Reducing and Improving the Use of Restrictive Interventions & Practice

40 years of cross-sector experience
in practice and liability issues

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HEALTHCARE CONFERENCES UK

Introduction

- Violence, aggression and other challenging behaviours are an increasing problem across many sectors
- Many issues arise following drug or alcohol consumption as well as with persons suffering from mental ill-health
- Many differences in approaches but some common themes
- More recent concerns (staffing levels, workforce fitness, Covid, etc) require greater input from HR (JDs), OH, supervision.
- What are the most appropriate and safest approaches for both patients and staff?

Overview

- confusion about which staff should be trained and in what skills
- overuse of coercive and restrictive interventions remains a significant issue
- with restraint, injuries (physical/psychological) / fatalities are specific concerns
- main focus continues to be on reducing all kinds of coercive and restrictive interventions to a minimum whilst maintaining safety
- has staff safety been forgotten?
- need for cross-sector oversight / standardised approach
- plenty to learn from coronial Regulation 28 reports
- several controversies remain unanswered

Three fundamentals for managing VAAoCBs

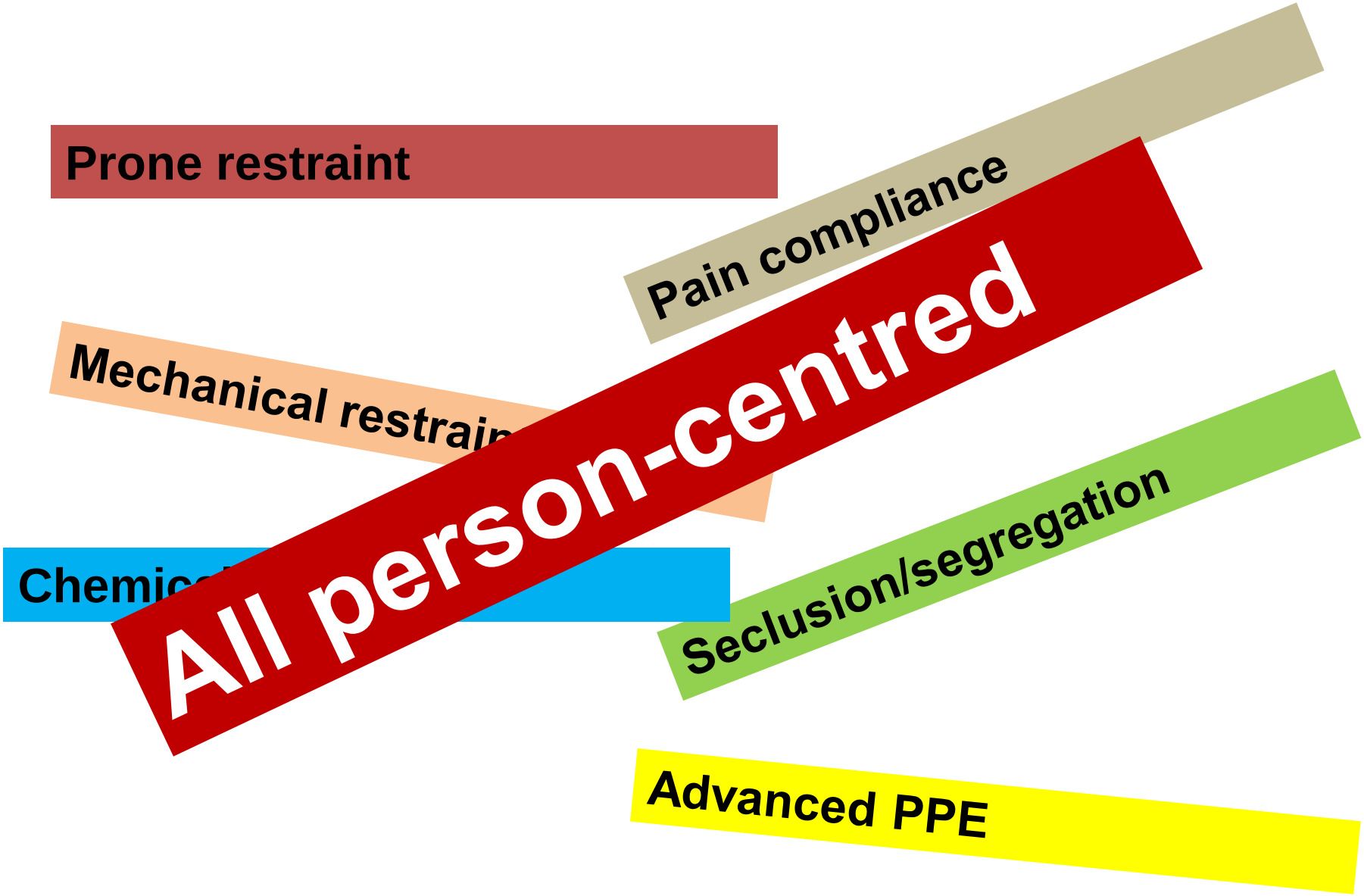
1. What is the best way to keep everyone safe?

