

Restraint and Restrictive Interventions Policy

Sample policy template. This is a Verivius-authored template anchored to the statutory regulation and current CQC/professional guidance. Providers must adapt the operational sections to their own organisation, service type, workforce, premises and professional requirements. Where this template and live law or regulator guidance diverge, the live source wins.

Statutory anchor: Regulation 13 (safeguarding service users from abuse and improper treatment, including disproportionate restraint), Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (SI 2014/2936). This policy also engages the Mental Capacity Act 2005 and the Human Rights Act 1998 (Article 5 ECHR). **Primary source:** <https://www.legislation.gov.uk/uksi/2014/2936/regulation/13> **Last reviewed:** 2026-07-19
Verivius pack version: v1.1, 2026-07-19

Policy owner: Registered Manager. **Applies to:** all staff authorised to use or oversee restrictive interventions, and all people the service supports.

1. What the regulation says

Service users must be protected from abuse and improper treatment in accordance with this regulation. (Reg 13(1) (the headline duty))

Systems and processes must be established and operated effectively to prevent abuse of service users. (Reg 13(2) (prevention systems))

Systems and processes must be established and operated effectively to investigate, immediately upon becoming aware of, any allegation or evidence of such abuse. (Reg 13(3) (investigation systems))

A service user must not be deprived of their liberty for the purpose of receiving care or treatment without lawful authority. (Reg 13(5) (lawful authority for deprivation of liberty))

ill-treatment (whether of a physical or psychological nature) of a service user, (Reg 13(6) (b) (ill-treatment))

neglect of a service user. (Reg 13(6)(d) (neglect))

The full text is at <https://www.legislation.gov.uk/uksi/2014/2936/regulation/13>. Where this policy and the regulation diverge, the regulation wins.

2. Plain-English summary

Service users must be protected from abuse and improper treatment. You need effective systems to prevent abuse, and effective systems to investigate any allegation or evidence of abuse as soon as you become aware of it. Care must not be provided in a way that discriminates, uses disproportionate control or restraint, is degrading, or significantly disregards the service user's needs. Service users cannot be deprived of their liberty without lawful authority.

3. Purpose

This policy sets out how the Service prevents restrictive interventions, decides whether an intervention is lawful and necessary, keeps the person safe during its use, and learns from every episode. Its purpose is to make least-restrictive practice visible in care plans, staff decisions, incident records and governance review.

4. Scope

This policy applies to:

- every form of restraint or restrictive intervention the Service might use
- everyone the Service supports, with particular care for people with a learning disability or autism, for whom the risks of restraint are higher
- the staff authorised to use, and the managers who oversee, restrictive interventions

Before adoption, the provider identifies which restrictive practices could arise in each service, which roles may authorise or use them, which techniques are prohibited, where emergency clinical help is obtained, and who gives legal or safeguarding advice. The local procedure must state where care plans, capacity decisions, incident records and restraint reviews are kept.

5. The Service's commitment

The Service is committed to the least restrictive practice and to preserving people's human rights. It works to reduce and, wherever possible, eliminate restrictive interventions through positive behaviour support (see the positive behaviour support policy). Restraint is never used as a punishment, for the convenience of staff, or in place of adequate staffing or care planning.

6. Definitions

The Service recognises restraint in all its forms, and distinguishes it from ordinary, agreed support:

- **Physical restraint:** any direct physical contact that restricts or subdues a person's movement.
- **Mechanical restraint:** the use of a device to restrict movement.
- **Chemical restraint:** the use of medication to control or subdue behaviour, rather than to treat a diagnosed condition.
- **Environmental restraint:** restricting access to a person's surroundings, for example locking doors or removing aids.
- **Restriction or restraint:** the classification depends on the purpose and effect of the measure and the statutory definition, not on consent alone. A restriction of liberty of movement may be restraint whether or not the person resists. Staff record the measure used, its effect, the person's response and the legal basis relied on.

7. Roles and responsibilities

- **Registered Manager:** accountable for the lawful, proportionate use of restraint, reviews every use, and drives reduction.
- The **roles** authorised to apply and manage restraint are defined, for example the senior care worker or nurse on shift, **by role, not by naming individuals**.
- **All staff** prioritise de-escalation, use restraint only within their training and this policy, and report and record every use.
- The **senior person on duty** coordinates immediate clinical checks, safeguarding decisions and contact with the person's representative after an episode.
- The **training lead** keeps the approved-technique map, competence evidence and refresher dates current.

