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	CNS Adult Safeguarding	September 2018
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	Health & Safety Risk Manager	September 2018
	Alcohol Liaison CNS	September 2018
	Head of Governance	September 2018
	Associate Directors of Nursing	September 2018
	Matrons	September 2018
	Patient Experience and Public Involvement	September 2018
	Emergency Planning Officer	September 2018
	Emergency Department Consultant	September 2018

Related Trust Policies (to be read in conjunction with)	Consent Policy - 04080 Privacy & Dignity – 10120 Admission Policy - 05117 Discharge & Patient Transfer Policy - 06064 Learning Disability & Autism Policy – 09116 Safeguarding Vulnerable Adults Policy - 08034 Mental Capacity Act Policy - 11001 Deprivation of Liberty Safeguards Policy - 11002 Equality and Diversity Policy - 04011 Use of Hand Control Mittens 15008 Making Reasonable Adjustments Policy 15010 Disputes Policy - 04036 Violence & Antisocial Behaviour - 04031 Dementia Policy – 10081 Carers Policy – 13003 Security Policy – 04051 Being Open & Duty of Candour – 08063 Slips Trips & Falls 07009 HM Prison and Police Arrest Patients 14012

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1.0 Introduction

1.1 Restrictive Physical Intervention (RPI) is defined as "any method which restricts the movement of an individual by physical means, including mechanical means, holding and physical restraint."

1.2 The purpose of this policy is to provide guidance for staff on the use of restrictive interventions that will ensure that restrictive interventions are used in a dignified, transparent, legal and ethical manner.

1.3 These guidelines support the work of the Trust and clinical staff in caring for adult Patients (18>) who are disorientated for any variety of reasons; who present with a risk of harm to themselves or others and maybe inadvertently disrupting their essential medical care.

1.4 The use of dignified restrictive interventions will only be implemented by first line staff, once all primary and secondary interventions are deemed to be unsuccessful and all other options have been exhausted.

1.5 In this situation the use of dignified restrictive interventions are reasonable and proportionate to the identified risks and only to be used as a last resort.

2.0 Policy Statement

2.1 The Trust is bound by and adheres to the law and maintains compliance with Department of Health legislation and ethical frameworks and to this end promotes effective governance, openness and transparency.

2.2 The Trust is committed to providing safe care for patients and a safe environment for all patients, staff and visitors. The Trust acknowledges and understands that many patients accessing the hospital setting may have a cognitive impairment and during an acute stage of physical/mental illness could become disturbed which possibly will endanger their personal safety and the safety of others if not managed effectively.

2.3 The Trust supports all reasonable and measured actions taken by staff, to ensure that the quality of life for their patients is enhanced, that their needs are better met, which results in a reduced need for restrictive interventions and promotes recovery.

2.4 The Trust promotes a culture which is committed to developing therapeutic and supportive environments where physical interventions are only utilised as a last resort, for the shortest period of time and never applied unnecessarily as a first line of intervention.

2.5 The Trust recognises and accepts its duty to comply with new legislation and is committed to providing the guidance and training necessary, in relation to restrictive interventions, in order to reduce the risk of harm to both patients and staff.

2.6 The Trust upholds its obligation to report to commissioners on the use of restrictive interventions and through mandatory reporting mechanisms – the National Reporting and Learning Systems (NRLS).

3.0 Scope

3.1 This policy applies to patients who lack capacity either temporarily or long term.

3.2 This policy applies to staff that are involved in the prescription of and/or use of restrictive interventions of adults without capacity who present with challenging behaviour**.**

3.2 For the purposes of this policy, Adults are people aged 18 years and over.

Exclusions

3.3 There are particular services, and conditions that are excluded from this policy, as follows:

- Planned care and services delivered within the MHDU and ITU department
- Children's services
- Patients admitted to hospital for detox – i.e. planned alcohol withdrawal
- Where the patient has capacity - See Security Policy

4.0 Equality & Diversity

4.1 The Trust is committed to the provision of a service that is fair and meets the needs of all individuals.

4.2 An Equality Impact Assessment is attached to the policy (Refer to Appendix One)

5.0 The Four Types of Restraint

5.1 Physical Restraint

5.1.1 The definition of "physical restraint" refers to 'any direct physical contact where the intervener's intention is to prevent, restrict, or subdue movement of the body, or part of the body of another person'.

5.1.2. An example of this can be seen where - one or more members of staff are physically holding the person – using support holds to keep them still, moving the person, or by blocking their movement to stop them from leaving.

5.1.3 Staff must never restrain people in a way that impacts on their airway, breathing or circulation, such as face down, restraint on any surface, not just on the floor.

5.1.4 Physical restrictive intervention is exceptional within the acute hospital setting, seldom used and should only ever be used by appropriately trained staff having due regard for the safety and dignity of patients.

5.1.5 The trained member of staff should take responsibility for communicating with the person throughout any period of restraint in order to continually attempt to de-escalate the situation.

5.1.6 During physical restrictive intervention the mouth and/or nose must never be covered and techniques must not incur pressure to the neck region, rib cage and/or abdomen. There must be no planned or intentional restraint of a person in a prone/face down position on any surface, not just the floor.

5.1.7 Staff will take observations that include vital clinical indicators such as pulse, respiration and complexion/colour (with special attention to pallor or discolouration) must be carried out and recorded, and staff should be trained so that they are 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.

5.1.8 Support staff must continue to monitor the individual for signs of emotional or physical distress for a significant period of time following the application of restraint.

5.1.9 Where incidents of any restrictive practice occur, there should always follow retrospective recording, including an entry within DATIX a panel review and debrief to ensure learning and continuous safety improvements from the findings of the quarterly thematic analysis.

5.2 **Mechanical restraint**

5.2.1 The definition of "mechanical restraint" refers to 'the use of a device to prevent, restrict or subdue movement of a person's body, or part of the body, for the primary purpose of behavioural control'.

5.2.2 Mechanical restraint involves the use of equipment. Examples include the use specially designed hand mittens; everyday equipment, such as using a heavy table or specifically designed belts to stop the person getting out of their chair; or using bedrails to prevent a person from getting out of bed. Controls on freedom of movement – such as using keypads – can also be a form of mechanical restraint.

5.2.3 Relevant Staff must make themselves familiar with other policies which compliment this policy i.e. The Use of Hand Mittens/ Bedrails and implement accordingly.

