Use of Restrictive Physical Intervention for Adult Patients

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Author:	Interim Quality and Safety Officer Mental Health	
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The latest approved version of this document is online.
If the review date has passed please contact the Author for advice.

Version Control

Version	Summary of Changes/Amendments	Issue Date
1	Initial Issue	24/05/17

ENGAGEMENT & CONSULTATION

Key Individuals/Groups Involved in Developing this Document

Role / Designation
Consultant Psychiatrist, Interim Head of Mental Health, Interim Quality and safety Lead for Mental Health, Interim Senior Nurse AMH.

Circulated to the following for Consultation

Date	Role / Designation
08/02/2017	Consultant Psychiatrist
08/02/2017	Medical Director
08/02/2017	Clinical Director Mental Health
08/02/2017	Director of Primary and Community Care & Mental Health
08/02/2017	Director of Nursing
08/02/2017	Head of Complex & Unscheduled Care
08/02/2017	Interim Head of Mental Health
08/02/2017	Assistant Director Mental Health
08/02/2017	Interim Head of Nursing AMH
08/02/2017	Assistant Director of Quality and Safety
08/02/2017	Head of Safeguarding Children and Adults
08/02/2017	Heads of Nursing and Midwifery
08/02/2017	Head of Workforce and Organisational Development
08/02/2017	Head of Therapies

Evidence Base

Please list any National Guidelines, Legislation or Health and Care Standards relating to this subject area?

- NICE Guidance CG25 "The short-term management of disturbed/violent behaviour in psychiatric in-patient settings and emergency departments
- Framework for Restrictive Physical Intervention Policy and Practice. Welsh Assembly Government (March 2007)
- Mental Health Measure (2010) Wales
- Mental Health Act 1983 Code of Practice for Wales. Welsh Assembly Government (2008)
- Mental Capacity Act 2005 Deprivation of Liberty Safeguards (MCA DoLS)
- All Wales Interim Policy & Procedures for the Protection of Vulnerable Adults (2014)
- Safe Management of Mental Health In-patients. Welsh Assembly Government circular: CNO(2008)01 / CMO(2008)01
- National Control and Restraint Association (General services) (NCRGSA)
- British Institute of Learning Disabilities (BILD)
- All Wales NHS Violence and Aggression Training Passport and Information Scheme
- NMC The Code for Nurses and Midwives - (NMC 2015)
- Data Protection & Confidentiality Policy (2013)
- Consent to Treatment Policy (2011)
- Confidentiality: NHS Code of Practice: Supplementary Guidance: Public Interest Disclosures (2010): http://www.dh.gov.uk/publications
- Confidentiality & Disclosure of Health Information Toolkit http://www.bma.org.uk
- Social Services and Well being (Wales) Act 2014

- Powys Teaching Health Board Chaperone Guidelines
- Health and Safety at Work Act 1974.
- Human Rights Act 1998.
- Mental Health Act 1983 (2007).
- Children Act 1989.
- Care Standards Act 2000.
- Safeguarding Vulnerable Groups Act 2006.
- BMA Guidance
- Guidance to Police Officers Requested to Assist with Rapid Tranquillisation of Mentally Ill Patients. Metropolitan Police (2010).
- Providing Medical Care and Treatment to People who are Detained Guidance. British Medical Association (October 2007)

Health and Care Standards 2015

Theme 1 Staying healthy

1.1 Health promotion, protection and improvement

Theme 2 Safe care

2.1 Managing risk and promoting health & safety
2.3 Falls prevention
2.5 Nutrition & hydration
2.6 Medicines management
2.7 Safeguarding children & adults at risk
2.9 Medical devices, equipment & diagnostic systems

Theme 3 Effective care

3.1 Safe & clinically effective care
3.2 Communicating effectively
3.3 Quality improvement, research & innovation
3.4 Information governance & communications technology
3.5 Record keeping

Theme 4 Dignified care

4.1 Dignified care
4.2 Patient information

Theme 5 Timely care

5.1 Timely access

Theme 6 Individual care

6.1 Planning care to promote independence
6.2 Peoples rights
6.3 Listening and learning from feedback

Theme 7 Staff and resources

7.1Workforce

Nursing and Midwifery Strategy

Theme 1: Caring with humanity, dignity, kindness and compassion
Theme 2: Providing safe, effective, harm-free care.
Theme 3: Listening to patients and improving the way we work, securing a reputation for excellence.
Theme 5: Working with partners for the benefits of patients

IMPACT ASSESSMENTS

Equality Impact Assessment Summary					
	No impact	**Adverse**	**Differential**	**Positive**	**Statement** This document been developed to support PTHB employees working in In-patient Mental Health Units to appropriately and safely use Physical Restraint Interventions. It has been assessed to ensure that no one receives less favourable treatment on the protected characteristics of their age, disability, gender, sexual orientation, race, religion / belief or human rights.
Age	X				
Disability	X				
Gender	X				
Race	X				
Religion/ Belief	X				
Sexual Orientation	X				
Welsh Language	X				
Human Rights	X				

Risk Assessment Summary

Have you identified any risks arising from the implementation of this policy / procedure / written control document?
This policy minimises risk to patients and service users by providing a framework which enhances public protection and protection of PTHB who may be required to use restrictive interventions to maintain the safety and Well-being of Service users and others

Have you identified any Information Governance issues arising from the implementation of this policy / procedure / written control document?
None identified.

Have you identified any training and / or resource implications as a result of implementing this?
There is a requirement for Mandatory and Update Training.

1 Introduction

Powys Teaching Health Board is committed in its duty under the Health & Safety at Work. Act 1974, to provide a safe and secure environment for patients, staff and visitors.

Regrettably, staff, patients and visitors can be exposed to violent or aggressive behaviour. Occasionally, behaviour exhibited by individuals will be extremis and warrant specialist interventions, such as restrictive physical intervention, in order to protect the patient, the public or the staff. Managing aggressive and dangerous behaviour by restrictive physical intervention must only be used as a last resort, in an emergency and when there seems to be a reasonable possibility that harm would occur if the intervention were not used. Restrictive physical intervention techniques will vary according to the client group, which will be determined by the divisional director and /or risk assessment where appropriate, although in some cases there will be emergency situations where restrictive physical intervention is the appropriate response.

This policy provides guidance within a legal and ethical framework, underpinned by best practice principles, for staff implementing restrictive physical intervention (RPI, also known as restraint).

2 Policy Statement

The purpose of restrictive physical intervention is firstly to take immediate control of a serious, significant or dangerous situation and secondly to contain or limit the person's freedom for no longer than is necessary to end or reduce significantly the threat to themselves or those around.

