# CAMHS Physical Restraint Care Plan

| **Patient Details:** | |
|---|---|
| Name: | |
| Date of Birth: | |
| MRN: | |
| Date Physical Restraint Ordered: | |
| Time Physical Restraint Commenced: | |
| Date Physical Restraint Ended: | |
| Time Physical Restraint Ended: | |
| First Order: | |
| Renewal Order: | |
| Renewal Order: | |

| **Pre Physical Restraint** | **Yes / No / N/A** | **Comments / Follow-Up Required** |
|---|---|---|
| Has A Risk Assessment Been Completed? | ☐ Yes ☐ No ☐ N/A | |
| **Initiation** | | |
| Was Physical Restraint Initiated By A Registered Nurse/ Registered Medical Practitioner? | ☐ Yes ☐ No ☐ N/A | |
| Was The Most Senior Registered Nurse/Registered Medical Practitioner Initiating The Renewal Order? | ☐ Yes ☐ No ☐ N/A | |
| Is Physical Restraint Initiation Documented In The Clinical File? | ☐ Yes ☐ No ☐ N/A | |
| Has The Person Been Informed Of The Reasons For;<br>• Likely Duration Of The Physical Restraint<br>• Behaviour Which Leads To The End Of Physical Restraint | ☐ Yes ☐ No ☐ N/A | |
| Has The Person's Representative Or A Nominated Person Been Notified (With Consent), And Has Evidence Been Recorded In The Clinical File? | ☐ Yes ☐ No ☐ N/A | |
| If A Person's Representative Or Nominated Person Was Not Contacted, Has The Reason Been Documented In The Clinical File? | ☐ Yes ☐ No ☐ N/A | |
| Are ADON / Line Manager/Duty Doctor/Consultant Informed? | ☐ Yes ☐ No ☐ N/A | |
| Are All Persons And Their Roles Identified During The Episode Of Physical Restraint Documented In The Clinical Practice Form And The Clinical File? | ☐ Yes ☐ No ☐ N/A | |

Name: Date of Birth:

| | | |
|---|---|---|
| **Recording** | | |
| No Later Than 30 Minutes Following The Medical Examination, Has The NCHD Contacted The Consultant Psychiatrist? | ☐ Yes ☐ No ☐ N/A | |
| Was The NCHD Review Completed Within 2 Hours? | ☐ Yes ☐ No ☐ N/A | |
| Has The Consultant Reviewed The Person And Signed The Physical Restraint Register Within 24 Hours? | ☐ Yes ☐ No ☐ N/A | |
| **Ending** | | |
| Was The Time, Date And Reason For Ending Physical Restraint Recorded In The Person's Clinical File | ☐ Yes ☐ No ☐ N/A | |
| Is The Original Physical Restraint Clinical Practice Form In The Person's File Completed And Placed? | ☐ Yes ☐ No ☐ N/A | |
| Has The Physical Restraint Information Leaflet Been Given To The Person? | ☐ Yes ☐ No ☐ N/A | |
| Has A Risk Assessment Been Completed Following The Ending Of Physical Restraint? | ☐ Yes ☐ No ☐ N/A | |
| **Post Physical Restraint** | | |
| Is There Documented Evidence That The Person's Physical And Psychological Health Was Monitored Closely For A Minimum Of 2 Hours After The Restriction? | ☐ Yes ☐ No ☐ N/A | |
| Has An In-Person Debrief With The Restrained Person Taken Place After An Episode Of Physical Restraint Within Two Days And Recorded On The Template In This Booklet? | ☐ Yes ☐ No ☐ N/A | |
| If The Person Declines To Participate In The Debrief, Is The Decision Recorded In The Person's Clinical File? | ☐ Yes ☐ No ☐ N/A | |
| Was The Person's Representative Invited (With Consent) To Debrief, And Were Details Documented In The Clinical File? | ☐ Yes ☐ No ☐ N/A | |
| Has The Person's Individual Care Plan Been Updated To Reflect The Outcome Of The Debriefing? | ☐ Yes ☐ No ☐ N/A | |
| Was The Person Debriefing Tool Completed Within Two Days? | ☐ Yes ☐ No ☐ N/A | |
| Has The MDT Review Occurred No Later Than Five Working Days? | ☐ Yes ☐ No ☐ N/A | |
| Was The Person's Representative Invited (With Consent) To The MDT Review, And Were Details Documented In The Clinical File? | ☐ Yes ☐ No ☐ N/A | |
| Has The MDT Review Been Documented In The MDT Review Template In This Booklet? | ☐ Yes ☐ No ☐ N/A | |
| Was ICP Updated To Reflect The Physical Restraint Episode? | ☐ Yes ☐ No ☐ N/A | |