5.2.4 Where incidents of any restrictive practice occur, including mechanical restrictive intervention then there should always follow retrospective recording, including an entry within DATIX to ensure learning and continuous safety improvements. Where planned mechanical restraint is used staff will always follow the key principles of the MCA & make an application for DOL safeguards.

5.3 Chemical restraint

5.3.1 The definition of “chemical restraint” refers to ‘The use of medication which is prescribed, and administered for the purpose of controlling or subduing disturbed/violent behaviour, where it is not prescribed for the treatment of a formally identified physical or mental illness’.

5.3.2 Chemical restraint is a short term management plan which involves using medication to restrain. An example of this is sedation and rapid tranquilisation. This should not be a regularly prescribed medication – rather it includes medication to be used as required (PRN) or in treatment for delirium. This will include PRN medication which is administered either orally or I.M (intramuscular injection).

5.3.3 Relevant Staff must make themselves familiar with other policies which compliment this policy i.e. Delirium Policy.

5.3.4 Where incidents of any restrictive practice occur, including chemical restrictive intervention, there should always follow retrospective recording, by the prescribing clinician, including an entry within DATIX and debrief to ensure learning and continuous safety improvements. Where chemical restraint is used to manage behaviour, staff will always follow the key principles of the MCA & make an application for DOL safeguards

5.4 Seclusion

5.4.1 The definition of “seclusion” refers to ‘The supervised confinement and isolation of a person, away from other users of services, in an area from which the person is prevented from leaving.’ ‘Its sole aim is the containment of severely disturbed behaviour which is likely to cause harm to others.’

5.4.2 An example of seclusion can be viewed as a control tactic which is generally used within a psychiatric hospital/MH treatment settings or HMS prison. Seclusion of an agitated person in a quiet room free of stimulation may help de-escalate a situation which may be dangerous to the agitated person or those around him.

5.4.3 Following amendment to the Act made in 2007, Staff must not use seclusion other than for people detained under the Mental Health Act (1983).

5.4.4 Seclusion is a restrictive intervention which use is uncommon within the acute hospital setting, and seldom used only in exceptional circumstances ie Prisoners, or patients sectioned under the mental health act and where the patient is legally detained, they will be supported in the hospital setting by other agencies/Police/Prison Officers/MH staff.

5.4.5 Where incidents of any restrictive practice occur, which includes seclusion, there should always follow retrospective recording, including an entry within DATIX and debrief to ensure learning and continuous safety improvements.

5.4.6 Where seclusion is used for prisoners or MH patients then staff must request a copy of the release documentation and place in Pt notes. **A copy to be requested of Section 17 Leave of Absence (MHA) Or Release on Temporary Licence (ROTL) from correctional facilities & Datix should be raised.**

6.0 Primary Strategies

6.1 The Protocol for Reducing the Need for Restrictive Interventions must be followed, see Appendix 2

6.2 Any patient who can reasonably be predicted to be at risk of being exposed to restrictive intervention must have an Individualised Behavioural Support Plan (Individualised Positive Behavioural Support)

6.3 The rapid risk assessment must be completed see Appendix 4

6.4 Following assessment, where the risk is outlined as “Low” staff will follow primary interventions.

6.5 Early intervention using primary preventative strategies focus on improvement of quality of life and ensure that needs are met.

6.6 Following assessment, where the risk is outlined as “Medium” an IBS must be initiated and consideration given for a referral to be made to relevant specialist Teams/Lead Nurses.

6.7 Following assessment where the risk is outlined as “High” an IBS must be initiated and a referral must be made to relevant specialist Teams/Lead Nurses.

6.8 In some cases, for those patients requiring urgent medical intervention, it may be necessary to immediately instigate the tertiary strategy. Where there are known risks in delaying treatment, then the priority will always be to maintain patient, staff and public safety and the use of primary and/or secondary interventions will not be appropriate.

Individualised Approaches

6.9 Some patients using the health service may on occasion present with behaviour that challenges but which cannot reasonably be predicted and planned for on an individual basis.

6.10 There may be some individuals that can reasonably be predicted to present with behaviours that challenge as follows:

- People with learning disabilities
- People, who are elderly, confused and/or have dementia

- People with autistic spectrum conditions
- People with mental health conditions, i.e. personality disorder,
- People who are detained i.e. in psychiatric settings; under police custody or prisoners.

6.11 Occupational Therapists (OTs), people who use the services, families and carers must be involved in planning, reviewing and evaluating all aspects of care and support.

6.12 Individualised support plans must be implemented for all people who use the service who are known to be at risk of being exposed to restrictive interventions. Staff may need to refer to the specialist nurses for support in this process.

6.13 The SPELL Framework is recommended for staff to use as an evidenced based tool for understanding and responding to the needs of adults on the autism spectrum. It is a useful approach in identifying underlying issues, in reducing the disabling effects of the condition, and in providing a cornerstone for communication. It also forms an ethical basis for primary preventative intervention.

See Learning Disabilities & Autism Policy

SPELL is mnemonic which stands for:

- **S**tructure (communication - what will happen step by step)
- **P**ositive (approaches and expectations – build on strengths),
- **E**mpathy (validation)
- **L**ow arousal (consider the environment i.e. reduced sensory stimulus)
- **L**inks (working collaboratively with carers/family)

6.14 Other primary and individualised approaches are not limited but may include:

- Reorientation
- Making some reasonable adjustments – *see Reasonable Adjustments policy*
- Increased observation and monitoring
- 1:1 Staffing/family or carer support – *see Carers Policy*
- Change in patient's physical environment/side room
- Review of medication regime
- Assessment and treatment of pain – using Abbey Pain Scale/DISDAT Tool
- Consider basic needs - Offer food, fluid, toileting

6.15 It is important for Staff to bear in mind that all negative behaviours have a function and that there could be a number of reasons for it and staff should work systematically in addressing these. These may include barriers in communication - difficulty in processing information, unstructured time, over-sensitivity (hyper) or under-sensitivity (hypo) to something, environment - a change in routine or physical reasons like feeling unwell, tired or hungry. Not being able to communicate these

difficulties can lead to anxiety, anger and frustration, and then to an outburst of behaviours deemed to be challenging.

6.16 Patients will be treated with compassion, dignity and kindness at all times.

6.17 There should always follow retrospective recording and clearly written documentation.

Recovery Based Approaches

6.18 Recovery-based approaches and delivery of care in accordance with the principles of positive behavioural support is essential.