Restrictive physical interventions must be regarded in the same way as any skilled clinical intervention with an individual. At all times the human and legal rights of the individual must be respected. The objective must be to meet identified need within the context of the aims and objectives of the service setting, whilst at the same time safeguarding the individual, those they interact with and those who provide services to them.

The person in control of the incident will have to carefully assess the situation and use their own judgement as to what may be deemed 'serious' or 'significant' before using such interventions. Furthermore, any physical intervention must be *justifiable, appropriate, reasonable and proportionate to a specific situation and be applied for the minimum possible duration*.

3 Aims

This policy aims to support staff working with adult and elderly patients admitted to an in-patient Mental health unit; to identify those situations where it may be necessary to consider the use of restrictive physical interventions to safeguard individuals, and to ensure that all appropriate alternate strategies have been considered before this course of action is adopted.

It also clarifies the agreed training requirements for Health Board staff to safely undertake restrictive physical interventions.

4 Objectives

To reduce the necessity for physically restrictive intervention through encouraging the development of preventative strategies.

To enable clinicians to work with the individual towards reducing the level of response needed where a potential need for restrictive physical intervention is identified as part of the individual planning and service delivery process.

Where situations requiring restrictive physical intervention are identified as unavoidable, to ensure that there is prior planning and training to ensure safer outcomes for all concerned.

5 Scope

This policy applies to all staff employed by Powys Teaching Health Board (PTHB) to work on In Patient Mental Health Units and Community Mental Health Staff who may be called to assist.

Where service users are receiving an intensive package of care through a third party on behalf of PTHB (e.g. specialist Mental Health placement), the third party provider would be expected to comply with the spirit and principles of this policy.

6 Roles and Responsibilities

6.1 Chief Executive

Responsible for:

- Ensuring that arrangements are in place for identifying, reducing and managing risk associated with violence & aggression at work.
- Providing resources for putting the policy into practice.

- Making sure that there are arrangements for monitoring incidents of violence and aggression.

6.2 Employees

Responsible for:

- Taking reasonable care of themselves and other people who may be affected by their actions.
- Co-operating and adhering to Policies, Procedures and Guidelines designed for safe working.
- Reporting all incidents involving verbal abuse, threats and physical assault through the Datix incident reporting system.
- Use best endeavours to ensure physical fitness is maintained to undertake training, and to notify line manager where personal fitness may place an individual at risk
- Ensuring they are competent and up to date with their physical intervention training.
- Reporting any dangers they identify or any concerns they may have about potentially violent situations or the environment in which they work via line manager and Powys Teaching Health Board DATIX incident reporting system.
- Using physical interventions as a means of preventing physical damage, attack, injury or self injury in situations of Extremis.
- Using physical interventions as a planned clinical intervention to support an agreed care plan.
- Reporting any skill deficit to their manager.
- Ensuring they use physical interventions as a last resort and in situations of Extremis and the interest of the service user remains paramount.
- Ensuring that, when they use physical intervention, this is comprehensively documented in accordance with policy requirements.

6.3 Service Managers

Responsible for:

- Specifying the appropriate type of Restrictive Physical Intervention training for each service.
- Developing localised policies for the use of Restrictive Physical Intervention, where appropriate.
- Ensuring that this is communicated to Senior and Line Managers.
- Ensuring that robust mechanisms are in place to deliver the appropriate training (e.g. corporate training, cascade training, external contract).

6.4 Senior & Line Managers

Responsible for:

- Ensuring that all staff are aware of the policy.

- Ensuring that risk assessments are carried out and reviewed regularly.
- Putting procedures and safe systems of work into practice which are designed to eliminate or reduce the likelihood of violence and aggression.
- Ensuring that, where identified through risk assessment, the techniques of physical interventions are taught to all staff and used safely, minimally and appropriately and only in Extremis
- Ensuring that training and competency levels of staff are appropriate, in line with divisionally agreed requirements.
- Ensure that all staff groups at risk are provided with appropriate information, instruction and training, including updates and refresher training when necessary. This includes providing at risk staff with adequate time to carry out appropriate training.
- Ensuring that, where bank or agency staff are used, these staff are recognised as competent with the appropriate training for their service if they may be required to participate in any restrictive physical intervention.
- Facilitating formal debriefing sessions when restrictive physical intervention has been used.
- Providing support to staff exposed to violence and aggression.
- Ensuring that risk assessments are undertaken and control measures implemented to ensure that staff unable to participate in RPI do not do so (e.g., pregnant staff, those with health conditions which prevent safe participation).

6.5 Quality & Safety Department

Responsible for:

- Providing relevant corporate policies in conjunction with Divisional Managers.
- Ensuring appropriate support for staff exposed to aggression and violence.
- Identifying incidents to be reported to the Health & Safety Executive under RIDDOR 1995.
- Supporting managers with incident investigation where appropriate.
- Collating incident reports and undertaking analysis of incident trends.

6.6 Workforce and Organisational Development

Responsible for:

- Head of Learning and Development to ensure that courses/updates in restrictive physical intervention are made available to PTHB clinicians to enable them to carry out the guidance in this policy**.**
- To Liaise with Trade Unions as required.

7 Principles and Expectations

7.1 Legal Context

7.1.1 There are a numerous pieces of legislation which impact on the use of restrictive physical intervention. These are:

- Mental Capacity Act 2005 Deprivation of Liberty Safeguards (MCA DoLS)
- Powys Teaching Health Board Chaperone Policy 2015
- Health and Safety at Work Act 1974.
- Human Rights Act 1998.
- Mental Health Act 1983 (2007).
- Children Act 1989.
- Care Standards Act 2000.
- Safeguarding Vulnerable Groups Act 2006

7.1.2 Staff may be faced with unforeseen and unexpected incidents which may require the application of physical restraint. In these situations, the use of physical intervention will need to be considered under Common Law Reasonable Force (see appendix 1), particularly if the individual has capacity at the time of the incident.

7.1.3 It must be noted that the inappropriate use of restraint is against the law. Restrictive physical intervention can constitute assault, battery or false imprisonment and can lead to both civil and criminal prosecution and litigation.

7.1.4 The risks inherent in restrictive physical intervention must be balanced against the likely risk of not intervening when an individual is placing them self or others at risk (see section 7.3).

7.2 Service Context

7.2.1 All services should be provided within the context of constructive relationships that engage and empower individuals as far as possible and promote their care and welfare. However, vulnerable adults can sometimes present behaviours that challenge and place themselves and/or others at risk of serious harm. Responding to this behaviour requires a range of strategies that may involve the need to intervene physically.

7.2.2 Where the behaviour of a service user causes concern such that restrictive physical intervention is a possibility, consideration should first be given to whether the care environment is appropriate for their needs, and if more suitable alternatives are available.

