b>Trust Wide Monitoring</b>	Matrons for each clinical area that have tear proof clothing will be expected to provide data relating to 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).				

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### Appendix 3 – Guidance on considerations for case note records if tear proof clothing is implemented

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- Datix reference number
- Was the decision to utilise Tear Proof clothing patient choice, planned (pre-approved) or unplanned (emergency).
- Decision made by (name of Nurse in Charge of the clinical incident) including other people involved with decision
- Who you have informed about the use of TPC
- Authorising Responsible Clinicians details for restricted access to normal day time clothing
- Authorising Responsible Clinicians details for restricted access to Underwear (if applicable)
- Date and time implemented
- Including duration of other interventions
- Detail what discussions have taken place with service user
- Describe what clothing has been removed from the patient including any jewellery (religious or cultural significance) underwear or sanitary wear and rationale for this.
- Describe if spectacles or hearing aids have been removed and what alternatives have been considered.
- Describe how have you removed the normal daytime clothes?
- Describe patients views and consent regarding the implementation of TPC

Within the rationale for implementing tear proof clothing:

- Include risk issues
- What measures have been taken to promote privacy and dignity?
- What interventions have been prior to use attempted/discussed including observations and engagements?
- Include reasons of why interventions have not been attempted and why they have failed where applicable
- Has PAT/RT/ERD been used?
- The patients views of the use of TPC
- Plans for what needs to happen to end use of tear proof clothing
- What support will be in place during use of and after the use of tear proof clothing
- Use of alternatives methods before Tear Proof clothing and how long these were used
- Detail when first review is planned, who this will include
- Detail the notifications sent informing of the tear proof clothing use
- Has carer/advocate been informed /involved?
- Detail the plan for debrief with service user and whether this was appropriate at the time
- Add detail to when patients disclose these reviews should occur

***It should be noted this list is not exhaustive.***

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## Appendix 4 – Guidance on considerations for recording of the review of Tear proof clothing use

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- Date and time of review
- Document in domain in intervention plan regarding Behaviour That Challenges Policy and Restrictive Interventions Policy
- The details of all the clinicians included in completing the review
- How the patient is involved in the review process
- Was this episode – Patient choice / planned / unplanned (including who was notified and authorising RC / on call consultant)
- Rational for implementation of tear proof clothing including all details documented in initial implementation note. (ie. Previous interventions etc)
- Describe and identify who the patient's Responsible clinician (RC, next of call and out of hours consultants are with contact details)
- Details of patients views on implementation of tear proof clothing
- Details of ongoing measures taken to protect dignity
- Rational for implementation of tear proof clothing
- Review of mental state and risk behaviours since implementation
- Duration of tear proof clothing use
- Review documented debrief to identify needs to support patient back into their own clothing
- Review of any personal items or aids removed such as jewellery glasses etc and considerations gaining access back.
- Review use of underwear and sanitary wear.
- Review least restrictive interventions such as observations and engagements – Link in with supportive engagement and observation protocol.
- Describe the plan going forward- Collaborative discussion including patient views to include required steps to bring the restriction to end, Including support options available.
- Review safety summary
- Notification of review sent and to relevant parties
- Planned dates of next review.

**Appendix 5: Guidance on considerations for recording of Tear proof clothing use when procedure is terminated.**

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- Date that the use of Tear Proof clothing was terminated
- Time that the use of Tear Proof clothing was terminated
- Description of the Clinical presentation and rationale for terminating the use of tear Proof clothing
- Details of the post incident review and plan to complete a post incident review with both Patient and staff involved in implementing the procedure.
- Details of who has been notified that the use of Tear Proof clothing has terminated.

## Appendix 6: Complex Case Panels

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### Background

Due to the nature of its client group, it is recognised that occasions will arise that pose complex or urgent clinical questions that cannot be addressed through the MDT alone. The service recognises that under such circumstances it may be necessary to draw upon wider expertise in order to:

- Gain new insights regarding diagnosis, formulation, treatment and/or management.
- To understand and agree a consensus position.
- To identify and manage any risks, whether to the individual, staff or the organisation.
- To identify how best to support the team e.g. emotional, practical, professional.