6.19 Recovery based approaches supports the underpinning principles of the human rights act by enhancing personal independence, promoting and honouring choices and increasing social inclusion.

6.20 The use of CPA, Hospital passports and This is Me are all supporting documents and will ensure the individualised and recovery based approaches are maintained by enabling the person to retain their own preferences, goals and aims, through empowerment, self-determination and unconditional engagement.

6.21 The CPA (Care Programme Approach); Hospital Passport and This is Me document is a skilled individualised assessment which is person centred and values based. It offers a background of the person's history, identifies health and social care needs and known risks which will give staff a unique understanding and context of possible reasons why a person may present with negative behaviours.

6.22 The individualised and recovery based model is the primary preventative model which is essential for achieving a reduction in the use of restrictive interventions carried out against a person's wishes

7.0 Secondary Preventative Strategies

7.1 Secondary preventative strategies aim to ensure that early signs of anxiety and agitation are recognised and responded to quickly.

Positive Behavioural Support Plans

7.2 A generic positive behavioural support plan is available on request from LD Lead Nurse and can be easily adapted based on the patient's previous risk assessments which have identified known trigger factors and aims to address these.

7.3 The behaviour support plan details responses and techniques for staff to use when a person starts to become anxious, aroused, agitated or distressed. These techniques include distraction, diffusion and sometimes de-escalation (3 D's). The aim is to promote relaxation and avert any further escalation to a crisis.

7.4 Any person who can reasonably be predicted to be at risk of being exposed to restrictive interventions must have an individualised behaviour support plan in place.

7.5 It is important for Staff to note that using distraction is not indicated with patients diagnosed with dementia – in this instance staff should use Validation theory. See Dementia Policy

8.0 Tertiary Strategies

8.1 When a person's level of agitation further escalates to a crisis point where they place either themselves or others at significant risk of harm. This may result in the need for restrictive interventions.

8.2 Within behaviour support plans, interventions now required are identified as tertiary strategies, which may include details of planned restrictive interventions to be used in the safest possible manner, for the shortest time and which should only be used as an absolute last resort.

8.3 Where incidents of any restrictive practice occur and tertiary strategies are implemented, there should always follow retrospective recording, including an entry within DATIX to ensure learning and continuous safety improvements.

8.4 On occasion, where the risks far outweigh the benefits and in order to maintain patient safety, it may be necessary, to immediately instigate the tertiary strategy. Omission of the need to follow through without the use of primary and secondary strategies must always follow retrospective recording, including an entry within DATIX outlining the reason for this decision.

9.0 Decision Making Process

9.1 Assessment

9.1.1 This is an ethically sensitive decision and restrictive interventions can only be undertaken and applied as an absolute last resort following:

- A clinical risk assessment process
- Staff can clearly demonstrate the focus on proactive as well as reactive management
- All identified reasonable adjustments have been made
- Clear primary preventative strategies, have all been exhausted
- Secondary preventative strategies as outlined in the behavioural support plan have all been exhausted. The aim at this point is to ensure that early signs of anxiety and agitation are recognised and responded to by including 3 D's – Distraction, diffusion & de-escalation techniques. See Appendix Three

9.2 Safe & Ethical Practice

9.2.1 Staff will understand that the legal and ethical basis allowing use of restrictive interventions as a last resort is founded on eight overarching principles. These are as follows:

- Restrictive interventions should never be used to punish or for the sole intention of inflicting pain, suffering or humiliation on the person
- Staff must not doubt that there is a real possibility of harm to the person or to staff, the public or others if no action is undertaken
- The nature of techniques used to restrict a person must be proportionate to the risk of harm and the seriousness of that harm
- Any action taken to restrict a person's freedom of movement must be the least restrictive option that will meet the need
- Any restriction should be imposed for no longer than absolutely necessary
- The reason for using restrictive interventions must have a lawful basis for doing so. The method and any consequences will be recorded, made open and transparent and will be subject to audit and monitoring
- Restrictive interventions should only ever be used as a last resort
- Full involvement from people who use the services, family, carers and/or advocates is essential when reviewing plans for restrictive interventions

10.0 Mental Capacity Act (MCA)

10.1 The MCA presumes that all adults have the ability to make their own decisions and protects their right to make and act on their own free and informed decisions. It also provides important safeguards where people lack the capacity to make their own decision. Staff will adhere to the five principles of the MCA are shown below:

- A person must be assumed to have capacity unless it is proved otherwise
- A person must not be treated as unable to make a decision unless all practicable steps to help have been taken without success
- A person is not to be treated as unable to make a decision merely because an unwise decision is made
- An act done, or decision made under the Act for, or on behalf of a person who lacks capacity, must be done in their best interests
- Before an act is done, or a decision made, consideration must be given to whether the same outcome can be achieved in a less restrictive way

10.2 People who lack capacity to consent is governed by the Mental Capacity Act 2005 (MCA 2005). Staff using restrictive intervention is required by law to have regard to the Mental Capacity Act 2005 Code of Practice.

10.3 Staff should make themselves familiar with other policies which compliment this policy i.e. The MCA & DOL's safeguard' and implement accordingly.

10.4 Staff will need to seek a person's consent if they are proposing to act in connection with the care or treatment of that person. This means that staff must explain any proposed procedure in an accessible and easily understandable way to enable a person to make their own decisions.

10.5 Guidance is given on the delivery of safe and therapeutic care and safeguards around the use of restrictive interventions in chapter 15 of the MHA Code of Practice.

11.0 Discontinuation of the Use of Restrictive Interventions

11.1 All restrictive interventions may only be used whilst the unsafe situation and clinical justification continues and must be discontinued at the earliest possible time.

11.2 Wherever risks outweigh the benefits then the use restrictive interventions should be stopped immediately.

11.3 Where the use of restrictive interventions has worsened the patient's agitation then its use should be stopped immediately.

11.4 Where the use of restrictive interventions place either staff or patient at risk of physical or emotional harm then its application should be stopped immediately

11.5 Staff will provide first aid procedures and support in the event of an injury or distress arising as a result of restrictive interventions used which must be Datixed.

12.0 Communication, Record Keeping & Reporting

12.1 Clear communication is essential in relation to the use restrictive interventions. Written information should be used to supplement verbal information wherever possible and offered to patient and carer.