The provider records its authorised-role and technique map before this policy is approved. A person must not use a technique merely because they have seen another worker use it.

8. The legal framework: necessity, proportionality and last resort

A restrictive intervention is lawful only where it is:

- **necessary** to prevent harm to the person or to others
- a **proportionate** response to the likelihood and seriousness of that harm
- the **least restrictive** option that will work
- a **last resort**, after de-escalation has been tried or is clearly not safe

Where the person lacks capacity for the decision, the Service follows the Mental Capacity Act, makes a best-interests decision, and, where the restriction may amount to a deprivation of liberty, seeks lawful authority (see the consent policy).

Whether a restriction amounts to a deprivation of liberty is determined by a multifactorial assessment following the Supreme Court's AGNI judgment of 2 June 2026. The previous "acid test" is no longer the legal test. The Service follows the current government deprivation-of-liberty guidance and Code of Practice, records the factors considered, and seeks legal advice where the position is uncertain. The deprivation-of-liberty assessment is separate from the decision about consent to care or treatment. The Mental Capacity Act 2005 and Regulation 11 consent requirements continue to apply.

9. Restrictive-intervention workflow

1. **Prevent and de-escalate.** Staff follow the person's communication, care and positive-behaviour-support plans, reduce known triggers, offer space or alternatives, and seek senior support early.
2. **Make an immediate risk decision.** The authorised worker identifies the harm that is likely without intervention, considers capacity and consent, and decides whether action is necessary, proportionate and the least restrictive available option.
3. **Use only an authorised response.** Staff use only approved techniques within their current competence. Prone restraint and techniques that restrict breathing are not part of the Service's planned response and are avoided. Any departure required to respond to an unforeseen emergency is stopped as soon as the immediate danger passes and is escalated for clinical and legal review.
4. **Monitor continuously.** One worker monitors breathing, circulation, consciousness, pain, distress and the person's verbal and non-verbal response. The intervention stops immediately if safety is compromised or the risk has passed.
5. **Restore safety and dignity.** Staff check for injury or distress, arrange medical help where needed, explain what happens next in an accessible way, and notify the senior person on duty.
6. **Record and report.** The episode is entered in the incident register before the end of the shift. Safeguarding, police, duty-of-candour, CQC-notification and deprivation-of-liberty thresholds are considered and the decision is recorded.
7. **Review and reduce.** The person and staff are offered separate debriefs. The Registered Manager reviews the episode, updates care and risk plans, assigns improvement actions, and checks whether patterns require a formal restraint-reduction plan.

10. After any use of restraint

- the person is supported and checked for injury or distress, and medical help is sought where needed
- staff and, where appropriate, the person are offered a debrief

- the incident is recorded in full and analysed under the incident-reporting policy, and a safeguarding referral and a statutory notification are made where the threshold is met
- the person's care plan and positive behaviour support plan are reviewed and updated to reduce the chance of it happening again

11. Training requirement

- staff who may use restraint complete training in de-escalation and in safe restraint, from a recognised, certified provider, before they use any technique, and are refreshed on the required cadence
- training prioritises prevention and de-escalation over physical intervention
- the Service records who is trained and competent, and the next refresher date

12. Audit

The Service checks, on a stated cadence, that:

- every use of restraint was necessary, proportionate, the least restrictive option, and a last resort, and was recorded
- de-escalation was tried first, and the use of restraint is reducing over time
- staff are trained by a certified provider and are in date
- post-incident reviews happened and care plans were updated, and any safeguarding or notification thresholds were met

Audit findings are recorded in the provider's audit register. Actions are logged in the improvement-actions register with an owner and due date, and unresolved systemic risks are linked to the risk register.

13. Records and evidence

Every use of restraint must be recorded. The record includes:

- the date, time, location and people present
- the antecedent, immediate risk and harm the intervention was intended to prevent
- the person's capacity, consent and any best-interests or other legal-authority decision relevant at the time
- de-escalation and less restrictive options tried, or why they were not safe to try
- the type of intervention, staff involved, duration and reason it was necessary and proportionate
- physical and psychological monitoring during the intervention
- any injury, pain or distress, and the clinical response

- the person's account and the staff account, kept distinguishable from fact and observation
- debriefs offered or completed, and any representative informed
- safeguarding, police, duty-of-candour, CQC-notification and deprivation-of-liberty decisions, including reasons where no referral or notification was made
- care-plan, risk-assessment, training or staffing changes and the linked improvement action

The restraint record is cross-linked to the person's care record, the incident register and, where applicable, the safeguarding, risk, training and improvement-actions registers. Records are retained securely for the period set by the provider's retention schedule and applicable records-management guidance.