7.2.3 Integral to any physical intervention is the duty of care that is exercised by a staff member toward an individual. When dealing with

situations requiring protective action, duty of care does not imply that the needs of one individual automatically override the safety needs of others (including staff members) placed at risk. Threatening or reckless behaviour needs to be managed to minimise harm to all concerned. Any action that involves the restriction of choice and movement must be considered alongside the professional duty of care and proportionate to the level of risk presented.

7.2.4 The staff member's duty of care extends to ensuring that an individual is monitored and cared for throughout any incident. Autonomy, in line with their age and understanding, should be returned to that individual as soon as it is safe to do so. Clear policies and practice guidance together with prior consultation, preparation, planning, training and supervision will do much to enable staff to exercise their duty of care even where rapid decisions are needed in response to imminent dangers. It will enable them to manage in a way that seeks proportionate and safer outcomes for the individual concerned, themselves and others.

7.2.5 Duty of care extends to corporate responsibilities in meeting health and safety requirements. Therefore, employers must at all times ensure that they maintain their duty of care to employees whose work includes physical intervention. The expectations placed upon staff using restrictive physical intervention should not contravene health and safety requirements. Records of staff trained must also be retained.

7.2.6 Restraint of any form (see appendix 1) must never be used for purposes other than safeguarding from harmful behaviour, e.g. to compensate for inadequate staffing levels or just so staff can do something more easily.

7.2.7 Under no circumstances should the use of restraint be threatened or intended as a punitive sanction, or as a means to intentionally humiliate, degrade or to discriminate, e.g. corporate punishment, deprivation of food or sleep, inappropriate clothing and restrictions on visits.

7.3 The Exercise of Professional Judgement

7.3.1 Whilst exercising their duty of care, individual members of staff must use their professional judgement. Professional judgement is the process of informed decision making which draws on relevant experience and accredited knowledge within an understanding of existing professional guidance, practice, standards, legislation and research. Professional judgement is key to deciding upon the most

appropriate course of action to ensure safer outcomes for individuals and others in situations that pose a risk of serious harm.

7.3.2 The provision of specific direction will not be encompassed into this policy as such an approach can constrain the capacity of a trained and competent person to use their professional judgement and it is the intention of the Powys Teaching Health Board to encourage the exercise of discretion in such circumstances. Additionally because of the diverse functions within the Powys Teaching Health Board, e.g. Adult Mental Health and Older Persons Mental Health etc., it is essential that the most appropriate techniques are identified divisionally to match the setting and individuals likely to be affected (see section 10).

7.3.3 However, only professionally recognised and approved strategies, methods and techniques must be used. The intervention must not exceed 'reasonable force' within the given situation.

7.3.4 Strong emphasis is placed upon the benefits of effective and detailed care planning, using multi-disciplinary, professional judgement to minimise the likelihood that unplanned restrictive physical intervention will be required.

7.4 Situations of Extreme Danger - Extremis

7.4.1 Professional judgement must underpin the safe use of any physical intervention on patients, including the use of restraint. This includes recognising when restraint cannot safely continue.

7.4.2 In situations of real danger, as a last resort, care professionals may judge that it is necessary to deviate from agreed protocols for the use of restraint to save life or prevent serious harm to individuals. The principle that should guide professionals in these circumstances is that the application of reasonable force is defendable in law. Untoward patient incidents that result from the use of restraint may give rise to legal proceedings, and in such circumstances staff may be required to give good reasons for any departures from guidance on the use of restraint.

7.5 Use of Restrictive Physical Intervention on Non-Patients

7.5.1 PTHB staff can be exposed to violence and aggression from those who are not receiving healthcare services from the organisation. These individuals are likely to be relatives, friends or acquaintances of our patients, although hospitals and clinics can also attract people with no legitimate reason for visiting the site.

7.5.2 Although, as with patients, the majority of incidents involving aggression from non-patients are resolved via de-escalation and diffusion tactics and do not become physical, a tiny minority of incidents do escalate to become dangerous.

7.5.3 If a situation is causing concern, at the earliest possible opportunity, ideally before the staff member is faced with the potential to defend themselves physically, the police should be contacted to support resolution.

7.5.4 Where staff are faced with violence in these circumstances, as an absolute last resort to prevent serious harm and where de-escalation has not worked and/or the option of retreat from the situation is not possible, the principle that should guide staff is the use of reasonable force (see appendix 1).

7.6 Mental Capacity Considerations

7.6.1 Before a decision to utilise restrictive physical intervention is made, the Mental Capacity Act 2005 must be considered, the five key principles being:

- Every adult has right to make his or her own decisions, and everyone should be assumed to be capable of doing this unless actually proved otherwise.
- Everyone should be given the support they need to make their own decisions, before they are judged incapable of doing this.
- People should have the right to make 'eccentric' or 'unwise' decisions – it is their capacity to make decisions, not the decisions themselves that may be in question.
- Anything done for or on behalf of people without capacity must be in their best interests.
- Anything done for or on behalf of people without capacity should restrict their rights and freedoms as little as possible.

7.6.2 Four key questions should be considered:

- Is the patient incapacitated?
- Is restraint needed?
- Is restraint to be used to prevent harm?
- Is the restraint to be used the least restrictive?

7.6.3 The deprivation of liberty safeguards, make it clear that a person may only be deprived of their liberty:

- In their own best interests to protect them from harm, **and**
- If it is a proportionate response to the likelihood and seriousness of
  the harm **and**

- If there is no less restrictive alternative.

7.6.4 Where deprivation of liberty may be a possibility, staff must follow the Deprivation of Liberty Safeguards (DoLS) process, and obtain authorisation where this is deemed appropriate.

7.7 Constraints

7.7.1 Where the potential exists for the use of restrictive physical intervention, a number of important factors have to be balanced. These factors include:

- knowledge of the individual and their history;
- knowledge of the impact and effects of physical intervention
- techniques and methods;
- ensuring the welfare and safety of all those involved;
- staffing levels relevant to the situation;
- ensuring professional transparency and accountability;
- ensuring that all actions are appropriate and acceptable within recognised professional practice, civil law and criminal law.

7.7.2 The use of restrictive physical intervention should be minimised through preventative strategies and alternative approaches. Before any restraint, staff should consider if delaying and watching from a distance may support de-escalation of the situation rather than intervening physically.

7.7.3 Restrictive physical intervention is only to be used to prevent potential serious harm to patients, visitors and staff and is consistent with the promotion of an individual's welfare. The application of restrictive physical intervention must always be an option of last resort and must always be the minimum action necessary for the minimum time necessary to manage the situation as safely as possible and taking account of any known health problems.

7.7.4 Any restraint must stop if the person being restrained becomes physically unwell i.e. vomiting, fitting, breathlessness, loss of consciousness or following advice/ intervention from a medical professional.

