

Surname:
First Name:
Hospital Number:
NHS Number:

Risk Assessment: Planned Restrictive Physical Intervention for Children & Young People

Please File in Consent Forms/Living Wills Section of Patient Notes

Name or Assessor:

Date:

Factors to be considered when undertaking a risk assessment of child or young person with potential to require low level restrictive intervention:

- Have you considered all alternative therapeutic interventions, and if so what are they?
- Has a Mental Capacity or Gillick/ Fraser Competent assessment been undertaken by a person qualified to do so?
- Does the child or young person have the physical and mental ability to comply with instructions/requests?
- All restraint techniques must be led by member of nursing team.

For details of how to assess capacity contact Safeguarding Teams for advice. Capacity must be documented in the patient medical record.

Factors to consider prior to planned Restrictive Physical Intervention episode	Yes	No	Details of action taken
Risk to airway - If tracheostomy in situ, is there a risk it could become dislodged			
Does patient have any illness or injury that could be adversely affected by a Restrictive Physical intervention episode, , or do they have any additional needs that could impact on their understanding of the intervention.			
Is there a risk of not receiving medication or treatment if intervention does not take place			
Risk of damage or contamination to wound sites			
Risk of falling from bed			
Risk of accidental dislodging of permanent or temporary			



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devices /implants			
Risk of laceration or tissue damage			
Do the potential risks of carrying out the intervention outweigh the benefits			
Do you have adequate staff to carry out the physical intervention			
Are the staff adequately trained			
Are the staff physically able to undertake the physical intervention (e.g. no injury/restrictions/maternity issues)			
Planned Physical Interventions (restraint) techniques to be used if required. N.B. all techniques are a minimum two staff procedure. Please circle as necessary: Breakaway Techniques Walking Figure of Four Walking Double forearm hold Seated d-escalation Bed restraint Other:			

Assessor signature (Nurse/Registered Practitioner):

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Print Name:

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Designation:

.....

Date & Time:

.....

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Reason for Restrictive Physical Intervention discussed with patient/parent/carer **Yes/No** (please circle). If not please give reasons:

Other therapeutic interventions considered:

Actions taken to minimize risks of planned PI:

Any other identified risk?

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