PR.128 – Restrictive Intervention Policy (Adults)

Document Summary
This policy provides guidance and support for staff to reduce and manage incidents of violence and aggression and to provide a framework for the use of restrictive interventions.

Document Number & Version	PR.128 V3
Date Ratified	June 2021
Committee Ratified at	Policy Review Group
Date Implemented	June 2021
Next Review Date	June 2026
Accountable Director	Medical Director
Document Author(s)	Advanced Practitioner, MHA, MCA, DOLs

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Document Submission Cover Sheet

Committee / Group Name: Clinical Effectiveness & Audit Committee

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Type of Document	Policy	*If other state:*	
Reason for submission ☒:	For Approval ☐	For Ratification ☒	For Noting ☐

Applicable to ☒: **Trust Wide** ☒

Division: Surgical ☐ Medical ☐ Integrated Care ☐ Clinical Support ☐

Directorate / Specialty *give detail* _____

Document Title: *(succinct & key word first)*	PR.129 Restrictive Intervention Policy (Adults)		
Your Ref No:	PR.128	**Version:**	3
Author(s) Name:		**Designation:**	Advanced Practitioner, MHA, MCA, DOLS – Adult Safeguarding Team
Date submitted:	15/04/2021		

Reason for producing the document	To provide advice, support, and a framework for staff that may be required to use restrictive intervention
References used in document production	See references section
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Content checked ☒	Date Email sent to author/secretary to add to committee agenda 28/05/2021

For Committee Use Only

On agenda for Meeting on: 13/05/2021

Meeting Outcome

Document for Approval: CEAC 13/05/2021

Approved ☒	Committee Document Number assigned *(item number from Minutes)*: 6.1 Returned to Author by e-mail on not required	
Not approved ☐	Feedback to author:	Sent by e-mail: Click here to enter a date.

Document for Ratification: Policy Review Group 04/06/2021

Ratified ☒	Committee Document Number assigned *(item number from Minutes)*: 3 Returned to Author by e-mail on 07/06/2021	
Not Ratified ☐	Feedback to author:	Sent by e-mail: Click here to enter a date.

Document for Noting:	Noted ☐	No further action

Committee Comments:	

For Policies only – to go to Policy Team

Final version Word document, Cover Document and minutes to be sent to Policy Team (policy@wvt.nhs.uk)

DOCUMENT HISTORY

Issue Status e.g. Draft or Final	Catalogue and Version Number	Document Title	Date	Actioned by: (Job Title)	Page/ Section/ Paragraph	Comments
Final	V3	Restrictive Intervention Policy (for Adult patients only)	May 2021	Deputy Director of Nursing	Full document review	-Split into two policies (Rapid Tranquilisation Policy and Restrictive Intervention Policy) -Full review following NED comments -Amended after Sodexo Review (porter section in particular) -Amended to note that many sections not relevant to community sites.

TABLE OF CONTENTS

1 SCOPE

This policy covers all staff and persons within Wye Valley NHS Trust, and others who are acting on behalf of the Trust, caring for adult patients i.e. those 16 years and older. There are several sections within the policy that are not suitable for community settings, each section not suitable for community settings will have a sentence stating as much.

For patients aged 16 years and younger please see the Trust paediatric clinical guideline for 'Management of Acutely Disturbed Adolescents (including sedation)'.

2 INTRODUCTION

The Trust is committed to delivering the highest standards of health, safety and welfare to its patients, visitors and people who receive healthcare in the community and employees. For the purposes of this document the term "Care Environment" refers to Trust Acute Hospital(s) and Community Hospital(s), as well as Community Clinic(s) and the patient's own home (including residential homes).

Restrictive interventions can delay recovery and has been linked to causing serious physical and psychological trauma, and even death. Restrictive interventions should therefore only ever be used in extreme life threatening situations or as part of an agreed care plan (DoH, 2014).

The Trust recognises that violence and aggressive behaviour can escalate to the point where restrictive interventions may be needed to protect the safety of a person or persons whether that be a patient, member of staff or general public, but strongly advocates that this is always used only as a last resort and when there is no other alternative action that can be taken to prevent serious harm.

The general principles that guide the development and implementation of this policy have been adopted from those outlined in recent guidance on the use of restrictive practices (RCN, 2013) and these are:

- Human rights must be protected and honoured at all times
- Understanding people's behaviour allows their unique and individual needs to be identified and quality of life enhanced
- Involvement and participation of service users, their families and carers is essential
- People must be treated with compassion, dignity and kindness
- Health and adult social care services must keep people safe and free from harm
- Positive relationships between services and the people they support are key to recovery; they must be protected and preserved

For the purposes of this policy, 'restrictive interventions' are defined as:

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

- Take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken; and
- End or reduce significantly the danger to the person or others; and

- Contain or limit the person's freedom for no longer than is necessary

If restrictive interventions are used it must only ever be as a last resort and it is undertaken in a proportionate and least restrictive way, ensuring that the patient's human rights are upheld (Human Rights Act, 1998).

For people who lack the capacity to consent to the use of a restrictive intervention, services will balance people's right to autonomy with the right to be protected from harm. Any decision to use restrictive interventions must be made in the best interests of the person within the framework of the Mental Capacity Act (MCA) (sections 4, 5 and 6).

3 STATEMENT OF PURPOSE

The purpose of this document is to provide guidance to managers and staff of the Trust's legal and professional responsibilities in relation to the nature, circumstances and use of approved restrictive interventions currently adopted by the Trust. Its aim is to help all involved act appropriately in a safe manner, thus ensuring effective responses in potential or actual difficult situations.

4 DEFINITIONS

4.1 Environmental Restraint or Restrictive Intervention

Environmental restraint is where the design of the environment involves limiting a person's ability to move as they wish, such as preventing a person from leaving a ward area.

4.2 Mechanical Restraint or Restrictive Intervention

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'.

4.3 Physical Restraint or Restrictive Intervention

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'.

4.4 Chemical Restraint or Restrictive Intervention

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'.