7.7.5 Professionals must never use restrictive physical intervention methods and techniques which are reliant on pain to gain submission or compliance. However, people have the right to protect themselves against serious injury using reasonable force.

7.7.6 In all situations, behaviour and action must be reasonable and proportionate with regard to action, force and duration. It must also

be intended to protect and safeguard individuals either from themselves or others.

7.7.7 Patients involved in restraint must be closely monitored and communicated with throughout the restraint and afterwards

8 Risk Assessment

8.1 The Risk Assessment Approach

8.1.1 Effective risk assessment begins with a full exploration of all alternative measures to minimise risk before restraint is considered.

8.1.2 Risk assessment must be undertaken by staff who have an understanding of the agreed restrictive physical intervention techniques within the division (i.e.; Crisis Prevention Institute, Positive Behavioural Management, Safe Enough to Care, and Safe Physical Intervention Techniques).

8.1.3 An attempt to gain the consent of the patient should always be made.

8.1.4 The clinical risk assessment plan developed by the multi-disciplinary team will specify the purpose and method of restraint to be used, when and for how long (as short a time as possible). The purpose of restrictive physical intervention must be communicated by the Nurse in Charge to all involved in the restraint and might be:

- To make the immediate area safe
- To move the restrained person to a safe environment
- To enable rapid tranquillisation
- To deliver a planned treatment in line with Mental Health Act
- To communicate to staff who attend who can be involved in restraint. (Employees attending who are not part of the MDT Team can not restrain patients for the purpose of administering medication)

8.1.5 If taking the restrained person to the floor is considered as an option, supine (rear take down) must be the first option to comply with the latest Welsh Government guidance. Staff should refer to the content of the agreed techniques for their department when considering take down to the floor (see section 10). If prone (face down) restraint is used it will need to be justified and documented accordingly within the patients care plan and relevant PTHB paperwork (see section 9.5). Documentation should also state when the restraint is released.

8.1.6 Planning should clearly identify (staffing) resource requirements and be robust enough to identify alternate means to execute the plan if the position changes (e.g. consider police for additional support).

8.1.7 Effective planning must contain a contingency to cover unexpected, potentially extreme situations.

8.1.8 All staff must undertake relevant training applicable to their role and be deemed competent in accordance with divisional arrangements.

8.1.9 The decision to use any equipment to restrain an individual should be made in a multidisciplinary forum so that a comprehensive perspective is sought.

8.2 Physical Restraint Using Equipment

8.2.1 It is not usual to permit the use of equipment to restrain a patient, but in some very rare circumstances, it may be considered that equipment may be required to facilitate optimal care for the patient. If this is the case, equipment should only be considered when alternative therapeutic measures have proved ineffective to obtain the desired outcome. The balance of proportionality should be assessed i.e. is the patient safer 'with' or 'without' the intervention?

8.2.2 When used as part of a planned clinical intervention, the decision to use equipment must be made by the multidisciplinary team with a referral to the Deprivation of Liberty Safeguards team if the intervention is deemed to be a deprivation of liberty.

8.2.3 Where a staff member believes that the use of equipment may have the effect of restraint, although this is not the primary intended purpose, advice should be sought from the relevant policy or guidance document (e.g. Deprivation of Liberty Safeguard code of practice).

8.2.4 Equipment used for physical restraint must be used in accordance to national guidelines and manufacturers instructions.

8.2.5 Staff must only use equipment for physical restraint if they have been trained in its use.

8.3 Training and Supervision

8.3.1 Staff must have had adequate and appropriate training. They must only use the restrictive physical intervention methods and techniques in which they have received training and in which they have demonstrated competence in use and application. The only

exception to this is where it is imperative to use other methods/techniques to avoid greater, imminent harm than the harm that is likely to be caused to the individual. Any techniques used must be deemed as 'reasonable' force for the situation.

8.3.2 Training in strategies, methods and techniques must include the potential health impact of such interventions and include monitoring the individual's health during and post incident and knowing how to respond appropriately should health problems occur.

8.3.3 Training should be available to all staff as appropriate and regularly updated and provided by a trainer with appropriate experience and qualifications. As a minimum requirement such training will be structured to incorporate knowledge, skills and values alongside organisational policies, procedures and practice. In circumstances where there is engagement of external experts, a minimum requirement is that any specialist training fulfils the criteria as specified in the All Wales NHS Violence and Aggression Training Passport and Information Scheme and documented confirmation should be supplied to the Powys Teaching Health Board prior to formal engagement.

8.3.4 A specification for training requirements and the elements of the curriculum taught must be retained in writing within the services. This will be subject to audit by the Health & Safety Team, in conjunction with relevant clinicians.

8.3.5 Staff must have access to relevant professional supervision and support.

8.4 Planning

8.4.1 Forward consideration of the potential use of restrictive physical intervention should take place following assessment as part of the individual planning process (patients care plan). This should take account of personal history, and ensure that care is appropriate to specific individual needs including emotional, developmental, environmental, gender, cultural, communication and health needs. Planning should also take into account an assessment and evaluation of the risks involved in the use of restrictive physical intervention, reference to a body of expert knowledge and established good practice and the ongoing responsibility to monitor and review the continued relevance and appropriateness of restrictive physical interventions.

8.4.2 Where possible restrictive physical intervention should be approached in the same way as any professional intervention with a

person through seeking to maximise the learning potential of the situation for the individual. This should be done by consulting and involving the individual throughout the assessment, planning and reviewing processes. This will help individuals to learn about their own behaviours that challenge, seek alternative strategies and to retain as much autonomy and choice as possible.

8.4.3 Available research and professional experience strongly indicate that the most effective way to manage behaviours that challenge that may require restrictive physical intervention is through a range of person-centred preventative and responsive strategies

8.4.4 Preventative strategies will reduce the risk the use of restrictive physical interventions by:

- affecting the overall culture of interactions between professionals and groups/individuals to minimise the role of restrictive physical interventions;
- using assessment, planning and reviewing to avoid inappropriate provocation and encourage early non-physical actions to minimise the need for physical interventions;
- Avoiding actions which might compound an individual's previous harmful experiences.

8.5 Preventative Strategies

8.5.1 Preventative strategies support the comprehensive risk assessment process that is integral to planning and service provision for both individuals and groups. They are essential for building and maintaining constructive relationships which engage and empower children, young people, adults and older people in their own care appropriate to their age, understanding and capacity. Preventative strategies can also play a significant role in maintaining self-esteem, which is often affected through the experience of direct restrictive physical intervention.