### Arranging a complex case panel

Initial representation should be to the relevant clinical director and/or head of service. If the need for a complex case panel is agreed, the following should be arranged:

- An agreed invite list, considering:
  - Immediate clinical team; RC, ward manager, named nurse, psychologist, modern matron, IMHA etc.
  - Senior team; CD, HOS, SCD/DMD, Head of Nursing etc.
  - Relevant others, e.g. physical health practitioners, OT, S&LT, dieticians, PBS practitioners, DBT practitioners, security leads, PAT trainers, MHA leads
  - Independent others, e.g. psychiatrists, psychologists, modern matrons
  - Safeguarding team representative
  - Trust Positive and Safe Lead Nurse
  - Equality, Diversity and Human Rights Team
- A suitable time and venue, giving as much notice as reasonably possible and ensuring adequate time is set aside to reasonably cover the issues
- An agenda which clearly articulates the clinical dilemma and question(s) being posed.
- Any relevant background information, distributed to the participants before the meeting e.g. previous reports, current care plans.

### **During the meeting**

- The meeting will be chaired (usually by the CD or HOS).
- Normal rules of confidentiality will apply.
- Healthy challenge and debate will be encouraged, always adhering to the Trust's Values and Behaviours.
- Contemporaneous minutes will be taken that capture the broad areas discussed and detail all decisions, all actions (including who is responsible and by when) and any unresolved issues.

### **Post meeting**

- Minutes of the meeting to be placed on the patient's Paris record (clearly identifying if any third party information is enclosed).
- If appropriate, the outcome of the meeting is to be shared with the patient and that discussion will be documented on Paris.
- If a duty of candour arises, this should be clearly documented and assurance given to the Clinical Director and/or Deputy Medical Director when it has been completed.
- Arrange to be discussed at relevant QUAG, particularly identifying any lessons learned or if an escalation of any issue is required.

## Appendix 7 – Clinical Template for PARIS Tear Proof Clothing Entries

<b>Team/Ward/ Unit:</b>	<b>Specialty:</b>
<b>Team manager:</b>	<b>Date:</b>
<b>Reviewer name:</b>	<b>Patient PARIS ID:</b>

Ref		Yes	No	Don't Know/Na	Comments
1	Rationale for use?				
2	Name of Authoriser?				
3	Escalation of use? ie Lesser Restrictive Practices				
4	Was this planned or in response to emergency risk?				
5	In line with current risk assessment?				
6	Has a Incident ID (DATIX) been provided?				
7	Has MDT been considered in relation to use of TPC? Name all staff and list role titles				
8	How often is a review been conducted?				
9	Are there plans or considerations for ending the restriction at current moment?				
10	Has patients views been considered?				

## Appendix 8 - Equality Analysis Screening Form

Please note; The Equality Analysis Policy and Equality Analysis Guidance can be found on InTouch on the policies page

Name of Service area, Directorate/Department i.e. substance misuse, corporate, finance etc.	Trust-wide clinical services			
Name of working party, to include any other individuals, agencies or groups involved in this analysis	Trust wide task and finish group set up to undertake this piece of work  Significant trust wide consultation took place in 2019 when the procedure was first developed Trust wide Audit completed March 2021			
Policy (document/service) name	Tear Proof Clothing Use			
Is the area being assessed a...	Policy/Strategy	<input type="checkbox"/>	Service/Business plan	<input type="checkbox"/>
	Procedure/Guidance	<input checked="" type="checkbox"/>	Code of practice	<input type="checkbox"/>
	Other – Please state			
Geographical area covered	Trust-Wide			
Aims and objectives	Whilst staff will make every attempt to support an individual's behaviour using the principles of Positive Behaviour Support and least Restrictive Practice, it is acknowledged that occasions may occur where due to the level of distress or presentation of a patient's behaviour, staff will be required to restrict a patient's access to their typical day time clothing providing them with special tear-proof clothing as an alternative. This type of restriction has the potential to cause harm and distress to a patient, as such it must only be used when clinically indicated and no other alternative that maintains the safety of the patient is available. The aim of this procedure is to provide clear guidance in situations where this may occur.			
Start date of Equality Analysis Screening	1 <sup>st</sup> December 2021			