4.5 When Might Restraint be Used?

- When a person is displaying behaviours that is putting others at risk of harm
- When a person is displaying behaviours that is putting themselves at risk of harm
- When a person requires treatment by legal order for example under the Mental Health Act
- Requiring lifesaving treatment
- Needing to be maintained in secure settings

https://restraintreductionnetwork.org/wp-content/uploads/2016/11/Lets-talk-about-restraint.pdf

4.6 The Safe and Ethical Use of all Forms of Restrictive Interventions

The legal and ethical basis for organisations to allow their staff to use restrictive interventions as a last resort is founded on eight overarching principles (DoH, 2014):

1. Restrictive interventions will never be used to punish or for the sole intention of inflicting pain, suffering or humiliation

2. There must be a real possibility of harm to the person or to staff, the public or others and damage to property if no action is undertaken

3. The nature of techniques used to restrict will be proportionate to the risk of harm and the seriousness of that harm

4. Any action taken to restrict a person's freedom of movement will be the least restrictive option that will meet the need

5. Any restriction will be imposed for no longer than absolutely necessary

6. What is done to people, why and with what consequences, will be subject to audit and monitoring and will be open and transparent

7. Restrictive interventions will only ever be used as a last resort

8. People who use services, carers and patient advocates will be involved in reviewing plans for restrictive interventions

4.7 What is 'Reasonable' in Law?

The management of difficult and challenging behaviour is an activity requiring compassion and respect for the rights of the individual, balanced against the risk of harm to themselves, staff and members of the public.

Restraining any challenging or aggressive behaviour by physical or chemical means should only be used when it is reasonable to do so.

Restraint will only be considered when all other practical means of managing the situation, such as de-escalation, verbal persuasion, voluntary 'time out', or gaining consent to taking medication, have failed or are judged likely to fail in the circumstances. The self-respect, dignity, privacy, cultural values, race, and any special needs of the patient/person will be considered in so far as is reasonably practicable.

For the purposes of considering what may be construed as reasonable in law the Criminal Law Act 1967, Section 3 states:

'A person may use such force as is reasonable in the circumstances in the prevention of crime, or in effecting or assisting in the lawful arrest of offenders, suspected offenders, or persons unlawfully at large'.

Using this example, it is not possible to set out comprehensively when it is reasonable to use force; no two threatening situations are ever identical. However, what constitutes 'reasonable' will require staff in each situation to consider the following points carefully:

- Where a technique is applied, it will be done in a manner that attempts to reduce, rather than provoke a further aggressive reaction

- The numbers of staff involved will be the minimum necessary to restrain the individual, whilst minimising injury to all parties

- The force used will be proportionate to the risk and the minimum necessary to be able to contain the situation

- To take no action could be seen as negligent where the outcome results in self-inflicted injury to the individual, in injury to others or damage to property

- To convict a person of using unreasonable force, a court will be satisfied that no reasonable person in a similar position would have considered the action of the use of such force justified.

5 DUTIES

5.1 Board of Directors

The Board of Directors are responsible for determining the governance arrangements of the Trust including effective risk management processes. It is responsible for ensuring that the necessary clinical policies, procedures and guidelines are in place to safeguard patients and reduce risk. In addition they will require assurance that clinical policies, procedures and guidelines are being implemented and monitored for effectiveness and compliance.

5.2 Chief Executive Officer (CEO)

The Chief Executive has overall responsibility for patient safety and ensuring that there are effective risk management processes within the Trust, which meet all statutory requirements and adhere to guidance issued by the Department of Health.

The CEO holds each line manager accountable for meeting objectives and to work together towards meeting the objectives approved by the Board.

5.3 Director of Nursing/Medical Director

The Director of Nursing is the Executive with delegated responsibility for implementation of Governance arrangements within the Trust.

The Director of Nursing and the Medical Director are responsible for overseeing the implementation of this document.

5.4 Line Managers

Line Managers are responsible for ensuring that:

- This document is made available to all staff within their department

- The staff, they are responsible for, implement and comply with this document

- Those staff who will undertake any procedural elements contained within this document have been trained and deemed competent to do so

5.5 Local Security Management Specialist

All incidents relating to physical intervention will be managed by the Clinician, however where the Local Security Management Specialist is available they are responsible for:

- Being fully conversant with this policy and relevant associated policies
- Providing advice and support for an incident review
- Acting as liaison with the police when requested
- Providing CCTV evidence when required

5.6 All Staff

All staff who come in contact with patients or people who could demonstrate challenging behaviour may require restrictive interventions to keep them or others safe from harm, are responsible for complying with this policy and also to attend relevant training such as conflict resolution and physical restraint training.

Note: Restrictive interventions will not be undertaken in community clinics or patients domiciliary settings. In situations of medium risk, staff should consider using breakaway techniques and de-escalation. In situations of high risk, staff should remove themselves from the situation and, if there is immediate risk to life, contact the police.

6 PROCEDURE

This section will cover the following:

1. Prevention – preventing the need for restrictive interventions
2. Care Planning
3. De-Escalation Techniques
4. Environmental restraint
5. Mechanical restraint
6. Physical Restraint
7. Chemical Restraint/Rapid Tranquilisation
8. Record Keeping
9. Post Incident Reviews
10. When to Call Porters / the Police/ Emergency Restraint

6.1 Preventing the Need for Restrictive Interventions

6.1.1 The Patient's Behaviour, Underlying Condition and Treatment

A person's behaviour can be defined as 'challenging' if it puts them or those around them at risk. Challenging behaviour can include:

- Aggression: which can include scratching, biting, hitting, grabbing, pinching, hair pulling, throwing objects, verbal abuse, spitting, shouting and screaming.

- Self-harm: which can include head banging, scratching, picking, pulling, eye poking, grinding teeth and eating things that aren't food.

- Destructiveness: which can include damage to property, stealing, destruction of clothing and lack of awareness in terms of danger and withdrawal.

- Disruptiveness: which can include rocking, repetitive movements, repetitive speech and repetitive manipulation of objects.

