Essex Partnership University
NHS Foundation Trust

Therapeutic and Safe Interventions and De-Escalation Policy

POLICY REFERENCE NUMBER:	RM05
VERSION NUMBER:	2.1
KEY CHANGES FROM PREVIOUS VERSION:	Addition of Appendix 8d
REPLACES EPUT DOCUMENT	Restrictive Practice Policy, RM05 (renamed)
AUTHOR:	Restrictive Steering Group
CONSULTATION GROUPS:	HSSC CGQSC
IMPLEMENTATION DATE:	November 2017
AMENDMENT DATE(S):	April 2021
LAST REVIEW DATE:	April 2021
NEXT REVIEW DATE:	April 2024
APPROVAL BY CLINICAL GOVERNANCE AND QUALITY SUB-COMMITTEE:	February 2021
RATIFICATION BY QUALITY COMMITTEE:	April 2021
COPYRIGHT	2017-2021

POLICY SUMMARY

This policy aims to ensure that all staff are provided with the information required to enable them to adhere to the principles that underpin the use of restrictive practices and the aim to reduce the use of restrictive physical interventions within the Trust. These principles follow safe and therapeutic responses to disturbed behaviour (MHA Code of Practice, 1983, updated 2015) current best practice guidance.

The Trust monitors the implementation of and compliance with this policy in the following ways;

Through the monitoring of Datix forms, compliance figures for training.

Services	Applicable	Comments
Trustwide	✓	

The Director responsible for monitoring and reviewing this policy is Executive Nurse

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

THERAPEUTIC AND SAFE INTERVENTIONS AND DE-ESCALATION POLICY

CONTENTS

THIS IS AN INTERACTIVE CONTENTS LIST – PLEASE CLICK ON THE SECTION HEADINGS TO GO TO THE SECTIONS

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

TASID POLICY

Assurance Statement

The Trust provides a service to people who may require support to when presenting with behavioural disturbances and this policy and associated procedural guidelines aims to promote a consistent positive and therapeutic approach to averting behavioural disturbances, through early recognition and de-escalation.

The governance arrangements within this policy ensures that the Trust takes all reasonable steps to promote appropriate use of and prevention strategies and avoid the misapplication of restrictive practices, particularly physical interventions in line with procedural guidelines.

- The policy aims to outline and define restrictive practices;
- Enable the practitioner to ensure that their practice is lawful, necessary, reasonable and proportionate;
- Guide the practitioner in applying the least restrictive option available
- Promote open communication
- Ensure that dignity, respect, accountability, autonomy and fairness are the fundamental elements of the management of behavioural disturbances

Responses to behavioural disturbance include;

- **Primary interventions** e.g. Positive Behavioural support plans, No Force First model, Trauma Informed Care approach, medication intervention/review enhanced levels of observation.

- **Secondary interventions** e.g. De-escalation

- **Tertiary intervention** e.g. Physical restrictions, debriefing of patients and staff, rapid tranquilisation, seclusion procedure, long term segregation procedure.

1.0 INTRODUCTION

1.1 The Trust recognises and acknowledges that staff need to support people whose needs and risk histories may present with behaviours that challenge. This can be in an emotional or physical way and can be challenging.

1.2 Recovery Based Approaches are used to delivery care in accordance with the principles of a positive, safe and supportive environment.

1.3 Restrictive practices may have to be used to safely manage challenging behaviours. This may involve the physical containment of an individual. For example door locks to ensure patient / residents cannot leave a designated building or area. There may be other examples of more subtle restrictive practices which may be harder to acknowledge such as prescribed medication in the form of a chemical restraint by means of sedative medication on a short or

long term basis, inappropriate use of blanket rules. For guidance in relation to such practices a number of additional policies and clinical guidelines have been developed.

1.4 The Trust advocates, that any violence and aggression will not be tolerated. The Trust recognises that staff have a right to work, and patients / residents have a right to be cared for, in safe environments. See Trust policy Criminal Behaviour within a Mental health Environment CP22 (Zero Tolerance).

1.5 The most common reason for needing to consider the use of restrictive physical interventions are:

- Physical assault by the patient / resident
- Dangerous, threatening or destructive behaviour
- Self-harm or risk of physical injury by accident
- Ensuring and maintaining privacy and dignity where an individual's mental state prevents independent self-management
- Extreme and prolonged over activity that is likely to lead to physical exhaustion
- Attempts to escape or abscond (where the patient / resident is detained under the MHA or deprived of their liberty under MCA).

2.0 DUTIES

2.1 The Chief Executive has overall responsibility for ensuring the principles of this policy and associated guidelines set out by statutory and regulatory authorities such as the Department of Health, Commissioners and the Care Quality Commission and other associated policies are implemented across the organisation. The duty to ensure that all measures needed for the therapeutic prevention, monitoring and management of restrictive practices is delegated to Directors within their areas of responsibility. The Chief Executive has overall responsibility to ensure that patient / residents are protected from abuse and appropriate resources exist to meet the needs of this policy.

2.2 The Board of Directors are fully committed to a safety culture within the organisation and will ensure the effectiveness of restrictive intervention reduction plans. The Board of Directors has to ensure the development of action plans in response to the audit of annual positive behavioural support plans.

2.3 The Executive Chief Operating Officer is the Executive Lead for the therapeutic prevention and management of challenging behaviour including restrictive practices and restrictive practice reduction plans. This will ensure:

- Policy and procedures are embedded into clinical practice as well as ensuring they are monitored and updated regularly using latest recommendations.
- Implementation and regular review of this policy.
- That the board receives information and develops action plans in response to the annual audit of behavioural support plans and restrictive interventions statistical data looking at the quality design and application

- That executive board members who authorise the use of physical interventions undertake awareness training so they are fully aware of the techniques their staff are being taught.
- All operational managers are aware of this policy, understand its requirements and support its implementation with relevant staff.

2.4 Executive Medical Director / Consultants

- The Executive Medical Director and consultants are responsible for ensuring procedures are understood and carried out by medical staff involved in the implementation of this policy.

2.5 The Trust's Risk Management Team is responsible for:

- Ensuring there is a restrictive practice group which monitors and considers Datix reporting regarding restrictive practices. Managing statistical incident information and identifying trends across the organisation.
- Acting as an advisor on non-clinical risk management in the workplace and reporting actions required to reduce or eliminate the risk to staff.
- Providing reports to service commissioners on the use of restrictive practices
- Recording episodes of restrictive interventions (planned or unplanned) and capturing information on the level of intervention to ensure that the least restrictive option has been used.
- Ensuring accurate internal data is gathered and reported through the mandatory reporting mechanisms
- Provide information and reports when requested on statistics in relation to restrictive practices, or to show staff how to download reports from the system.

2.6. Directors and Senior Management will:

- Monitor the implementation and use of this policy by their teams.
- Take action to ensure that all staff are appropriately TASID trained relevant to their role and responsibility (subject to health related exceptions).
- Ensure that there are a minimum of 3 restraint trained staff are on duty on mental health wards if it is not possible to staff the ward in line with agreed establishments.
- Lead and monitor the use of risk reduction plans by their teams.
- Investigate Datix incidents relating to restrictive interventions where there is a significant risk or where injuries were sustained.
- Ensure that appropriate incident prevention and management processes are in place, implemented and monitored in their teams.
- Ensure the least restrictive interventions are used at all times
- Ensure that patient / residents are protected from abuse.

2.7. Local Security Management Specialist is responsible for:

- Leading on day to day work in the Trust to tackle violence against staff and professionals in accordance with the NHS national framework and guidance.
- Having professional awareness of the complex reasons for violence within services and participation in strategic planning to promote the Trusts pro-security culture.
- Providing reports and trend analysis to the Health, Safety & Security Committee regarding violence and aggression incidents.
- Providing advice and support to Trust staff on undertaking risk assessments and risk reduction plans related to challenging behaviour including violence and aggression.
- Providing post incident support to all staff that have been assaulted as well as any member of staff affected by an incident of violence.
- Liaison with the police as appropriate in relation to potential criminal prosecution.

2.8 Workforce, Development & Training Department is responsible for:

- The TASID trainers will monitor the Datix as well as the details from both the weekly restrictive practice report and monthly Prone Restraint incident Analysis report for their clinical areas.

- The TASID Instructor allocated to the clinical areas will provide support, advice and guidance regularly, by phone, email and visiting the clinical areas when necessary.