8.5.2 A key preventative strategy is the use of behaviour management therapies and de-escalation techniques to reduce the need for restrictive physical intervention, which should always be a method of last resort. This strategy requires full knowledge of service users' care plans and an awareness of 'trigger' factors that can result in behaviours that challenge. Any preventative or responsive strategy used to counter behaviours that challenge should be included in individual service users' care plans.

8.6 Responsive Strategies

8.6.1 Responsive strategies are necessary because situations will always arise that require immediate and direct interventions. The need for such responses can often be predicted and planned for in the programme of care. There will also be exceptional circumstances, or circumstances which cannot be predicted, that require appropriate and proportionate responsive interventions.

8.6.2 The need for responsive strategies acknowledges that, despite the use of preventative measures, the behaviour of some individuals in particular situations will require a restrictive physical response to safeguard and reduce the risk of harm.

8.6.3 In any situation where restraint is used, consideration must be given to the safety and wellbeing of others in surrounding areas. This includes the need to communicate with others whilst the restraint is ongoing to ensure that those in the surrounding area do not attempt to inappropriately involve themselves in the restraint, and are not made inadvertently unsafe by the staff response to the incident.

8.6.4 Where emergency situations arise, the welfare, safety and health needs of both individuals and professionals need to be protected. Any action taken must be properly recorded. The management of such situations must be open to scrutiny.

8.6.5 Unplanned physical restraint refers to those incidents requiring restrictive physical interventions which are unforeseen and unexpected.

8.6.6 Unplanned physical intervention results in more injuries than planned and should be avoided wherever possible.

8.6.7 It is recognised, however, that an unplanned response will sometimes be unavoidable. Extreme care should be taken under these circumstances to minimise risk.

8.6.8 It is intended that the application of principles and expectations will reduce the need for restrictive physical intervention, achieve safer practice and result in better outcomes.

8.6.9 Where restraint is used regularly with particular individuals, this should be an additional trigger for staff to consider if a DoLS application should be made.

8.7 Disagreement about the use of Restraint

8.7.1 When determining whether restraint should be used, there is an expectation that this decision will be made through the use of best

practice and legislation, including the application of a 'best interest' decision where necessary.

8.7.2 Individual patients and/or carers should be involved in care planning. It is good practice that any disagreement by the carers (to planned restraint) or amongst the clinical team, to the use of restrictive physical intervention must be recorded in the medical notes and a second opinion assessment should be sought before the restraint is applied, with outcomes of the assessment documented. Where the decision is made within a Multi-Disciplinary Team (MDT) the involvement of a trainer in decision making may be useful.

8.7.3 If the carers remain opposed to the use of planned restraint or the clinical team continues to disagree after the second assessment, then further consideration will need to be given as to what is considered to be in the patient's best interests before any final decision is made whether to proceed. It may be appropriate to seek advice from the DoLS team in the first instance. However, the final decision will be made within the MDT.

8.8 External Agency Involvement (Police)

8.8.1 Police involvement may be requested to respond to, or help prevent a criminal or civil offence. Once this plan has been instigated, the management of the situation lies with the Police, who will act solely within the legal framework but may also be restricted by health consideration of the person.

8.8.2 The involvement of Police Officers in restraining patients to allow them to be medically tranquillised is not supported or recommended by the Police Force. Police support should not be sought for this purpose.

8.8.3 In extreme circumstances, where police officers are present during the violent restraint of a violent person who Health Board staff wish to tranquillise, Police Officers may support restraint to prevent a breach of the peace until sufficient Health Board staff are available to safely restrain and administer rapid tranquillisation.

9 Action Following Incidents

9.1 Guiding Principles

9.1.1 All incidents that involve restrictive physical intervention should be subject to a post incident de-brief where possible, that allows lessons to be learned for both individuals and professionals. Such

debriefs, which should include the service user (where practicable), as well as the staff involved, must be recorded and can also act as a checklist to ensure that post-incident procedures are adhered to.

9.1.2 Actions will be taken in the immediate aftermath of the incident, and when further time has elapsed.

9.2 Post-Restraint Health & Welfare Assessment

9.2.1 The patient should be examined following any restraint. All injuries, however minor, should be body mapped, documented and medically reviewed. Physical checks should include:

- Injuries / body mapping
- Temperature
- Pulse
- Respiration rate
- Blood Pressure
- Oxygen Saturation

9.2.2 Restraint can be traumatic. Staff should engage with the patient who has been restrained to support their psychological and emotional welfare and allow them to discuss the restraint and any issues surrounding this. Individuals should also be given the opportunity to make representation or raise a concern in line with 'Putting Things Right' guidance.

9.3 Staff Support

9.3.1 Immediately following the restraint, staff should be asked to confirm if they have sustained any injuries during the intervention, and supported to seek the appropriate treatment if injuries are present. If injuries have been sustained this should be reported as an incident separate to the report on the restraint.

9.3.2 Direct involvement in restraint can be distressing for the staff participating in the intervention. Staff must be given the opportunity to discuss the incident in a supporting environment, with the aim of learning lessons and informing any care plan changes (see section 9.6).

9.4 Support for Witnesses

9.4.1 Witnessing a restraint can be very unsettling, particularly when an unplanned intervention occurs within a clinical setting which houses vulnerable patients. Although efforts should be made to clear witnesses away from the area, supporting their safety and the dignity

of the restrained person, this might not always be possible. Staff should monitor the welfare of any patient witnesses.

9.4.2 In certain cases, it may be necessary to capture witness details to enable statements

9.5 Documentation

9.5.1 A detailed record should be made in the patient notes/care plan, incorporating the purpose of the restraint, actions taken leading up to it, the decisions and actions taken throughout and in the immediate aftermath.

9.5.2 All incidents involving the use of restrictive physical intervention must also be reported as incidents via the Datix Web system. This will also support escalation to senior management colleagues for review. Incident recording documentation must be timely, transparent and accountable.

9.5.3 There must be a clear audit trail which is accessible to all involved, including individuals and their representatives/advocates and those agencies with a legal right to access such information.

9.5.4 A permanent record, separate from any individual file or care plan, should be kept of all incidents involving restrictive physical intervention. Staff are expected to complete a Datix Web incident report. (Appendix 5) This record must reflect the rationale for restraint, purpose of the intervention and the action taken throughout the restraint and in the immediate aftermath. It should detail the individual staff members participating in the restraint, including the specific role that they played (e.g. person A held patient's left arm) and the techniques adopted throughout.

9.5.5 The risk assessment for the patient and/or task and/or environment (where relevant) should be reviewed and updated to capture any learning from the incident.

9.5.6 In some cases, it may be appropriate to consider whether the application of the Protection of Vulnerable Adults (POVA) procedure should be initiated as a result of the intervention.