12.2 The rationale for use of restrictive intervention should be explicit and clearly documented on the care plan and held within the patient notes.

12.3 Staff implementing the use of restrictive interventions should always enter a Datix; staff will be reassured that the entry on the database is not for action or investigation but for patient safety reasons. This will ensure compliance with CQC regulations for effective recording and on-going monitoring.

12.4 A copy of any reasonable adjustments; risk assessment; MCA; Individualised Behavioural Support Plan; CPA; Hospital Passport or This is Me document & care plans should be kept within the patient notes.

12.5 Following any occasion where a restrictive intervention is used, whether planned or unplanned, a full record should be made and Datixed. This should be

recorded as soon as practicable (and always within 24 hours of the incident). The record should allow aggregated data to be reviewed and should indicate:

- The names of the staff and people involved
- The reason for using the specific type of restrictive intervention (rather than an alternative less restrictive strategy)
- The type of intervention employed
- The date and the duration of the intervention
- Whether the person or anyone else experienced injury or distress
- Any further actions taken i.e. first aid/debrief.

12.6 Following restrictive intervention the DATIX and the patient notes should provide details on the communication and information offered to the patient and their family/carer in line with the Trusts “Being Open” Policy.

12.7 Wherever possible, people who use services, family carers, advocates and other relevant representatives should be engaged in all aspects of planning their care including how to respond to crisis situations, post-incident debriefings, rigorous reporting arrangements for staff and collation of data regarding the use of restrictive interventions.

12.8 Any injury sustained to a patient; member of staff; visitor as a result of the use of restrictive intervention should be reported according to Trust policy and documented in patient notes and Datix completed.

12.9 The use of tertiary restrictive interventions may be needed on a patient in an emergency situation without staff implementing primary and secondary interventions as the first protocol will require an incident form - DATIX being completed in line with Trust policy and the rationale documented in patient notes. The event will then be reviewed at panel.

12.10 Staff are informed that when completing a Datix, the four different types of restrictive interventions as tertiary strategies are identified within a mandatory field. To offer further clarity to Staff when recording a Datix, a drop down box is included to ensure the correct definition is used consistently.

13.0 Training

13.1 Education and training are central to promoting and supporting change. Staff who may be required to use restrictive interventions must have high quality specialised training utilising break away techniques.

13.2 This policy promotes ongoing education, training and awareness, surrounding the issues regarding management of patients’ agitation and the use of alternative approaches to restrictive interventions. These issues will be covered within Induction & in mandatory training within a rolling programme.

13.3 Frontline Staff and staff working in known high risk areas must be a priority in accessing training and to be able to demonstrate necessary competencies prior to implementing restrictive interventions. Clinical managers/ward sisters/charge nurses are responsible for ensuring competence and uptake of relevant training of their staff.

13.4 Training will be targeted around the specific needs of the patient population being served. Work based training will be facilitated by each appropriate Lead Nurse/specialty where appropriate.

13.5 Training is currently provided on:

- Conflict Resolution
- Safeguarding
- MCA & DOL's
- Dementia
- LD/Autism Awareness

13.6 The emphasis of training and education should always be on managing and dealing effectively with difficult situations/conflict resolution in order to avert the need for restraint therapies.

13.7 Training records must record precisely the techniques that a member of staff has been trained to use.

13.8 Staff are responsible to ensure they attend all mandatory training to increase awareness and remain compliant.

14.0 Post Incident Management

14.1 When incidents occur and where restrictive interventions have been necessary which have resulted in harm, distress, or injury then staff should be involved routinely in post-incident reviews and debriefs. These will be planned so that lessons are learned shared and result in change.

14.2 The debriefing session is based on the culture of no apportioned blame, and should be facilitated by a person with appropriate training.

14.3 In the event that there is a clear detrimental effect on staff the advice of HR should be sought and a referral made to Occupational Health Team.

14:4 A panel is held regularly to review all cases of physical restraint. The restraint panel determines whether the incident could have been avoided and makes recommendations based on the learning outcomes.

15.0 Duties and Responsibilities

15.1 To demonstrate effective leadership, the Chief Nurse is the named responsible and accountable lead at Trust Board level that will authorise and approve the restrictive interventions taught and used in practice.

15.2 The Matron is responsible for ensuring debriefing takes place within their departments and that staff receives appropriate support.

15.3 The Trust must comply with all expected data requirements, including recording and reporting on restraint and injuries sustained in the National Reporting Learning Set (NRLS). The Governance/Risk Management Team are responsible for reporting internal data to NRLS as part of National Patient Safety reporting. Information needs to include:

- Staff name and patient involved - unique identifiers
- Reason for restrictive intervention
- Type of intervention used
- Any injury or distress caused to the person or anyone else
- The reason for using the specific type of restrictive intervention (rather than an alternative less restrictive strategy)
- The date and the duration of the intervention
- Any further action taken/required i.e. first aid

15.4 The Associate Directors of Nursing are responsible for ensuring all incidents requiring methods of restraints are reported via the clinical incident reporting system Datix.

15.5 The Health and Safety risk manager will provide quarterly figures to the local security management specialist and the LD Liaison Nurse for review. The LD Liaison Nurse will write up quarterly reports for CQRG & shared within the Safeguarding forums.

15.6 The local security management specialist together with LD Liaison Nurse will review the quarterly figures in conjunction with behavioural support plans and the findings will be presented to the Trust Board annually.

15.7 To ensure transparency the Trust Board will maintain and offer information to Commissioners and publish a public, annually updated, accessible report on the use of restrictive interventions incorporated within main public report.

15.8 The Trust Board will receive and develop action plans where appropriate in response to an annual audit of behavioural support plans.

15.9 All clinical staff have a responsibility in practice to ensure they receive regular supervision

16.0 Audit, Monitoring & Evaluation

16.1 An annual audit is to be undertaken jointly by the Safeguarding Team & LD Liaison Nurse which outlines the training strategy, restrictive intervention techniques used (how often) and reasons why, whether any significant injuries resulted, and details of ongoing strategies for bringing about reductions in the use of restrictive interventions.

16.2 There must be clear and accurate recording of the use of restrictive interventions in which to evaluate progress against their restrictive intervention reduction programmes. This requirement is completed by the LD Liaison Nurse.