- The TASID trainers will ensure the course delivery is continually updated to ensure that the training and educational needs meet national standards as well as clinical requirements.

- The TASID trainers will ensure that any changes in professional knowledge and practice are regularly discussed within Restrictive Practice group and fed back to the training team and clinical areas.

- The TASID trainers are part of the PMVA partnership (which consist of Avon & Wiltshire University Trust, Oxford Health University Trust, Surrey & Borders University Trust and Somerset University Trust) ALL are required to attend annual revalidation, where both physical and theory elements of training are revalidated by the organisation within the partnership.

- All TASID Instructors (not the clinical based instructors) are required to attend the partnership revalidation to be assessed by all the PMVA leads. The TASID lead is required to be part of the assessment process of the revalidation of each instructor.

- The physical techniques which are facilitated in TASID course are required to be reviewed every 2 years by independent physiotherapies, who will REBA risk assess each technique, Following National standards.

- Clinical based instructors are required to be revalidated yearly, by the full time Tasid instructors. To ensure both Physical skills and theory elements of the training are up to the required standards to teach Tasid and to be signed off by the Tasid lead.

- New fulltime or clinical based base TASID instructors are required to undertake a 3 week (15 day) TASID training course. Which will be facilitated by the full time TASID instructors and assessed and sign off by the TASID lead.

2.9. Managers and other Persons in Charge will:

- Monitor the implementation and use of this policy.
- Take action to ensure that all staff are appropriately TASID trained iTASID relevant to their role and responsibility (subject to health related exceptions)
- Ensure that there are a minimum of 3 TASID trained staff on duty on mental health/ learning disability wards if it is not possible to staff the ward in line with agreed establishments (unless local staffing is less than this number)
- Ensure that the Trust Risk Management Team is appropriately notified of all incidents via Datix as per incident reporting policy.
- Actively review information recorded via Datix incident forms and investigates incidents appropriately. Ensure that appropriate incident prevention and management processes are in place, implemented and monitored in their teams.
- Ensure staff and patient receive immediate debrief and offered post incident debrief.
- Where required undertake a critical incident analysis for lessons learned to be shared via appropriate reporting structures.
- Complete and review appropriately a Workplace Risk Assessment for Violence & Aggression for their service and area of responsibility (See Trust Risk Assessment Policy) ensuring that systems and procedures are in place for the effective management of any identified risk.
- Ensure all patients have a Behavioural support plan where appropriate completed on admission.
- Ensure No Force First approach is applied to all patents care.
- Ensure a Trauma Informed Care approach (which is an integral element principal of the no force first approach) is applied to all patients care.
- Ensure staff are aware of Restrictive Practice Framework.
- Where required ensure staff have access to security devices / alarms. (Lone working devices and pinpoint).
- Active engagement at ward manager/ Matron level in Restrictive Practice Steering Group.

2.10 Individual staff:

- All staff have a responsibility to attend TASID training yearly and adhere to all new standards, procedures and techniques delivered in these sessions
- All individual staff have a duty of care to ensure that least restrictive intervention possible is practiced.
- Ensure staff adopt a No Force First approach to patient care which is an integral principal of the no force first approach.
- Ensure staff are aware and support the implementation of the Restrictive Practice Framework.
- Ensure every patient in their care has a Positive behavioural support plan where appropriate completed on admission to service/unit.
- All individuals have a duty of care to ensure that patient / residents are protected from abuse.
- Must assess risks and take precautions where they believe that a situation could result in a violent or aggressive incident and where required record information about a patient / resident and brief other relevant staff as necessary to maintain their safety.
- Must take all necessary actions to prevent personal attacks to themselves and others and to defend themselves if appropriate using the minimal amount of force to ensure their safety and escape.
- Undertake appropriate and approved training appropriate to their role.
- Must ensure that they report all incidents surrounding prevention and management of violence and aggression using Datix as well as discussing with the line manager if there is a change in clinical risk.
- Where an individual has been issued with a lone worker device, or other safety devices, they must use it in compliance with the training and instruction provided and to report any problems using the device.
- Are accountable for attending appropriate training in line with Induction & Mandatory Training Policy. Is this necessary
- Have a dual responsibility with The Trust for their health and safety in relation to patient / residents' challenging behaviour including violence and aggression.
- Will always respond in a safe and timely manner to emergency incidents to ensure the safety of staff and others.
- Will immediately report non availability of required alarms or other safety equipment.
- Must ensure Positive Behavioural support plans are written, implemented and reviewed as appropriate.
- If patients / residents wish to formally raise a concern they will be reminded of how to access the local complaints process and independent advocacy services. They will be made aware of how to request the Trust policy' on restrictive interventions.
- The safeguarding team will be informed whenever a patient / resident raise concerns about restrictive interventions. Patient / residents who need alternative support will be offered this support to access and use the complaints procedure.

3.0 DEFINITIONS

The Trust follows the Department of Health guidance and definition of Restrictive Practice set out in the Positive and Proactive Care: Reducing the Need for Restrictive Interventions, 2014 document:

'Deliberate acts on the part of other person(s) that restrict an individual's movement, liberty and/or freedom to act independently in order to:

- Take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken; and
- End or reduce significantly the danger to the person or others; and
- Contain or limit the person's freedom for no longer than is necessary'

RM05 – TASID Policy

Page 9 of 113.2 The Skills for Care and Skills for Health, a Positive and Practice Workforce (2014) provide a simple definition:

"Making someone do something they don't want to do or stopping someone doing something they want to do."

The Mental Health Act Code of Practice advices it is "any direct physical contact where the intention is to **prevent, restrict, or subdue** movement of the body (or part of the body) of another person. More specific examples are available in the associated guideline.

4.0 PRINCIPLES

This policy is broken down into 4 main components

1. Standards supporting pre-delivery of Restrictive Practices
2. Standards supporting delivery of Restrictive Practices
3. Standards supporting post-delivery of Restrictive Practices
4. Standards supporting Risk Reductions of Restrictive Practices

4.1 TASID training to reflect the RRN standards:

- Ensure Behavioural Support Plans are available on all units to be completed with patient on admission to service or unit where appropriate.
- Ensuring the Trust has communicated NO First Force model to all relevant staff.
- Ensure the trust has communication Trauma Informed Care approach to all relevant staff.
- Ensure a 2 tier debriefing process is in place for staff and patients.
- Ensure Restrictive Practice strategy is communicated with all relevant staff.
- Ensure Restrictive Practice Framework is communicated with all relevant staff.

4.2 TASID training has achieved certification against the RRN standards via BILD:

- Ensure a Behavioural support Plan is completed/reviewed for patients where appropriate on admission to service or unit.
- Ensure staff are adopting a No Force First Approach to patient care.
- Ensure staff are adopting Trauma Informed Care approach to patient care.
- Ensure staff and patients are offered the 2 Tier debriefing process.
- Ensure Restrictive Practice Strategy is implemented.
- Ensure Restrictive Practice Framework is implemented.

4.3 Ensure TASID training is reported monthly, evaluated and peer reviewed annually:

- Ensure staff and patients review Behavioural Support plans after each restrictive practice physical intervention, including No Force First approach and Trauma Informed care approach
- Ensure staff and patients received a minimum of immediate debrief post physical intervention and offered a post debrief via psychology team
- Ensure Restrictive Practice Strategy is completed including DATIX reporting

4.4 Ensure TASID training/trainers:

- Adheres to the RRN standards re; revalidation updated skills etc.
- Ensure all techniques are independently risk assessed.
- Engage with Restrictive Practice Steering Group.
- Proactive in responding to clinical needs.

5.0 MONITORING OF IMPLEMENTATION AND COMPLIANCE

5.1 This policy will be made available across the organisation via the Trust Intranet site and all staff must adhere to this policy and associated policies and clinical guidelines.

5.2 The Executive Chief Operating Officer & Executive Nurse will be responsible for overall monitoring and review together with the Restrictive practice leads, training manager and Local Security Management Specialist.

5.3 This policy will be reviewed at least every 3 years taking into account emerging research, local audit recommendations and lessons learnt from reports, enquiries and positive practice initiatives.