Name: Date of Birth:

| Nurses Signature: | Dates: |
|---|---|

| **Risk Assessment** | | |
|---|---|---|
| Please Indicate In The Areas Where There Is A Change In Data | | |
| **Risk To Self (S)** | **Risk To Others (O)** | **Please Specify** |
| History Of Previous Suicide Attempts | | |
| Expressing Current Suicidal Thoughts Or Fantasies | | |
| Previous History Of Engaging In Self-Harm | | |
| Expressing Current Self-Harming Thoughts Or Fantasies | | |
| History Of Impulsive Behaviour | | |
| An Expression Of Concern From Others About Suicide | | |
| **Risk To Others (O)** | **Risk To Others (O)** | **Please Specify** |
| History Of Episodes Of Harm To People | | |
| History Of Damage To Property (Fire Setting/Vandalism) | | |
| Does The Person Have An Intention To Cause Harm Or Damage? | | |
| History Of Impulsive Behaviour | | |
| History Of Sexual Assault/Abuse/Harassment | | |
| Are There Child Protection Issues | | |
| An Expression Of Concern From Others About The Risk Of Violence | | |
| **Risk Of Self Neglect (S.N.)** | **Risk To Others (O)** | **Please Specify** |
| Recent Or Previous Poor Personal Self-Care | | |
| Recent History Of Misuse Of Alcohol/ Substances | | |
| History Of Non-Compliance Of Medical Treatment | | |
| **Summary Of Risk:** | **Risk To Others (O)** | **Please Specify** |
| | | |

| Risk Category: | High Risk | Medium Risk | Low Risk |
|---|---|---|---|
| Mode Of Assessment | | | |

Name: Date of Birth:

| |
|---|
| **Risk Management Plan:**<br>(Including Who Is To Do What, Further Areas Of Information Needed, Identifying How Risks Are Being Taken) |
| **Involvement and Agreement of Person and Carer In Process:** |
| Service User/Carer Comments |
| Service User Signature (Optional) |
| Carer Signature (Optional) |

| | |
|---|---|
| Completed By: | Grade: |
| Date: | Time: |

Name: Date of Birth:

| **Post Physical Restraint Nursing Care Plan** |
| --- |
| Known Clinical Needs (Including Mental And Physical Considerations); |
| Risk Management Plan; |
| De-Escalation Strategies To Be Used; |
| The Personal Preferences With Physical Restraint And Take Into Account Outcomes Of Any Previous Debrief With The Person, If Applicable; |
| Support Plans For The Person And Details Of How The Person's Mental Health Needs Will Continue To Be Met During Physical Restraint Episodes; |
| There Are Notable Signs That A Person's Behaviour Is No Longer Deemed An Unmanageable Risk Towards Themselves Or Others, E.G., Evidence Of Tension Reduction, Improved Communication, Etc. |

Name: Date of Birth:

| **Communication** | |
|---|---|
| Date & Time Physical Restraint Was Initiated | |
| Date & Time Physical Restraint Ended: | |
| Name Of NCHD Informed: | By Whom: |
| Time NCHD Informed: | By Whom: |
| Name Of Consultant / On-Call Informed: | |
| Time Consultant / On-Call Informed: | By Whom: |
| Name Of ADON / Line Manager Informed: | |
| Time ADON / Line Manager Informed: | By Whom: |
| Name Of Representative Informed: | |
| Date And Time Representative Was Informed: | |
| Was The Person Informed Of The Reason(S) For Physical Restraint? | ☐ Yes ☐ No<br>If No, Reason: |
| Was The Person Informed Of The Likely Duration Of Physical Restraint? | ☐ Yes ☐ No<br>If No, Reason: |
| Was The Person Informed Of The Circumstances Leading To The Discontinuation Of Physical Restraint? | ☐ Yes ☐ No<br>If No, Reason: |
| Was The Person's Consent Obtained To Contact Their Representative? | ☐ Yes ☐ No<br>If No, Reason: |
| Was The Persons Representative Contacted (Person Must Give Consent)? | ☐ Yes ☐ No<br>If No, Reason: |