9.5.7 In certain circumstances it may be useful to assess the assailant's capacity after the incident to aid potential future prosecutions by the Crown Prosecution Service. It is the senior clinicians' responsibility to document carefully in the notes the details of the incident and the capacity of the assailant at the time of the

incident. There is also an expectation that staff will assist the police and provide witness statements where appropriate.

9.5.8 All Datix Web reported incidents will be reviewed at a local level and by a member of the Health and Safety team. Significant incidents will require an investigation, with any learning being shared through Clinical Governance forums. Similarly, where trends are identified, these should be reviewed at divisional level, with lessons learnt shared across the organisation, where relevant.

9.6 De-briefing

9.6.1 The use of debriefing after a restraint event is essential and needs to: consider the facts, acknowledge feelings, aim to be a learning opportunity and focus on planning for prevention of further episodes. Effective debriefing requires honesty and transparency within a non-judgemental, no-blame environment to ensure the safety for everyone involved and facilitate learning.

9.6.2 The goals of debriefing are to:

- prevent future use of restraint
- reverse or minimise the negative effects of the episode
- address organisational problems and make improvements

9.6.3 *Immediate debriefing (Acute debriefing)* is a valuable tool in any restraint reduction initiative. It needs to be a safe learning opportunity immediately after the event, where both the service user and the staff members involved in a restraint can:

- share feelings and perceptions
- review clinical data and revise the treatment plan
- revise the person's crisis prevention plan
- identify areas for performance improvement

9.6.4 *Critical incident review (Formal debriefing).* Immediate debriefing should be followed by a meeting with the involved staff, service user, service leaders, and service user advocates, where appropriate. The review needs to consider the incident from a more systemic point of view, to consider whether improvements are needed across the whole service.

9.7 Complaints and Advocacy

Service users and their representatives must have clear information about how to make their views known, how to make a complaint, and how to access the services of an advocate and to be given assistance to do so if requested.

10 Techniques and Training Requirements

10.1 Organisational Approach

10.1.1 In recognition of the diverse needs of Health Board service users, it is appropriate that staff receive training in the restrictive physical intervention techniques most appropriate to the needs of their client group(s).

10.1.2 The decision on the most appropriate type of physical intervention techniques for staff to be trained in will be made at directorate level. The directorate management team within each area that restraint training is provided will take responsibility for agreeing the content of training packages, including the techniques, in consultation with staff.

10.1.3 It is expected that the directorate will regularly review the type of training agreed for use by staff, recognising amendments in individual techniques resulting from evolving research and guidance, the changing needs of the clientele within services and analysis of incident data.

10.2 Adult Mental Health Inpatient Services

10.2.1 Staff working within acute adult mental health inpatient services must receive training and be assessed as competent in PMVA (SPIT). (This is the current identified training which may be subject to change. Should the identified training be changed Staff will be notified before its implementation)

10.2.2 Following completion of the foundation course, staff will undertake an annual refresher course, incorporating theory, de-escalation and breakaway techniques and an extensive range of restrictive physical intervention techniques

10.2.3 The current identified training SPIT course includes safe techniques to lower the combative person to a lying position on the floor and restrain them there.

10.2.4 Although participants are trained in safe techniques to lower the restrained person into a prone (face-down) position, the restrained person must not be kept in this position, due to the risk of asphyxia.

10.3 Older Adult Mental Health Inpatient Services

10.3.1 All staff working in older adult inpatient units receive Safe Enough to Care (SETC) training (this is the current identified training which may be subject to change. Should the identified training be changed Staff will be notified before its implementation)

10.3.2 Staff are trained and assessed as competent on an annual basis. The training course incorporates theory, de-escalation and breakaway techniques and a range of physical intervention techniques which recognise the potential physical frailty of the client group.

11 Quality Assurance and Audit

11.1 Documentation

11.1.1 Each incident involving the use of Restrictive Physical intervention will be reported through Datix online incident reporting. Details of the incident and nature of the intervention together with the outcome of the investigation will be recorded, together with emerging themes.

11.1.2 CR01 form will be completed for each incident.

11.2 Communication

11.2.1 The Board will be informed of any incident which may adversely affect organisational reputation, by the Assistant Director of Mental Health or Head of Mental Health.

11.2.2 The Head of Mental Health will provide within the reports for the Mental Health Assurance committee the occurrences of Restrictive Physical intervention. The report will also focus on providing assurance to the Board that lessons identified during the investigation of an episode of Restrictive Physical Intervention are learnt and that appropriate remedial action is implemented, monitored and evaluated for effectiveness.

12 External Reference Sources

- Mental Capacity Act 2005 & Amendments (2007) Code of Practice
- Deprivation of Liberty Safeguards Code of Practice
- RCN Guidance "Let's Talk About Restraint" Rights, Risks and Responsibility (2008)
- NICE Guidance CG25 "The short-term management of disturbed/violent behaviour in psychiatric in-patient settings and emergency departments"

- NMC The Code of Professional Conduct (2015)
- Framework for Restrictive Physical Intervention Policy and Practice. Welsh Assembly Government (March 2007)
- Mental Health Act 1983 Code of Practice for Wales. Welsh Assembly Government (2008)
- Safe Management of Mental Health In-patients. Welsh Assembly Government circular: CNO(2008)01 /CMO(2008)01
- National Control and Restraint Association (General services) (NCRGSA)
- British Institute of Learning Disabilities (BILD)
- All Wales NHS Violence and Aggression Training Passport and Information Scheme
- BMA Guidance
- Guidance to Police Officers Requested to Assist with Rapid Tranquillisation of Mentally Ill Patients. Metropolitan Police (2010).
- Providing Medical Care and Treatment to People who are Detained Guidance. British Medical Association (October 2007)
- Aneurin Bevan Health Board Use of Restrictive Physical Intervention Policy

Appendix 1

Reference to Definitions

Restrictive Physical Intervention

Direct physical contact between persons where reasonable force is positively applied against resistance, either to restrict movement or mobility or disengage from harmful behaviour displayed by an individual.

Restraint

Restrictive physical intervention is sometimes referred to as 'restraint'. Restraint is a wider term which incorporates a range of different activities and approaches intentionally designed to prevent a person from doing what they appear to want to do.

Someone is using restraint if they:

- use force, or threaten to use force, to make someone do something that they are resisting **or**
- restrict a person's freedom of movement, whether they are resisting or not

Types of restraint include:

- Physical intervention (as above),
- Mechanical restraint (involving the use of equipment),
- Chemical restraint (using medication, such as sedation, which does not have a directly therapeutic purpose),
- Environmental restraint (designing the environment to limit activity e.g. through the use of electronic key pads, baffle locks or seclusion),
- Psychological restraint (depriving a person of lifestyle choices, e.g. by telling the person what time to go to bed or get up; depriving individuals of possessions they consider necessary to do what they want to do, e.g. by taking away outdoor clothing, glasses, walking aids)

It is not possible to give a list of what kind of equipment, physical holding, or medication constitutes restraint, as it depends upon the circumstances. A piece of equipment, physical hold, or medication may equal restraint in some circumstances, but not others.