5.4 Any amendments to this policy will be submitted to the following for consideration and endorsement prior to being ratified:

- Clinical Governance & Quality Sub-Committee
- Health Safety & Security Sub-Committee
- Workforce Development & Training Department

5.5 This policy will be monitored for its effectiveness by Restrictive Steering Group and the training team.

6.0 POLICY REFERENCES / ASSOCIATED DOCUMENTATION

1. DOH Positive and Proactive Care; reducing the need for restrictive interventions 2014
2. Mental Health Act (MHA) 1983: Code of Practice revised 2015
3. National Institute of Clinical Excellence (NICE) Violence and aggression: short-term management in mental health, health and community settings (NG10)
4. National Institute of Clinical Excellence (NICE) Violent and aggressive behaviours in people with mental health problems (QS154) June 2017
5. Restrictive Reduction Network 2019
6. Equality and Human Rights ACT 2015
7. BILD accreditation 2019
8. Care Act 2014
9. Children and Families Act 2014
10. Deprivation of Liberty Act 2010
11. Health and Safety at Work Act 1974
12. Mental Capacity Act 2007
13. Mental Health Units (Use of Force) Act 2018

7.0 REFERENCE TO OTHER TRUST FRAMEWORKS / POLICIES / PROCEDURES

1. Restrictive Practice Framework EPUT 2019
2. CG6 - Advance Decisions and Statements Clinical Guideline
3. CP3 - Adverse Incident Policy
4. CLPG28 - Clinical Risk Assessment and Safety Management Procedure
5. CLP8 - Engagement and Supportive Observation Policy
6. RM08 - First Aid Policy
7. SSOP31 - Protocol for the use of Handcuffs in escorting patients
8. HR21 - Induction, Mandatory Training and Essential Training Policy
9. RM17 - Lone Working Policy
10. CLP75 - Search Policy
11. CLP41 - Seclusion and Long Term Segregation Policy
12. CG71 - Self Harm Clinical Guideline
13. CG52 - Pharmacological Management of Acutely Disturbed behaviour
14. CG92 - Global Restrictive Practices Clinical guideline
15. HR26 - Employee Wellbeing and Management of Sickness and Ill Health Policy

END

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

RISK FACTORS

Certain risk factors can indicate an increased risk of physically violent behaviour. The following lists are not intended to be exhaustive and these risk factors should be considered on an individual basis.

Demographic and Personal Information	
History of disturbed or violent behaviour. History of misuse of substances or alcohol. Carers reporting service user's previous anger or violent feelings. Previous expressions of intent to harm others. Evidence of rootlessness or social restlessness. Previous use of weapons. Previous dangerous impulsive acts. Denial of previous established dangerous acts. Severity of previous dangerous acts.	Known personal trigger factors. Verbal threat of violence. Evidence of recent severe stress, particularly a loss event or the threat of loss. One or more of the above in combination with any of the following: - cruelty to animals - reckless driving - bed wetting - loss of a parent before age 8

Clinical Variables	
Misuse of substances and or alcohol. Drug effects (disinhibition, akathisia). Active symptoms of Schizophrenia or mania in particular: - Delusions or hallucinations focused on a particular person. - Command hallucinations. - Preoccupation with violent fantasy. - Delusions of control (especially with a violent theme) - Agitation, excitement, overt hostility or suspiciousness.	Poor collaboration with suggested treatments. Antisocial, explosive or impulsive personality traits or disorder. Organic dysfunction.

Situational Variables	
Extent of social support. Immediate availability of a potential weapon. Relationship to potential victim (for example known difficulties in relationship are known).	Access to potential victim. Limit setting (for example, staff members setting parameters for activities, choices, etc). Staff attitudes.

Source NICE Clinical Guideline QS154 Violent and aggressive behaviours June 17.

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

ANTECEDENTS AND WARNING SIGNS

Certain features may serve as warning signs to indicate that a service user may be escalating towards physically violent behaviour. The list is not intended to be exhaustive and these warning signs should be considered on an individual behaviour.

Antecedents and Warnings	
• Tense and angry facial expressions. • Increased or prolonged restlessness, body tension pacing. • General over-arousal of the body systems, (increased breathing and heart rate, muscle twitching, dilating pupils). • Increased volume of speech, erratic movements. • Prolonged eye contact. • Discontentment, refusal to communicate, withdrawal, fear, irritation.	• Unclear thought processes, poor concentration. • Delusions or hallucinations with violent content. • Verbal threats or gestures. • Replicating or behaviour similar to that which preceded earlier disturbed / violent episodes. • Reporting anger or violent feelings. • Blocking escape routes.

Source NICE Clinical Guideline QS154 Violent and aggressive behaviours June 17.

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

DE-ESCALATION TECHNIQUES

DEFINITION

The use of techniques (including verbal and non-verbal communication skills) aimed at preventing potential or actual behaviours of concern from escalating.
Restraint Reduction Network 2019

One member of staff should take the primary role in communicating with them. That staff member should assess the situation for safety, seek clarification with the service user and negotiate to resolve the situation in a non-confrontational manner. Its aim is to aim to build emotional bridges and maintain a therapeutic relationship.

Use of the following primary interventions may help the de-escalation process.

- Care plan
- Risk plan
- Positive behaviour support plans (PBSP)
- Existing therapeutic relationship
- Consider which de-escalation techniques are appropriate for the situation.
- Pay attention to non-verbal cues, such as eye contact and respond accordingly.
- Adopt a non-threatening but safe body posture.
- Appear calm, self-controlled and confident without being dismissive or over confident.
- The use of calm down methods to use the patient's own strengths and usual coping mechanisms to help them calm down.
- Manage others in the environment (for example removing other service users from the area, getting colleagues to help and creating space) and move towards a safe area.
- Explain to the service user and others nearby what they intend to do, giving clear, brief, assertive instructions.
- Give clear, brief, assertive instructions.
- Encourage the service user to discuss the issues at hand.
- Ask for facts about the problem and encourage reasoning.
- Attempt to establish a rapport emphasising co-operation.; offer and negotiate realistic options; avoid threats; ask open questions and ask about the reason for the service user's anger.
- Show concern and attentiveness through non-verbal responses.
- Do not patronise and do not minimise the service user's concerns.
- Listen carefully and demonstrate empathy.
- Ensure that staff non-verbal communication is non-threatening and non-provocative.
- Where there are potential weapons, the service user should be relocated to a safer environment and or attempt to remove the potential weapon without putting self or others at risk.
- If a weapon is involved ask for it to be placed in neutral location rather than handed over.

- Consider asking the service user to make use of a designated de-escalation area to help calm and diffuse their anger.
- At all times encourage the service user to discuss and negotiate their wishes.

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

FACTORS TO CONSIDER WHEN PLACING PATIENTS ON OBSERVATIONS

In addition to the antecedents and warning signs given in Appendix 2 the following may give an indication that observation above the general level should be considered.

Use the least intrusive level of observation necessary, balancing the service user's safety, dignity and privacy with the need to maintain the safety of those around them.

Give the service user information about why they are under observation, the aims of observation, how long it is likely to last and what needs to be achieved for it to be stopped.

- History of previous suicide attempts, self-harm or attacks on others.
- Hallucinations, particularly voices suggesting harm to self or others.
- Paranoid ideas where the service user believes that other people pose a threat.
- Thoughts or ideas that the service user has about harming themselves or others.
- Threat controls override symptoms.
- Past or current problems with drugs or alcohol.
- Recent loss.
- Poor adherence to, or non-compliance with, medication programmes.
- Marked changes in behaviour or medication.
- Known risk indicators.

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

RISK ASSESSMENT FACTORS TO BE CONSIDERED WHEN A PATIENT HAS SPECIFIC NEEDS

When physical interventions are considered as part of risk management plans then further assessment and risk management needs to be considered when the patient/resident has particular needs. These include:-

(i) Children and adolescents
(ii) People with learning disabilities

Consider factors surrounding confused and impaired consciousness and communication strategies with the service user.

(iii) Pregnant women

Promote liaison with appropriate pregnancy support services identifying general good practice guidance and key concerns in the management of pregnancy and acutely disturbed behaviour. Acutely disturbed behaviour equals behaviour demonstrating a high risk of imminent harm towards the unborn baby and the mother.

(iv) The elderly

Consider factors such as frailty and physical health and confused mental states and ability to respond to instruction.

(v) People with a physical disability, including Risk of HIV or other infectious Diseases

Here consideration would need to be made in relation to how the service user can be safely restrained. This may require that the service user has a modified / tailored made restraint procedure prepared for them.