16.3 Evidence will be gathered through ongoing audit as to whether staff document robust and clear information regarding the use of restrictive intervention.

16.4 Monitoring of this policy is primarily through Matrons with the aim to:

- Overseeing and supporting staff through the use of restrictive interventions
- Monitoring & reviewing the effectiveness of the policy
- Making recommendations for future developments of the procedures
- Utilising the forums in which patient/relatives views are considered and to ensure information is appropriate
- Ensuring staff gain competencies through access to training
- Through audit review compliance of MCA (2005) and the use of IBS plans
- Ensuring post incident reviews/debriefs happen routinely

16.5 A snap shot audit will be undertaken 6 monthly by the LSMS, and Safeguarding Lead to review the following:

- Numbers being reported
- To review whether the appropriate primary and secondary interventions have been applied
- Taking further action/review of the policy as necessary

16.6 For patients with LD/autism, the LD Liaison Nurse will include findings within the quarterly reports and annual report.

16.7 Statistical data on the numbers of restraints will be included within the annual Trust's Quality Account which is made available to the public.

17.0 When Conflicts Arise

17.1 There may be occasions where the use of restrictive interventions may lead to a complaint from relatives or carers. It is self-evident that staff may be required to account for their actions in such circumstances. However, the Trust will always support employees who have acted in a way which is deemed reasonable and measured at the time of incident and can demonstrate that they have adhered to appropriate Trust policies and procedures.

17.2 Any disagreement by family members or carers to the use of restrictive interventions or any disagreement amongst the clinical team must be recorded in the patient's medical notes and a second opinion assessment should be sought before the restraint is applied. If restraint is planned and appropriate to delay outcomes of the assessment should be documented.

17.3 Where the family members or carers remain vehemently opposed to the use of restrictive interventions or the clinical team continues to disagree after the second assessment, and 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 Safeguarding Lead in the first instance then full MDT input and finally follow MCA due process.

17.4 The views of relatives, carers or IMCA are not determinative, although their views regarding what the patient would wish for must be taken into account.

17.5 If the dispute has to be referred to the Court of Protection then Section 6 of the MCA permits action to be taken in the meantime where it is necessary to sustain life or to prevent serious deterioration.

18.0 Use of Breach Data

18.1 A Datix must be completed for all breaches of this policy.

18.2 The data gathered from the risk events will be used in order to restore the trusting relationship between carer, patient and health team improve the service by:

- Responding appropriately to complaints
- Acting on recommendations made by senior management based on learning outcomes
- Implementing an action plan concerning knowledge and performance issues
- Ensuring that there is compliance with the Duty of Candour and the individual's professional duty to be open and honest with patients about their care

19.0 Communication and Implementation of this Policy

19.1 The Director of Nursing will be advised of this policy and guidelines and will take responsibility to cascade the information to ward/department sisters/charge nurses who in turn will cascade the information within their individual departments.

19.2 It is the responsibility of ward sisters/charge nurses and heads of departments to ensure members of their team are made aware of the policy for implementation and that the policy and procedures folders are updated.

19.3 Corporate Services will ensure that the policy is uploaded to the intranet and website, once ratified.

19.4 This policy will also be further publicised within the Trust staff news briefing.

19.5 Relevant Managers/Lead/Specialist Nurses will be responsible for raising awareness of this policy during training sessions.

20.0 References

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Appendix 1

Equality Impact Assessment (EIA)

Policy for Reducing the Need for Restrictive Interventions (15005)

Equality or Human rights Concern.	Does this item have any differential impact on the equality groups listed? Brief description of impact.	How is this impact being addressed?
Gender	All identified patients requiring additional support in order to receive treatment will be treated the same irrespective of their Gender.	Staff communication is encouraged to support Patient/Carers; all complaints would be fully investigated and responded to.
Race and ethnicity	All identified patients will be treated the same irrespective of their race and ethnicity.	MEHT operates within the requirements of the Race Equality Act 2010. Language may be a barrier – interpreters are made available when required.
Disability	It is acknowledged that some identified vulnerable patients may also live with other disabilities including mental health & learning disabilities.	Patient information and advice is accessible, up to date, and free from jargon. All areas have disabled access re: wheelchairs; lifts; toilets. Any issues regarding a patient's disability would be taken into consideration at time of patient's assessment and all support tailored to meet individual need.
Religion, faith and belief	All identified vulnerable patients will be treated the same irrespective of their belief system	There is access to the multi faith chaplaincy team who offer advice, & support for Pts, relatives, carers & staff
Sexual Orientation	All identified vulnerable patients will be treated the same irrespective of their sexual orientation.	MEHT staff is bound to comply with equalities legislation. Staff training is available for equality & diversity. All complaints would be fully investigated and responded to.
Age	This policy is specific to adults 18> All identified vulnerable patients will be treated the same regardless of age.	MEHT acknowledges the different needs of younger and older patients with regards to restrictive interventions and the law. A separate policy will be made available to address the needs of children.
Transgender people	All identified vulnerable patients will be treated the same irrespective of their gender status	MEHT staff is bound to comply with equalities legislation. Staff training is available for equality & diversity. All complaints would be fully investigated and responded to.
Social class	No variance - All vulnerable identified patients will be treated the same irrespective of their social class group.	Staff communication is encouraged to support Pt/carers.
Finances	Some vulnerable patients may have additional difficulties with regards to transport/financial concerns.	Advice is available regarding facilities; concessions; advocacy services. Carer's champions and social work team are available within MEHT.

Date of Assessment: 6th September 2018

Name of Assessor(s): Sandie Morton-Nance

Appendix 2

Flowchart – A Protocol for Reducing the Need for Restrictive Intervention

Does the patient lack capacity?

YES

Apply the Mental Capacity Act (MCA) principles – utilise the MCA form to support decision making process

A Deprivation of Liberties Safeguard's (DoLS) Application is required if patient requires constant intervention.