Harmful Behaviour

Examples of harmful behaviour and the need for this approach:

- Include significant destruction of property.
- Violence directed towards others.
- Violence that arises from panic, distress or confusion.
- Self-directed violence or self-injury.
- Sexually inappropriate behaviour

In service settings that are intended for whatever reason to restrict liberty, such as an acute mental health unit, harmful behaviour extends to situations

where staff believe that a child or adult may have a realistic chance of success in absconding.

Where the individual is subject to treatment by a legal order, for example under the Mental Health Act, and non-compliant with this, restrictive physical intervention may be appropriate.

Reasonable Force

Consideration must always be given to alternative non-physical action except in the most exceptional circumstances e.g. the use of verbal de- escalation and therapeutic intervention. What might be considered as reasonable force will differ from case to case.

The principle that should guide professionals considering the application of reasonable force is to use the minimum intervention (in terms of force and time) necessary to reduce harm and damage. The force used must be consistent with the intended outcome e.g. the force used to stop a very young child hitting another will differ significantly from that needed to prevent a violent attack from a physically strong adult.

Crown Prosecution Service guidance states:
"You are not expected to make fine judgements over the level of force you use in the heat of the moment. So long as you only do what you honestly and instinctively believe is necessary in the heat of the moment that would be the strongest evidence of you acting lawfully and in self-defence. This is still the case if you use something to hand as a weapon. As a general rule, the more extreme the circumstances and the fear felt, the more force you can lawfully use in self-defence."

Mental Capacity

Mental capacity, sometimes referred to solely as 'capacity' is the ability to make a decision. An individual lacks capacity if s/he is unable to make a particular decision at a specific time. This inability must be caused by an impairment or disturbance of the mind or brain, whether temporary or permanent.

It should be recognised that an individuals behaviour may change when their mental capacity is impaired, for example, people may act in a more unpredictable or aggressive manner following a head injury or when suffering from mental illness.

When making decisions regarding the use of restrictive physical intervention, due consideration must be given to the patient's mental capacity and its impact on the situation. Where there is reason to doubt that the person has mental capacity, the Health Board's Assessment of Mental Capacity Procedure must be followed.

Appendix 2

Safe Practice of Restrictive Physical Intervention

Designate person to take charge of incident (this may not be the person involved in the restraint e.g. police restraining aggressive individual in MIU who requires urgent treatment).

- Maintain a calm approach.
- Clear all unnecessary staff, patients, and visitors away from area.
- Identify lead person for restraint.
- Lead person to communicate plan to all involved in restraint
- If the plan is to move restrained person, ensure all are aware of where the end location is and clear any debris or objects of concern e.g. potential weapons, from current and target locations and the path between them.
- Maintain dignity e.g. move observers away, screen area.

Need for restraint identified

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Appendix 3

Planned Restraint Flowchart

Usually no emergency, reason is to aid treatment, investigation or patient safety

↓

Document reason and legal basis (MCA, MHA. best interest decision)

↓

Consider proportionality and alternatives

↓

Reassess need for treatment/investigation/safety

↓

If still needed use least restrictive method first:
Distraction De-escalation
Additional support from relatives, staff or patients friends

↓

Reassess need, can we defer → **Yes** → **Defer**

↓

Plan whether physical, mechanical and/or chemical restraint will be needed

↓

Define and document how (what technique) how long, and how often, define proportionality

↓

Use least restrictive option. Could be physical or chemical restraint (Sedation, lowest dose/shortest time)

↓

Use Proportionate, reasonable and necessary restraint

↓

Before any repeat, reassess need and proportionality, alternatives, and option to defer

↓

Document actions and capacity assessment in notes, complete CR01 form and incident report, document post incident review

↓

Initiate incident review with staff and patient. Document

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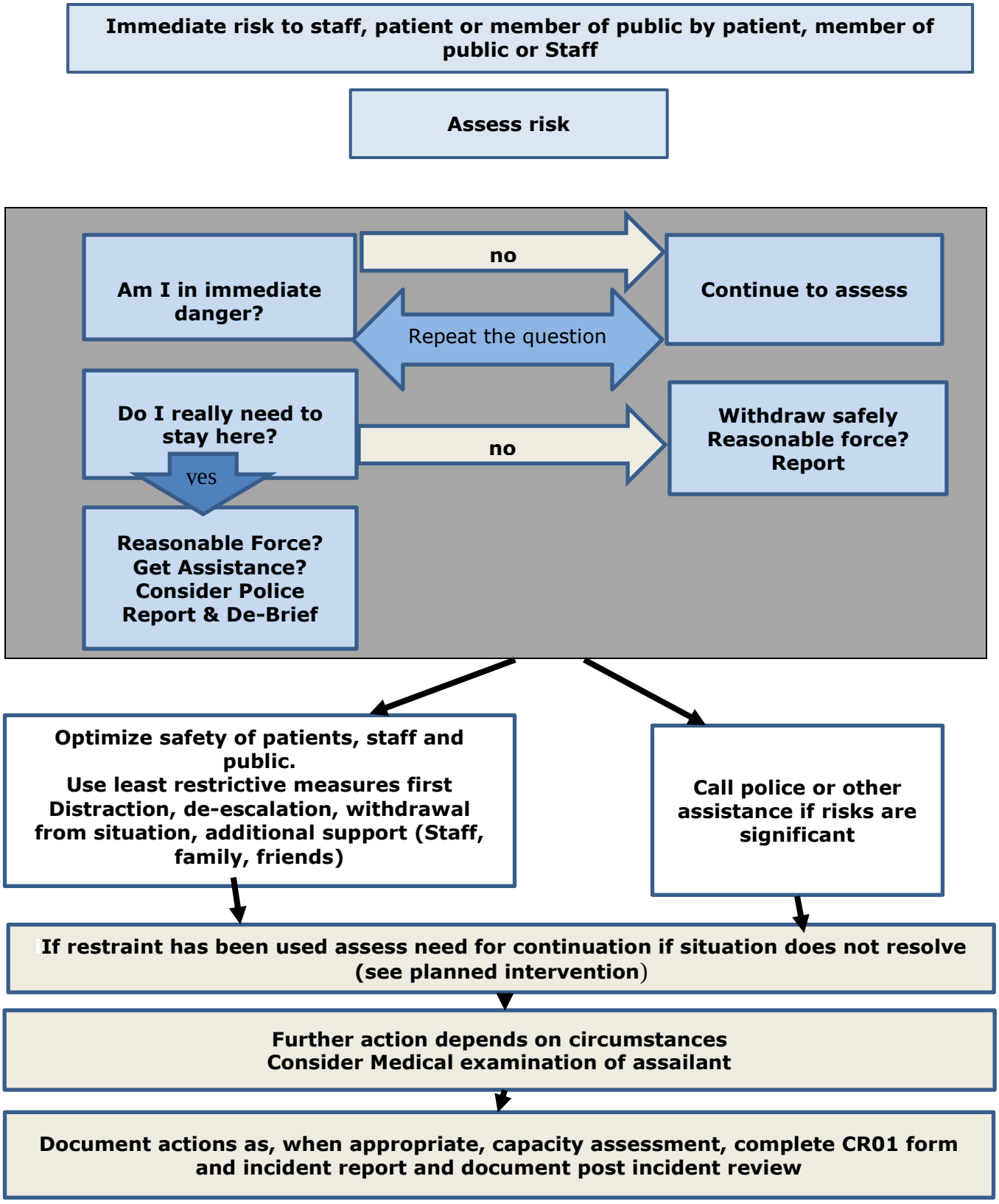
Appendix 4