Understanding a patients challenging behaviour and responding to individual needs should be at the centre of patient centred healthcare. It is important that staff assess the patients' needs in order to establish what therapeutic behaviour management might be most beneficial.

Common reasons for challenging behaviours can be:

- Biological causes – Traits of challenging behaviour often present in those with health problems that affect communication and issues with the brain such as dementia, autism, learning disabilities or mental health issues. Other physical causes to consider are:

    - Hypoxia
    - Hypotension
    - Pyrexia
    - Need to empty bladder or bowels
    - Pain or discomfort
    - Drug and alcohol withdrawal
    - Intoxication (due to alcohol, drug overdose or recreational drug misuse)
    - Reactions/side effects to medications
    - Brain injury or cerebral irritation
    - Infections such as a UTI, or LRTI or sepsis causing delirium
    - Other physical conditions such as diabetes, epilepsy, COPD

- Known ways of communication. The patient may not know how, or can't communicate their needs in a way that others understand

- Environmental causes – this can include over or under stimulation, inconsistences in staff (including awareness, approach, staffing levels and unfamiliar faces), extreme noise levels or temperature, lighting issues, lack of privacy, long waiting times, lack of information and restrictions or denials of requests.

6.1.2 The Patient's Mental Capacity

It is necessary to consider the patient's mental capacity. A mental capacity assessment relates to a single point in time and to a specific decision. Individual patients cannot simply be described as "lacking capacity". A patient's capacity may fluctuate from time to time.

The Mental Capacity Act presumes that all persons 16 and over have the ability to make their own decisions and protects their right to make and act on their own free and informed decisions.

The five principles of the Mental Capacity Act are shown below:

- A person will be assumed to have capacity unless it is proved otherwise
- A person will not be treated as unable to make a decision, unless all practicable steps to help have been taken without success
- A person will not 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, will be done in their best interests
- Before an act is done, or a decision made, consideration will be given to whether the same outcome can be achieved in a less restrictive way

Staff will explain any proposed procedure in an easily understandable way to enable a patient or their representative to give consent to make their own decisions. See Trust Consent Policy (PR.09 WVT Consent Policy). Staff will support the patient or their representative to give consent to ask questions and to weigh up information relevant to the decision to be made.

Prior to any intervention, staff must ensure that all efforts must be made to establish if the patient has made an Advanced Decision, in relation to any means of restrictive intervention, or if there is a Lasting Power of Attorney for Health and Welfare in place. Staff can check with the patient's relatives, or GP practice, or the Office of Public Guardian for the documents and a copy of any statements or LPA must be obtained and kept in the patient's medical notes. Patients who come into hospital from a health care provider will have care plans and a hospital passport in place. There is the possibility, that particular behaviours are already known and there will be an acknowledged way of dealing with it. The patient may have already consented to an action being taken in the event of an incident, and this may be documented in their care and behaviour management plan.

Any action intended to restrict a patient who lacks capacity will not attract protection from liability unless the following conditions are met:

- Before doing the act, reasonable steps are taken to establish whether the individual lacks capacity in relation to the matter in question: and
- When doing the act, it is reasonably believed that the person being cared for or treated lacks capacity in relation to the matter, and it will be in the best interests of the person being care for or treated for the act done
- The person taking action will reasonably believe that restraint is necessary to prevent harm to the person who lacks capacity, and
- The amount or type of restraint used and the amount of time it lasts must be a proportionate response to the likelihood and seriousness of harm

Mental capacity assessments must be clearly recorded and documented in the patient's medical notes.

6.2 Care Planning

Where there is a known likelihood that restrictive interventions might need to be used, an appropriate care plan with a review date will be devised by the Multidisciplinary Team in advance, and in discussion and agreement with the person, patient, their carers, relatives or advocates. To support informed choice for the patient, care planning will include information given regarding Chemical Restraint/Physical Intervention. Ensuring that patients understand the main side effect of the medications recommended in this policy where appropriate will form part of the documented care planning.

Care planning will include:

- The assessment of the triggers and causes of a person's challenging behaviour, whether these are environmental, physical or psychological
- The treatment and management strategies to address the causes of the challenging behaviour
- The prevention of the harmful behaviours by recognizing the triggers to them and the behavioural modification strategies such as de-escalation, verbal persuasion, distraction and diversion
- Encouraging patients to recognize their own triggers and early warning signs of violence and aggression and other vulnerabilities, and to discuss and negotiate their wishes should they become agitated
- Taking into account any previous violent or aggressive episodes, because these are associated with an increased risk of future violence and aggression
- Restrictive interventions that have worked effectively in the past, when they are most likely to be necessary, and how potential harm or discomfort can be minimised
- The management plan when or if the person's behaviour does escalate to a point where they place either themselves or others at significant risk of harm
    - This could include the use of restrictive interventions if deemed necessary
    - If restrictive interventions are deemed necessary, then the reasons for this, and when, and how it will be implemented, will be clearly documented in the patient's medical notes.
- Individual risk factors which suggest a person is at increased risk of physical and/or emotional trauma will be taken into account when planning and applying restrictive interventions. For example, this would include recognizing that for a person with a history of traumatic sexual/physical abuse, any physical contact may carry an additional risk of causing added emotional trauma. Or for a person known to have muscular-skeletal problems, such as a curvature of the spine, some positions may carry a risk of injury

6.3 De-escalation Techniques

6.3.1 Distraction Techniques

Distraction techniques are a form of a coping skill and these techniques can be used to distract and draw attention away and help de-escalate any potential challenging behaviours. What may work for one patient may not work for another, so it is important to liaise with their care provider and/or friends and family to see what may work best for them. Examples of distraction

techniques can include music therapy, the use of memory boxes, animal assisted therapy, going for a walk round the ward/hospital, art therapy, crosswords and puzzles etc.

Intervention and de-escalation will be instigated early if it becomes clear that an aggressive episode of behaviour is likely to occur, and this will be individualised to the person concerned. These approaches will include and focus on negotiation, communication, use of staff body language and personal space. The overall aim will be to maintain safety at all times.