Name: Date of Birth:

| *2-Hour Observation Record Of The Person's **Level Of Distress;** The **Person's Behaviour** (What The Person Is Doing And Saying); The Person's **Level Of Awareness**; The Person's **Physical Health**, Especially Concerning **Breathing, Pallor Or Cyanosis**. The Person's **Psychological Health.*** | |
|---|---|
| **Start Date /Time Of Observation:** | |
| Time: | Level Of Awareness: |
| | Behaviour/Level Of Distress: |
| | Breathing: |
| | Skin (Pallor Or Cyanosis): |
| Time: | Level Of Awareness: |
| | Behaviour/Level Of Distress: |
| | Breathing: |
| | Skin (Pallor Or Cyanosis): |
| Time: | Level Of Awareness: |
| | Behaviour/Level Of Distress: |
| | Breathing: |
| | Skin (Pallor Or Cyanosis): |
| Time: | Level Of Awareness: |
| | Behaviour/Level Of Distress: |
| | Breathing: |
| | Skin (Pallor Or Cyanosis): |

Name: Date of Birth:

| *2-Hour Observation Record Of The Person's **Level Of Distress;** The **Person's Behaviour** (What The Person Is Doing And Saying); The Person's **Level Of Awareness**; The Person's **Physical Health**, Especially Concerning **Breathing, Pallor Or Cyanosis**. The Person's **Psychological Health.*** | |
|---|---|
| **Start Date /Time Of Observation:** | |
| Time: | Level Of Awareness: |
| | Behaviour/Level Of Distress: |
| | Breathing: |
| | Skin (Pallor Or Cyanosis): |
| Time: | Level Of Awareness: |
| | Behaviour/Level Of Distress: |
| | Breathing: |
| | Skin (Pallor Or Cyanosis): |
| Time: | Level Of Awareness: |
| | Behaviour/Level Of Distress: |
| | Breathing: |
| | Skin (Pallor Or Cyanosis): |
| Time: | Level Of Awareness: |
| | Behaviour/Level Of Distress: |
| | Breathing: |
| | Skin (Pallor Or Cyanosis): |

Name: Date of Birth:

| **Ending Of Physical Restraint Risk Assessment** |
|---|
| **Please Insert A (√) In The Relevant Answer To The Criteria For Each Section; Dk= Don't Know; It Is Not Possible To Rate At Present.** Where Risk Identified, Please Outline More Details In The Please Specify Section |

| **Risk To Self (S)** | **Yes** | **No** | **DKI** | **Please Specify** |
|---|---|---|---|---|
| History Of Previous Suicide Attempts | ☐ | ☐ | ☐ | |
| Expressing Current Suicidal Thoughts Or Fantasies | ☐ | ☐ | ☐ | |
| Previous History Of Engaging In Self-Harm | ☐ | ☐ | ☐ | |
| Expressing Current Self-Harming Thoughts Or Fantasies | ☐ | ☐ | ☐ | |
| History Of Impulsive Behaviour | ☐ | ☐ | ☐ | |
| An Expression Of Concern From Others About Suicide | ☐ | ☐ | ☐ | |

| **Risk To Others (O)** | **Yes** | **No** | **DKI** | **Please Specify** |
|---|---|---|---|---|
| History Of Episodes Of Harm To People | ☐ | ☐ | ☐ | |
| History Of Damage To Property (Fire Setting/Vandalism) | ☐ | ☐ | ☐ | |
| Does The Person Have An Intention To Cause Harm Or Damage | ☐ | ☐ | ☐ | |
| History Of Impulsive Behaviour | ☐ | ☐ | ☐ | |
| History Of Sexual Assault/Abuse/Harassment | ☐ | ☐ | ☐ | |
| Are There Child Protection Issues | ☐ | ☐ | ☐ | |
| An Expression Of Concern From Others About The Risk Of Violence | ☐ | ☐ | ☐ | |
| Recent Or Previous Poor Personal Self-Care (Hygiene, Diet) | ☐ | ☐ | ☐ | |
| Recent History Of Misuse Of Alcohol/Substance | ☐ | ☐ | ☐ | |
| History Of Non-Compliance Of Medical Treatment | ☐ | ☐ | ☐ | |

| **Vulnerability Of Service User (S.U.)** | **Yes** | **No** | **DKI** | **Please Specify** |
|---|---|---|---|---|
| Risk Due To Mobility/Wandering | ☐ | ☐ | ☐ | |
| Risk Due To Mental Faculties/Cognitive Capacity | ☐ | ☐ | ☐ | |
| History Of Physical, Sexual, And Emotional Harm Or Abuse By Others | ☐ | ☐ | ☐ | |
| History Of Financial Abuse Or Neglect By Others | ☐ | ☐ | ☐ | |

| **Absconding Risk (A)** | **Yes** | **No** | **DKI** | **Please Specify** |
|---|---|---|---|---|
| Expressing A Desire To Leave/Not Come Into Hospital | ☐ | ☐ | ☐ | |
| Current Plans/Actions That Indicate Intention To Abscond-E.G. Watching Doors/Checking Doors/Windows/Packing Bags | ☐ | ☐ | ☐ | |
| Previous Absconsion History | ☐ | ☐ | ☐ | |
| Currently Impulsive | ☐ | ☐ | ☐ | |