Unplanned Restraint Flowchart



Appendix 5

DatixWeb Incident Reporting Guide
Use of Breakaway and/or Restraint

Where an incident results in an individual being restrained, or staff need to physically break away from a physical attack, it is important that this is captured accurately within the incident report. Restraint or physical force must only be used to take immediate control of a serious, significant or dangerous situation when an individual is considered to pose significant risk to themselves or others. **Completion of this information via DatixWeb replaces the need for a paper CR01 form to be submitted.**

Recording that breakaway/restraint was used

- The restraint section is accessed only when either "Abusive, violent or disruptive behaviour" or "Abusive, violent, disruptive or self-harming behaviour" are selected in the *Stage of Care* field.
- If yes is selected in either the '*breakaway used*' or '*restraint used'* fields, additional drop-down boxes appear.
- *Breakaway/restraint Type* refers to the training courses offered by the Health Board. In addition, the option of "Reasonable Force (not trained technique)" is provided to recognise that all staff may find themselves in situations of serious risk. Only 1 option can be selected.
- *Breakaway Technique Used* and *Restraint Technique Used* refer to the specific actions undertaken during the incident. More than 1 technique can be selected.
- Where restraint is used, staff are expected to give details of how long the episode lasted for.

Recording the finer details

- In line with all other incidents, where breakaway or restraint are used, staff are expected to record the actions leading up to the incident and what occurred during the incident within the *Description of Incident* field.
- Where staff are involved in a physical intervention with a client or visitor, it is important that the incident description includes details of the action taken before the physical intervention occurs. I.e., what was said and done, by whom to de-fuse the situation and whether this had any impact.

Recording who did what

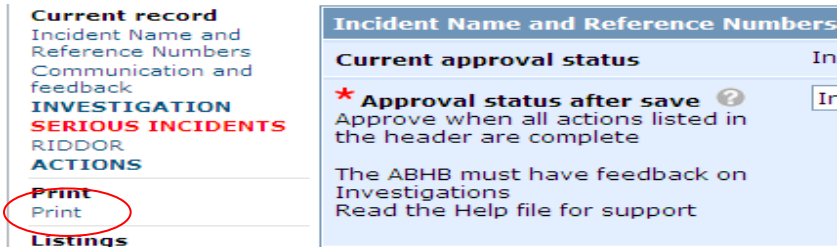
- The *Contacts* section of the form can be used to record who was involved in a restraint. The details of each person involved in the restraint should be added as a separate contact.
- Within the *Contact role* field, the option of Restrainer is now available.
- When Restrainer is chosen, an additional drop down box *Restrained Body Part* opens and as many options that apply can be selected.

Printing a copy of the DATIX CR01 form

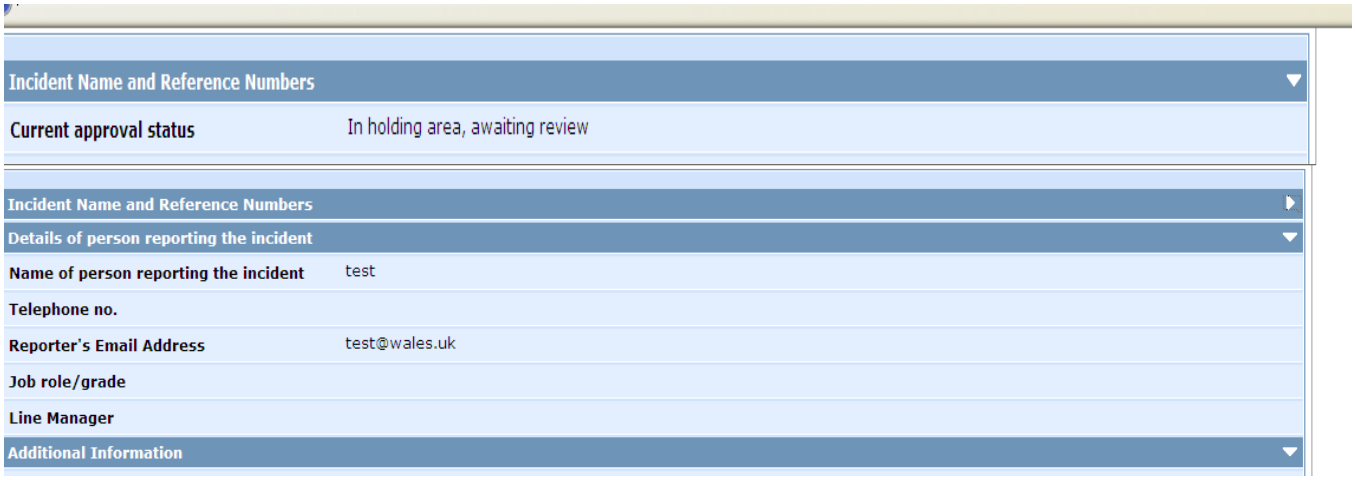
If you are submitting the report via a Datix DIF1 form, please choose the 'submit and print' option for a paper copy.

If you are logged into Datix as a DIF2 reviewer, Open the incident and follow the instructions below:

- Select the Print option from the menu at the top left of the screen (adjacent to *Incident Name and Reference Numbers* section).



- This opens the entire form in a new window. If required, individual sections of the form can be hidden to print only relevant sections.
- To hide a section, left click on the down arrow ( ) This will hide the section, and the arrow will point to the right ( ).



- The minimum information that should be printed is:

  Incident Name and Reference Numbers
  Incident Details
  Detailed Description
  Restraint
  Other Contacts

Once the form contains the required information, print using the print option on the tool bar at the tool bar at the top of the screen.