Where possible agitated patients should be separated from other patients (using quiet areas of the ward/area, comfort rooms, gardens or other available spaces) to aid de-escalation, ensure that staff do not become isolated.

6.3.2 Involving Relatives and/or Carers

Relatives and carers can provide a known and reassuring face to patients, and their presence can assist greatly in reducing their anxieties that may cause distress, aggression and violence. Consider calling the relative or carer to sit with the patient if they are becoming distressed, agitated and becoming either verbally or physically aggressive.

6.3.3 Environment

The patient's environment can include both the physical environment and the level and qualification of staff. Consideration will include how to manage the patient's environment or care setting to limit the potential for violent and/or aggressive behaviour. A noisy environment can cause increased anxiety and agitation in some patients. Similarly, frequent changes of ward or bed space can increase these levels.

6.3.4 Verbal/Non-Verbal Communication

Your body language and tone of voice can often prevent an aggressive situation from escalating. Talk in a firm but quiet, calm voice and do not hurry the person. Do not stand over the patient or keep your arms crossed as these actions imply threat or dominance.

6.4 Environmental Restrictive Interventions

Environmental restraint is where the design of the environment involves limiting a person's ability to move as they may wish. This may include preventing a patient from leaving the ward, keeping the ward locked, keeping the patient confined to a high observation bay, receiving 1:1 care, etc. Depending on the patient, their condition, and the circumstances, ward staff should consider applying for a Deprivation of Liberty Safeguards (DOLS). This is a legal framework which is only relevant to patients who lack capacity, to consent to being accommodated for the purpose of care and treatment that they are receiving in hospital and the care plan in place includes restrictions that amount to a deprivation of liberty. Ward staff must assess a patient's mental capacity to see if they are able to consent to being accommodated in hospital for care and treatment prior to considering a DOLS application. Ward staff can access further information and guidance and the DOLs Policy on the intranet.

If ward staff have reason to believe that a patient has a mental health disorder and the patient is making attempts to leave the ward, then staff must refer to the Trust policy: PR158: Patients Detained or Liable to be Detained under Section 5(2) of the Mental Health Act 1983 Policy and Guidance which can also be found on the intranet.

If a patient has mental capacity and is not subject to the Mental Health Act, then ward staff cannot legally detain a patient.

If a patient's behaviour indicates that they may require an enhanced level of care, ward staff must refer to the Trust Policy PR.170 – Care of Inpatient Adults at Increased Risk of Harm Requiring Enhanced Care Policy on the Trust intranet.

6.4.1 Mechanical Restrictive Interventions

Mechanical restriction is where a device is used to restrict a patient's movement. This may include the use of hand mittens to prevent a patient pulling out invasive lines, the use of bed rails to help a patient from falling out of bed, or the use of wheelchair lap belts or hoists. These may only be used in accordance with Trust Policies and Procedures. Safe use of Bed Rails Policy can be found on the Intranet.

If mechanical restrictions are to be used, and the patient lacks capacity to consent to these restraints (such as bed rails) then a capacity assessment must be competed and a best interests decision needs to be taken and clearly documented in nursing documentation. This can also be explained to any family/friends of the patient. If the patient has an appointed Power of Attorney for Health and Welfare, they must be consulted prior to any implementation being made, as they must be involved in any decision making process.

6.4.2 Physical Restraint

Consideration will be given to the cause of aggressive or violent behaviour which, if treated could reverse this behaviour e.g. oxygen when hypoxic, pain relief when in pain. Consider the triggers for violent and aggressive behaviour in APPENDIX A. Such specific treatment should be implemented as a priority to prevent restrictive interventions being needed. The content of this section (6.4.2) is not suitable for community settings.

Physical restraint should only be used when all other therapies have failed and as a last resort.

- In all wards/clinical departments where the use of restraint is foreseeable there will be a cardiac arrest trolley available

- Allocate responsibility to an identified senior member of staff to co-ordinate the incident. Important qualities include familiarity with the person, ability to use clear, direct and uncomplicated communication throughout the procedure, and knowledge of any risks associated with physical restraint

- Allocate responsibility to an appropriately qualified member of staff to support the restrained person during and after the treatment

- Ensure that all members of staff that will be involved in the physical restraint have had the relevant training. Each person involved in physical restraint will be given a role by the staff member that is co-ordinating the incident.

- An appropriate care plan must be devised by the clinician in charge and the nursing staff, which must address the method of physical intervention to be used, when and for how long for and any other treatments must be clearly documented. If emergency restraint is required, then this must also be documented accordingly post incident.

Implementation of Physical Interventions/Restraints

Any staff using physical restrictive interventions will:

- Wherever possible use de-escalation techniques irrespective of the stage of the restraint

- Ensure that the patient's human rights are respected

- Never restrain a person in a prone/face down position on any surface, not just the floor
- Ensure that one member of staff leads the team and assumes control of the person being restrained throughout the process. He or she will ensure that the restrained person's head and neck is appropriately supported, protected and the airway and breathing are not compromised
- Monitor the person's airway and physical condition throughout the physical restraint to minimize the potential of harm or injury
- Communicate with the person throughout any period of physical restraint, in order to continually attempt to reassure the person throughout procedure or to de-escalate the situation
- For safety reasons, only hold / apply pressure to the person's limbs. Under no circumstances will direct pressure be applied to the neck, thorax, abdomen, back or pelvic area
- Avoid prolonged physical intervention / immobilization, it must be necessary and proportionate to a specific situation, and will be applied for the minimum possible amount of time
- Use skills and techniques that do not cause the application of pain
- Ensure that the level of force applied will be reasonable, necessary and proportionate to a specific situation, and will be applied for the minimum possible amount of time
- Post-restraint, ensure the person who has been restrained is appropriately observed for a period of up to 24 hours. During this time physical observations will be recorded appropriately and the observing nurse be fully aware of the possibility of restraint/positional asphyxia (see APPENDIX B for more information).