(vi) People with diverse backgrounds that may need an interpreter.

Consideration of the extra time required for effective communication is essential.

Where a service user with particular needs has been identified it may be necessary to consider the support of other specialist services. For instance

- Infection Control
- Health and Safety
- PMVA Lead
- Manual Handling Co-ordinator / Ergonomist
- Specialist Speech and Language Therapist
- Specialist Professional such as Midwife
- Pharmacy

Where additional considerations to manage the individual needs of a service user has been made then this should be recorded. The record should show the risk assessment and the specific care plan that has taken place in relation to the particular individual need.

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

WEAPONS (INCLUDING KNIFES, FIREARMS) AND HOSTAGE TAKING

1.0 Trust Staff Response

1.1. Staff must **not** attempt to disarm a user suspected of having a weapon without the assistance of the police.

1.2. If it is suspected that a user has a weapon then the police must be informed immediately using 999, and giving the location and an explanation for the grounds for suspicion.

1.3. If possible and appropriate evacuate the area as quickly and calmly as possible, ensuring the safety of other patients / residents, staff and visitors is paramount.

1.4. If possible and appropriate close and lock any doors in the immediate vicinity to help isolate and contain the area, the aggressor and situation. In the event of hostage taking it may be more appropriate to leave doors open and/or unlocked.

1.5. Observation of the immediate area should be maintained if it is possible to do so without endangering the staff carrying out the observation.

1.6. The Senior Manager (Manager on call) responsible for the unit, the Consultant (or Consultant on call) responsible for the patient and the Associate Director (or Director on call) for the Service must be contacted.

1.7. In all instances where the Police and other emergency services are called to manage an incident involving weapons or hostage taking then the following must be informed.

- Chief Executive
- Medical Director
- Trust Chair
- Clinical Director for the relevant Directorate
- Communications Manager
- LSMS

1.8. The Senior Manager or Associate Director will take over from the Nurse in Charge in the management of the Trust's response to the incident and also take over liaison with the police.

2.0 Police liaison and management of the situation

2.1. Once the police arrive the nurse in charge should establish with the police the appropriate course of action. In most instances it will be appropriate for the police to lead the effort to disarm the user.

2.2. The nurse in charge must provide the police with a full risk assessment on the individual concerned so that the response of the police is proportionate and appropriate.

2.3. The Police will set up a perimeter which they control in order to ensure the safety of police officers and others who may already be within the perimeter or entering it.

2.4. If the police are called to attend a serious incident involving weapons or a serious incident involving hostage taking the Trust's Major Incident Policy must be activated and a Major Incident Control Centre established. The following factors will be considered:

- Ongoing police liaison
- Movement in, around and out of unit site
- Potential risks for adjoining units
- Evacuation and relocation plans
- Contact with relatives
- Press liaison
- Communication with the Health Authority and PCTs

2.5. The police must be provided with:-

- A list of patients / residents and staff on the unit concerned (including ancillary staff)
- A secure and private area for the use of specific officers
- Access to staff with detailed knowledge of environment or individuals concerned.

2.6 The incident may last for lengthy period of time and management plans for staff arriving on and going off duty will need to be made. In addition the welfare of other patients / residents will need to be considered up to and after the incident has been resolved.

2.7 Once the user has been disarmed, his/her room and all his/her belongings must be searched in order to establish that no other weapons are hidden.

2.8 Urgent consideration should be given to placing the patient / resident in a more secure environment if the patient / resident are currently residing on an open unit. A full risk assessment on the user concerned must be carried out.

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Therapeutic and Safe Intervention and de-escalation (TASID) the management of Violence and Aggression

The Therapeutic and Safe Interventions and De-escalation training model the Trust have adopted under pins all the principals of the Restraint Reduction Network (RRN) Training Standards 2019 where the focus is on prevention strategies. TASID adopts the world health organisation's approach to reducing violence and aggression Primary Secondary and Tertiary.

Use a restrictive intervention only if de-escalation and other preventive strategies, including p.r.n. medication, have failed and there is potential for harm to the service user or other people if no action is taken. Continue to attempt de-escalation throughout a restrictive intervention. Do not use restrictive interventions to punish, inflict pain, suffering or humiliation, or establish dominance.

Ensure that the techniques and methods used to restrict a service user:

- Are proportionate to the risk and potential seriousness of harm.
- Are the least restrictive option to meet the need.
- Are used for no longer than necessary.
- Take account of the service user's preferences, if known and it is possible to do so.
- Take account of the service user's physical health, degree of frailty and developmental age.

1.0 Decision Making for the Use of Physical Intervention/Restraint Tertiary

1.1 Where risk assessments identify that physical intervention/restraint may be needed, their implementation should be planned in advance and recorded as tertiary strategies within the positive behaviour support plans (or equivalent).

1.2 On other occasions, behavioural disturbance may not have been predicted by risk assessments. In such cases emergency management of the situation and the use of physical intervention/restraint should be based on clinical judgement which takes account of relevant best practice guidance (such as those published by the National Institute for Health and Care Excellence (NG10)) and all available knowledge of the patient / resident's circumstances.

1.3 Restrictive interventions should be used in a way that minimises any risk to the patient / resident's health and safety and that causes the minimum interference to their autonomy, privacy and dignity, while being sufficient to protect the patient / resident and other people. The patient / resident's freedom should be contained or limited for no longer than is necessary. Unless there are cogent reasons for doing so, staff must not cause deliberate pain to a patient / resident in an attempt to force compliance with their instructions (for example, to mitigate an immediate risk to life).

1.4 The choice and nature of physical intervention/restraint will depend on various factors, but should be guided by:

- The patient / resident's wishes and feelings, if known (e.g. by an advance statement).
- What it is necessary to meet the needs of the individual based on a current assessment and their history.
- The patient / resident's age and any individual physical or emotional vulnerability that increase the risk of trauma arising from specific forms of restrictive intervention.
- Whether a particular form of restrictive intervention would be likely to cause distress, humiliation or fear.
- Obligations to others affected by the behavioural disturbance.
- Responsibilities to protect other patient / residents, visitors and staff, and the availability of resources in the environment of care.

1.5 Any use of restrictive interventions must be compliant with the Human Rights Act 1998 (HRA), which gives effect in the UK to certain rights and freedoms guaranteed under the European Convention on Human Rights (ECHR).

1.6 Where an incident occurs, either spontaneously or as the result of a deterioration of a situation that has not responded to preventative strategies or de-escalation techniques and it is necessary to use advanced management interventions of Physical intervention / Rapid tranquilisation this is considered a Psychiatric Emergency and requires the presence of the following to ensure a safe conclusion of the incident:

- Alarm systems to summon other staff to assist in the management of the incident.
- Grab bags must be available on all inpatient / resident wards / units containing Resuscitation Equipment, including Defibrillator, Bag Valve Mask, and Oxygen, suction, all of which must be contained in good working order
- Attendance of a Doctor.
- Site Co-ordinator upon arrival will be informed and updated on the situation.

1.7 For Nursing Homes where an incident occurs either spontaneously or as the result of a deterioration of a situation that has not responded to prevention strategies or de-escalation techniques and it is necessary to use advanced management interventions of Physical intervention / Rapid tranquilisation this is considered a Psychiatric Emergency and requires the presence of the following to ensure a safe conclusion of the incident:

- Alarm systems to summon other staff to assist in the management of the incident.
- Grab bags must be available containing Resuscitation equipment including Defibrillator, Bag Valve Mask, and Oxygen, cannula, fluids, suction, all of which must be contained in good working order.
- Nurse in Charge

Source: NICE Clinical Guideline QS154 Violent and aggressive behaviours June 17.

- Contact Nursing Home Manager

1.8 Where a patient / resident is restrained unintentionally in a prone/face down position, staff should either release their holds or reposition into a safer alternative as soon as possible.

1.9 In all circumstances where restraint is used one staff member must monitor the patient / residents head, airway and physical condition throughout the restraint to minimise the potential of harm or injury. Observations that include vital clinical indicators such as pulse, respiration and complexion (with special attention to pallor or discoloration) must be carried out and recorded. Staff must be trained to be competent to interpret these vital signs. If the person's physical condition and/or their expressions of distress give rise to concern, the restraint must stop immediately.

1.10 Staff must continue to monitor the patient / resident for signs of emotional or physical distress for a significant period of time following the application of restraint.

