PSY-SOP-003: Restraint and seclusion: last resort and strict documentation

Standard operating procedure (SOP) · PSY-SOP-003 · Version 0.1 · Draft for local review

Supports: 52.3

At a glance

- Restraint and seclusion are used only as a last resort, when there is an immediate risk of serious harm and less restrictive options have failed or are not possible.
- Every use is authorised by a senior clinician, monitored continuously, and recorded in the restraint record (CLN-FRM-004) as it happens.
- The least restrictive method and the shortest time are used, and the patient is released as soon as the risk has passed.
- Each episode is reviewed afterwards with the patient, and reported to the governance meeting.
- Stop and act at once if: a patient's breathing, circulation or consciousness is affected, or the restraint is causing pain or injury.

1. Purpose

To make sure that restraint and seclusion are used only as a last resort, for the shortest time and in the least restrictive way, with clear authorisation, continuous monitoring and full documentation, so that patients' rights and safety are protected (52.3).

2. Scope

Item	Coverage
Applies to	All clinical staff in the mental health and behavioural units, and any ward where a patient may need restraint or seclusion
Patients	Adults and young people with mental illness, learning disability or acute behavioural crisis, and any patient who is confused or at risk of harm to self or others
Methods	Physical restraint (holding), mechanical restraint (devices), chemical restraint (medicine given to control behaviour without consent), and seclusion (confinement alone in a room)

3. Definitions

Term	Meaning in this SOP
Restraint	Any action that restricts a person's freedom of movement against their will or without their consent, to prevent harm
Seclusion	The confinement of a patient alone in a room, for the purpose of managing behaviour, with the door locked or held shut
Chemical restraint	Medicine given to control behaviour when the patient does not consent, and not as part of treatment for a physical condition
Least restrictive option	The option that gives the most freedom while still managing the risk, such as verbal de-escalation, time out, or a supported safe space

4. Background

Restraint and seclusion carry risks of physical injury, psychological harm, and death from positional asphyxia or cardiac events. They can damage trust and make future care harder. Good practice reduces their use through early de-escalation, understanding of triggers, and planning with the patient.

5. Responsibilities

Role	Responsibility
Senior clinician (consultant or delegated senior doctor)	Authorises restraint or seclusion, reviews it at set intervals, and decides when it ends
Nurse in charge	Ensures trained staff are present, monitoring is in place, and the record is complete
Trained staff	Use the approved method, monitor the patient continuously, and communicate with the patient throughout
Service manager	Keeps the procedure, the training and the audit in place, and reports to the governance meeting
Medical director	Approves this SOP and receives serious incident reports

6. Before any restraint or seclusion

1. Try verbal de-escalation first, and record what was tried, including time, approach and the response.

2. Consider the patient's known triggers and preferences, from the care plan and advance decisions.
3. Check the medical cause of the behaviour: pain, infection, low blood sugar, medicine effect or intoxication.
4. Decide with the senior clinician that restraint or seclusion is the only option to prevent serious harm, and record the reason in the notes.

7. Procedure

7.1 Authorisation

1. A senior clinician authorises the restraint or seclusion in person or by direct telephone conversation, and records the authorisation with the time, the reason and the planned review time.
2. Where authorisation cannot be obtained at once because of an emergency, the staff member on duty may act to prevent serious harm, and the senior clinician must authorise or end the restraint within 30 minutes.

7.2 Method

1. Use the approved method only, with the number of trained staff set in the local procedure, and never use a method that restricts breathing or pins a patient face down.
2. Use the least restrictive method that will manage the risk.
3. Give the patient an explanation at each stage in simple language, and tell them what will happen and when it will stop.

7.3 Monitoring

1. A trained member of staff monitors the patient continuously, with observations recorded at least every 15 minutes, including breathing, colour, circulation, consciousness and comfort.
2. Check the restraint fit, the position and the circulation at each observation.
3. Offer food, fluid, toilet access and medicines as needed during the episode.
4. Record each observation on the restraint record.

7.4 Release and review

1. End the restraint or seclusion as soon as the risk has passed, and record the time.

2. Review the episode with the senior clinician within one hour of release, and at the set interval if it continues.
3. Offer the patient a debrief within 24 hours, to talk about what happened and what would help next time, and record it in the care plan.

8. Decision points

Situation	Action
Patient is vulnerable to physical injury or breathing difficulty	Stop the restraint at once and reposition the patient. Call the senior clinician and the medical team
Patient asks to stop and the risk has passed	Stop at once and record the request
Restraint is needed for longer than the authorised time	The senior clinician reviews, extends or ends it, and records the reason
Patient has a physical health problem that makes restraint unsafe	Do not use restraint. Call the medical team and escalate to the senior clinician for another approach

9. Escalation

- Injury to the patient or staff member during restraint: report under INC-SOP-001 within 24 hours and inform the medical director.
- Restraint used for longer than 4 hours, or a pattern of repeated use for one patient: the senior clinician and the service manager review the care plan within 24 hours.
- Concern about the method used: stop the practice and inform the service manager the same day.

10. Monitoring

The service manager audits every restraint and seclusion episode each month for authorisation, monitoring, documentation, duration and debrief, and reports the results to the governance meeting each quarter.

Measure	Target
Episodes authorised by a senior clinician with reason recorded	100 percent
Observations recorded at the set interval during the episode	100 percent
Patients offered a debrief within 24 hours	100 percent
Episodes lasting longer than the local limit without senior review	0

11. Records

- Restraint and seclusion record (CLN-FRM-004), completed during the episode.
- Authorisation record with time and reason.
- Continuous observation log (PSY-REG-001).
- Debrief record.
- Incident reports.

12. Training

All staff who may use or monitor restraint complete training in de-escalation, the approved method, and monitoring at induction and every year, with a practical assessment and a drill. Staff take part in the de-escalation drills in PSY-REG-003 at least twice a year.

13. Related documents

Code	Document
CLN-FRM-004	Restraint and seclusion record
PSY-REG-001	Continuous observation log
PSY-REG-003	De-escalation drill register
PSY-FRM-001	Suicide risk screening record
INC-SOP-001	Root cause analysis of serious incidents

14. Evidence

This SOP is based on the reference sources listed below and on the requirement of criterion 52.3 of the ASF standards. The authorisation rules and the method must be checked against

the national mental health law and the facility's approved method at each review.

E-learning for this document

- No course linked yet. Request a restraint reduction and de-escalation course from the academy (see the Standard 52 request list).

References

1. World Health Organization. QualityRights: Guidance on Restraint and Seclusion. Current edition.
2. National mental health legislation and its code of practice (to be inserted by the facility at adoption).
3. Facility approved restraint method and de-escalation policy (to be inserted by the facility at adoption).

Change history

Version	Date	Change
0.1	2026-10-26	First draft for review. Not yet approved by the ASF Expert Committee.

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