Physical and Psychological Monitoring

Any person subject to physical interventions, will need to be appropriately observed for a period of up to 24 hours. During this time physical observations must be recorded and the observing nurse must be fully aware of the possibility of restraint/positional asphyxia. The monitoring required and the frequency will be dictated by the patient's condition, and this must be decided and clearly documented by staff involved in the physical restraint.

This is especially important:

- Following a prolonged or violent struggle
- If the person has been subject to enforced medication or rapid tranquilisation
- If the person is suspected to be under the influence of alcohol or elicit substances
- If the person has a known medical condition which may inhibit cardio-pulmonary function e.g. obesity (when face down), asthma, heart disease.

If the person's physical condition and/or their expressions of distress give rise to concern, the restraint must stop immediately. Ward staff must be familiar with the Trust Policy PR.122. Identification and Intervention required for the Deteriorating Patient Policy and escalate any concerns to medical staff as appropriate.

The checks will include:

- Care in the recovery position where appropriate
- Pulse, blood pressure, respiration, oxygen saturations (including if the patient is requiring oxygen) temperature and consciousness level (AVPU).
- Fluid and food intake and output

If consent and co-operation for these observations is not forthcoming, then it should be clearly documented in their medical records why these observations could not be performed and what alternatives have taken place.

If there are any concerns regarding physical health, or if the patient is over sedated, asleep or unarousable then physical observations as above should be recorded every 15 minutes and an urgent medical requested by the nursing staff carrying out these observations.

6.4.3 Clinical Holding

Clinical holding can be defined as a proactive holding of a part of the body to allow a procedure to take place, for example holding an arm while blood is being taken in order to prevent reflex withdrawal and consequent unnecessary pain, distress or injury to the patient, staff or accompanying persons.

Clinical holding should only be used in connection with the care and treatment in the best interests of patients who lack capacity.

The use of clinical holding must be:

- The last resort after using other methods of achieving agreement to care and treatment, including person-centred approaches and attempts at de-escalation
- Must be reasonable and proportionate to the act in connected to the care and treatment
- Must be undertaken in the least restrictive manner possible and for the shortest amount of time possible
- Must be undertaken in a way which minimizes injury and avoids pain and distress for the patient
- Undertaken in a manner which preserves as much dignity for the patient as possible
- Staff must establish if the patient has an Advanced Statement to refuse treatment in place prior to any procedures being carried out. If the patient has an appointed Power of Attorney for Health and Welfare, they must be consulted prior to any implementation being made, as they must be involved in any decision making process

6.4.4 Rapid Tranquilisation/Chemical Restraint/Covert Medications

Chemical restraint can be defined as the use of medications that are 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.

Chemical restraint will be used only for a person who is highly agitated, overactive or aggressive, is making serious threats or gestures towards others, is being destructive to their surroundings or when other therapeutic interventions have failed to manage the behaviour.

If rapid tranquilisation is required then staff must refer to PR.171 – Rapid Tranquilisation Policy for Adult Patients Displaying Acutely Disturbed or Violent Behaviour for further guidance on the procedure. Rapid tranquilisation is not suitable in community settings.

In some circumstances medications can be given covertly. This means that medicines are deliberately disguised, usually in food or drink so that the patient doesn't know that they are taking it. There is therefore an element of deception in this act, so therefore should only be considered in exceptional circumstances, as a last resort, and once certain legal requirements have been satisfied. If medicines are being considered to be administered covertly, staff must refer to the PR.151 Covert Administration of Medicines Policy and Guidelines (found on the intranet) which covers the legal requirements for that process.

6.5 Record Keeping

Any incident of challenging behaviour that has required restrictive interventions to be applied, must be documented in the patient's medical records and reported as an incident using the DATIX incident reporting system by an allocated member of staff that was involved with the incident.

6.6 Post Incident Reviews

Following an incident whereby restrictive interventions have been deployed it is best practice to undertake a post incident review.

The aims of post incident reviews are to:

- Evaluate the physical and emotional impact on all individuals involved (including any witnesses)
- Identify if there is a need for, and if so, provide counselling or support for any trauma that might have resulted
- Help people who use services and staff to identify what led to the incident and what could have been done differently
- Determine whether alternatives, including less restrictive interventions, were considered
- Determine whether service barriers or constraints make it difficult to avoid the same course of actions in the future
- Where appropriate, recommend changes to the service's philosophy, policies, care environment, treatment approaches, staff education and training
- Where appropriate avoid a similar incident happening on another occasion

Whenever a restrictive intervention has been used, staff and people will have separate opportunities to reflect on what happened. People with cognitive and/or communication impairments may need to be helped to engage in this process. People who use services will not be compelled to take part in post incident reviews. They will be told of their right to talk about the incident with an Independent Advocate (which may include an Independent Mental Health Advocate or Independent Mental Capacity Advocate), family member or another representative.

Immediate or post incident reviews will:

- Acknowledge the emotional responses to the event
- Promote relaxation and feelings of safety
- Facilitate a return to normal patterns of activity
- Ensure that all appropriate parties have been informed of the event
- Ensure that necessary documentation has been completed
- Begin to consider whether there is a specific need for emotional support in response to any trauma that has been suffered

In more serious incidents a more in depth review process, typically the next day, will be considered. Reviews will be in a blame free context. The aim being to understand from the person's point of view how the service failed to understand what they needed, what upset them and how things could be done better next time. See Trust Incident Management Policy (HS.05 WVT Incident Management Policy).

The Care Team together with the person, their families and advocates will consider whether behaviour support plans or other aspects of individual care plans need to be revised / updated in response to the post incident review. Any organizational factors such as the need for policy reviews, environmental modifications, staffing reviews or training needs will be formally recorded and reported.

6.7 When to Call Porter/the Police/Emergency Situations

6.7.1 Porter Assistance

The Trust has a duty under the Health and Safety at Work Act 1974 to provide a safe and secure environment for its staff, patients and visitors.