NO

Work with the patient; build up trust - gain consent prior to any treatment & care intervention

The following protocol must be followed:

Any Patient who can reasonably be predicted to be at risk of being exposed to restrictive interventions must have in place:

- **Individualised Behaviour Support (IBS) plan**
- **Risk assessment**
- **Capacity Assessment**

Once completed, if the risk assessment indicates a moderate to high risk level then:

- **Implement the Individualised Behavioural Support Plan (IBS). The primary and secondary interventions will be outlined within the IBS and will include the tertiary strategy if required**

In the event that primary and secondary interventions are unsuccessful & all other options have been exhausted:

- **As a last resort, the least restrictive Tertiary strategy needs to be agreed**
- **A Datix incident reporting form completed identifying the type & method of restrictive intervention being used within the categories**
- **Application for DoLs should be made**

Appendix 3

MANAGING PATIENTS WHO MAY BECOME CHALLENGING – USING PRIMARY & SECONDARY PREVENTATIVE STRATEGIES

Staff must note that they need to familiarise themselves with other Organisational Policies i.e.: LD Policy; Autism Policy; Dementia; Safeguarding; MCA; Risk; Delirium; Restricted Interventions; DOLS.

Before a decision for this strategy is to be implemented, the document needs to be considered in conjunction with other evidenced based Primary Preventative Strategies.

The Three D's:

The "Three D's" are practical intervention techniques used in conflict resolution.
(Diffusion, Distraction & De-escalation)
A Low Arousal approach is used to encourage staff to support the patient and manage their behaviour in a dignified way.

1. Distraction Techniques:

Use techniques which aim to **distract** and refocus the challenging individual. Distraction is used as a self soothing technique.
Some examples of distraction would be for Staff to interrupt the negative mood by involving the patient in:
Making a cup of tea & choosing a biscuit
Watching a movie or TV show,
Reading a book, completing a puzzle
Listening to (energizing) music, or the radio
Calling a friend or family member,
Doing some gentle exercises –i.e.: stretching & bending.
Offer gentle relaxation exercises by encouraging the person to tense various muscle groups, holding for 10 seconds and then "letting go".
Introduce humour and banter in a conversation because laughing also has a relaxing effect, and will help to reduce body tension.
Or
Carrying out some detail-orientated tasks like
Writing,
Cleaning & organising the bed area
Singing
Doing something artistic – i.e. colouring in.

2. Diffusion Strategies:

Diffusion techniques involve cognitive behavioural therapy by encouraging the patient to identify the emotion – to express what they are feeling - and to describe their unhelpful thoughts. Staff can

then help by repeating back the unhelpful thoughts and then by expressing them differently, in a non-threatening way: slowly, calmly in a soft voice or write them down i.e. changing the negative to a positive.
Some examples of diffusion techniques would be for Staff to interrupt the negative mood by involving the patient in:

An introduction to **diffusion i**nitially through movement i.e.: 'walk-around' whilst talking – then:

- Take your mind for a walk - Walk behind the patient chattering like minds do, while the patient chooses where to walk.
- Just offer your noticing - Use the language of observation (e.g., noticing) when talking about the thoughts.
- Put them out there - Sit next to the patient and put each thought and experience out in front of you both as an object
- Sound it out – repeat the patients difficult thoughts very, very slowly
- Carry your keys - Assign difficult thoughts to the keys
- Write on some cards - Write difficult thoughts down and then help to create a new story integrating those same facts into other stories.

Before anything happens staff should also seek to defuse any situations arising. Staff should aim to do nothing to escalate the situation whilst being prepared to exit if necessary. Staff should seek to:

- Appear confident
- Displaying calmness
- Create some space
- Speak slowly, gently and clearly
- Lower your voice
- Avoid staring
- Avoid arguing and confrontation
- Show that they are listening

Staff should adopt a non-threatening body posture:

- Use a calm, open posture (sitting or standing)
- Reduce direct eye contact (as it may be taken as a confrontation)
- Allow the patient adequate personal space
- Keep both hands visible – palms up
- Avoid sudden movements that may startle or be perceived as an attack
- Avoid audiences – as an audience may escalate the situation

3. De-escalation Techniques:

When a potentially volatile situation threatens to erupt verbal de-escalation/crisis intervention may be appropriate in the first instance.

Staff should be aware that they will no longer be able to reason with the patient at this stage and therefore the only objective is to reduce the level of arousal so that discussion becomes possible.

Staff should ***Never*** attempt to de-escalate a potentially violent situation without first making sure your colleagues and security are made aware of what is going on.

Self Control:

Staff will need to ensure that their verbal and non-verbal communication is non-threatening.

1. Appear calm, controlled and confident without being dismissive or over-bearing.
2. Keep your facial muscles relaxed and be aware of your own non-verbal behaviour, such as body posture and eye contact.
3. Remember that your anxiety can make the patient feel more anxious which can lead to an escalation of aggression.
4. Use a slow, calm, low and monotonous tone of voice
5. Try not to become defensive - even if comments or insults are directed at you, remember they are not about you. You don't need to defend yourself or anyone else from insults, or curses.
6. Remember that you have choices – you can leave, you can tell the patient to move/leave and you can call security or the police should de-escalation not be effective.
7. Remember to remain respectful even when firmly setting limits or calling for help.
8. Consider which de-escalation techniques are appropriate for the situation.

Physical Stance

1. Never turn your back for any reason. Do not stand full front to the patient. Stand at an angle so you can sidestep away if needed.
2. Always be at the same eye level but do not maintain constant eye contact. Allow the patient to break his/her gaze and look away.
3. Encourage the client to be seated, but if he/she needs to stand, then you need to stand up also, moving towards a 'safer place', i.e. avoid being trapped in a corner.
4. Allow greater body space between you both than normal.
5. DO NOT point; shake your finger; argue or become confrontational
6. DO NOT smile as this could be interpreted as patronizing or indicate fear.
7. DO NOT touch – even if some touching is generally culturally appropriate and usual in your setting. Cognitive dysfunction in agitated people allow for easy misinterpretation of physical contact as hostile or threatening.
8. Keep hands out of your pockets, palms up and available to protect yourself.
9. Try not to become defensive or judgmental.

The Verbal De-escalation Discussion

Remember, that talking someone down does take practice. The aim is to transfer your sense of calm and genuine interest in what the patient wants, respectfully setting clear boundaries in the hope that the patient actually wishes to respond more positively.

Staff can do this by initially calling for assistance & then interacting with Patient:

1. Explain your purpose or intention

   a. All communication to be addressed to the person
   b. Give clear, brief, assertive instructions, negotiate options and avoid threats.