1.11 Staff must only use methods of restrictive intervention for which they have received and passed professional training. Training records must record precisely the techniques that a member of staff has been trained to use.

1.12 A member of staff should take responsibility for communicating with the person throughout any period of physical intervention in order to continually attempt to de-escalate the situation.

1.13 Staff must not cause deliberate pain to a person in an attempt to force compliance with their instruction. Where there is an immediate risk to life, in accordance with NICE guidelines, recognised techniques that cause pain as a stimulus may be used to mitigate that risk. These techniques must be used proportionately and only in the most exceptional circumstances and never for longer than is necessary to mitigate the risk to life. These techniques can only be used by trained staff having due regard for the safety and dignity of patient / residents.

1.14 People must not be deliberately restrained in a way that impacts on the airway, breathing or circulation. The mouth and/or nose must never be covered and techniques should not incur pressure to the neck region, ribcage and/or abdomen. There must be no planned or intentional physical intervention of a person in a prone/face down position on any surface, not just the floor. This will best be achieved through the adoption and sustained implementation of restrictive practice reduction programmes and the delivery of care pathways that incorporate Positive and Proactive Behaviour Support Plans or equivalent.

1.15 Where unplanned or unintentional incidents of any restrictive practice occur there should always be recording and debrief to ensure learning and continuous safety improvements.

Source: NICE Clinical Guideline QS154 Violent and aggressive behaviours June 17.

1.16 Staff must not deliberately use techniques where a person is allowed to fall, unsupported, other than where there is a need to escape from a life threatening situation.

1.17 Staff must not use physical restraint or breakaway techniques that involve the use of pain, including holds where movement by the individual induces pain, other than for the purposes of an immediate rescue in a life threatening situation.

1.18 Prone restraint should not form part of a planned intervention and must be viewed as an unplanned event. There may be exceptional circumstances where a patient / resident may request to be restrained in the prone position and these will need to be discussed as an MDT with the patient / resident to explore the reason for this request and appropriate plan recorded and circulated to all staff.

2.0 Using Physical Intervention/Restraints

2.1 When a decision to use physical intervention has been made the Nurse in charge should where ever practical carry out the following actions:-

- Assemble a physical intervention team.
- Inform the team of what the patient / resident is likely to do.
- State any possibility of infection and take appropriate precaution.
- Direct other staff not involved in the physical intervention with tasks such as removal of obstacles, management of other service users etc.
- Feeding in substitute members of staff where fatigue or injuries dictate.
- Prepare Rapid tranquilisation medication when this decision is made.
- Prepare the seclusion room (if appropriate) if this decision is made.
- Ensure the attendance of a doctor / duty doctor.
- Ensure Emergency resuscitation equipment is present at the incident.

2.2 The designated team if possible and time allows should determine team roles, especially the allocation of the lead for the physical intervention who will take on the responsibilities listed below. Be briefed on the situation and possible causes and determine a plan of management of the incident including expected outcome of the physical intervention.

2.3 One member of staff should assume control throughout the process. He or she is responsible for:-

- Liaison with the nurse in charge.
- Maintaining de-escalation techniques with the patient / resident and creating a dialogue of communicating the actions the team will take with the patient / resident to achieve a quick and favourable outcome.
- Setting out for the patient / resident the clear, positive instructions and expectations of behaviour that will end the use of physical intervention.
- Respond to and reinforce all compliance by the patient / resident.

- Protecting and supporting the patient / residents head and neck, where required. (The protection of the head constitutes a duty of care owed to the patient / resident).
- Ensuring their airway and breathing are not compromised.
- Ensuring vital signs are monitored.
- Leading the team through the process by giving clear instructions and relevant information.

2.4 If a physical intervention ends up on the floor a head person must physically be in place or an identified member of the team accepts that responsibility. In exceptional circumstances if this is not practicable (possibly due to environmental factors) then another member of staff must take over the roles and responsibilities of the head person as outlined above.

Other considerations for the use of physical intervention must include.

- Strict avoidance of excess weight being placed on any area, but particularly the areas of fingers, head, neck, thorax, abdomen, back or pelvic area.
- Where possible the use of at least one same staff to patient / resident gender especially where female patient / resident physical intervention is concerned, if necessary substitute physical intervention staff as required and safe to do so.
- Determining the end of Physical intervention must be the decision of the physical intervention team leader. They should take into account where appropriate advice from other physical intervention team members the Doctor and Nurse in Charge and considered factors such as:-
- Has the patient / resident calmed sufficiently for physical intervention to be terminated. If so what follow up interventions are to follow? I.e. observation levels, movement to low stimulus environment etc.
- Has physical intervention been used for an excessive amount of time with no response from the patient / resident? Consider Rapid Tranquillisation and or Seclusion as alternatives to lengthy physical intervention with attendant risks.
- Maintain continual assessment of the patient / resident to enable early reintegration into the main ward environments.

2.5 When physical intervention has been used, staff must report the incident on Datix and include all the restraint details. Following any violent incident event in mental health and learning disability services, the priority is reconciliation. The continued development of the therapeutic relationship between staff patient / resident can be enhanced by the acknowledgement of any incident event. Ideally on the day following any incident where appropriate staff and the patient / resident should meet to discuss the event, the rationale for any procedures used, triggers and causes of the incident and plans regarding how future incidents may be avoided.

2.6 In Community Health Services a post incident review would be undertaken prior to any future service provision to the patient / resident.

Source: NICE Clinical Guideline QS154 Violent and aggressive behaviours June 17.

3.0 Post Incident Management

3.1 Account for all patient / residents and staff ensuring their safety and wellbeing, (incidents have been used to distract staff to allow other patient / residents to self-harm or abscond etc.). Determine the safety of the environment for continued care of patient / residents.

3.2 A Doctor must examine the patient / residents for physical injuries especially where an injury has occurred or is suspected and or adverse symptoms are observed this might include breathlessness, fainting or potential head trauma. This examination must be recorded in the healthcare records. Any injuries or adverse symptoms of the patient / resident, staff or others must be reported.

3.3 Nursing staff must carry out basic vital signs observations as soon as possible after the event especially if physical intervention and rapid tranquilisation procedures have been used. This should be repeated up to every 4 hours (more frequent if necessary) and for up to a period of 24 hours minimum and recorded on a MEWS chart. After this period the Doctor and Nurse should decide if monitoring should continue on a regular basis if necessary.

3.4 In conjunction with the Doctor, make an assessment of the patient / resident potential to relapse consider all possibilities regarding safety, including observation status and staffing levels. Consideration must be given that includes transfer to more secure services such as a Psychiatric Intensive Care Unit (PICU).

3.5 If required inform senior management of the incident and the seriousness of the incident. Update frequently on actions taken.

3.6 Anyone present at the time of the incident will be offered immediate debrief support this includes staff, patients / residents and visitors who were involved or in the area.

3.7 If there are 5 incidents with 1 patient / resident in 1 week a review needs to be undertaken with someone not involved in the incident.

3.8 All incidents of prone restraint must be reviewed and lessons learnt.

3.9 Patients / residents should be given the opportunity to record and have filed within their healthcare records their view and account of their experience, including that of any intervention used.

Essex Partnership University
NHS Foundation Trust

Therapeutic and Safe Interventions and De-escalation Procedure

PROCEDURE REFERENCE NUMBER:	RMPG05
VERSION NUMBER:	2.1
KEY CHANGES FROM PREVIOUS VERSION:	Appendix 8d added
REPLACES EPUT DOCUMENT	Restrictive Practice Procedure (renamed)
AUTHOR:	Restrictive Practice Steering Group
CONSULTATION GROUPS:	HSSC
IMPLEMENTATION DATE:	16 November 2017
AMENDMENT DATE(S):	July 2019 (Chair's Action CGQSC); April 2021 (3y review); December 2021
LAST REVIEW DATE:	April 2021
NEXT REVIEW DATE:	April 2024
APPROVAL BY CLINICAL GOVERNANCE AND QUALITY SUB-COMMITTEE:	February 2021
RATIFICATION BY QUALITY COMMITTEE:	April 2021
COPYRIGHT	2017-2021

PROCEDURE SUMMARY
These procedural guidelines aim to ensure that staff are provided with the current evidence based information and guidance to prevent and manage restrictive practices.
The trust monitors the implementation of and compliance with this procedure in the following ways:
The monitoring of the use of physical interventions through Datix forms, regular Audit undertaken in conjunction with Workforce Development & Training Department and Risk Management Team and supported by the Clinical Audit Team. Also by the dissemination of information from lessons learnt from physical intervention incident analysis.