A situation may be identified by the clinician as an emergency if:

- The patient is at risk of causing imminent serious harm to themselves or others. If you have an honestly held belief that you, the patient or another person(s) are in imminent danger, physical restraint can be lawfully used with the patient or:
- If the patient is subject to a Deprivation of Liberty Safeguards (DOLS) or detained under the Mental Health Act and despite planned restrictions is trying to leave trust premises or refusing emergency care and treatment. Preventing a patient from leaving the hospital will ordinarily be in response to an emergency situation and will therefore be a short term measure. This must be followed up by a full assessment and plan for ongoing intervention.

Staff must call for assistance to inform of any potential threats to staff or patient safety or if staff are being threatened or attacked. Porters will remain on the ward/department until the patient has been managed appropriately and the lead clinician stands down the incident. Porters will always respond to all matters of security and will assist the clinical teams; the incident is led by the clinical staff. Porters have received security and incident training, the use of safe, lawful restraint techniques. Porters who have attended this training will wear a specific uniform that identifies them as having the training – they will also where a stab vest when applicable. WVT clinical staff have clinical responsibility for the patient at all times. .

CONTACT DETAILS FOR SECURITY INCIDENT SUPPORT:

Ext: 2222 – Provide the following details to the switchboard "SECURITY INCIDENT - IMMEDIATE ASSISTANCE REQUIRED (AND THE LOCATION OF THE INCIDENT)"

All 2222 emergencies are responded to by Porters within 5 minutes.

All incidents relating to physical intervention will be managed by the clinician.

All staff have a responsibility for:

- Assisting with patients who may require physical intervention
- Being competent to carry out physical interventions of patients when required
- Completing physical intervention training successfully
- Ensuring when carrying out physical interventions, that they take their lead from the clinician in charge
- Documenting all episodes of physical intervention through the Trust's Incident Reporting Process (HS.05 WVT incident Management Policy)

Careful consideration will be given to the degree of involvement by a porter and/or the police. Some patients' behaviour may deteriorate in the presence of a uniformed officer therefore it is appropriate in some circumstances that they maintain as low a profile as possible. The degree of intervention or interaction with the patient will be determined by the healthcare clinician and the police (if present). If the patient who has become violent or challenging and has come from a social care provider such a care home or supported living setting then the staff from that provider may be present (particularly if they have attended A&E). Staff can utilise the staff's knowledge and expertise when managing the patient's distress.

Following the initial incident i.e. when the lead clinician deems the situation safe, portering assistance and/or the police will not be detained in the ward or clinical area for observations/deterrent purposes.

6.7.2 The Police

The Police will attend the Trust when a crime has been committed or is currently being committed. The Porters at the County will always be called for assistance in the first instance for incidences occurring at Wye Valley NHS Trust. Police will attend, but may not be able to affect an arrest or take actions other than to help calm the situation where a patient lacks capacity, unless life is threatened.

When the Police arrive at the scene all relevant information, including the mental capacity of the patient at the time of the incident, will be provided to them so that they can determine the appropriate course of action.

In cases where a clinician determines that a patient requires urgent medical attention but is incapable of informed choice, the clinician may administer the appropriate treatment. Police officers requested to restrain an individual for the purposes of such treatment to prevent death or serious injury, may lawfully apply proportionate and use necessary force in order to assist. In such cases the Mental Capacity Act 2005 and the common law defence of necessity apply. Police will only restrain a patient when informed by a clinician that the individual is in need of urgent medical attention and is incapable of informed choice.

Details of the attending police officers, i.e. their name, collar number, the police station at which they are based and the action that they have taken will be recorded and added to the clinical incident report.

7 TRAINING

Physical Restrictive Intervention Training (de-escalation and management of incidents) is organised and delivered by the Midland Partnership Foundation Trust. This includes all aspects of physical interventions that might delivered which also includes breakaway techniques. When staff have been trained they will be expected to update/refresh every 3 years.

- During physical and chemical restraint there must be at least one member of staff involved in the process that is trained in Immediate Life Support (ILS), with other members of the team trained in Basic Life Support (BLS).
- All staff involved with restrictive interventions must be familiar with this policy and its place in the pathways for managing acute behavioural disturbance.
- All staff directly involved with physical restraint must have had the relevant restraint training.
- All staff must complete conflict resolution mandatory training and refresher training.
- Staff involved in the administration of intramuscular (IM) injections and Intravenous (IV) administration as part of chemical restraint must be competent and confident in administration in appropriate muscle sites that do not require the patient to be held in a prone or face-down position.
- Inpatient staff must be trained in skills to undertake a post-incident debrief.
- NICE guidance NG10 (www.nice.org.uk/guidnce/ng10) states that staff working in settings where restrictive interventions could be used must understand and be able to apply the Human Rights Act 1998, the Mental Capacity Act 2005, and the Mental Health Act 1983.

8 MONITORING COMPLIANCE WITH THIS DOCUMENT

The table below outlines the Trust's monitoring arrangements for this document.

Aspect of compliance or effectiveness being monitored	**Monitoring Method**	**Individual responsible for the monitoring**	**Frequency of the monitoring activity**	**Group/ committee which will receive the findings / monitoring report**	**Group / committee / individual responsible for ensuring that the actions are completed**
Datix incident report forms	Review of incident	Ward sister	As when incidents occur	Quality and Safety Committee	Quality and Safety Committee

9 REFERENCES/BIBLIOGRAPHY

- The Mental Capacity Act 2005
- National Institute for Health and Care Excellence (NICE) Guideline (NG10) Violence and: Short-term management in mental health, health and community settings https://www.nice.org.uk/guidance/ng10
- Positive and Proactive Care: Reducing the need for Restrictive Interventions: Department of Health (DoH) 2014
- Criminal Law Act 1967
- Human Rights Act 1998
- Health and Safety at Work Act 1974
- Mental Health Act 1983

10 RELATED TRUST POLICIES / PROCEDURES

- PR.168 Safe Use of Bed Rails Policy
- HSAB Deprivation of Liberty Safeguards Policy (DOLS) Policy 2015)
- HS.05 WVT Incident Management Policy
- HR.16 Statutory and Mandatory Training Policy
- PR.09 WVT Consent Policy
- PR.122 Identification and Intervention required for the deteriorating patient policy
- PR. 151 Covert Administration of Medicines Policy and Guidelines
- PR.158 Patients detained or liable to be detained under Section 5 (2) of the Mental Health Act 1983 Policy and Guidance
- PR.170 Care of inpatient Adults at Increased Risk of Harm Requiring Enhanced Care Policy
- PR.171 Rapid Tranquilisation Policy for Adult Patients Displaying Acutely Disturbed or Violent Behaviour

11 EQUALITY IMPACT ASSESSMENT

Please read EIA Guidance when completing this form.