If considering any coercive or restrictive intervention, ask:

2. Is it necessary, proportionate, lawful, safe?

3. Just because we can doesn't mean we should

… other issues fall into place



Reducing coercive & restrictive interventions

Two broad categories:

- Cat 1: where no force is needed (abuse)

  examples: *Angellica Arndt (2005)*

  Winterbourne View (2011)

  Whorlton Hall (2019)

  Yew Trees (2020)

- Cat 2: where some kind of intervention is necessary but not of the kind or ferocity used (excessive force)

Angellica Arndt 3/3/1999 – 26/5/2005 (aged 7)

- lost biological family as toddler
- Reactive Attachment Disorder and Attention Deficit Disorder
- during lunch staff told her to stop blowing bubbles in her milk and stop laughing
- continued to blow bubbles and laugh
- taken to cool-down room, restrained prone by two adults, one holding her ankles and another pressing down on her shoulders
- 98-minute total restraint
- vomited and lost control of bladder/bowels. Complained of headache and eye pain. Struggled/cried for help. Possibly passed out

- presented to the media as “aggressive child”
- homicide due to "complications from chest compression/asphyxiation“
- center fined $100,000 (negligence). $12,000 (restitution to family)

Brad Ridout *“I did what I was trained to do when Angellika had behavioral problems”*

60 days in jail plus a year of probation

All kinds of restrictive interventions must be minimised (restraint, seclusion, LTS, coercion, etc.)

Eliminating any kind of intervention is like squeezing a balloon.

The problem will move elsewhere where risks could be greater.

Who should deal with VAAoCB?

- These questions must be answered by reference to your own organisation. What might work for one organisation may not be safe or appropriate for others.

Who should be trained?

A clinical care example

Clinicians:

- train all or some? If some, which ones? Need to consider interest and fitness of staff, age, gender, time away for training/refresher training, etc.
- which skills?
- the ‘use-it-or-lose-it’ principle

Security:

- can only be in one place at a time
- often seen as a dumping ground for VAAoCB
- are you always content with the way security handle issues?

No training for staff – rely on police?

Right Care, Right Person National Partnership Agreement (26 July 2023)

Who should be trained?

A clinical care example

Right Care, Right Person National Partnership Agreement (26 July 2023)

- agreed with government, police and NHSE
- aim of reducing the “inappropriate and avoidable” involvement of police in responding to incidents involving people with mental health
- new threshold for police response to mental-health related incident is (a) to investigate a crime that has occurred or is occurring or (b) to protect people, when there is a real and immediate risk to the life of a person, or of a person being subject to or at risk of serious harm.
- when it comes to police powers under section 136 MHA, the decision to attend an incident will be determined by the threshold and the decision to use section 136 will be made by an officer at the scene of the incident. Police attendance at section 135 warrants will need to be pre-planned and subject to local partnership arrangements.

Consequence?

organisations must have clear policies and strategies in place to ensure they have the necessary capability, competence and capacity to deal with incidents of mental ill-health without needing external support.

What should they be trained in?

example 1	CRT, security awareness	clinical holding	personal safety (breakaway)	restraint
patient-facing staff	✓			
clinical staff	✓	✓	per R.A.	
security staff	✓	✓	✓	✓

NOTE: THIS QUESTION CAN ONLY BE ANSWERED FOLLOWING SUITABLE & SUFFICIENT RISK ASSESSMENT AND TRAINING NEEDS ANALYSIS

- all patient-facing staff: conflict resolution, non-escalation/de-escalation, security awareness
- clinical staff: also receive training in clinical holding skills as well as breakaway training in accordance with their risk profile
- security staff: also trained in restraint skills

What should they be trained in?

example 2	CRT, security awareness	clinical holding	personal safety (breakaway)	restraint
patient-facing staff	✓			
clinical staff	✓	✓	per RA	
security staff	✓	✓	✓	✓
C-PMVA response team	✓	✓	✓	✓

- **C-PMVA response team:** clinical team made up of staff who have been trained to a high standard in all skills designed to manage VAAoCB. Different versions.
- operating on similar lines to a Resuscitation Team.
- enhanced training in physical skills specifically designed for all clinical areas of the Trust and will be selected strategically by location.
- when a patient or visitor becomes violent or aggressive which cannot safely be managed by ward staff, an emergency call will be sent via the ward's pager system to summon the assistance of the Response Team.
- The role of the Response Team will be to provide expertise and leadership in actual or potentially-violent situations, wherever they arise, and work together with ward staff to bring the matter under control as quickly and safely as possible, following the least restrictive approach as set out in the Trust policy.

The Response Team (composition)

- at least 4 clinically-based staff made up where possible, of nursing, medical and psychiatric staff who have been trained to an advanced level in dealing with violent and aggressive incidents.
- precise make-up of each team will be determined, where possible, by the nature and severity of each incident.
- advanced life support expertise.
- availability of response bag containing, amongst other things, “emergency medical devices that may be required for immediate life support, such as Automated External Defibrillators” (see RRN 2.10.6). The bag might also contain rapid tranquilisation and any mechanical restraining devices the Trust might authorise.

Key advantages include:

- cost, time and the pooling of expertise
- provide a team of highly-trained clinical staff to manage incidents, including those of a more serious nature, without recourse to security or police.

What training model is most appropriate for your organisation?