Services	**Applicable**	**Comments**
Trustwide	✓	

The Director responsible for monitoring and reviewing this procedure is Executive Nurse

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

TASID PROCEDURAL GUIDELINES

CONTENTS

THIS IS AN INTERACTIVE CONTENTS LIST – PLEASE CLICK ON THE SECTION HEADINGS TO GO TO THE SECTIONS

APPENDICES

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

TASID PROCEDURAL GUIDELINES

1.0 INTRODUCTION

1.1 The procedural guidance aim is to promote a consistent positive and therapeutic approach to averting behavioural disturbances, by encouraging a culture across the organisation that is committed to enhance the therapeutic environment.

The Trust has adopted the No Force First approach to facilitate the reduction of any restrictive practice. The key components of this are:

- Commitment to the concept of 'No Force First'.
- Re-defining the relationship between staff and services users as one of 'risk-sharing partnership' rather than 'risk management control' through a review of institutional rules that unnecessarily hinder and frustrate service users.
- Promotion and development of the use of 'recovery focused' positive and continually optimistic language about service users that seeks to avoid negative stereotyping.
- Defining the use of restraint and seclusion as a 'treatment failure' and critically reviewing incidents on that basis.
- Promotion of the concept of trauma informed care – seeing challenging behaviour in the context of previous traumatic events experienced by the service user

1.2 This procedural guidance will provide an overview of restrictive practices to all staff. It will also look at the process for managing behavioural disturbances using primary, secondary and tertiary approaches including reporting and evaluating the use of restrictive interventions/practices.

1.3 When episodes of challenging behaviour do occur these guidelines provide clear and effective strategies as recommendations for actions staff may take to deescalate, manage or intervene to bring the episode to a safe and rapid conclusion.

1.4 The Trust recognises the need to support staff at all times, and especially following an episode of challenging behaviour. The guidance, therefore, must be read in conjunction with Trust guidelines for Employee Wellbeing and Sickness Absence HR26 and associated documents which set out systems and processes to ensure that staff feels supported and that lessons are learnt and shared following incidents.

2.0 DEFINITIONS

2.1 The Trust follows the Department of Health guidance and definition of Restrictive Practice set out in the Positive and Proactive Care: Reducing the Need for Restrictive Interventions, 2014 document:

'Deliberate acts on the part of other person(s) that restrict an individual's movement, liberty and/or freedom to act independently in order to:

- Take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken; and
- End or reduce significantly the danger to the person or others; and
- Contain or limit the person's freedom for no longer than is necessary'

2.2 The Skills for Care and Skills for Health, a Positive and Practice Workforce (2014) provide a simple definition:

"Making someone do something they don't want to do or stopping someone doing something they want to do."

3.0 PRACTICE STANDARDS

3.1 Restrictive practices are not only confined to physical interventions. Any actions or inactions that contravene a person's Human rights may be seen as restrictive practice. These rights must be at the centre of decision-making. Human Rights based approach, focused on the minimisation of the use of restrictive interventions, and ensuring any use of restrictive interventions and other restrictive practices is rights-respecting.

Below are some categories of restrictive practices and how these are applied. Any restrictive practice must be lawful and have a legitimate right and reason to do so. This is not an exhaustive list.

3.2 Physical Restraint

"Any direct physical contact where the intervener's intention is to prevent, restrict, or subdue movement of the body, or part of another person" *(Positive and Proactive Care: reducing the need for restrictive interventions. DoH April 2014).*

3.3 Environmental Restrictions

This is to limit people's ability to move as they might wish, such as locking doors or parts of the building. This includes the use of electronic keypads with numbers to open doors, complicated door locking mechanisms and door handles.

3.4 Chemical Restraint

This refers to the use of drugs to modify a person's behaviour. Medication that is prescribed to be taken as and when required (PRN) can be used as a form of restraint unless applied responsibly.

3.5 Forced Care

Actions to encourage / coerce an individual into acting against their will, for example having to be restrained in order to comply with instruction or request, or non-application of Section 5/4 following advising an individual you will use it if they attempt to leave.

3.6 Cultural Restrictions

Preventing an individual from following the behaviours and beliefs characteristic of a particular social, religious or ethnic group chosen by them.

3.7 Decision making

Making a decision on the person's behalf or not accepting or acting on a decision the person has made.

3.8 Community contact

Preventing an individual from participating in community activities, including working, education, sports and community events or from spending time in the Community such as parks, leisure centres and shopping centres.

3.9 Contact with family and friends

Preventing or limiting contact with the individual's peer groups, friends or family. For example not allowing the person to receive visitors, make phone calls or allowing them contact with specific friends or family member.

3.10 Blanket Rules / Global Restrictions

Blanket / Global restrictions refers to policy rules or customs that will restrict a patient / residents' rights and liberty that are routinely implemented to all patient / residents within a service without an individual risk assessment to justify its application. There needs to be justification for the implementation of blanket restrictions. They should be avoided unless there is specific justifications which are deemed appropriate and necessary to address the risk or risks identified for particular individuals, the impact of a blanket restriction on each patient / resident should be considered and documented in their records.

3.11 Deprivation of access to normal daytime clothing

Individuals must never be deprived of appropriate clothing with the intention of restricting their freedom of movement; neither should they be deprived of other aids necessary for their daily living (COP 26.161). However there are circumstances where it will be appropriate and necessary to use restrictive clothing in order to prevent risks to self-i.e. tear-resistant clothing. Where this is implemented, a rationale for this must be recorded, the patient must be informed of reasons, reviews must be evidence (including least restrictive alternative strategies) and the use must be for the shortest amount of time.

To ensure privacy and dignity special tear-resistant clothing must only be used when a patient is either in Seclusion or being nursed in Long Term Segregation

For guidance on the use of tear–resistant clothing please refer to Appendix 3c of CLP41, the Policy for the use of Seclusion & Long–Term Segregation.

4.0 UNACCEPTABLE METHODS OF RESTRAINT/RESTRICTVE PRACTICES

4.1 The following methods of restriction are unacceptable, especially if the individual requests or is consenting to any of the following. It may be considered and applied as appropriate, this must be clearly documented. Inappropriate use of restrictions may be viewed as abuse and a safeguarding concern. The following is not an exhaustive list.

4.2 Inappropriate bed height

This is unacceptable form of restraint as it could also lead to an increased risk of falls to the patient and risks to staff.

4.3 Inappropriate use of wheelchair safety straps

Straps supplied with wheelchairs should always be used when provided for the safety of the user. Although patient / residents should only be seated in a wheelchair when this type of seating is required and not as a means of restraint or to restrict the individual's movement when there are lesser options available.

4.4 Using low chairs for seating

Low chairs should only be used when their height is appropriate - they should not be used with the intention of restraining a person; low chairs also pose a risk to staff in relation to manual handling.

Chairs by way of construction immobilise an individual e.g. Reclining chairs, bucket seats. This type of chair should be used for the comfort of the individual and not for the purpose to restrict movement.

4.5 Locked doors

Where units have locked doors for identified risks, there should be clear signage displayed informing individuals and visitors that the doors are locked and who they need to speak to gain exit from the area. If an individual wished to leave and is being prevented by the locked door that patient / resident is being restricted.

4.6 Arranging furniture to impede movement

Furniture should only be used for its intended purpose

4.7 Removal of outdoor shoes and other walking aids or the withdrawal of sensory aids e.g. glasses

As with the above they should be enabled to prevent confusion and disorientation.

4.8 Prone physical restraint

Prone restraint should not be used other than in exceptional circumstances;

- medical reasons
- potentially to exit from seclusion room
- administration of prescribed medication only if other IMI sites are felt not appropriate

Utilisation of supine, seated de-escalation or the release of the patient / resident in a controlled manner if it is deemed appropriate and safe to do so enabling them to move of their own volition to an area mutually agreed with them and staff as alternatives.

4.9 Safety pods

This equipment enables staff to restrict patients/clients movement without the need to go to the floor and may also enable staff de-escalate in them. however if a patient/clients has been placed in a safety pod and left alone but the client is unable to get them out of the safety pod this may be seen as a mechanical restraint.