2. Encourage reasoning (for their behaviour)
   a. Encourage reasoning by the use of open questions and enquire about the reason for the aggression.
   b. Questions about the 'facts' rather than the feelings can assist in de-escalating (e.g. we need to make your toes better)
3. Show concern through non-verbal and verbal responses.
4. Listen carefully and show empathy, acknowledge any grievances, concerns or frustrations.
5. Remember that there is no other motivation except for trying to calmly bring the level of arousal down to baseline.
6. Do not get loud or try to yell over a screaming person. Wait until he/she takes a breath; then talk. Speak calmly at an average volume.
7. Respond selectively; answer all informational questions no matter how rudely asked.
8. DO NOT answer abusive questions - These types of questions should not get any response.
9. Explain limits and rules in an authoritative, firm, but always respectful tone. Give choices where possible in which both alternatives are safe ones (e.g. would you like to continue our meeting calmly or would you prefer to stop now and I will come back later when things can be more relaxed?)
10. Empathize with feelings but not with the behavior (e.g. "I understand that you feel angry and that is ok; but it is not okay for you to threaten me or my staff.)
11. Do not argue or try to convince.
12. Ask the patient to "help me to understand what your are saying to me"
13. Give the consequences of inappropriate behavior without threats or anger.
14. Trust your instincts. If you feel that de-escalation is not working, STOP! You will know within 2 or 3 minutes if it's working.
15. If it's not working you will need to call for help.

Other relevant information:

Do not try de-escalation techniques when a patient has anything to hand which could be used as a weapon – immediately call for back up – the safety of yourself and all others is paramount.

In the event that the risks of harm far outweigh any benefits then these planned interventions need to be aborted immediately – and alternative strategies need to be actioned – i.e.: Security; Police & Planned Tertiary Restrictive Interventions & Practise.

Appendix 4

Surname:	DOB:
First Name:	NHS No:

Rapid Risk Assessment for All Vulnerable Groups

Care Issue	Assessment Criteria	Score
Personal Safety	• No issues identified	**0**
	• Requires regular observation & reinforcement to maintain safety	**1**
	• Level of cognitive; mental health or physical disability requires half hourly checks to maintain safety. • Mental health status affects ability to maintain safety. • Additional sensory disability; blind or deaf.	**2**
	• Unable to maintain own safety due to level of learning disability/autism/dementia/mental health issue - may wander, remove medical devises i.e.: cannula; drains etc. • Complex physical disabilities require continuous observation & management of posture to maintain airway. • High risk of pressure area breakdown (Waterlow) • High risk of falls (Falls assessment) • Safeguarding issue identified.	**3**
Swallowing, Nutrition & Hydration	• No previous or current history of swallowing issues	**0**
	• Previous history of swallowing issues but has not been formally assessed • Requires support to ensure adequate food and fluid intake	**1**
	• Requires safe positioning or additional support for eating drinking/non oral feeding • Long term feeding via PEG or NGT and is NBM • History of recurrent chest infections or unintentional weight loss	**2**
	• Assessment indicates high risk of Dysphasia • On modified food/thickened fluids • Requires one to one support whilst eating/drinking to ensure safe swallowing	**3**
Communication	• Good verbal communication and understanding • Indicates when/where pain	**0**
	• Some verbal communication – uses non verbal systems to supplement • Requires additional time to process information and respond	**1**
	• Uses some non verbal signs, facial expressions, body language or behaviour to communicate • Requires extra time and/or information in alternative format	**2**
	• Extremely limited communication • Requires support from Carers to anticipate & interpret need	**3**
Mental Capacity	• Assessment indicates no capacity issues • Can make own decisions/and can consent to treatment with clear explanations	**0**
	• Understands simplified explanation of procedures • Requires reinforcement, extra time, accessible information to support decision making	**1**
	• Has difficulties understanding complex treatments/interventions but will consent with reinforcement and support	**2**
	• Is unable to understand, retain, weigh up, communicate back and make decisions related to treatment/interventions (lacks capacity) • Very unlikely to comply with treatment/interventions	**3**
	• No known seizure activity	**0**

Epilepsy	• Seizures well controlled by medication or infrequent	**1**
	• Poorly controlled or unpredictable seizures • Seizure activity increased by illness or anxiety	**2**
	• Seizure activity is prolonged or difficult to recognise leading to loss of consciousness • High risk of airway obstruction or aspiration during seizure activity (history)	**3**
Behaviours and Anxiety	• No issues identified	**0**
	• May become anxious in new environment, needs reassurance and extra time to reduce anxiety/disorientation • May display inappropriate behaviour, needs clear boundaries and reinforcement	**1**
	• Regularly displays inappropriate behaviours i.e.|: stripping • Sometimes displays aggressive behaviours	**2**
	• Sever hospital phobia or unable to wait • Regularly displays aggressive behaviours to self/others or environment – high risk of injury • Requires own Carers to manage needs	**3**

Score – 0-8 = LOW RISK (Use Primary Strategies)	Score – 9 – 12 = MEDIUM RISK (Use Primary/Secondary Strategies)	Score – 13 – 18 = HIGH RISK (Tertiary Stategies may be indicated)

Nursing – Care Bundles

LOW RISK	MUST DO'S	Tick on Completion	Initials
❖	Use all primary strategies as appropriate		
❖	Complete all Trust risk assessments ie: Falls; Waterlow; MUST		
❖	Implement basic nursing care monitoring charts ie: Food & Fluid charts, epilepsy charts, TPR		
❖	Refer to intranet - for relevant policies; guidelines etc		
❖	Refer to– Communication Resource Folder; This is Me document; CPA or Hospital Passport		
❖	Liaise with/identify Ward Link Nurse		
❖	Liaise with Carers to identify usual support/communication needs – ask for copies		
❖	Refer to relevant Specialist Teams/Lead Nurses for further support/advise if needed		
❖	Ie: CNS Dementia; EAT Team: LD Lead; Safeguarding CNS		
❖	Ensure data base/IT system identifies Pt with LD/Autism flag (!)		
❖	Consider – Red Tray		
❖	Document decisions in relation to Pt's mental capacity – MCA2 if answer is no to any question:		
❖	Is the person able to		
-	Understand the information relative to the decision		
-	Retain the information long enough to make the decision		
-	Use or weigh up the information to make the decision		
-	Communicate the decision back by appropriate means		
MEDIUM RISK	**MUST DO'S AS ABOVE PLUS...**	**Tick on Completion**	**Initials**
➢	Use all primary/secondary strategies as appropriate		
➢	Implement Individualised Behavioural Support Plan		
➢	Consider increased support needs. Refer to LD policy; safeguarding policy; delirium policy		
➢	For LD/Autism request Traffic Light Assessment – HLN may have a copy or CPA from MH CNS		
➢	HLN may advise on further reasonable adjustments to be made – *see policy*		