Three broad models:

External training provider

- quickest to set up
- good training providers can provide invaluable ongoing assistance
- can be costly

Internal

- train-the-trainer
- self-sufficient
- better overall outcome
- usually in conjunction with external experts to provide initial and ongoing support. Particularly important with emerging themes/regs/laws

Hybrid

- often used as an interim solution

Training currently provided

Prison estate: Use of Force (previously included C&R)

Youth custody: MMPR (minimising and managing physical restraint)

Police: Personal Safety

High-Secure NHS hospitals: Positive & Safe

NHS/healthcare: no standard approach

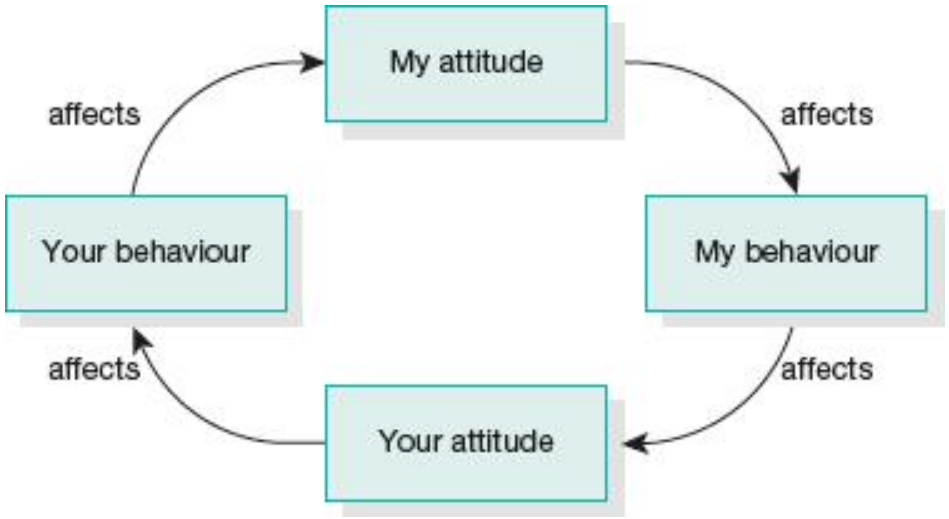
Security: depending on whether they are contracted or directly employed: either SIA training (basic level) or specialist healthcare training

In most cases **conflict-resolution** and **de-escalation** training is either not provided or is very poor

Conflict resolution/de-escalation training

- known by different names but should include training in:
  - conflict resolution
  - non-escalation strategies
  - de-escalation strategies
  - security awareness
- incompatible with zero-tolerance approaches
- often a tick-box exercise
- not sufficiently relevant to specific setting/population
- often dull, uninspiring and irrelevant
- CRT is often more important than PI training because it has the potential to manage a potentially aggressive incident at an early stage without the need for any kind of restrictive intervention
- how do we make it successful?

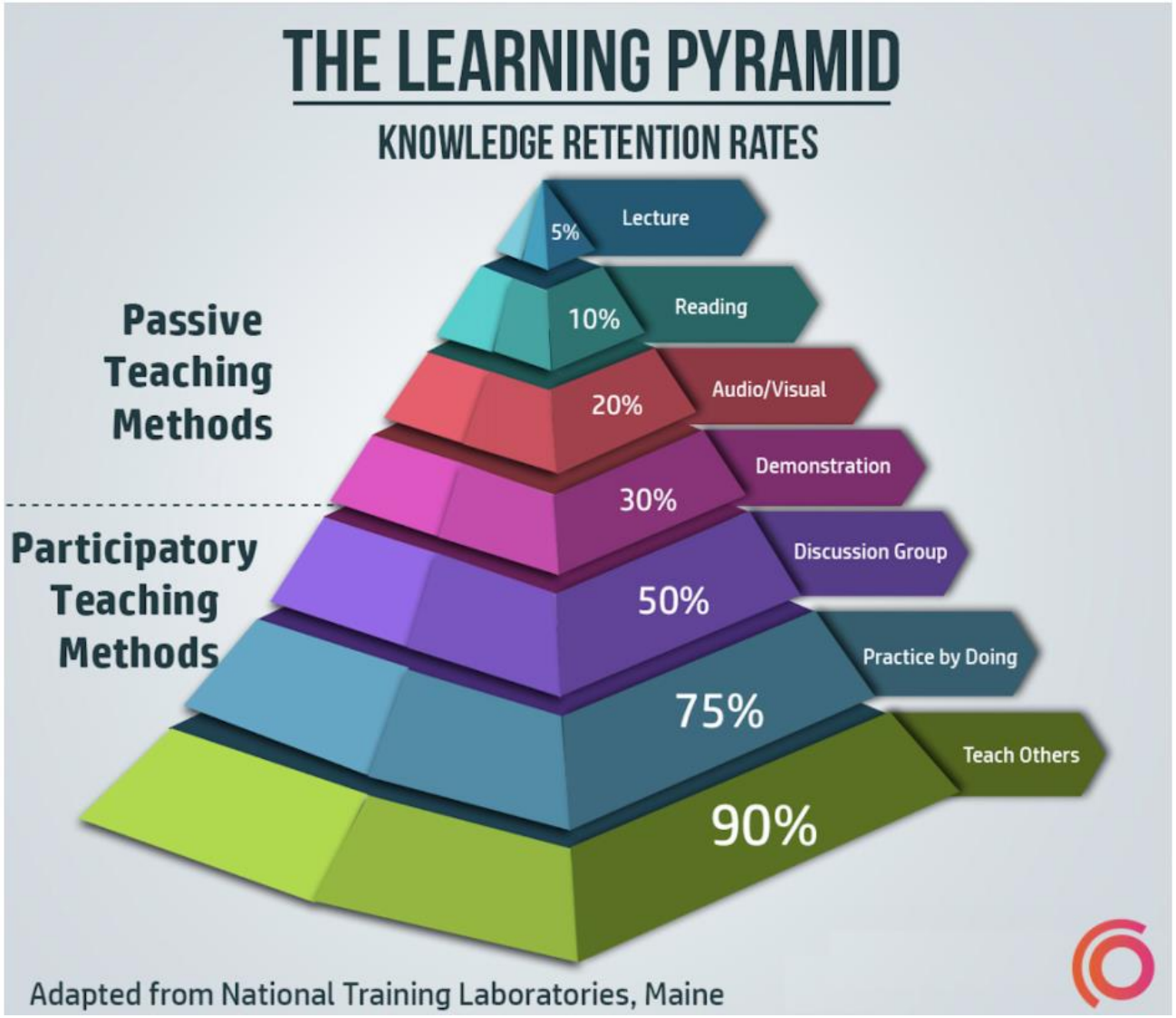
Betari box – the cycle of conflict



"When anger rises, think of the consequences."