Name: Date of Birth:

| **Summary Of Risk** |
|---|
| **Service User Protective Factors**<br>*(E.G. Supportive Family, Spirituality Belief System, Willingness To Seek Help, Economic Security)* |
| **Place The Appropriate Headings S, O, S.N, S. U., And A Within The Risk Category Rated Most Suitable For Each Section In The Risk Screen.** |

| **Risk** | **Catagory** |
|---|---|
| **High-** Imminent Risk | |
| **Medium -** Background Risk But No Imminent Risk | |
| **Low –** No Evidence Of Risk | |

S=Risk To Self, O=Risk To Others, S. N. =Self-Neglect, S.U. = Service User, A=Absconsion

| **Risk Management Plan:**<br>(Including Who Is To Do What, Further Areas Of Information Needed, Identifying How Risks Are Being Taken) |
|---|
| **Discussed With:** |
| **Information Sources Available During Assessment** |
| **How Was This Assessment Made?**<br>(E.G. Interview With Service User &/Or Carer, Observations, Service Notes/Discussion, Multiple Sources) |
| **Involvement And Agreement Of Person And Carer In Process:**<br>Service User/Carer Comments |

| Completed By | Date: |
|---|---|

Name: Date of Birth:

| **Medical Examination 2 Hours Post Initiation Of Physical Restraint** | | | | |
|---|---|---|---|---|
| Date Of Assessment: | Time: | Mode Of Assessment: | | |
| Person Name: | Date of Birth: | Legal Status: | | |
| Current Mental State | | | | |
| Current Physical State | | | | |
| Medical History | | | | |
| Current Medication | | | | |
| Forensic History | | | | |
| History Of Trauma | | | | |
| Risk Statement / Current And Historic | | | | |
| Risk Management Plan | | | | |
| Blood Pressure | Temperature: | Pulse: | O2 Sats: | Resp. Rate: |

Name: Date of Birth:

| **2 Hourly Post Restraint Medical Review Record** | |
|---|---|
| Date: | Time: |
| | |
| Doctors Signature: | Date: |

| **Date: Resident Feedback Following Episode Of Restraint** | |
|---|---|
| To Be Completed With A Secluded Person Within 48 Hours After A Restraint Episode | |
| What Is Your Understanding Of Why You Were Physically Restrained? | What Was Your Experience Of The Episode Of Restraint? |
| Do You Think There Could Have Been An Alternative To Using Physical Restraint? | What Alternatives Would You Like Staff To Try If This Situation Occurred Again? |

Name: Date of Birth:

| **Post-Physical Restraint Debriefs Are To Be Completed Within 48 Hours Of Ending The Restraint Episode.** | | | |
|---|---|---|---|
| Who Was In Attendance? | Psychiatrist | NCHD | OT |
| Key Nurse | CNM | Social Worker | Community Teams |
| Service User | Psychologist | Other: | |

| | |
|---|---|
| Discuss De-Escalation Strategies That Could Be Used To Avoid The Use Of Restrictive Practices In Future | |
| Discuss Preferences In The Event Of Future Restrictive Practices (What Restrictive Practices The Person Prefers). | |
| Signature : | Date & Time: |
| Was Debriefing Refused? ☐ Yes ☐ No If Yes, Give Reason: | |

| **Multidisciplinary Team Review, No Less Than Five Days Post-Restraint Episode.** |
|---|
| Outline What Trigger/Antecedent Events Contributed To The Restraint Episode; |
| Outline Any Missed Opportunities For Earlier Intervention In Line With The Principles Of Positive Behaviour Support; |
| Outline Alternative De-Escalation Strategies To Be Used In Future; |
| Was Restraint Used For The Shortest Possible Duration? |
| Outline Outcomes Of The Person-Centred Debrief, If Available; |
| Outline Factors In The Physical Environment That May Have Contributed To The Use Of Restraint. |

| | |
|---|---|
| MDT Member: | Date/Time: |