5.0 ASSESSMENT AND DECISION MAKING

5.1 Risk Assessment and decision making is an integral part of providing care and treatment.

5.2 Risk Factors (**Appendix 1)** and Antecedents and Warning signs (**Appendix 2**) must be taken into consideration in the assessment and decision making process.

5.3 Risk Factors to consider when placing patients on observation are set out in **Appendix 4.** Also see Engagement & Supportive Observation Policy and Procedure, CLP8.

5.4 Risk Factors to be considered when a patient has specific needs are set out in **Appendix 5.**

5.5 Individual assessment should be carried out in partnership with the individual and considers the following.

- The individual's behaviour and underlying condition and treatment, understanding a patient / resident's behaviour, responding to their individuals identified needs and mutually agreeing a way forward. This should always be at the centre of individualised care. All individuals require a rigorous assessment to establish a positive and proactive support plan to identify appropriate management process.
- The patient / resident's mental capacity and mental health. The individual's mental capacity requires consideration as consent must be gained to use any type of restriction unless they lack capacity to make this decision and the restrictive practice is sanctioned under the Mental Health or Mental Capacity Act.
- The environment should be made to reduce the negative effects a care environment. Negative effects of a care environment include high levels of noise and disruption, inappropriate temperature control, inappropriate levels of stimulation, negative attitudes of care staff and poor communication skills.
- The risk to patient / residents and others, when using restrictive practices a balance needs to be achieved that minuses the risk of harm or injury to the individual and others within the area whilst maintaining the dignity, choice and personal freedom of the individual.
- Assessment should always place the individual at the centre of the process, involving them and those important to them as practical to do so. Evidence of personal centred care should always be documented and signed by the individual and identified staff member undertaking the assessment.

5.6 If a restriction is deemed appropriate the following must always be considered.

- The practice needs to have a legitimate goal, it must be necessary to protect the health and wellbeing of the individual or to protect the safety or human rights of others in the area. This should always be the least restricted option.
- Individuals effected by the restriction must be involved in the decision making process to the fullest extent of their capacity.

- The restrictions that are being instigated must be proportionate to the level of risk identified and the least restrictive option to achieve a safe outcome.

- The principles of dignity and respect must be observed at all times and especially at times when restrictive interventions are being implemented.

- There must be continuous review and evaluation of the practice being implemented to ensure that is used for the shortest possible time period and that it is necessary and the most effective practice at this time.

5.7 If the individual has capacity and can give valid consent and their agreement can be gained without pressure, then the restriction can be put in place as long as it does not contravene the law. The individual has the right to withdraw consent / agreement at any time and it is required that they are informed of this right at the outset.

5.8 If the individual withdraws their consent but it is felt that the restriction should continue but it is deemed that the practice should continue, this can only be achieved if the restriction is supported by the Mental Capacity Act or the Mental Health Act, Criminal Law or the Public Health Act.

5.9 **Appendix 8a** outlines the process for when considering placing of a risk of violence marker on a patient record, **Appendix 8b** provides staff with the referral form in doing so.

6.0 PRIMARY PREVENTATIVE STRATEGIES

Behavioural disturbance and the use of restrictive practice can be minimised by promoting a supportive and therapeutic culture within the care environment. Unless an individual is subject to specific justifiable restrictions (e.g. for security reasons), primary preventative strategies should typically include the following,

6.1 Positive and proactive support plans/positive behaviour support Plans

These are created to help understand and **support** children, young people and adults who display **behaviour** that others find challenging. They are designed to guide us in our responses and actions at times of distress. Patients should be involved when making decisions about their care, this is a human right.

This plan should be implemented alongside a risk management plan. The two plans will proactively and reactively manage risk and support the **reduction of restrictions**. Restrictions include any intervention (environmental, physical, relational, psychological or pharmacological) that prevent a person in your care from pursing free action.

This plan should be developed with support from a clinician with behavioural expertise following an assessment and functional analysis of the problem behaviour.

6.2 Advance Decisions

People who are identified as being at risk of presenting with behavioural disturbance which could include challenging behaviour must be given the opportunity to have their wishes and feelings recorded in an advance

statement, if they have the capacity to do so (Trust Policy Advance Decisions and Statements CG6).

6.3 Care and Treatment plan

Staff should ensure that patient / clients who are assessed as being liable to present with behavioural disturbances have a care and treatment plan which includes primary, secondary and tertiary preventative strategies. These individualised care plans, should be available and kept up to date and include the primary, secondary and tertiary interventions.

- Engaging with individuals and their families
- Care and support
- Considering the regulatory framework
- Patient / resident Community
- Patient / resident Characteristics

6.4 Risk assessments

The assessment of clinical risk in mental healthcare is challenging but provides an opportunity to engage with patients, and their careers and families in order to promote the patients' safety, recovery and wellbeing[4]. A good risk assessment will combine consideration of psychological (e.g. current mental health) and social factors (e.g. relationship problems, employment status) as part of a comprehensive review of the patient[5] to capture their care needs and assess their risk of harm to themselves or other people.

6.5 Staff primary prevention strategy

All staff must be aware that their own personal safety is paramount in any situation where they are faced with episodes of aggression or violence. This includes the right to defend themselves using the justifiable, appropriate and reasonable force to ensure they can escape to an area of safety.

6.6 All clinical staff working in inpatient environments will have access to a personal alarm. Staff who work alone or may visit clients in the community will have access to Lone Worker devices, It is the responsibility of each member of staff to familiarise themselves with the use and circumstances in which alarms should be used.

7.0 SECONDARY PREVENTATIVE STRATEGIES

7.1 De-escalation is a secondary preventative strategy. The use of techniques (including verbal and non-verbal communication skills) aimed at defusing anger and averting aggression. P.r.n. medication can be used as part of a de-escalation strategy but p.r.n. medication used alone is not de-escalation. (NICE 10 2015)

7.2 De-escalation techniques are set out in **Appendix 3.**

7.3 It involves the gradual resolution of a potentially violent or aggressive situation where an individual begins to show signs of agitation and/or arousal that may indicate an impending episode of behavioural disturbance which could include challenging behaviour.

7.4 De-escalation strategies promote relaxation, e.g. through the use of verbal and physical expressions of empathy and alliance. They should be tailored to individual needs and should typically involve establishing rapport and the need for mutual co-operation, demonstrating compassion, negotiating realistic options, asking open questions, demonstrating concern and attentiveness, using empathic and non-judgemental listening, distracting, redirecting the individual into alternate pleasurable activities, removing sources of excessive environmental stimulation and being sensitive to non-verbal communication.

8.0 TERTIARY INTERVENTIONS

8.1 Physical interventions / restraints are a tertiary preventative measure.

8.2 A physical intervention / restraint is defined as:

"Any direct physical contact where the intention is to prevent, restrict, or subdue movement of the body (or part of the body) of another person".

Manual restraint *A skilled, hands-on method of physical restraint used by trained healthcare professionals to prevent service users from harming themselves, endangering others or compromising the therapeutic environment. Its purpose is to safely immobilise the service user. (NICE 10 2015).*

Therapeutic and Safe Intervention (TASI previously referred to as PMVA) is set out in **Appendix 7.**

Mechanical restraint *A method of physical intervention involving the use of authorised equipment, for example handcuffs or restraining belts, applied in a skilled manner by designated healthcare (NICE 10 2015).*

9.0 LEGAL CONSIDERATIONS

9.1 All staff that utilise these interventions must be aware of the legal framework that authorises their use. The main guidance is given in Chapter 1 of the Mental Health Act Code of practice 2015 and should be followed for every incident. Where departures from the guidance occur they should be rigorously recorded and justified as being in the patients best interest.

9.2 The use of Physical intervention must be as a last resort, defensible in law and within Trust Policy and Procedures.

9.3 The use of "Reasonable Force" is legally permitted. All staff must be aware that their own personal safety is paramount in any situation where they are faced with episodes of challenging behaviour. In a one on one situation removal of yourself to a safe **area is the first course of action.**

9.4 Staff need to ensure that the risk is assessed prior to carrying out any physical intervention to maintain the safety of themselves and service users.