Confucius (c.551 – c.479 BCE)

Conflict resolution/de-escalation training



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Participative De-escalation Training Programme™

Some concerns

- Key definitions
- Inaccurate data
- Reporting issues – what do you want to record?
- Responsibility
- Training time / costs
- Absence of standardised approach

ROYAL COLLEGE OF NURSING ANNUAL CONGRESS Liverpool, 2013

Resolution: *"That this meeting of RCN Congress asks Council to lobby UK governments to review, accredit and then regulate national guidelines of approved models of physical restraint"*

Resolution passed:-
For: 99.8% (470). Against: 0.2% (1). Abstain: 1

What has happened since?

- New BILD/RRN certification
- Mental Health Units (Use of Force) Act 2018
- SWC Expert Group endorsement programme

Key policies/guidance in UK (healthcare)

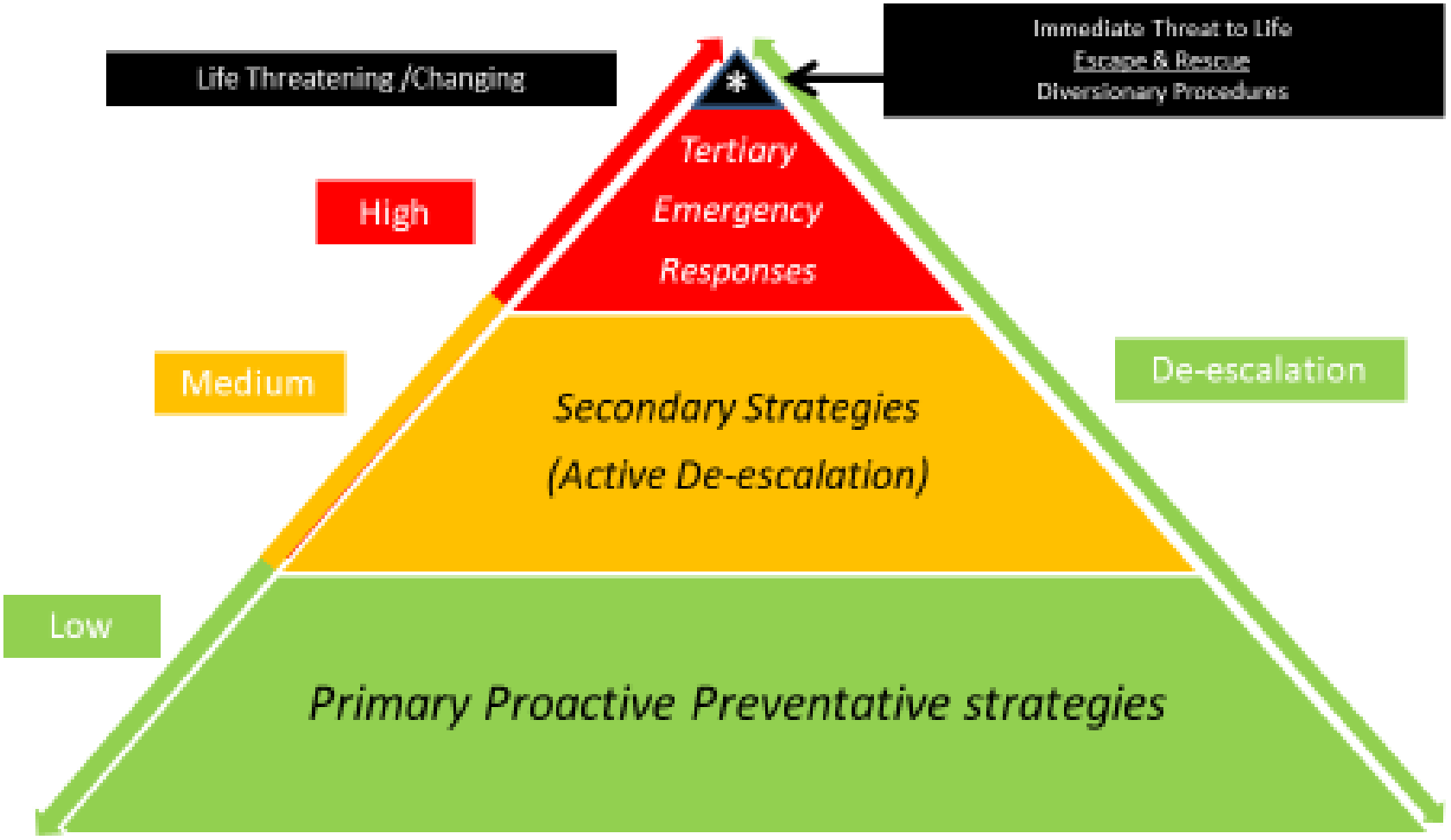
No shortage of policies/guidance. Not always consistent.