Section 1

Name of Lead for Activity:	
Job Title:	Advanced Practitioner, MHA, MCA, DOLS

Details of individuals completing this assessment	Name	Job Title	Email Contact
		Advanced Practitioner, MHA, MCA, DOLS	
Date assessment completed		**30/12/2020**	

Section 2

Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.)	**Title: Restrictive Intervention Policy (Adults)**			
What is the aim, purpose and/or intended outcomes of this Activity?	To provide advice, support, and a framework for staff that may be required to use restrictive interventions.			
Who will be affected by the development & implementation of this activity?	X X ❑ ❑	Service User Patient Carers Visitors	X ❑ ❑ ❑	Staff Communities Other _____
Is this:	X Review of an existing activity ❑ New activity ❑ Planning to withdraw or reduce a service, activity or presence?			
What information and evidence have you reviewed to help inform this assessment? (Please name sources, e.g. demographic information for patients / services / staff groups affected, complaints etc.)	Other associated Trust Polices Mental Health Act 1983 Mental Capacity Act 2005			
Summary of engagement or consultation undertaken (e.g. who, and how, have you engaged with, or why do you believe this is not required)				
Summary of relevant findings				

Section 3

Please consider the potential impact of this activity (during development & implementation) on each of the equality groups outlined below. **Please tick one or more impact box below for each Equality Group and explain your rationale**. Please note it is possible for the potential impact to be both positive and negative within the same equality group and this should be recorded. Remember to consider the impact on e.g. staff, public, patients, carers etc. in these equality groups.

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Age	X			The implementation of this policy is to enable a standardised approach to care of all patients requiring RT.
Disability	X			
Gender Reassignment	X			
Marriage & Civil Partnerships	X			
Pregnancy & Maternity	X			
Race including Traveling Communities	X			
Religion & Belief	X			
Sex	X			
Sexual Orientation	X			
Other Vulnerable and Disadvantaged Groups (e.g. carers; care leavers; homeless; Social/Economic deprivation, travelling communities etc.)	X			
Health Inequalities (any preventable, unfair & unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental & economic conditions within societies)	X			

Section 4

What actions will you take to mitigate any potential negative impacts?			
Risk identified	**Actions required to reduce / eliminate negative impact**	**Who will lead on the action?**	**Time frame**

None identified			

How will you monitor these actions?
Not required.

When will you review this EIA? (e.g. in a service redesign, this EIA should be revisited regularly throughout the design & implementation)
At next review date

Section 5

Please read and agree to the following Equality Statement

Equality Statement

1.1. All public bodies have a statutory duty under the Equality Act 2010 to set out arrangements to assess and consult on how their policies and functions impact on the 9 protected characteristics: Age; Disability; Gender Reassignment; Marriage & Civil Partnership; Pregnancy & Maternity; Race; Religion & Belief; Sex; Sexual Orientation

1.2. WVT will challenge discrimination, promote equality, respect human rights, and aims to design and implement services, policies and measures that meet the diverse needs of our service, and population, ensuring that none are placed at a disadvantage over others.

1.3. All staff are expected to deliver services and provide services and care in a manner which respects the individuality of service users, patients, carers etc. and as such treat them and members of the workforce respectfully, paying due regard to the 9 protected characteristics

Signature of person completing EIA:	
Date signed:	30.12.2020
Comments:	
Signature of Lead for this activity:	

Date signed:	30.12.2020
Comments:	

APPENDIX A – Triggers to Violent and Aggressive Behaviour

Violent or aggressive behaviour can be an attempt at communicating an unmet need. This behaviour is usually 'triggered' by something. If you recognise a trigger that agitates or calms a person, it is important to communicate this to all staff caring for that person. There may not be any rational explanation for these triggers but, if they are recognised, they can help you manage and prevent violent and aggressive behaviour.

Understanding aggression

Aggression may be a defensive reaction to a threatening invasion of personal space. Aggressive resistance to care may result if the purpose is poorly communicated or understood and staff are not recognised

- An elderly lady would only let one particular nurse attend to her personal needs. The member of staff kept the lady calm by singing to her

Resistance may be an expression of need to assert choice and remain independent. Giving instructions to 'stop it' or act differently may provoke an aggressive response

- An elderly gentleman with dementia was quite happy when fed tea and toast and was allowed to sit next to the nursing station having previously been aggressive and found wandering at all times of the day and night.

Night time can be very traumatic, with shadows, loud noises and no recall of where the person is. It is important to try to manage triggers at all times if possible and acknowledge that feelings of disorientation may be heightened at night.

Abrupt or sudden approaches towards a person who is poorly sighted /hard of hearing as well as confused/frightened, may result in a hostile act of self-protection. Make sure you are in full view and give the patient a chance to recognize you. If something can be done later when the patient is more settled then defer.

Aggression may be linked to delusions – fixed false beliefs which cannot be reasoned with e.g. staff are trying to poison them/ other patients are out to kill them.

Blaming others may be the means by which the frightening implications of a deteriorating memory are denied.

An unexpected change of routine, a misplaced article or a name that cannot be recalled may result in an uncontrolled outburst of temper. Not knowing where you are, why you are there and the faces around you, cause distress. The person may respond by wanting to go home.

Wandering

Some people may repeatedly walk the same route. Their actions are not under voluntary control. Some may be looking for 'landmarks' that make sense. Agitated wandering occurring at dusk may be a desire to leave the ward; the person thinks it is time to 'go home' from work/school.