➢	Confirm the level of support which may be offered by familiar Carers and document this in notes		
➢	Increase level of supervision and observations – use 1:1		
➢	Use alternative methods to assess potential clinical issues eg: Pain; DISDAT Tool; Purple Folder;		
➢	Make referrals to appropriate Health Care Professionals ie: SALT; Dietician; Physio; OT;		
➢	If additional support needs are apparent prior to discharge then refer to HAT's Team		
➢	Consider further involvement of Community ie LD Specialist Team; Mental health Team		
HIGH RISK	**MUST DO'S AS ABOVE PLUS...**	**Tick on Completion**	**Initials**
✓	Tertiary Strategies may be required – see restrictive interventions guidelines		
✓	Implement Individualised Behavioural Support Plan		
✓	Complex discharge needs = will require Specialist input		
✓	Complete full risk assessment; dependency assessment and support tool		
✓	Inform GP of admission & discharge		
✓	Refer to Specialist Teams/Lead Nurses or appropriate CNS for advise; support & information		
✓	Agree additional support needs – Specialling with Senior Nurse & Funding		
✓	Ensure principles of MCA are followed in relation to lack of capacity & "Best Interest" decisions		
✓	Datix all tertiary strategies used.		
✓	Pre-discharge planning meeting (MDT) & respond to any continuing care needs		
✓	Refer to Discharge Co-ordinator or HLN/CNS if CHC checklist is required		
✓	Support safe & timely discharge – discharge summary		

DOCUMENT ALL ACTIONS CLEARLY IN PATIENTS HEALTH CARE RECORDS - Once completed keep rapid risk assessment in patient notes - Rapid Risk Assessment completed by:

Print Name & Designation:	**Signature:**	**Date of Completion:**

Appendix 5

Principles & Definitions

The principles that underpin this policy are those directed through statute Law; Common Law Judgements and Department of Health policies as follows:

- The *Human Rights Act* (1998) imposes a duty on public authorities, including NHS Trusts, Local Authorities, and police forces and instructs all services exercising functions of a public nature not to act in a manner that is incompatible with the European Convention on Human Rights (ECHR) rights that have been made part of UK law by the HRA.

- The *Department of Health* (2002) offers g*uidance on providing safe services for people with learning disabilities and autistic spectrum conditions.*

- The *NICE* (2005) guidelines, (recently reviewed in 2015), examined and reported on the evidence base for the emergency management of acute behavioural disturbance across a selection of healthcare settings. Interventions and topics that are examined include: the care environment, prediction of violence and aggression, training, service user perspectives, emergency departments and the use of intensive supportive observations and a range of restrictive interventions.

- The *Mental Capacity Act* (2005) & the *Deprivation of Liberty Safeguards* (2007) sets out a clear framework for those people who lack capacity and all significant decisions made on their behalf has to be in the best interests of the person. Where a decision is made to use restrictive interventions, staff must balance the patient's right to autonomy with the right to be protected from harm.

- Within the *DOH* (2008) *MHA* (1983) *Code of Practice,* chapter 15 provides guidance on a range of interventions which may be considered for the safe and therapeutic management of hospital in-patients (whether or not they are detained under the Mental Health Act 1983) whose behaviour presents a particular risk to themselves or to others. The revised (2014) compliments latest guidelines with a stronger focus on positive and proactive care as well as additional safeguards around the application of restrictive interventions.

- Investigations into abuses at Winterbourne View Hospital and Mind's *Mental Health Crisis in Care: physical restraint in crisis* (2013) showed that restrictive interventions have not always been used as a last resort in health and social care. Reports show that restraint has also been used inappropriately resulting in a lasting detrimental effect on the people who use services including the staff. The document calls for changes to practice, as reports show that the over use of restrictive interventions, used for too long are often a major contribution to delaying recovery, and have been linked with causing serious physical and psychological trauma.

- The principles and approaches outlined within *NHS Protect* (2013) apply to any adult patient in an NHS healthcare setting. Although specific techniques and interventions may differ, strategies for delivering high quality personalised care that meets a person's needs remain the same. The importance of positive engagement, communication between staff and de-escalation approaches are strongly emphasised.

- *Positive and Proactive Care* and *A Positive and Proactive workforce* (2014) provides a framework to radically transform culture, leadership and professional practice to deliver care and support which keeps people safe,

  and promotes recovery. The guidance makes clear that restrictive interventions may be required in life threatening situations to protect both people who use services and staff or as part of an agreed care plan. It advocates a whole scale system-wide change to be made, ensuring a modern, compassionate and therapeutic healthcare service.

- NHS England & Local Government Association (2014) has produced the *Core Principles Commissioning Tool* as a direct response to the events revealed at Winterbourne View. Its aim is to inform decisions concerning the commissioning of services, It describes the core principles that should be present across all services for people with learning disabilities and/or autism who either display or are at risk of displaying behaviour which challenges. The document highlights the importance of a person centred focus on outcomes, with all decisions being based on the best interests of the individual and a full recognition that family carers are most often those who know what the 'best interests' are. It recommends a rigorous adherence to the core principles which will result in improving individuals' quality of life and reduce the prevalence and incidence of behaviour that challenges and the use of restrictive interventions.

- *Skills for Care/Skills for Health* (2014) *is a* guide is for commissioners and employers who are responsible for the development of a skilled, knowledgeable and competent health and social care. The document provides advice on the training and development of staff with the aim of ensuring that the use of restrictive interventions is minimised.

- The Care Act (2014) introduces new responsibilities for local authorities and sets out a clear legal framework for how local authorities and other parts of the system should protect adults at risk of abuse or neglect. It reminds health service practitioners of their statutory duties to safeguard vulnerable adults. It aims to assist Practitioners in preventing and responding to neglect harm and abuse to patients in the most vulnerable situations.

Definitions

Behaviours that challenge services is not easy for anyone to understand and manage. Patients presenting with difficult behaviours is defined in this situation as:

“Displaying behaviour of such an intensity, frequency or duration as to threaten the quality of life and/or the physical safety of the individual or others and is likely to lead to responses that are restrictive”.