- *Positive & Proactive Care*, DH, April 2014
- *NHS Protect*, March 2015
- *Mental Health Act Code of Practice*
- NICE Guideline NG10, May 2015 *(Violence and Aggression: Short-term management in mental health, health and community settings)*
- NICE Violence & Aggression Quality Standard QS154
- Mental Health Units (Use of Force) Act 2018 and Statutory Guidance (7 December 2021).

Wide choice of interventions
(physical/mechanical)

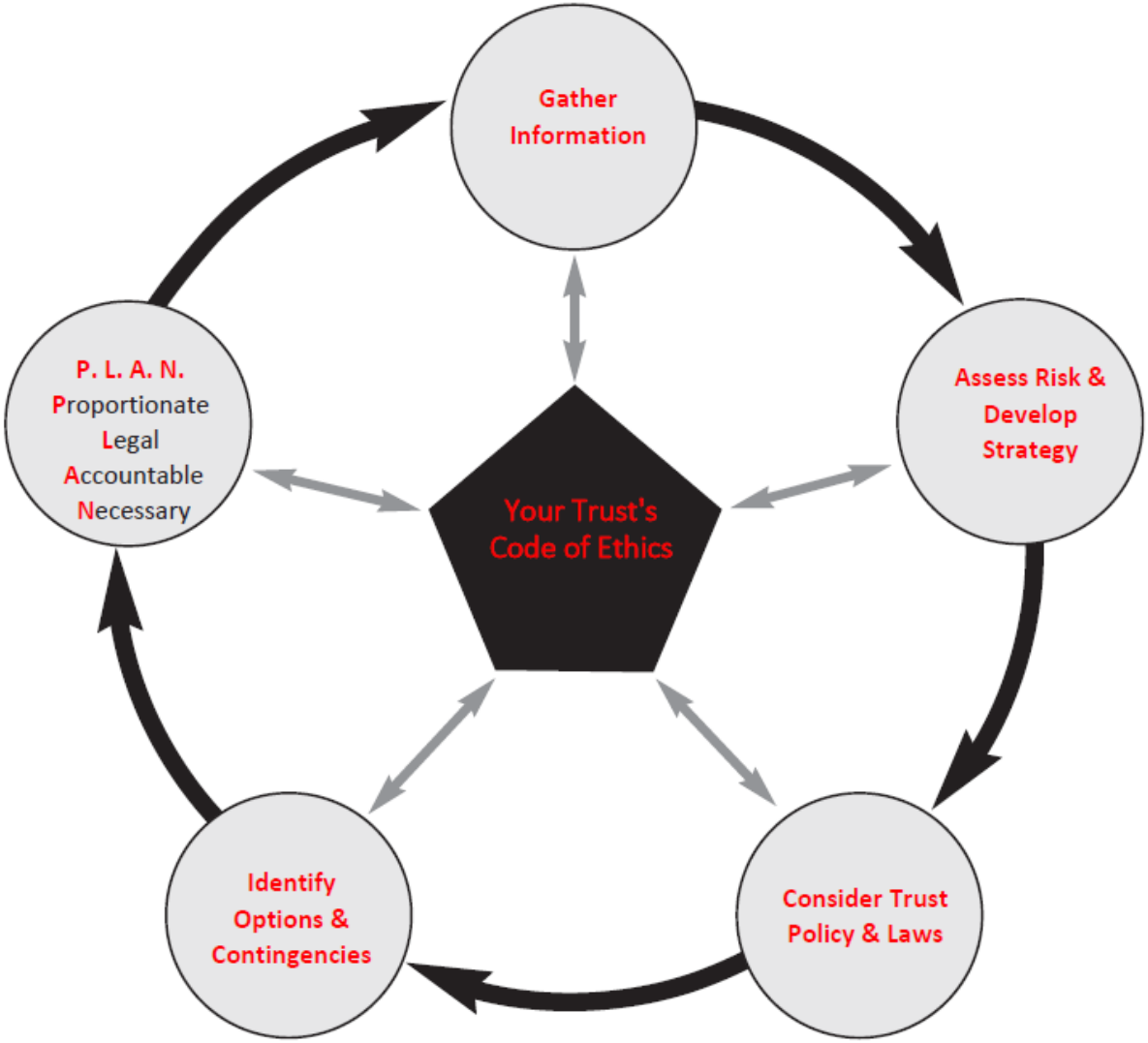
- many different techniques/equipment to choose from
- absence of standardisation (outside of police/prison/high secure hospitals)
- concerns about using mechanical restraints. Justified?
- current practice is to reduce the number of skills taught; eg.
  - HOMES (Home Office Manual for Escorting Safely)
    - 12 core techniques
  - High Secure Hospitals
    - Breakaway – 4 fundamental skills

'Hierarchy of Responses'
Primary, Secondary & Tertiary Strategies
(Risk Potential)



The SWC Decision-Making Model ™

specifically for managing VAOCBs



Four key controversies

(1) ‘No-restraint’ policies

(2) Prone restraint positions

(3) Pain-compliance techniques

(4) Mechanical restraints

(1) No-restraint policies

- Can apply to all staff or to some.
- Why do they exist?
- “Behaviour is a matter for the police”.
- Unsafe and potentially dangerous.
- Unenforceable/unlawful.
- Places organisation at risk (civil claims, HSE investigations/ prosecutions, etc).

Mental health trust prosecuted after nurses stabbed

HSE brought case against Oxleas NHS Foundation Trust after an inpatient stabbed two members of staff at the Bracton Centre in Dartford in July 2016.