(This is the date you are asked to write or review the document/service etc.)	
End date of Equality Analysis Screening (This is when you have completed the equality analysis and it is ready to go to EMT to be approved)	Review and approved by equality & Diversity officer 7 <sup>th</sup> January 2022

**You must contact the EDHR team if you identify a negative impact. Please contact the team.**

1. Who does the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan benefit?					
People whose behaviour challenges services and the Trust staff who support them.					
2. Will the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan impact negatively on any of the protected characteristic groups below?					
<b>Race</b> (including Gypsy and Traveller)	Yes	<b>Disability</b> (includes physical, learning, mental health, sensory and medical disabilities)	Yes	<b>Sex</b> (Men, women and gender neutral etc.)	Yes
<b>Gender reassignment</b> (Transgender and gender identity)	Yes	<b>Sexual Orientation</b> (Lesbian, Gay, Bisexual and Heterosexual etc.)	No	<b>Age</b> (includes, young people, older people – people of all ages)	Yes
<b>Religion or Belief</b> (includes faith groups, atheism and philosophical belief's)	Yes	<b>Pregnancy and Maternity</b> (includes pregnancy, women who are breastfeeding and women on maternity leave)	No	<b>Marriage and Civil Partnership</b> (includes opposite and same sex couples who are married or civil partners)	No

**Yes** – Please describe anticipated negative impact/s

This type of restriction has the potential to cause harm and distress to a patient. Whilst all steps to mitigate its impact must be taken, it may not be removed. The EIA therefore highlights where potential negative impacts could not be reduced completely for patients with certain protected characteristics, examples of potential negative impact can be shown below although the list is not extensive:

**Age** – Whilst the procedure is relevant for all ages and can be applied to all services within the Trust, the current procedure has not considered CAMHS inpatient services at this time as it is not applicable to TEWV. If this changes however, the procedure will be reviewed again to ensure that the impact on CAMHS services is reviewed extensively.

**Disability** – Whilst the procedure is only implemented when all other interventions have been attempted to support patients in reducing behavioural disturbance and attempts at deliberate self-harm, the removal of clothing can leave patients feeling degraded and potentially expose them to significant psychological risk which therefore can have a negative impact on the protected characteristic of ‘Disability’.

The removal of underwear especially garments below the waist could have a negative impact on the protected characteristic of Disability’ due to the possible increased risk of trauma/re-traumatisation of a patient in these circumstances.

Whilst adjustments will always be considered to ensure that a patient with a disability will still have their needs met, it is acknowledged that the removal of aids that support a patient with a disability e.g., spectacles / hearing aids, prosthetic limbs may need to be removed for a time.

**Gender Reassignment** - Whilst the privacy and dignity of patients is a primary consideration when using tear proof clothing, TEWV are unable to mitigate against the possibility that through the process of using tear proof clothing, Trans patients may be outed through the removal of clothing.

**Religion or Belief and Race** – Whilst the impact will always be considered If personal items or clothing with religious or cultural significance need to be restricted, due to safety, there may be times where additional interventions which may help to minimise the potential harm cannot be put in place, this may therefore have a negative impact on the protected characteristic of ‘Religion or Belief’ and ‘Race’.

**Sex** – Whilst considerations will be made in relation to alternative materials, access to necessary sanitary products for a patient who is menstruating may not always be possible. It is acknowledged that this may have a negative impact on the protected characteristic of ‘Sex’.