10.0 PHARMACOLOGICAL MANAGEMENT OF ACUTELY DISTURBED BEHAVIOUR CLINICAL GUIDELINE (RAPID TRANQUILISATION COP 26.91 – 26.102)

10.1 For information regarding the use of medication in the management of acutely disturbed behaviours, staff must refer to the following Trust policies:

- Formulary and Prescribing Guidelines, Chapter 8 - Pharmacological Management of Acutely Disturbed Behaviour Clinical Guideline (PMAD-B)
- Safe and Secure Handling of Medicines Guidelines

11.0 SECLUSION AND LONG TERM SEGREGATION

11.1 For information regarding the use of seclusion and long-term segregation in the management of acutely disturbed behaviours, staff must refer to the Trust's Seclusion & Long Term Segregation Policy and Procedure CLP41.

11.2 Staff must also be familiar with and follow the guidance given in the Mental Health Act Code of Practice 2015.

12.0 WEAPONS AND HOSTAGE TAKING

12.1 Where a patient / resident presents with a weapon (of any description) or has taken a hostage as part of an episode of challenging behaviour the police must be called immediately. Staff must remove all persons from the area and isolate the patient / resident concerned. Safety of the staff and others takes priority in this matter.

12.2 The procedure described in **Appendix 6** should then be followed.

12.3 In all Community Services where a patient / resident presents with a weapon, the staff member will safely withdraw and dial 999 requesting emergency assistance or call a red alert on their lone worker device. (Please refer to the Trust Lone Working Policy and Procedure).

13.0 INCIDENT REPORTING AND RECORD KEEPING

13.1 All incidents and the interventions used are to be fully recorded in the patient / residents healthcare records and on Datix, see Adverse Incident Procedure and Online Incident Reporting Datix Guidance, Appendix 5.

14.0 SUPPORTING STAFF, PATIENT / RESIDENTS

14.1 Support for staff, patient is detailed in the Employee Wellbeing and Management of Sickness and Ill Health Policy HR26. Support for patients/ residents are referred to in section 15 of this procedure.

15.0 IMMEDIATE POST INCIDENT DEBRIEF AND FORMAL POST INCIDENT REVIEW

15.1 **Immediate post-incident debrief**

After using a restrictive intervention, and when the risks of harm have been contained, conduct an immediate post-incident debrief, including a nurse and a doctor, to identify and address physical harm to service users or staff, ongoing risks and the emotional impact on service users and staff, including witnesses.

This is to determine the factors that contributed to an incident that led to a restrictive intervention, identify any factors that can be addressed quickly to reduce the likelihood of a further incident and amend risk and care plans accordingly.

To ensure that the service user involved has the opportunity to discuss the incident in a supportive environment with a member of staff or an advocate or carer.

To ensure that any other service users who may have seen or heard the incident are given the opportunity to discuss it so that they can understand what has happened.

(NICE 10 2015).

15.2 Post Incident for staff is detailed in HR26, Employee Wellbeing, Sickness & Ill-Health Policy

15.3 Managerial decisions will determine the level of post incident review dependant on the seriousness of the incident event. Good practice determines that where tertiary interventions are used and or where significant injury to persons or damage to property result then post incident reviews should occur.

15.4 These discussion should only take place when those involved have recovered their composure.

15.5 The aim of post incident reviews should be to seek to learn lessons, support staff and patient / resident, and encourage the therapeutic relationship between staff patient / residents and their careers.

15.6 Post incident reviews should take place as soon as possible, but in any event within 72 hours after the incident. The review should look objectively at the lead up to the incident, the dealing of the incident and the aftermath of the incident.

15.7 The post incident reviews should wherever possible be led by a person not directly involved in the incident event and address:-

- Any precursors, causative factors and trigger points;
- What happened during the incident;
- Sequence of events;
- Address individual's roles and their decision making processes;
- How a successful outcome was achieved and how the event ended;
- What went well and demonstrated good practice;
- What lessons can be learnt;
- An evaluation of the effectiveness of response times surrounding the incident;
- What strategies / interventions could be used if the incident were to reoccur;
- Issues that senior managers or the MDT need to be aware off;
- Where possible, recommendations should be made as to future management plans for the service user or the organisation.

16.0 TRAINING

Restraint Reduction Network (RRN) Training Standards 2019 provide a national and international benchmark for training in supporting people who are distressed in education, health and social care settings. These standards will ensure that training is directly related and proportional to the needs of populations and individual people. They will also ensure that training is delivered by competent and experienced training professionals who can evidence knowledge and skills that go far beyond the application of physical restraint or other restrictive interventions. The Therapeutic and Safe Interventions and De-escalation training model the Trust have adopted under pins all the principals of the Restraint Reduction Network (RRN) Training Standards.

16.1 The Trust will provide education and training surrounding physical interventions through, the Workforce Development & Training Department as guided by risk assessment of staff roles and individual service areas. (See Induction & Mandatory Training Policy / procedure appendix 1 for the training matrix).

16.2 All new nursing staff to inpatient mental health areas will undertake initial training in physical interventions.

16.3 Senior clinical staff are responsible for team based training and ensuring ongoing competency of staff in managing risks associated with lone working. Each team must ensure staff are informed about current policy requirements, through team based induction, preceptorship and supervision.

16.4 The Workforce Development and Training Department will report monthly on compliance levels for mandatory training for the Executive Team, Clinical Governance and Quality, Service Management Teams and Health Safety and Security Sub-Committee.

16.5 Managers are responsible for checking that training has been undertaken by a member of staff and is valid, so as to aid in maintaining the minimum of 3 physical intervention trained staff per shift, unless specified in local operational procedures.

16.6 Staff who are booked onto mandatory training and are, for whatever reason, unable to attend, MUST inform their line manager and ensure that their training is rebooked at the earliest opportunity.

16.7 Staff who do not attend a mandatory training course will be recorded and reported as a DNA unless prior notification was given in line with Induction and Mandatory Training policy.

16.8 A withdrawals and DNA report will be produced monthly as part of the mandatory reporting system.

16.9 Managers must determine if additional training is required in any element of restrictive practice.

17.0 MONITORING AND REVIEW

17.1 The monitoring of the use of physical interventions is an essential part of managing a ward, area, unit or department, therefore all incidents involving physical interventions will be recorded as per Adverse Incidents including Serious Untoward Incidents Policy and monitored by the Ward Manager/Nursing Home Manager Team Leader and Clinical Manager.

17.2 Audit is undertaken in conjunction with Workforce Development & Training Department and Risk Management Team and supported by the Clinical Audit Team with results presented to the Clinical Governance and Quality Sub-Committee and Health, Safety & Security Sub-Committee. This will include as a minimum:

- Duties
- Requirement to undertake appropriate risk assessments
- Arrangements for ensuring the safety of lone workers (see Lone Working Policy)

17.3 Analysis of physical intervention incidents will be undertaken by the Restrictive Practice Group to identify trends and patterns of activity in the use of physical interventions.

17.4 Any lessons learnt from physical intervention incidents that are recognised through the reporting process and the Restrictive Practice Group will be fed into the Clinical Governance Committee for sharing across the organisation.

17.5 Monitoring of training compliance will be undertaken by Workforce Development and Training.

17.6 Datix forms involving physical interventions will be reviewed by trainers, using the Datix communication processes. All clinical inpatient areas have 2 nominated full time instructors who can be contacted they will also monitor the Datixes for their clinical areas. The nominated instructor will provide support and guidance to clinical areas. Any issues/concerns identified will be discussed with the clinical teams and management. The nominated instructor will also provide feedback to the TASI team which then will be feedback to the workforce team and the restrictive practice group.

18.0 POLICY REFERENCES/ASSOCIATED DOCUMENTS

1. Restrictive Practice Framework EPUT 2019

1. CG6 - Advance Decisions and Statements Policy
2. CP3 - Adverse Incident Policy
3. CLPG28 - Clinical Risk Assessment and Safety Management Procedure
4. CLP8 - Engagement and Supportive Observation Policy
5. RM08 - First Aid Policy
6. SSOP31 - Protocol for the use of Handcuffs in escorting patients
7. HR21 - Induction, Mandatory Training and Essential Training Policy
8. RM17 - Lone Working Policy
9. CLP75 - Search Policy
10. CLP41- Seclusion and Long Term Segregation Policy
11. CG71 - Self Harm Clinical Guideline
12. CG52 - Pharmacological Management of Acutely Disturbed behaviour
13. CG92 - Global Restrictive Practices Clinical guideline
14. HR26 - Employee Wellbeing and Management of Sickness and Ill Health Policy

END