Improvement Notice issued alleging the Trust *"failed to make a suitable and sufficient assessment of the risks to the safety of employees and third parties for the purposes of identifying the preventative and protective measures required to control violence and aggression demonstrated by the service users of the Burgess Ward."*

Breaches: ss 2(1) and 3(1) HSWA 1974 (duty to ensure H&S) and Reg 3.1 of the Management of Health & Safety at Work Regulations 1999 (risk assessments).

£400,000 fine for 2 South Wales MH providers (Parkcare Homes and Priory Central Services) after staff subjected to violent attacks over a 3-year period (sentenced 26/7/23)

Some injuries were very serious including loss of consciousness and permanent scarring

No suitable and sufficient risk assessments carried out and the equipment and environment was not fit to diffuse violent situations

Staff not provided with adequate information or training to cope with patients with aggressive behaviour nor provided with any PPE (including bite resistant clothing and personal safety alarms)

Repeated warnings from HSE about systemic failures leading to staff injuries but this were not remedied

HSE: “Care providers should plan and organise preventative measures to prevent violence towards staff and other patients.”

(2) Prone restraint positions

what is (should) the debate about?

- Safety (patient/staff)
- Control/secure
- Confusion (what is it?)
- Evidence?
- Attempts to ban its use. Is it banned?
- Alternatives/consequences?

Many key dates, but consider:

- **2004**: Dr Cary, Consultant HO Forensic Pathologist, evidence to Bennett inquiry: *"Prone restraint is an area that we know from cases around the world is a position in which people appear to die suddenly when restrained for long periods."* Sir John Blofeld recommended use of prone should be limited.
- **2005-7**: NICE did not accept this recommendation. *"No clear evidence that prone presented significantly greater risk than other positions"*.
- **2011**: Winterbourne View.
- **2013**: MIND pressures government to stop all *"face-down"* restraint of people with mental-health problems in healthcare settings. Data secured by MIND (FOI) reveals that at least 3,439 patients in England were restrained in a "face-down" position in 2011-12 despite the increased risk of death from this kind of restraint.
- **2014**: DH 'Positive & Proactive Care, para 70.

Putting restraint into (the wrong) context

Winterbourne View

Winterbourne View – Serious Case Review (p135)

Recommendation: Commissioners should ensure that all hospital patients with learning disabilities and autism have unimpeded access to effective complaints procedures - in the case of NHS-funded care, these arrangements must meet the statutory requirement laid down in the 2009 Local Authority and National Health Service Complaints (England) Regulations 2009

Recommendation: The Department of Health, Department for Education and the Care Quality Commission should consider banning the t-supine restraint of adults with learning disabilities and autism in hospitals and assessment and treatment units. An investment comparable to the banning of the corporal punishment of children is required. The use of restrictive physical intervention "as a last resort" characterises all policies and guidance and yet made no difference to the experience of patients at Winterbourne View Hospital.

detect instances of re-attendance from the same location as well as by any individual. The Department of Health may wish to highlight this to A&E departments, including it in their annual review of Clinical Quality Indicators.

Recommendation: Commissioners responsible for funding placements should be proactive in

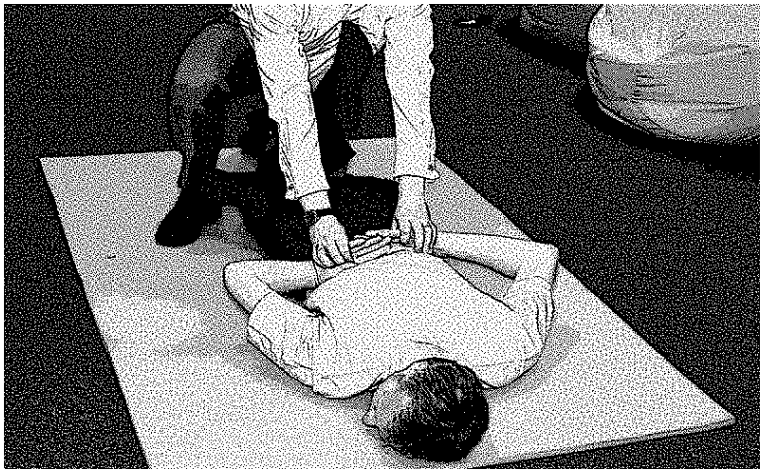

CALL-7

Lung function: prone v supine as a comparison to standing

Position 2. Flat on floor, supine.

Position 3. Flat on floor, prone.

Position 4. Prone, restraining staff apply body weight to torso (‘Chicken wing’).



Position 5. Prone, arms and legs restrained in flexed position (‘Figure four leg lock’)

Prone v supine as a comparison to standing

	Forced Vital Capacity (FVC) (mean lung function)	Forced Expiratory Volume in 1st second (FEV_1)
1. Standing control position	100%	100%
2. Supine (held by arms in 'chicken wing')	-3.56%	-3%
3. Prone (held by arms in 'chicken wing')	-7.8%	-7.87%
4. Forced prone (leaning in towards subject)	**-23.83%**	**-27.39%**
5. Forced prone (with fig 4 leg lock and arms restrained)	**-30.46%**	**-29.87% (one participant showing -57%)**

Reduction in lung function compared with position 1 : Bold = statistically significant
Experiment conducted by Parkes *et al.* See *Med Sci Law 2008 Apr;48(2):137-41*

Comparison of various seated positions

	All	BMI less than 25 (FVC)	BMI greater than 25 (FVC)
1. Standing control position	100%	100%	100%
2. Seated control position (upright; no restraints)	-4.3%	-6.5%	-2.5%
3. Seated – leaning forward to furthest point possible; not held/restrained	-28%	-18.2%	-36.3%
4. Seated – as 3; but restrained with double fig-4 arm holds	**-32.5% (1 participant showing -80.6%; 5 showing greater than -50%)**	**-17.6%**	**-44.7%**