Please describe any positive impacts

By having a procedure in place for the use of TPCC, there will be a positive impact on the following:

- Manage and reduce high levels of behaviour distress and risk behaviours to swallowing and ligature attempts
- How to effectively commence and demission the use of TPC within practice
- Use TPC safely
- Monitor and review the use of TPC
- Audit the use of TPC within inpatient services

Whilst rare, on occasions an individual patient may request to use tear proof clothing as part of their individually identified coping strategies and as an aid to support their recovery. This could therefore have a positive impact for some patients with regards to their recovery.

<p><b>3.</b> Have you considered other sources of information such as; legislation, codes of practice, best practice, nice guidelines, CQC reports or feedback etc.?  <b>If 'No', why not?</b></p> <ul style="list-style-type: none"> <li>• Department of Health/Care Quality Commission Findings</li> <li>• Service user complaints</li> <li>• Data collection/Analysis</li> <li>• Feedback from equality bodies, e.g. Care Quality</li> <li>• Internal feedback from Regional Staff Networks, Trades Unions and staff support networks, e.g. LGB, etc</li> <li>• Research (both internal &amp; external)</li> <li>• Community Consultation/Consultation Groups</li> <li>• Investigation findings</li> <li>• Internal Consultation</li> </ul>	<p>Yes</p>	<p>✓</p>	<p>No</p>	
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**Sources of Information may include:**

- Feedback from equality bodies, Care Quality Commission, Equality and Human Rights Commission, etc.
- Investigation findings
- Trust Strategic Direction
- Data collection/analysis
- National Guidance/Reports

- Staff grievances
- Media
- Community Consultation/Consultation Groups
- Internal Consultation
- Research
- Other (Please state below)

4. Have you engaged or consulted with service users, carers, staff and other stakeholders including people from the following protected groups?: Race, Disability, Sex, Gender reassignment (Trans), Sexual Orientation (LGB), Religion or Belief, Age, Pregnancy and Maternity or Marriage and Civil Partnership

**Yes** – Please describe the engagement and involvement that has taken place

Trust wide consultation took place in 2019, feedback of which has been incorporated into the procedure.

**No** – Please describe future plans that you may have to engage and involve people from different groups

5. As part of this equality analysis have any training needs/service needs been identified?

**Yes**

Training covered as part of Mandatory Positive approaches training

A training need has been identified for;

Trust staff

Yes

Service users

No

Contractors or other outside agencies

No

**Make sure that you have checked the information and that you are comfortable that additional evidence can provided if you are required to do so**

If you need further advice or information on equality analysis, the EDHR team host surgeries to support you in this process, to book on and find out more please contact the team.

## Appendix 9 – 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
<b>1.</b>	<b>Title</b>		
	Is the title clear and unambiguous?	Y	
	Is it clear whether the document is a guideline, policy, protocol or standard?	Y	
<b>2.</b>	<b>Rationale</b>		
	Are reasons for development of the document stated?	Y	
<b>3.</b>	<b>Development Process</b>		
	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?	Y	
<b>4.</b>	<b>Content</b>		
	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	
<b>5.</b>	<b>Evidence Base</b>		
	Is the type of evidence to support the document identified explicitly?	Y	
	Are key references cited?	Y	
	Are supporting documents referenced?	Y	

	<b>Title of document being reviewed:</b>	<b>Yes/No/ Not applicable</b>	<b>Comments</b>
<b>6.</b>	<b>Training</b>		
	Have training needs been considered?	Y	
	Are training needs included in the document?	Y	
<b>7.</b>	<b>Implementation and monitoring</b>		
	Does the document identify how it will be implemented and monitored?	Y	
<b>8.</b>	<b>Equality analysis</b>		
	Has an equality analysis been completed for the document?	Y	
	Have Equality and Diversity reviewed and approved the equality analysis?	y	Reviewed by E&D 7 <sup>th</sup> Jan 2022
<b>9.</b>	<b>Approval</b>		
	Does the document identify which committee/group will approve it?	Y	
<b>10.</b>	<b>Publication</b>		
	Has the policy been reviewed for harm?	Y	
	Does the document identify whether it is private or public?	Y	Public
	If private, does the document identify which clause of the Freedom of Information Act 2000 applies?	n/a	