14. Related policies in this pack

- [Positive Behaviour Support Policy](#)
- [Safeguarding Adults Policy](#)
- [Consent Policy](#)
- [Mental Capacity Act Policy](#)
- [Safeguarding Children Policy](#)
- [Incident Reporting, Investigation and Learning Policy](#)
- [Professional Boundaries and Conduct Policy](#)
- [Training, Competency and Mandatory Training Policy](#)
- [Risk Management and Risk Register Policy](#)

15. Sources and further reading

This template is based on CQC's guidance for providers and managers, the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, and other topic-specific legislation and guidance listed below. It is a starting point for adaptation, not a substitute for legal, clinical, HR, safeguarding or specialist professional advice.

- CQC Regulation 13: Safeguarding service users from abuse and improper treatment
- CQC supporting document: Restraint policy (<https://www.cqc.org.uk/guidance-regulation/registration/supporting-documents-provider/document/restraint-policy>)
- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (<https://www.legislation.gov.uk/uksi/2014/2936/regulation/13>)
- Mental Capacity Act 2005
- Human Rights Act 1998 (Article 5 ECHR)
- UK Supreme Court 2026 judgment guidance on what constitutes a deprivation of liberty (<https://www.gov.uk/government/publications/changes-to-the-definition-of-deprivation-of->

liberty/uk-supreme-court-2026-judgment-on-what-constitutes-a-deprivation-of-liberty)

- Deprivation of Liberty Code of Practice
(<https://www.gov.uk/government/publications/deprivation-of-liberty-code-of-practice>)
- Mental Capacity Act Code of Practice and current government guidance
- Mental Health Act Code of Practice where applicable
- Restraint Reduction Network training standards
- Local authority safeguarding procedures

16. When to seek further advice

Seek specialist advice where the issue involves serious harm, safeguarding, deprivation of liberty, restraint, children, professional misconduct, controlled drugs, radiation, termination of pregnancy, infection outbreak, water safety, employment dismissal, DBS barring referral, or regulatory enforcement.

17. Document control

Version	Date	Author	Changes
v1.0	2026-06-05	Verivius (sample)	New template authored to CQC's "what to include" for a restraint policy: a least-restrictive, human-rights policy statement; clear definitions of physical, mechanical, chemical and environmental restraint versus general restriction; the necessity, proportionality and last-resort legal framework; roles authorised by role not by named individual (the CQC red flag); MCA best-interests alignment; implementation guidance on approved techniques, wellbeing monitoring and time limits; post-incident debrief, analysis and care-plan update; and mandatory de-escalation and safe-restraint training from a certified provider, prioritising de-escalation.
v1	2026-06-10	Verivius (sample)	Conformed to the Verivius policy standard: anchored to Regulation 13 verbatim quotes and plain-English summary from the guidance manifest; added the standard header, sources and further reading, and when-to-seek-further-advice blocks; updated the deprivation-of-liberty framework to the AGNI judgment (2 June 2026) and CQC statement (8 June 2026), removing the "acid test" as current law and noting that MCA and Regulation 11 consent requirements are unchanged.
v1.1	2026-07-19	Verivius (sample)	Added an operational restrictive-intervention workflow, local adoption decisions, fuller evidence fields and register links. Updated the deprivation-of-liberty section to current

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			government guidance and clarified that consent alone does not determine whether a measure is restraint.

This sample policy template was issued by Verivius. It is a template, not a substitute for legal advice or the provider's own policy-development process. Where this template and live law or regulator guidance diverge, the live source wins.

An example for guidance, not a ready-to-use policy. This sample is deliberately generic and is not a finished policy. Before any service uses it, rewrite it around your own service, procedures, roles and local arrangements, and remove or replace anything you cannot actually provide (for example a reference to specific training you cannot access). It is guidance, not legal advice, and you are responsible for ensuring any policy you adopt is current.