Reduction in lung function compared with position 1
Bold = statistically significant
Experiment conducted by Parkes *et al. Med Sci Law 2011; 51: 177–181*

Position 4

Historical context

04/14 - DH Positive & Protective Care "*ban*"

03/15 - NHS Protect "*may be exceptional circumstances"*

04/15 - MHA CoP *"cogent reasons"* requirement

05/15 - NICE Guideline NG10 preference for supine

2015 - DH clarified *"not a ban"*

- *exploited by some private training providers promoting supine as the safe solution*
- *supine & prone both carry risks – just different*
- *some countries/orgs have banned use of prone; others banned supine*
- *practical considerations for supine use*
- *avoid all takedowns/ground restraints wherever possible*

NICE CLINICAL GUIDANCE CG 2005

… the guideline development group believe that there are dangers related to restraint in any position and therefore decided not to highlight one position as safer than another, but to discourage restraint for prolonged periods in any position.

INDEPENDENT REVIEW OF RESTRAINT IN JUVENILE SECURE SETTINGS

Smallridge and Williamson, 2008

"In the light of the competing evidence we feel that we cannot make any recommendation to ban prone restraint, but we consider it prudent that when prone restraint is used there should be a re-assessment of the risks after control has been obtained in the initial restraint." (para 6.35)

Supine as an alternative to prone?

The British Journal of Psychiatry (2018)

BJPsych | The British Journal of Psychiatry (2018)
Page 1 of 5. doi: 10.1192/bjp.2017.31

Analysis

Restraint in mental health settings: is it time to declare a position?

Faisil Sethi, John Parkes, Eric Baskind, Brodie Paterson and Aileen O'Brien

Summary

The emergence of a drive to reduce restrictive interventions has been accompanied particularly in the UK by a debate focussing on restraint positions. Any restraint intervention delivered poorly can potentially lead to serious negative outcomes. More research is required to reliably state the risk attached to a particular position in a particular clinical circumstance.

Declaration of interest

F.S. is a consultant psychiatrist in Psychiatric Intensive Care at the Maudsley Hospital, London. He is on the Executive Committee of the National Association of Psychiatric Intensive Care and Low Secure Units, and was a member of the National Institute for Health and Care Excellence Guideline Development Group for the Short-Term Management of Aggression and Violence (2015). J.P. is a senior lecturer at the Faculty of Health and Life Sciences, Coventry University. E.B. is a consultant and expert witness in violence reduction and the use of physical interventions, independent expert to the High Secure Hospitals Violence Reduction Manual Steering Group and a member of the College of Policing Guideline Committee Steering Group and Mental Health Restraint Expert Reference Group. B.P. is the clinical director for Crisis and Aggression Limitation and Management (CALM) Training and formerly a senior lecturer for the Faculty of Health, University of Stirling. He is a nurse and psychotherapist and presently chairs the European Network for Training in the Management of Aggression. A.O'B. is a consultant psychiatrist, the Director of Educational Programmes for the National Association of Psychiatric Intensive Care and Low Secure Units, and the Dean for Students at St George's University of London.

There is a broad international consensus that where any form of coercion is used, preference should be given to the least restrictive and least dangerous measure.[1] Physical restraint is sometimes used as a discrete intervention, separate to the use of other coercive interventions such as mechanical restraint, enforced medication and seclusion, but where such options are available restraint will almost invariably be used to facilitate their application. Coercive interventions exist in a dynamic clinical context, where the availability of one intervention may have an impact on the frequency and nature of another.

The use of coercive interventions has historically been driven by an interaction between local and national cultures rather than being evidence based, and a number of countries are working towards reducing such interventions.[2] In the UK, this practice is comparatively unusual in that mechanical restraint[3] and seclusion are used infrequently; this is arguably a legacy of the restraint reduction movement of the 1800s which has also been an emergent policy to the floor and a preference for supine over prone restraint. The guidance also suggested considering the use of seclusion or rapid tranquilisation if the restraint lasts for more than 10 minutes.[8]

The revised Code of Practice of the UK Mental Health Act 1983 (MHA) states that unless there are cogent reasons for doing so, there must be no planned restraint of a person whereby they are forcibly laid on their front.[9] The Care Quality Commission produced a guide in 2015 focusing on the importance of training, individual care plans and debriefing.[10] Concerns about physical risk during restraint have also led to patient safety alerts for both England and Wales stressing the importance of monitoring vital signs.[11,12]

The National Health Service Benchmarking Network (NHSBN) has collected recent data on the use of restraint in England. Figure 1 summarises the totals/rates for (prone) restraint in over 90% of the beds in England in January 2016. The figure summarises the results from the NHSBN Restraint Audit (2016)[13] and displays a striking

Royal College of Emergency Medicine

“It has previously been suggested that restraint in the prone position contributed to deaths. Although this theory has not been supported by recent research, it would be prudent to ensure that there is no obstruction to ventilation and to minimise the risk of asphyxiation.”

Royal College of Emergency Medicine, Best Practice Guideline, “Acute Behavioural Disturbance in Emergency Departments”, February 2022

See further:

Vilke GM. Restraint physiology: A review of the literature. J Forensic Leg Med. 2020;75:102056. doi:10.1016/j.jflm.2020.102056

Time in restraint

Q: For how long is it safe to restrain someone, especially on the ground?