Curiosity and exploration may result in behaviours such as collecting items, fiddling with things and wandering. Trying to stop the person may result in frustration. Problems with perception, memory and understanding cause the once familiar to become mysterious.

‘Pottering with purpose’ may actually be a sign of contentment and may be reminiscent of work/hobbies. The person may feel isolated and alone walking around looking for a friendly, familiar face.

Noise making can be:

- A communication of pain or physical discomfort
- A response to unpleasant conditions e.g. being cold or uncomfortable
- A vocal confirmation of unmet needs e.g. toileting, hunger, thirst ‘help me’
- A stress reaction
- A response to hallucinations
- A result of under stimulation

Adopting a safe environment:

- Calm, well organized and familiar
- Adequate lighting to enable elderly patients to orientate themselves
- Family members should be invited to assist in the care
- Patient’s belongings such as photos, and other objects around them
- Regular and repeated visible and verbal clues to orientation e.g. time, calendar
- Reassurance and explanation to the patient and carer of any procedures or treatment, using short simple sentences
- Sensory aids should be available if possible. Some case studies mention toys, music etc. Inactivity can cause frustration and sensory deprivation may be compounded by poor vision/hearing
- Avoidance of inter and intra-ward transfers (inpatient areas only)
- Continuity of care from caring staff
- Maintenance or restoration of normal sleep patterns
- Approach and handle gently
- Eliminate unexpected and irritating noise (e.g. pump alarms)
- Ensure fluid balance and meeting nutritional needs
- Attend to bowel and bladder elimination
- Encouraging visits from familiar friends and relatives may help to calm an agitated patient.

Communication with the relative regarding the nature of the confusion is essential. Where relatives are asked to assist in the care of a disturbed or agitated patient, an explanation of why their involvement is necessary and how they can help will be given.

Wandering and Agitation

Patients who wander require close observation within a safe and reasonably closed environment. It is often preferable to try distracting the agitated wandering patient rather than using restraints or sedation. Relatives could be encouraged to assist in this kind of management. Attempts should be made to identify and remedy possible cause of agitation - e.g. pain, thirst, need for the toilet.

If serious agitation/ aggression is displayed that may threaten the safety of other patients removal to a side room may be necessary if possible.

Management of the patient presenting challenging behaviour is crucial in creating a safe environment. It is essential to:

- Know the patient
- Obtain information – past history/anecdotes from other carers
- Ensure information is disseminated - handover
- Recognise triggers
- Try different approaches to care – can something be done differently according to the individual's needs.

APPENDIX B – Positional Asphyxia and Excited Delirium

Physical restraint can lead to harm and even death. The person being restrained will have close observation by a member of medical or nursing staff including their airway, breathing and circulation at all times.

There are a number of potential adverse effects of the application of restraints. These include; being unable to breathe, feeling sick or vomiting, developing swelling to the face and neck, and the developments of petechiae (small blood-spots associated with asphyxiation) to the head, neck and chest.

Restraining an individual in a position that compromises the airway or expansion of the lungs (i.e. in the prone position) may seriously impair an individual's ability to breathe and can lead to asphyxiation. This includes pressure to the neck region, restriction of the chest wall and impairments of the diaphragm. When the head is forced below the level of the heart, drainage of the blood from the head is reduced and brain swelling can result. Swelling of the head and neck and bloodspots (petechiae) are signs of reduced drainage of blood from the head and neck. They are warning signs of actual or impending brain injury.

Pressure should not be placed on the neck, especially around the angle of the jaw or the windpipe. Pressure on the neck, particularly in the region below the angle of the jaw (carotid sinus) can disturb the nervous controls to the heart and lead to a sudden slowing or even stoppage of the heart.

This effect is most likely in persons:

- Who have had a heart attack or have angina
- With high blood pressure
- With diabetes
- Who are aged over 60

A degree of positional asphyxia can result from any restraint position in which there is restriction of the neck, chest wall or diaphragm.

This risk is increased where:

- The head is forced downwards towards the knees
- The subject is immobilised seated (the angle between the chest wall and the lower limbs is already decreased)
- The torso is compressed against or towards the thighs (restricts the diaphragm and compromises lung inflation)
- In the prone position where the body weight of the restrained person acts to restrict movement of the chest wall and the abdomen (restricting diaphragm movement)

Factors that predispose a person to positional asphyxia and sudden death under restraint include:

- Drug/alcohol intoxication (because sedative drugs and alcohol act to depress breathing so reducing oxygen taken into the body)

- Physical exhaustion (or any factors that increase the body's oxygen requirements, for example a physical struggle or anxiety)
- Obesity

Warning signs related to positional asphyxia:

- An individual struggling to breathe
- Complaining of being unable to breathe
- Evidence or report of an individual feeling sick or vomiting
- Swelling, redness or bloodspots to the face or neck
- Marked expansion of the veins in the neck
- Individual becoming limp or unresponsive
- Sudden changes in behaviour (both escalative and de-escalative)
- Loss of, or reduced levels of, consciousness
- Respiratory or cardiac arrest.

No person should be restrained face down (or in the case of a pregnant person, on her side) for longer than is absolutely necessary to gain control. There will be continuous observation of a person following relocation in the prone position until such time as the person is no longer lying face down (or in the case of a pregnant person, on her side).

Excited delirium

Excited delirium is both a mental state and physiological arousal. Excited delirium can be caused by drug intoxication (including alcohol) or psychiatric illness or a combination of both. 'Excited delirium' should not be confused with delirium that occurs commonly in frail elderly patients as the patient population, precipitants and management are different.

Differentiating someone in excited delirium from someone who is simply violent is often difficult. People suffering from excited delirium may:

- Have unexpected strength and endurance, apparently without fatigue
- Show an abnormal tolerance of pain
- Feel hot to touch.
- Be agitated
- Sweat profusely
- Be hostile
- Exhibit bizarre behaviour and speech

It may only become apparent that a person is suffering from excited delirium when they suddenly collapse: beware of sudden tranquillity after frenzied activity which may be caused by

severe exhaustion, asphyxia or drug related cardiopulmonary problems (problems with the heart and lungs)