(a) 3 minutes (Bennett Inquiry)

(b) 5 minutes (prison service manual 1999)

(c) 10 minutes (NICE NG10)

A: *none of the above*

Time in restraint – key issue in safety

‘The amount of time that restraint is applied is as important as the form of restraint and the position of the detainee.

Prolonged restraint and prolonged struggling will result in exhaustion, possibly without subjective awareness of this which can result in sudden death.’

Police Complaints Authority. ‘Policing Acute Behavioural Disturbance’, Revised Edition, March 2002

(3) Pain-compliance techniques

Pain compliance is generally unnecessary but may be safer alternative in certain high-risk situations.

Generally, where there is an immediate risk to life ... recognised techniques that cause pain as a stimulus may be used as an intervention to mitigate that risk (see, eg. *Positive & Proactive Care, DH, April 2014, para 69).*

But, never to force compliance with staff instructions.

Disingenuous to give intervention a different name to disguise it, eg:
"distraction techniques" (Adam Rickwood), "escape and rescue" (BILD/RRN), etc.

(4) Mechanical restraint

- *'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'* (Department of Health 2014, paragraph 78).

- not a complete alternative to physical restraint as they cannot be applied unless the subject is under some degree of control. In most cases staff will need physically to restrain the subject before applying mechanical restraints.

- any kind of physical intervention should be used only where necessary and mechanical restraint, being part of the intervention mix, is no exception.

- can be very helpful for de-escalation.

Manual Handling Operations Regulations 1992

- Physical restraint is a manual handling activity.
- The Manual Handling Operations Regulations 1992, as amended by the Health and Safety (Miscellaneous Amendments) Regulations 2002, applies.
- Employers are required to fulfil a number of criteria to reduce the risk of manual handling accidents at work.
- This includes a requirement that employers *"shall so far as is reasonably practicable avoid the need for his employees to undertake any manual handling operations at work which involve a risk of their being injured"* (reg. 4(1)(a)).

NICE NG10

6.6.3.18-19

- mechanical restraint in adults only in high-secure settings (except when transferring service users between medium- and high-secure settings)
- why so restrictive?
- contrary to the Manual Handling Regs
- generally unnecessary but *may* be safer in certain high-risk situations, eg:
  - preventing otherwise prolonged restraint/more risky positions
  - avoiding the use (or repeated use) of pain-compliance
  - wherever it is safer option in all of the circumstances
- not to be confused with bed cages, ties, used outside UK

Notts Healthcare NHS Trust v RC [2014] EWCOP 1136

Male adult - severe personality disorder - intelligence within normal range - has capacity - whilst detained in psych. hospital assaulted staff - 5 years' prison.

Serious self-harming (self-strangulation with ligatures and plastic bags, burning himself, head-butting and self-laceration, frequently re-opens wounds).

Transferred from prison back to psychiatric hospital - detained MHA. Mechanical restraint used to prevent him from using his hands to self-harm.

Engages 2nd limb of NICE NG10 para 6.6.3.19 - *"mechanical restraint to be used as a last resort and for the purpose of limiting self-injurious behaviour of extremely high frequency or intensity".*

But query 6.6.3.18 which restricts M.R. to high-secure settings. Why??? What alternatives did staff have?

- manual restraint to prevent his self-harming behaviour. Consider risks/prolonged restraint issues and para 6.6.3.13 (10 mins guideline)
- seclusion/forced rapid tranq not appropriate (6.6.3.14)
- why should it matter whether P's behaviour occurred whilst detained in low, medium or high secure hospital or continued while he was detained in prison hospital wing?

We recognise that the use of mechanical restraint may be considered to be the least restrictive intervention in some specific cases, and may present less risk to the individual than the alternative of prolonged manual restraint or transfer to a more restrictive setting.

This could provide a valid reason for using mechanical restraint in an emergency or 'unplanned' interventions, as well as planned interventions.

CQC 2018
Restraint: physical and mechanical guidelines

three important safety considerations

Safety person many restraint-related deaths could have been prevented had a competent safety person been present whose sole responsibility was the safety and well-being of the person restrained. In charge but not participating. Overall oversight important.

Prevention of Future Deaths reports -to- Prevention of Future Harm investigations important to note that the difference between P not being injured, being injured, and dying is often a matter of chance.

Assurance of necessity work I am carrying out suggests 46% of physical interventions were wholly unnecessary (261 reviews between 2018 – 2023).

Protecting your organisation from problems and harm

- ensure records are maintained and are accurate
- contentious documents (ie use of force forms) must be completed independently of other persons
- ensure everything is appropriately recorded
- always have your policies and physical skills independently reviewed
- where appropriate, engage independent investigators to review significant events
- where you intend to depart from guidance, set this out clearly, with reasons

The SWC checklist for safer interventions

Pre	During	Post
Have all interventions been risk assessed? (medical, legal, biomechanical, ethical, etc)?	Is it necessary?	Post-incident debrief
Have your processes been externally reviewed and signed off as appropriate?	Does it remain necessary throughout?	Lessons learnt
Are all staff sufficiently trained?	Can it be planned? (If so, reflect on necessity throughout planning and at point of implementation)	Restraint safety manager (➥national safety commissioner)
	The Safety Officer	External review
	Continuously think about the aim of the intervention?	Adverse incidents and Prevention of Harm investigations
	Are there less risky / restrictive alternatives?	

My mission

- Minimise the use of all kinds of restrictive and coercive intervention
- Where necessary, ensure they are appropriate, ethical, legal and safe
- Improve safety for staff and patients

Thank you for listening

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